

# HIGHMARK PROVIDER MANUAL

## A Procedural Guide for Professional and Facility Providers

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## DISCLAIMER

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### 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 BCBSH Inc. (Highmark Blue Cross Blue Shield Delaware) and Highmark West Virginia Inc. (Highmark Blue Cross Blue Shield West Virginia) (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 NEWSLETTERS/NOTICES 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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# 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 are in *Blue Italics*:** The most recent changes are presented in blue italic text to denote areas of revision or addition. The revision dates in the upper right corner of each page indicate the date those “blue” revisions were made to the unit.
- **Resource for all Highmark service areas:** Because the manual applies to all service areas in Pennsylvania, Delaware, and West Virginia, only the Highmark Blue Shield brand will be referenced. The icon for the [What Is My Service Area?](#) map can be found throughout the manual to help you determine the service area for your location.
- **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. A key to the state icons appears on the first page of each unit.
- **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 in the unit title. Also, you can look for the Facility Providers, Professional Providers, or All Provider Types icon on the first page of the unit.
- **Organized by Chapters/Units:** To make it easier to find answers, the manual is organized by chapters/units and a detailed list of topics is provided on the first page of each unit.
- **Tip Sheets:** The links for tip sheets are incorporated throughout the manual. By clicking on the links or Tip Sheet icons embedded in applicable sections, you can access printable desk references on various topics. All tip sheets are also available in one location – the **Tip Sheet Index** – that can be accessed from the **ADDITIONAL RESOURCES** box at the bottom of the manual home page.
- **Manual Archive:** The archive is also located in **ADDITIONAL RESOURCES** and contains the most recently “retired” version of each unit of the *Highmark Provider Manual*. Earlier versions of units are available upon request; email requests can be directed to the [Highmark Provider Manual Editor](#).
- **Can’t find the information you need?** All chapters/units of the manual are available in a single PDF document that can be accessed from the **ADDITIONAL RESOURCES** box – click on the dropdown arrow, and then select **View Entire Manual**. Click on the magnifying glass on the top left, enter your key word in the search box, and then use the back and forth arrows next to search box to locate all instances where your key word is referenced.
- **Intended to be an online resource:** Keeping the manual electronic allows us to provide you with the most up-to-date information. All revisions to this manual are controlled electronically. Paper copies and screen prints are considered uncontrolled and may not be the most recent revision.

**e-Subscribe** You can receive monthly email notifications of updates to the *Highmark Provider Manual* with **e-Subscribe**. To sign up for e-Subscribe, select **NEWSLETTERS/NOTICES** from the main menu on the Provider Resource Center, and then **E-Subscribe For Publications And Notifications**.

**We welcome your feedback in order to make the manual as helpful to you as possible.**

If you would like to comment on or make suggestions for additional improvements to the *Highmark Provider Manual*, please email your comments to [HPMeditor@highmark.com](mailto:HPMeditor@highmark.com). Please include your name and phone number for the manual editor to contact you, if necessary.





## QUICK REFERENCE

### HIGHMARK PROVIDER SERVICE CENTERS

Please use NaviNet® for all of your routine eligibility, benefit, and claim inquiries.  
For non-routine inquiries that require analysis and/or research, contact Highmark's Provider Services.

[What Is My Service Area?](#)

#### PENNSYLVANIA:

- Western Region: Professional Providers **1-800-547-3627**; Facilities **1-800-242-0514**
- Central & Northeastern Regions: Professional Providers **1-866-731-8080** ; Facilities **1-866-803-3708**
- Medicare Advantage:
  - o Freedom Blue PPO: **1-866-588-6967**
  - o Community Blue Medicare HMO: **1-888-234-5374**
  - o Community Blue Medicare PPO and Plus PPO: **1-866-588-6967**
  - o Security Blue HMO (Western Region only): **1-866-517-8585**
- Behavioral Health:
  - o Western & Northeastern Regions: **1-800-258-9808**
  - o Central Region: **1-800-628-0816**

#### DELAWARE:

- Highmark Delaware Provider Services: **1-800-346-6262**
- Behavioral Health: **1-800-421-4577**

#### WEST VIRGINIA:

- Highmark West Virginia Medical and Behavioral Health: **1-800-543-7822**
- Medicare Advantage Freedom Blue PPO: **1-888-459-4020**

**Please listen carefully to the available options to reach the appropriate area for your inquiry.**

**Hours of Availability:** 8 a.m. to 5 p.m. Monday through Friday

### HIGHMARK CLINICAL SERVICES

NaviNet® is the preferred for authorization requests. Contact Clinical Services for inquiries that cannot be handled via NaviNet.® **Hours of Availability:** Monday-Friday 8:30 a.m.-7 p.m.; Saturday & Sunday 8:30 a.m.-4:30 p.m. for urgent issues.

#### PENNSYLVANIA:

- Western Region:
  - o Medical Services: Professional Providers **1-800-547-3627**; Facilities **1-800-242-0514**
  - o Behavioral Health: **1-800-258-9808**
- Central Region:
  - o Medical Services: Professional Providers **1-866-731-8080**; Facilities **1-866-803-3708**
  - o Behavioral Health: **1-800-628-0816**
- Northeastern Region: Medical Services **1-800-452-8507**; Behavioral Health **1-800-258-9808**

**DELAWARE:** Medical Services **1-800-572-2872**; Behavioral Health **1-800-421-4577**

#### WEST VIRGINIA:

- Highmark West Virginia Products for Medical and Behavioral Health Services : **1-800-344-5245**
- Medicare Advantage Freedom Blue PPO: **1-800-269-6389**

**Please see the *Highmark Provider Manual's* [Chapter 1.2](#) for additional contact information.**



# CHAPTER 1: GENERAL INFORMATION

## UNIT 1: INTRODUCTION

### IN THIS UNIT



| TOPIC                                     | SEE PAGE |
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| How to Use This Manual                    | 4        |
| About Highmark                            | 7        |
| Highmark Works With Health Care Providers | 8        |

[What Is My Service Area?](#)

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The **PA ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The **DE ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

## 1.1 MANUAL PURPOSE AND HISTORY

### Purpose

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 Pennsylvania, Delaware, 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

### Who should use this manual?

The *Highmark Provider Manual* is applicable to all providers 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.

[What Is My Service Area?](#)

### Manual history

The online *Highmark Provider Manual* was first published in 2018, replacing the *Highmark Blue Shield Office Manual* (for professional providers) and the *Highmark Facility Manual* (for facility/organizational provider types).

The consolidation simplified and improved the experience for providers by providing one comprehensive resource for all providers participating in Highmark's provider networks in all service areas in Pennsylvania, Delaware, and West Virginia. This online manual replaces and supercedes any predecessor provider manuals previously used in any of Highmark's service areas.

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## 1.1 MANUAL PURPOSE AND HISTORY, Continued

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### Disclaimer

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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 NEWSLETTERS/NOTICES 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

### Introduction

The *Highmark Provider Manual* contains helpful information and resources to assist you in your daily interactions with Highmark members and with Highmark.

The *Highmark Provider Manual* is intended to be an online resource -- keeping the manual electronic helps us to provide you with the most up-to-date information. All revisions to this manual are controlled electronically; paper copies and screen prints are considered uncontrolled and may not be the most recent version.

### The Highmark Brand

Because this manual combines information for all Highmark service areas in Pennsylvania, Delaware, and West Virginia, you will only see a reference to the Highmark Blue Shield brand.

Where business applies to a particular service area only, it will be noted as such (see key below), or the information will be broken out into a separate link. If you are uncertain of your service area, please click the **What Is My Service Area?** icon, which is located throughout the manual, to access a map identifying our service areas.

[What Is My Service Area?](#)

### State symbol key



The key to the state symbols is provided on the topic page of each unit of the manual. The symbols will be used if the information within the block applies to just one or two states in Highmark's service areas. You'll see the symbol(s) after the block title to the left of the block of information, as illustrated to the left in the title of this block.

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The PA ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The DE ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The WV ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

### Organized by topic within chapters/units

The *Highmark Provider Manual* is organized by topic to make it easier for you to find answers. The six chapters identify the broader main topics, and each chapter is further divided into units on more specific topics. The first page of each unit provides a detailed topic menu of the sections within the unit.

*Continued on next page*

## 1.1 HOW TO USE THIS MANUAL, Continued

### Revision dates and blue italic text

The most recent changes in the manual are presented in blue italic text to denote areas of revision or addition. This visually attractive format works in conjunction with revision dates in the upper right corner of each page of a unit. This style is designed to help you identify new and updated information more quickly.

The **Why blue italics?** icon is located throughout the manual wherever blue italic text appears. You can click on the link in the icon for an explanation of the blue italic text as well as additional helpful tips for getting the most from the *Highmark Provider Manual*. This document can also be accessed from **ADDITIONAL RESOURCES** at the bottom of the manual's home page – select **How to Use This Manual**.

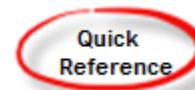


[Why blue italics?](#)

### Quick Reference

The [Quick Reference](#) is available at the top of the manual home page for easy access to a one-page printable document with the most frequently used telephone numbers for contacting Highmark in all service areas – the Provider Service Center and Highmark Clinical Services.

And the **Quick Reference** icon is placed in key locations throughout the manual to provide easy access to phone numbers for the Provider Service Center and Highmark Clinical Services when exploring the manual for information.



### Tip sheets

Printable “tip sheets” are featured throughout the *Highmark Provider Manual*. Tip sheets have been developed for information that may be referenced regularly for which a printed version may be helpful. The tip sheet icon will appear on pages where a related tip sheet is available. You can click on the icons for direct access to these printable reference documents.



**TIP SHEET**

All tip sheets available throughout the manual are also available in one location -- the **Tip Sheet Index**, accessible from **ADDITIONAL RESOURCES** located at the bottom of the manual home page.

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## 1.1 HOW TO USE THIS MANUAL, Continued

### Additional Resources

The access to **ADDITIONAL RESOURCES** is located by scrolling down to the bottom of the manual's home page:



Click on the dropdown arrow for access to the following:

- **Appendix:** Provides additional content relevant to specific chapters/units of the manual.
- **Contact Manual Editor:** Click on this selection to create an email to send your comments and suggestions about the manual to the *Highmark Provider Manual*'s editor at [HPMeditor@highmark.com](mailto:HPMeditor@highmark.com).
- **Disclaimer:** Disclaimer related to the use of the *Highmark Provider Manual*.
- **Glossary of Terms and Acronyms:** Includes definitions for terms and acronyms commonly used by Highmark, in health care, or in the manual.
- **How to Use This Manual:** This tip sheet explains the reason for the blue italic text and provides additional helpful tips for using the manual.
- **Manual Archive:** The most recently "retired" version of each unit of the manual is housed here.
- **Tip Sheet Index:** All of the manual's tip sheets are available here in one location for easy access.
- **View Entire Manual:** This selection opens to a PDF that combines all units of the manual into one document, which allows you to easily search the entire manual by keyword.

### How to provide feedback

**This manual is intended to be a key source of information for all of our participating providers and we welcome your feedback in order to provide the information you need.** To ensure this manual continues to fulfill its objective, Highmark is interested in hearing comments from users. If you would like to comment or recommend additions or enhancements to the *Highmark Provider Manual*, please contact us. Email your comments to:

[HPMeditor@highmark.com](mailto:HPMeditor@highmark.com)

Please include your name and telephone number for the manual's editor to contact you, if necessary, to clarify your recommendations.

As indicated above, the link to email the editor is also available from **ADDITIONAL RESOURCES** at the bottom of the manual's home page.

## 1.1 ABOUT HIGHMARK

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### A brief history of 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 Pennsylvania, Delaware, and West Virginia that serve five million members as well as hundreds of thousands additional Blue Plan members through the BlueCard® program:

- **Highmark Blue Cross Blue Shield** provides integrated Blue Cross and Blue Shield coverage throughout the 42 counties of western, north central, and northeastern Pennsylvania.
- **Highmark Blue Shield** serves the 21 counties of central Pennsylvania and the Lehigh Valley as a full-service health plan. As a partner in joint operating agreements, Highmark Blue Shield also services in conjunction with Independence Blue Cross in southeastern Pennsylvania.
- **Highmark Blue Cross Blue Shield West Virginia** serves the entire state of West Virginia plus Washington County, Ohio.
- **Highmark Blue Cross Blue Shield Delaware** serves the entire state of Delaware.

[What Is My Service Area?](#)

### Highmark Health

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

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### **An ongoing commitment to 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 electronically through websites like NaviNet®;
  - 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.
- 

### **Physicians involved in governance and policy decisions**

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.

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### **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.

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### **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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# CHAPTER 1: GENERAL INFORMATION

## UNIT 2: ONLINE RESOURCES & CONTACT INFORMATION

### IN THIS UNIT



| TOPIC                              | SEE PAGE |
|------------------------------------|----------|
| Variety of Informational Resources | 2        |
| Highmark Websites                  | 3        |
| Highmark Provider Directory        | 5        |
| Provider Resource Centers          | 6        |
| Provider Newsletters               | 10       |
| Special Bulletins and Mailings     | 12       |
| e-Subscribe                        | 13       |
| Provider Service Center            | 14       |
| Contact Information                | 16       |
| Mailing Addresses                  | 21       |

[What Is My Service Area?](#)

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



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The DE ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The WV ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

## 1.2 VARIETY OF INFORMATIONAL RESOURCES

[What Is My Service Area?](#)

### Overview of online resources for providers

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.

A variety of informational sources are available for use including:

|                                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Highmark's Informational Public Websites:</b>                                                                                           |
| • <a href="#">HighmarkHealth.org</a>                                                                                                       |
| • <a href="#">Highmark.com</a>                                                                                                             |
| • <a href="#">Highmark Blue Shield</a> (for Pennsylvania's Central & Northeastern Regions)                                                 |
| • <a href="#">Highmark Blue Cross Blue Shield</a> (Pennsylvania Western Region)                                                            |
| • <a href="#">Highmark Blue Cross Blue Shield Delaware</a>                                                                                 |
| • <a href="#">Highmark Blue Cross Blue Shield West Virginia</a>                                                                            |
| <b>HIGHMARK'S PROVIDER RESOURCE CENTERS for all Service Areas accessible from Highmark.com, our regional public websites, and NaviNet®</b> |
| • <a href="#">Pennsylvania Central, Eastern, and Northeastern Region Provider Resource Center</a>                                          |
| • <a href="#">Pennsylvania Western Region Provider Resource Center</a>                                                                     |
| • <a href="#">Highmark Delaware Provider Resource Center</a>                                                                               |
| • <a href="#">Highmark West Virginia Provider Resource Center</a>                                                                          |
| <b>Newsletters for Professional and Facility Providers:</b>                                                                                |
| • <i>Provider News</i>                                                                                                                     |
| • <i>Medical Policy Update</i>                                                                                                             |
| <b>Additional Sources:</b>                                                                                                                 |
| • Plan Central Messages via the NaviNet® home page                                                                                         |
| • Hot Topics on the Provider Resource Center                                                                                               |
| • Special Bulletins and mailings                                                                                                           |
| • e-Subscribe electronic subscriptions                                                                                                     |
| • Provider Service Center                                                                                                                  |

## 1.2 HIGHMARK WEBSITES

### Overview

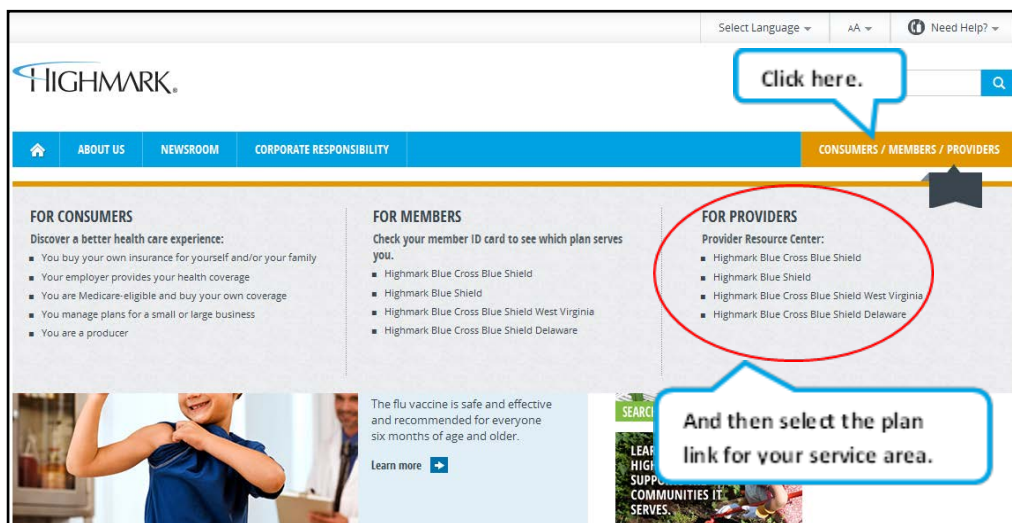
Highmark's informational public websites cover all core business and subsidiary companies. They provide a broad range of information to customers, health care professionals, and the public.

[What Is My Service Area?](#)

### Highmark.com

To learn about Highmark's history and access information about Highmark companies, subsidiaries, and affiliates, visit [highmark.com](http://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 websites for Highmark plans with service areas in Pennsylvania, Delaware, and West Virginia can also be accessed from [highmark.com](http://highmark.com).

Access to the Provider Resource Centers for all service areas is also available at [highmark.com](http://highmark.com). Click on the **CONSUMERS/MEMBERS/ PROVIDERS** button.



### Highmark's public websites

The public websites for Highmark Inc. service areas in Pennsylvania, Delaware, and West Virginia are as follows:

- [highmarkbcbs.com](http://highmarkbcbs.com) --serving the 29 counties of western Pennsylvania.
- [highmarkblueshield.com](http://highmarkblueshield.com) -- serving the 21 counties of central Pennsylvania and the Lehigh Valley and the 14 counties of northeastern Pennsylvania, as well as services offered in conjunction with Independence Blue Cross in southeastern Pennsylvania.
- [highmarkbcbsde.com](http://highmarkbcbsde.com) -- serving the three counties of Delaware.
- [highmarkbcbswv.com](http://highmarkbcbswv.com) -- serving the entire state of West Virginia and Washington County Ohio.

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## 1.2 HIGHMARK WEBSITES, Continued

### Highmark's public websites (continued)

These websites provide information specific to individuals, members, employers, producers, and providers living in these locations. You can also access the Provider Resource Center for your service area from these websites -- just scroll down to the **HELPFUL LINKS** box, and then click on **Provider Resource Center**.

### 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: **DISCOVER, SHOP, or MEDICARE**.

## 1.2 HIGHMARK PROVIDER DIRECTORY

### Overview

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.

### Striving to keep the Provider Directory updated!

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 in NaviNet® 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 through NaviNet. Select **Provider File Management** from the main menu on Highmark's Plan Central in NaviNet.

**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.

### Add your photo

**TIP SHEET**

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 NaviNet.® For complete instructions for uploading your photo, click on the **Tip Sheet** icon to the left.

### 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 directories, as determined by Highmark.

### FOR MORE INFORMATION

Please see [Chapter 3.3: Professional Requirements & Procedures](#) for additional details of CMS requirements and on reporting changes.

## 1.2 PROVIDER RESOURCE CENTERS

### Overview

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.

[What Is My Service Area?](#)

### Accessing the Provider Resource Center

The Provider Resource Center is available on our regional public websites – click on the **Provider Resource Center** link under **HELPFUL LINKS** on the home page.



Access to the Provider Resource Centers for all service areas is also available at [highmark.com](http://highmark.com). Click on the **CONSUMERS/MEMBERS/ PROVIDERS** button. And then select the link for the Highmark plan in your service area from the options under the **FOR PROVIDERS** heading (see image on page 3 of this unit).

You can click on the links below to directly access the Provider Resource Center applicable to your service area:

- [PA Central, Eastern, and Northeastern Region Provider Resource](#)
- [PA Western Region Provider Resource Center](#)
- [Delaware Provider Resource Center](#)
- [West Virginia Provider Resource Center](#)

For your convenience, the Provider Resource Center is also available to you in NaviNet.® Additional information not accessible on the public websites is available in the Provider Resource Center via your secure NaviNet logon.

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## 1.2 PROVIDER RESOURCE CENTERS, Continued

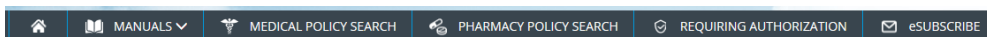
### PRC features

The Provider Resource Center (PRC) is designed to provide easy access to information and documents. See the descriptions below the image for details about each feature.



- 1 Message Center** All past "Important Provider Alert" messages will be posted here. See the next page for more about these alerts.

- 2 Quicklinks Bar** The Quicklinks Bar provides easy access to the information you use most. Click on the "home" symbol on the left to return to the PRC home page at any time.



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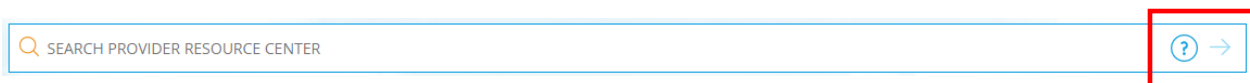
## 1.2 PROVIDER RESOURCE CENTERS, Continued

- 3 Important Provider Alerts** Important Provider Alerts will be displayed below the Quicklinks Bar. This feature will be used sparingly – but when an alert is displayed, it is important and requires your attention.

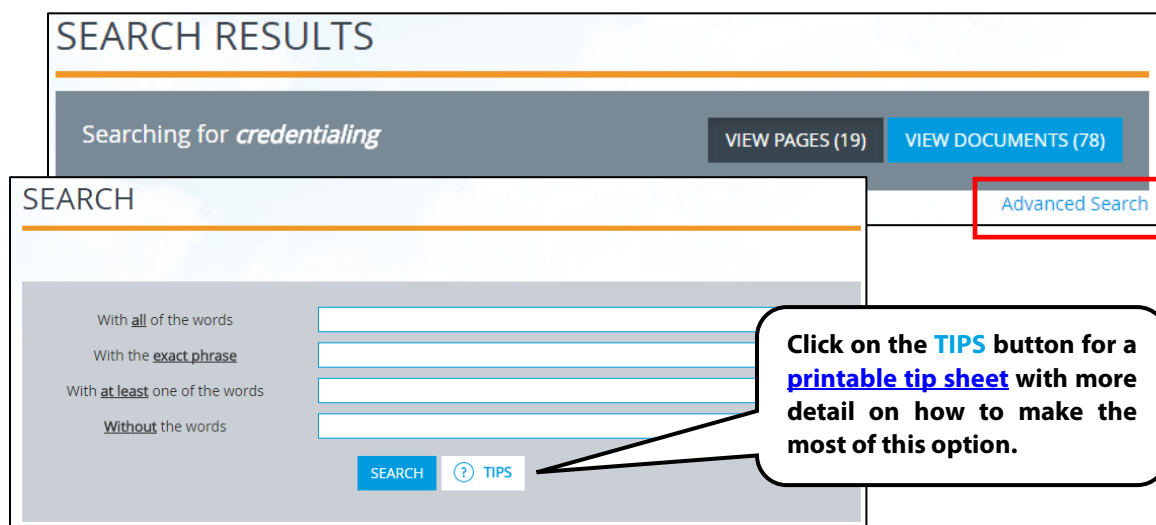
Once you have read and/or acted on the alert, you can click on the **X** and it will disappear. All past important alerts are available in the **Message Center**.



- 4 Search Bar** To search the entire PRC, enter a keyword in the search box, and then click on the blue arrow on the far right or hit Enter on your keyboard.



To display what you need quickly, search results are broken into two categories: Pages and Documents. The question mark in the search box and the Advanced Search option on the results page will take you to the advanced search feature.



- 5 Main left menu** The main menu includes nine general categories listed on the blue bars on the left. Click on a selection and it expands to display the options for related topics underneath. **Note:** Additional topics and options are available on the secure NaviNet PRC that are not available on the public site.

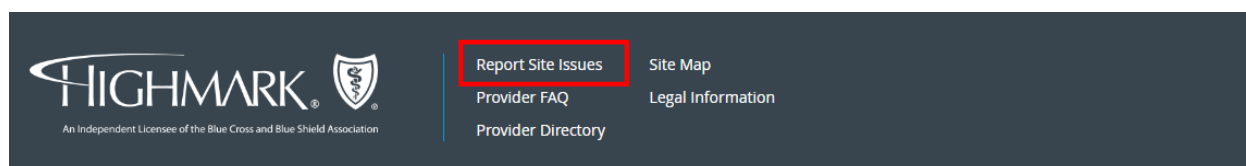
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## 1.2 PROVIDER RESOURCE CENTERS, Continued

- 
- 6 Center scrolling banner** The center section of the PRC home page is a rolling banner that we will use like a billboard to promote more general news or for quick reminders. The small orange circles at the bottom of the banner indicate how many messages are currently in the rotation. By clicking the left/right arrows or small circles, you can view each message. You can click on a message for more details about the message.
- 
- 7 Hot Topics** Hot Topics on the right side of the PRC home page displays announcements and news you need to know – such as Special Bulletin releases. Once the messages are removed from Hot Topics, they will always remain available in the Hot Topic Library, which is accessible by selecting **NEWSLETTERS/NOTICES** from the main menu on the left.
- 
- 8 More Quicklinks** At the bottom of the home page, three more **Quicklinks** buttons provide easy access to **Special Bulletins**, **Care Management Programs**, and information on **Value-Based Reimbursement Programs**.



- 
- 9 Footer** Links to additional information and functions are available in the PRC footer. If you identify a technical issue on the PRC, you can access an email function to report it by clicking on **Report Site Issues**.



- 
- What you can find on the PRC** The Provider Resource Center contains information including, but not limited to:
- Important announcements and updates
  - Current and archived newsletters
  - Medical policy
  - Clinical reference materials
  - Provider manuals
  - Forms
  - Reimbursement policies
  - Pharmacy/formulary information
  - Participation and credentialing information
  - And much more!
-

## 1.2 PROVIDER NEWSLETTERS

### Overview

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

### Provider News

*Provider News* is Highmark's bimonthly informational newsletter for health care professionals and facilities, and their office staffs, who participate in our networks and submit claims to Highmark using the 837P/837I HIPAA transactions or 1500/UB-04 claim forms.

*Provider News* contains the information that providers need to know to keep them informed of key developments at Highmark. In its six issues a year, this newsletter conveys important product and administrative news including billing, claims, and program updates. *Provider News* also offers tips and reminders, and it provides information about Highmark tools and resources. This publication may also contain administrative requirements, policies, procedures, or other similar requirements of Highmark that are binding upon Highmark and its contracted providers.

Current and past issues of *Provider News* are always available online under **NEWSLETTERS/NOTICES** on the Provider Resource Center. You can access the Provider Resource Center through NaviNet® or by selecting **Provider Resource Center** on the home page of Highmark's regional public websites (under **Helpful Links**).

### 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* under **NEWSLETTERS/NOTICES** on the Provider Resource Center.

*Continued on next page*

## 1.2 PROVIDER NEWSLETTERS, Continued

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### **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 under **NEWSLETTERS/NOTICES**. Current and past issues of *Provider News* and *Medical Policy Update* are always available on the Provider Resource Center.

**You may also sign up through e-Subscribe for electronic notification via email.** Please review the section later in this unit about signing up for our convenient e-Subscribe notification option.

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

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## 1.2 SPECIAL BULLETINS AND MAILINGS

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### Overview

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

Special mailings 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:

- *Special Bulletins* and *Special eBulletins*
- Letters
- Brochures
- Fact sheets
- Postcards
- Flyers included with checks and/or Explanation of Benefits

Because *Special Bulletins* and other mailings 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.

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### Distribution of Special Bulletins

*Special Bulletins* are printed and mailed to network providers in Pennsylvania and West Virginia. In Delaware, *Special Bulletins* are delivered to network providers via fax. *Special eBulletins* are published **electronically only** on the Provider Resource Center.

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### Also available online!

Our mailings and *Special Bulletins* can always be found on our Provider Resource Center. Select **NEWSLETTERS/NOTICES** from the main menu on the left, and then click on **Special Bulletins & Mailings**.

You can also access the Special Bulletins & Mailings page by clicking on the **SPECIAL BULLETINS** Quicklinks tab located at the bottom of the Provider Resource Center home page.

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## 1.2 E-SUBSCRIBE

### e-Subscribe overview

The **e-Subscribe** feature available 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.

Your e-Subscribe subscription provides you with electronic delivery of publications and communications specific to your provider type. Professional providers will receive prompt delivery of the latest *Provider News* and *Medical Policy Update* newsletters. In addition, you will receive monthly notifications of updates to the *Highmark Provider Manual*.

### Sign up now!

Sign up for e-Subscribe today to stay informed of the latest news at Highmark. To subscribe to receive free email notifications with newly released publications or information updates, select **NEWSLETTERS/NOTICES** on the Provider Resource Center, and then click on the **e-Subscribe for Publications and Notifications** link.

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@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.

### Publications always available online

Electronic copies of *Provider News*, *Medical Policy Update*, and *Special Bulletins* are always available under **NEWSLETTERS/NOTICES** on the Provider Resource Center through NaviNet® or via Highmark's public websites. Both current and past issues of all publications are available online for your convenience.

## 1.2 PROVIDER SERVICE CENTER

### Overview

Immediate answers to most inquiries can be found by using NaviNet® -- the preferred method for benefit and claim inquiries. For more complex issues or if NaviNet is unavailable, Provider Service Center representatives are available to answer questions and also provide information about Highmark programs.

[What Is My Service Area?](#)

### Contact information and availability

|                                                                                                                                                                                                                                                                                                                                               |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>PENNSYLVANIA WESTERN REGION:</b>                                                                                                                                                                                                                                                                                                           |  |
| Please contact the Provider Service Center as follows:                                                                                                                                                                                                                                                                                        |  |
| <ul style="list-style-type: none"> <li>Professional Providers: <b>1-800-547-3627</b></li> <li>Facility Providers: <b>1-800-242-0514</b></li> </ul>                                                                                                                                                                                            |  |
| Hours of operation are 8 a.m. to 5 p.m. EST, Monday through Friday.                                                                                                                                                                                                                                                                           |  |
| For Medicare Advantage, please use the following toll-free numbers:                                                                                                                                                                                                                                                                           |  |
| <ul style="list-style-type: none"> <li>Freedom Blue PPO: <b>1-866-588-6967</b></li> <li>Community Blue Medicare PPO: <b>1-866-588-6967</b></li> <li>Security Blue HMO (Western Region only): <b>1-866-517-8585</b></li> <li>Community Blue Medicare HMO: <b>1-888-234-5374</b></li> </ul>                                                     |  |
| <b>PENNSYLVANIA CENTRAL AND NORTHEASTERN REGIONS:</b>                                                                                                                                                                                                                                                                                         |  |
| Please contact the Provider Service Center as follows:                                                                                                                                                                                                                                                                                        |  |
| <ul style="list-style-type: none"> <li>Professional Providers: <b>1-866-731-8080</b></li> <li>Facility Providers: <b>1-866-803-3708</b></li> </ul>                                                                                                                                                                                            |  |
| Hours of operation are 8 a.m. to 5 p.m. EST, Monday through Friday.                                                                                                                                                                                                                                                                           |  |
| For Medicare Advantage, please use the following toll-free numbers:                                                                                                                                                                                                                                                                           |  |
| <ul style="list-style-type: none"> <li>Freedom Blue PPO: <b>1-866-588-6967</b></li> <li>Community Blue Medicare PPO/Plus PPO: <b>1-866-588-6967</b></li> <li>Community Blue Medicare HMO: <b>1-888-234-5374</b></li> </ul>                                                                                                                    |  |
| <b>PENNSYLVANIA EASTERN REGION:</b>                                                                                                                                                                                                                                                                                                           |  |
| Please contact the Provider Service department at <b>1-866-975-7290</b> .                                                                                                                                                                                                                                                                     |  |
| Hours of operation are 9 a.m. to 12 noon, and then from 1 p.m. to 4:30 p.m. EST, Monday through Friday.                                                                                                                                                                                                                                       |  |
| <b>DELAWARE:</b>                                                                                                                                                                                                                                                                                                                              |  |
| Please contact the Provider Service department at <b>1-800-346-6262</b> .                                                                                                                                                                                                                                                                     |  |
| Hours of operation are 8:30 a.m. to 5 p.m. EST, Monday through Friday.                                                                                                                                                                                                                                                                        |  |
| <b>WEST VIRGINIA:</b>                                                                                                                                                                                                                                                                                                                         |  |
| <ul style="list-style-type: none"> <li>Highmark West Virginia Provider Service: <b>1-800-543-7822</b><br/>Hours of operation are from 8 a.m. to 5 p.m. Monday through Friday</li> <li>Highmark Senior Solutions Company Medicare Advantage Freedom Blue PPO: <b>1-888-459-4020</b>. Hours: 8 a.m. to 8 p.m. Monday through Sunday.</li> </ul> |  |

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## 1.2 PROVIDER SERVICE CENTER, Continued

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**Before  
you call...**

When placing a call to Provider Services, 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.
-

## 1.2 CONTACT INFORMATION

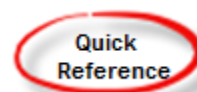
### Introduction

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

### Quick Reference

The [Quick Reference](#) is available at the top of the manual home page for easy access to a one-page printable document with the most frequently used telephone numbers for contacting Highmark – the Provider Service Center and Highmark Clinical Services.

And the **Quick Reference** icon is placed in key locations throughout the manual to provide easy access to phone numbers for the Provider Service Center and Highmark Clinical Services when exploring the manual for information.



### Contact information tip sheets

Please click on the applicable link below for a printable desk reference with complete Highmark contact information for your service area:

- [Highmark Contact Information for Pennsylvania Providers](#)
- [Highmark Delaware Contact Information for Providers](#)
- [Highmark West Virginia Contact Information for Providers](#)

[What Is My Service Area?](#)

### Authorization/precertification inquiries

NaviNet® is the preferred method for submitting authorization requests. Contact Highmark's Clinical Services for precertification/authorization inquiries that cannot be handled via NaviNet.

Please call the applicable number for your service area and/or provider type:

#### PENNSYLVANIA:

- Western Region:
  - o Professional Providers: **1-800-547-3627**
  - o Facilities: **1-800-242-0514**
- Central Region:
  - o Professional Providers: **1-866-731-8080**
  - o Facilities: **1-866-803-3708**
- Northeastern Region: **1-800-452-8507**

**DELAWARE: 1-800-572-2872**

**WEST VIRGINIA: 1-800-344-5245**

In Pennsylvania's Eastern Region, please call Independence Blue Cross at:  
**1-800-862-3648**

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## 1.2 CONTACT INFORMATION, Continued

### Behavioral health

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

- Pennsylvania:
  - o Western and Northeastern Regions: **1-800-258-9808**
  - o Central and Eastern Regions: **1-800-628-0816**
- Delaware: **1-800-421-4577**
- West Virginia: **1-800-344-5245**

Monday - Friday 8:30 a.m. to 7 p.m.; Saturday & Sunday 8:30 a.m. to 4:30 p.m.

### Baby Blueprints®

To enroll in this free maternity education and support program, expectant mothers can call: **1-866-918-5267**

[What Is My Service Area?](#)

### BlueCard® Eligibility

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

- NaviNet's Blue Exchange®
- BlueCard Eligibility telephone line: **1-800-676-BLUE** (2583)
- HIPAA 270/271 electronic transaction

### BlueCard® participation

BlueCard® participating physicians in other Blue Plan areas can be located by calling **1-800-810-BLUE** (2583), or online at <https://www.bcbs.com/>.

### Blues On Call<sup>SM</sup>

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:

**1-888-BLUE-428** (1-888-258-3428)

This phone number is available on the back of applicable Member ID cards.

### Caring Program



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: **1-866-823-0892**

*Continued on next page*

## 1.2 CONTACT INFORMATION, Continued

### Case management

The Highmark case management staff can be contacted by calling:

- Pennsylvania: **1-800-596-9443**
- Delaware: **1-800-572-2872**
- West Virginia: **1-800-344-5245**; for Medicare Advantage Freedom Blue PPO, please call **1-800-269-6389**

### 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 Customer Service Representative.

Quick  
Reference

### Council for Affordable Healthcare (CAQH)

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

- <https://proview.caqh.org>
- CAQH Help Desk: **1-888-599-1771**

### Electronic Data Interchange (EDI)

If you wish to begin to submit claims electronically or need assistance with electronic claims submission, contact the Highmark EDI Operations support line by calling **1-800-992-0246**.

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

- Pennsylvania: [highmark.com/edi](http://highmark.com/edi)
- Delaware: [highmark.com/bcbsde](http://highmark.com/bcbsde)
- West Virginia: [highmark.com/edi-wv](http://highmark.com/edi-wv)

[What Is My Service Area?](#)

### Federal Employee Program (FEP)

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

- Pennsylvania: **1-866-763-3608**
- Delaware: **1-800-721-8005**
- West Virginia: **1-800-535-5266**

**Hours:** Monday through Friday, 8:30 a.m. to 4 p.m. EST.

*Continued on next page*

## 1.2 CONTACT INFORMATION, Continued

### 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: 1-800-438-2478  
Fax: 717-302-2858

#### West Virginia:

614 Market Street  
P.O. Box 1948  
Parkersburg, WV 26102  
Phone: 800-788-5661  
Fax: 304-424-0331

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](#).

[What Is My Service Area?](#)

### Health Options



For information on Health Options, Highmark Delaware's managed care organization serving Delaware Medicaid recipients, please see the *Health Options Provider Manual*. The manual can be accessed from the Highmark Delaware Provider Resource Center main menu under **EDUCATION/MANUALS**, or from **MANUALS** on the **Quicklinks Bar**.

- Health Options Provider Services: **1-844-325-6252**
- Authorizations: **1-844-325-6254**
- Health Options website: <http://www.highmarkhealthoptions.com/>



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.

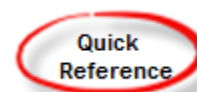
Highmark members and their families can reach a myCare Navigator health advocate by calling the following toll-free telephone number:

**1-888-BLUE-428** (1-888-258-3428)

This phone number is available on the back of applicable Member ID cards.

### National Imaging Associates (NIA)

NaviNet® is the preferred way to request prior authorization/notification for select advanced imaging services. If you do not yet have NaviNet®, you may contact National Imaging Associates (NIA) via the Highmark Provider Service Center phone number for your service area.



If questioning privileging applications, please call NIA at **1-888-972-9642**.

*Continued on next page*

## 1.2 CONTACT INFORMATION, Continued

### National Provider Identifier (NPI)

To obtain an NPI:

- Website <https://nppes.cms.hhs.gov>, or
- Phone: **1-800-465-3203** (TTY: 1-800-692-2326)

### NaviNet® Customer Care

To speak directly to a live NaviNet® Customer Care representative, please call the following number: **1-888-482-8057**

**Hours:** Monday-Friday 8 a.m. to 11 p.m.; Saturdays 8 a.m. to 3 p.m.

### Spending Account inquiries

For spending account questions or issues in Pennsylvania and West Virginia, please call the dedicated Provider Spending Account Information Line at **1-800-652-9478**.

For spending account questions or issues in Delaware, please contact Provider Services at **1-800-346-6262**.

[What Is My Service Area?](#)

### Traditional Medicare

**Pennsylvania and Delaware:** Novitas Solutions, Inc.

- Website: [www.novitas-solutions.com](http://www.novitas-solutions.com)
- Medicare Part A & B Provider Inquiries: **1-877-235-8073** (TTY: 1-877-235-8051)
- Hours: Monday-Friday 8:00 a.m.-4:00 p.m. ET

**West Virginia:** Palmetto GBA

- Website: [www.palmettogba.com](http://www.palmettogba.com)
- Medicare Part A & B Inquiries: **1-855-696-0705** (TDD: 1-866-830-3188)
- Hours: Monday-Friday 8 a.m. – 4:30 p.m. ET

### West Virginia Family Health (WVFH)



For information on West Virginia Family Health, West Virginia's managed care organization serving West Virginia Medicaid recipients, please see the *West Virginia Family Health Provider Manual*. The manual can be accessed from the Highmark West Virginia Provider Resource Center main menu under **EDUCATION/MANUALS**, or from **MANUALS** on the Quicklinks Bar.

- West Virginia Family Health Provider Services: **1-855-412-8002**
- WVFH website: <http://www.wvfh.com/>

### 1099-MISC issues

If you have questions about Form 1099-MISC issues, please call **1-866-425-8275**, or send via email to [1099inquiry@highmark.com](mailto:1099inquiry@highmark.com).

## 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 NaviNet and Highmark Electronic Data Interchange (EDI).

If you need to submit claims to Highmark on paper, please click the appropriate link below for a list of Claim Filing Addresses in your service area.

- [Pennsylvania Western Region Claims Filing Addresses](#)
- [Pennsylvania Central, Eastern, & Northeastern Regions Claims Filing Addresses](#)
- [Delaware Claims Filing Addresses](#)
- [West Virginia Claims Filing Addresses](#)

If you are considering a move from paper claim submissions, please see the manual's [Chapter 1.3: Electronic Solutions -- EDI & NaviNet](#) and [Chapter 6.2: Electronic Claim Submission](#).

[What Is My Service Area?](#)

### 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 **FORMS** from the main menu.

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.

*Continued on next page*

## 1.2 MAILING ADDRESSES, Continued

### Premier Blue Shield allowances and UCR profile



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 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 NaviNet for those NaviNet-enabled offices.

[What Is My Service Area?](#)

### Pre-service reviews

| PENNSYLVANIA                                                                      | DELAWARE                                                                                                                        | WEST VIRGINIA                                                   |
|-----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| Highmark<br>120 Fifth Avenue Place<br>Suite P4301<br>Pittsburgh, PA<br>15222-3099 | Highmark Delaware<br>Medical Management<br>Pre-Service Reviews<br>P.O. Box 1991<br>Del Code 1-8-40<br>Wilmington, DE 19899-1991 | Highmark West Virginia<br>200 Tracy Way<br>Charleston, WV 25311 |

### Retrospective reviews

| PENNSYLVANIA                                                                 | DELAWARE                                                                                                                          | WEST VIRGINIA                                                       |
|------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|
| Highmark<br>Medical Review<br>P.O. Box 890392<br>Camp Hill, PA<br>17089-0392 | Highmark Delaware<br>Medical Management<br>Retrospective Reviews<br>P.O. Box 1991<br>Del Code 1-8-40<br>Wilmington, DE 19899-1991 | Highmark West Virginia<br>P.O. Box 1948<br>Parkersburg, WV<br>26102 |

*Continued on next page*



## 1.2 MAILING ADDRESSES, Continued

### 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<br>Attn: Cashier<br>P.O. Box 890150<br>Camp Hill, PA<br>17001-9774 | Highmark Delaware<br>Attention: Treasury<br>P.O. Box 1991<br>Wilmington, DE<br>19899-1991 | Highmark<br>Attn: Cashier<br>P.O. Box 890150<br>Camp Hill, PA<br>17001-9774 |

[What Is My Service Area?](#)

### Refund checks for all other overpayments

| PENNSYLVANIA                                                                | DELAWARE                                                                                  | WEST VIRGINIA                                                               |
|-----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| Highmark<br>Attn: Cashier<br>P.O. Box 898820<br>Camp Hill, PA<br>17089-0150 | Highmark Delaware<br>Attention: Treasury<br>P.O. Box 1991<br>Wilmington, DE<br>19899-1991 | Highmark<br>Attn: Cashier<br>P.O. Box 898820<br>Camp Hill, PA<br>17089-0150 |

## CHAPTER 1: GENERAL INFORMATION

### UNIT 3: ELECTRONIC SOLUTIONS – EDI & NAVINET

#### IN THIS UNIT



| TOPIC                                            | SEE PAGE |
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| Electronic Data Interchange (EDI)                | 5        |
| About Trading Partners                           | 7        |
| Getting Started With Electronic Claim Submission | 10       |
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[What Is My Service Area?](#)

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The PA ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The DE ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The WV ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

## 1.3 INTRODUCTION

### Overview

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 NaviNet®

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 and other insurers
- Convenient technical support through a toll-free hotline
- Information on getting started in electronic claims filing – including a list of vendors who can help you with the appropriate computer equipment and software. These vendors can also help you use your PC to automate other office processes.

In addition, Highmark makes NaviNet® available to all participating providers. NaviNet is an internet-based application for providers to streamline data exchanges between their offices and health insurance companies.

Through Highmark's NaviNet provider portal, providers are able to submit claims through the HIPAA-compliant claim submission function on NaviNet. This provider portal also allows providers to verify enrollment, eligibility, benefits, claim status, and much more.

## 1.3 HIGHMARK ELECTRONIC TRANSACTION REQUIREMENTS

### Overview

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 NaviNet, EFT, and paperless EOBs required for all participating providers

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

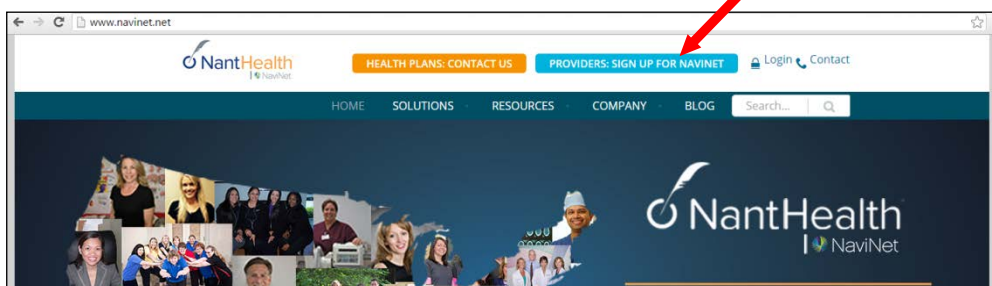
NaviNet is an easy online solution linking physician offices with Highmark and other health plans. NaviNet integrates all insurer-provider transactions into one system (e.g., eligibility and benefit inquiries, claim status inquiries, claim submission, authorization requests, etc.). This service is available 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 NaviNet --which is two days earlier than receiving them by mail.

### How to sign up for NaviNet

To sign up for NaviNet, you can call Highmark's Provider Service Center or go to [navinet.net](http://navinet.net), and then click on the **PROVIDERS: SIGN UP FOR NAVINET** button.



*Continued on next page*

## 1.3 HIGHMARK ELECTRONIC TRANSACTION REQUIREMENTS,

Continued

### Enrolling in EFT and paperless EOBs

After becoming NaviNet-enabled, providers must also enroll in electronic funds transfer (EFT) and paperless Explanation of Benefits (EOB) statements. This is done through the **EFT Attestation and Registration** transaction on NaviNet. To use this transaction, the practice's NaviNet Security Officer must enable the function for the EFT Responsible Party. Your NaviNet Security Officer is an employee of your practice or health system who has been assigned to serve as the primary contact with NaviNet.

The EFT Attestation and Registration transaction allows the person who is designated as the practice's "EFT Responsible Party" to electronically attest, register, and/or maintain banking information on behalf of the practice. Once you are enrolled and start receiving EFT payments, you will no longer receive paper EOB statements. You can view your electronic EOBs via NaviNet. To access EFT payment detail and EOBs, select the **AR Management** transaction from the Highmark Plan Central menu.

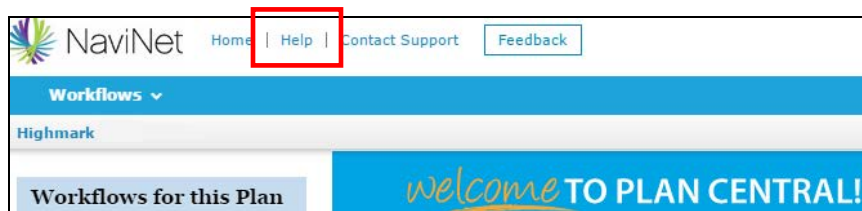
The printable PDF document, [EFT Attestation and Registration Guide](#), provides helpful instructions for using the EFT Attestation and Registration transaction. This document is available on the Provider Resource Center along with a video version. You can access these tools on the Provider Resource Center in your service area as follows:

- Pennsylvania: Select **Provider Training** from the main menu, and then click on **Provider Training**. The EFT tools are under the "NAVINET SELF SERVICE GUIDES" category.
- Delaware and West Virginia: Select **EDUCATION/MANUALS** from the main menu, and then **Provider Training**. The EFT tools are under the "NAVINET SELF SERVICE GUIDES" category.

[What Is My Service Area?](#)

### NaviNet support

NaviNet provides support for available transactions – just click on **Help** at the top of Highmark Plan Central to access NaviNet Support. Select the Highmark Health Plan for your location, and then click **Go**. You'll find a User Guide for EFT Attestation and Registration under the **Office & Provider Management** heading.



## 1.3 ELECTRONIC DATA INTERCHANGE (EDI)

### Overview

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.

Because of the 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                                          |
|----------------|-----------------------------------------------------------|
| <b>270/271</b> | Health Care Benefit Eligibility Inquiry and Response      |
| <b>276/277</b> | Health Care Claim Status Request and Response Transaction |
| <b>278</b>     | Health Care Services Review Request and Response          |
| <b>837I</b>    | Health Care Claim Institutional                           |
| <b>837P</b>    | Health Care Claim Professional                            |
| <b>835</b>     | Health Care Claim/Payment Advice                          |

*Continued on next page*

## 1.3 ELECTRONIC DATA INTERCHANGE (EDI), Continued

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### Highmark EDI Services (continued)

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: [highmark.com/edi](http://highmark.com/edi)
- Delaware: [highmark.com/bcbsde](http://highmark.com/bcbsde)
- West Virginia: [highmark.com/edi-wv](http://highmark.com/edi-wv)

The link to the EDI Services website is also available on the Provider Resource Center -- select **CLAIMS, PAYMENT & REIMBURSEMENT** from the main menu, and then **Electronic Data Interchange (EDI) Services**.

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[What Is My Service Area?](#)

## 1.3 ABOUT TRADING PARTNERS

### What is a trading partner?

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.

### The Trading Partner Agreement

Before a provider, clearinghouse, 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: [highmark.com/edi](http://highmark.com/edi)
- Delaware: [highmark.com/bcbsde](http://highmark.com/bcbsde)
- West Virginia: [highmark.com/edi-wv](http://highmark.com/edi-wv)

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### 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).

### EDI transaction application

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*.

*Continued on next page*



## 1.3 ABOUT TRADING PARTNERS, Continued

### EDI transaction application (continued)

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: [highmark.com/edi](http://highmark.com/edi)
- Delaware [highmark.com/bcbsde](http://highmark.com/bcbsde)
- West Virginia: [highmark.com/edi-wv](http://highmark.com/edi-wv)

[What Is My Service Area?](#)

### Trading Partner Profile

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

Changes to any of these 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.

[What Is My Service Area?](#)

### 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** from the Provider Resource Center main menu, or by clicking the applicable link below to access the site directly:

- Pennsylvania: [highmark.com/edi](http://highmark.com/edi)
- Delaware: [highmark.com/bcbsde](http://highmark.com/bcbsde)
- West Virginia: [highmark.com/edi-wv](http://highmark.com/edi-wv)

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## 1.3 ABOUT TRADING PARTNERS, Continued

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**Provider  
profile  
questions?**

If after visiting the EDI website you still have questions about your Trading Partner Profile, please call EDI Operations at **1-800-992-0246**.

---

## 1.3 GETTING STARTED WITH ELECTRONIC CLAIM SUBMISSION

### Making the transition from paper to EDI

Making the transition from the traditional, slow world of paper to electronic claims can be daunting. However, by choosing the right electronic data interchange (EDI) vendor or billing service, you will have professional help toward your goal of a more streamlined and efficient office.

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. Please click on the Tip Sheet icon for FAQs to help you get started with electronic claim submission.

**TIP SHEET**

### 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 vendor

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

- Do they offer electronic claims submission of Highmark Blue Shield 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?

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## 1.3 GETTING STARTED WITH ELECTRONIC CLAIM SUBMISSION,

Continued

### Selecting a practice management vendor (continued)

- 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?
- What hardware is included (PC configurations, modems, terminals)?
- Are you getting color monitors or black and white?
- Is the workstation a “dumb terminal” or a PC?
- 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 do they submit your claims to the carriers involved?
- What kind of tracking reports do they offer to their clients?
- Do they 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?

*Continued on next page*

## 1.3 GETTING STARTED WITH ELECTRONIC CLAIM SUBMISSION,

Continued

[What Is My Service Area?](#)

### Enrollment

If you will be submitting directly to any of the Highmark payers, enroll online 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](https://highmark.com/edi)
- Delaware: [highmark.com/bcbsde](https://highmark.com/bcbsde)
- West Virginia: [highmark.com/edi-wv](https://highmark.com/edi-wv)

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.

## 1.3 NAVINET AUTOMATED INQUIRIES AND TRANSACTIONS

---

### Overview

NaviNet® 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.

NaviNet gives users real-time access to Highmark's membership, claims, and provider and payment systems, making your job easier. NaviNet 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.

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

---

### NaviNet is the preferred tool for inquiries

NaviNet is the preferred Highmark tool for inquiring about member information. **NaviNet-enabled providers are expected to use this tool for all routine eligibility, benefit, and claim status inquiries. Practices must use NaviNet 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.

---

### Advantages of using NaviNet

NaviNet is an easy online solution that links physician offices with Highmark and other health plans. The benefits of using NaviNet's online service include:

- Eliminates waiting in a "call queue" (on hold).
  - Has no limit to the number of issues you can research online.
  - Presents information for all Highmark-supported product lines, including traditional indemnity, managed care, Medicare Advantage (PA and WV only), and the Federal Employee Program (FEP).
  - Presents the most current information on Highmark's systems. What you view on your screen is the same information Highmark staff views when they talk to you on the phone.
  - Has extended hours of availability:
    - Monday through Friday from 5 a.m. to 3 a.m.
    - Saturday from 5 a.m. to 11 p.m.
    - Sunday from 5 a.m. to 9 p.m.
- 

*Continued on next page*

## 1.3 NAVINET AUTOMATED INQUIRIES AND TRANSACTIONS,

Continued

### NaviNet Support: User Guides

If your staff requires training or a “refresher course” on how to use any of the NaviNet applications, please direct them to **NaviNet Support**. It is accessed by clicking on **Help** on the toolbar at the top of the screen on Highmark Plan Central.

A new window will then open for NaviNet Support. Under **Health Plans**, select the applicable Highmark option for your service area from the dropdown, and then click on the **Go** button. You will then be directed to NaviNet’s easy-to-use training modules called “User Guides.”

### NaviNet Support: FAQs and Case Management System

Before you contact NaviNet with a question, please see if it has been answered in NaviNet’s “Frequently Ask Questions.” You can find these FAQs by clicking on **Help** in NaviNet, and then selecting the **Contact Us** tab on the **NaviNet Support** page.

The best way to contact NaviNet is by opening a case. NaviNet’s case management system provides a central place for you to track any issues you may have with NaviNet. In the upper right corner of the NaviNet screen, click on the dropdown arrow next to **Welcome** and your name, and then select **My Account**. Once on the My Account page, select **Open a Case**.



### NaviNet Support: Live Customer Service

If you prefer to speak to a NaviNet Customer Service representative directly, live NaviNet Customer Service is available by calling:

**1-888-482-8057** (TDD/TTY: 1-800-480-1419)

Hours of availability are Monday through Friday from 8 a.m. to 11 p.m. ET and Saturday from 8 a.m. to 3 p.m. ET.

*Continued on next page*

## 1.3 NAVINET AUTOMATED INQUIRIES AND TRANSACTIONS,

Continued

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### **NaviNet Self Service Guides**

Highmark also provides guides for NaviNet users on the Provider Resource Center. These include guides to NaviNet basics and tips, a recorded webinar about the claims dashboard, and a webinar and guide for EFT registration and attestation.

To access these resources, select **Provider Training** from the main menu, and then **Provider Training** from the submenu.

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## 1.3 REAL-TIME CAPABILITIES

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### Overview

Highmark's real-time tools are available to all NaviNet®-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 Provider 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.

### NaviNet User Guides

User Guides are available in NaviNet for real-time estimate submission and claim submission. To access NaviNet User Guides for both professional and facility providers, select **Help** from the toolbar, click on the **Health Plan** tab, and then select the applicable Highmark option for your service area.

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## 1.3 REAL-TIME CAPABILITIES, Continued

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### 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.

To access the EDI website from the Provider Resource Center, select **CLAIMS, PAYMENT & REIMBURSEMENT** from the main menu, or click on the applicable link below to access the applicable site directly:

- Pennsylvania: [highmark.com/edi](http://highmark.com/edi)
- Delaware: [highmark.com/bcbsde](http://highmark.com/bcbsde)
- West Virginia: [highmark.com/edi-wv](http://highmark.com/edi-wv)

[What Is My Service Area?](#)

# CHAPTER 1: GENERAL INFORMATION

## UNIT 4: HIGHMARK MEMBER INFORMATION

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[What Is My Service Area?](#)

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



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## 1.4 UNIT DEFINITIONS

|                           |                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|---------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Member</b>             | A <b>member</b> is an individual who is enrolled in a health plan and who meets the eligibility requirements of the program.                                                                                                                                                                                                                                                                                                           |
| <b>Subscriber</b>         | A <b>subscriber</b> is a member whose employment or other status, except for family dependency, is the basis for eligibility for enrollment in a program.                                                                                                                                                                                                                                                                              |
| <b>Dependent</b>          | A <b>dependent</b> is any member of a subscriber's family who meets the applicable eligibility requirements and is enrolled in a program.                                                                                                                                                                                                                                                                                              |
| <b>Managed care plans</b> | <b>Managed care plans</b> are delivered through the use of 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). |
| <b>Indemnity plans</b>    | <b>Traditional indemnity</b> 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.                                                                                                              |

## 1.4 IDENTIFYING HIGHMARK MEMBERS

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### Overview

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 NaviNet,<sup>®</sup> Highmark's Internet-based inquiry system, or by performing an electronic HIPAA 270 Eligibility/Benefit Inquiry transaction.

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### Member ID cards

All Highmark members receive an identification card so you can easily identify them and have essential information in order 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 that you 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;
- Identification number – alphanumeric\* characters used to identify the member (the member's Unique Member Identifier [UMI], or "Member ID");
- 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;
- BlueCard<sup>®</sup> – 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.

*\*3-character prefixes (which can be three alpha characters or a combination of alpha and numeric characters) are used in conjunction with the 12-digit identification number to identify the member's coverage. Members may have more than one identification card, depending on the type(s) of coverage in which members are enrolled. Please verify the correct prefix is billed for the type of service reported.*

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*Continued on next page*

## 1.4 IDENTIFYING HIGHMARK MEMBERS, Continued

### IMPORTANT! Medicare Advantage



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.

[What Is My Service Area?](#)

### For new members without an 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.

### FOR MORE INFORMATION

Please see the next section of this unit for more information and examples of Member ID cards.

## 1.4 MEMBER IDENTIFICATION CARDS

### Overview

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.

### Design features

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 appears 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.

*Continued on next page*

## 1.4 MEMBER IDENTIFICATION CARDS, Continued

### 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.

|                                                                                   |                       |                                    |                                                                                                                  |
|-----------------------------------------------------------------------------------|-----------------------|------------------------------------|------------------------------------------------------------------------------------------------------------------|
|  |                       | Licensed Product Name <sup>1</sup> |                                                                                                                  |
| MEMBER NAME <sup>2</sup>                                                          |                       | DEPENDENT NAME <sup>3</sup>        |                                                                                                                  |
| FIRSTNAME M                                                                       |                       | FIRSTNAME LASTNAME                 |                                                                                                                  |
| LASTNAME                                                                          |                       | PCP NAME                           |                                                                                                                  |
| MEMBER ID                                                                         |                       | PCP Ph Number                      |                                                                                                                  |
| ZARXXXXXXXXXX                                                                     |                       | Effective Date                     |                                                                                                                  |
| Group                                                                             | 01650300 <sup>4</sup> | Office Visit                       | \$ <sup>5</sup>                                                                                                  |
| BS Plan                                                                           | 378/865               | Specialist Visit                   | \$                                                                                                               |
| RxGrp                                                                             | HMRK001               | Emergency Room                     | \$                                                                                                               |
| RxBIN                                                                             | 610014                |                                    |                                                                                                                  |
| Cov Eff Date                                                                      | XX/XX/XXXX            |                                    |                                                                                                                  |
| HEAR/VISION/DENTAL <sup>6</sup>                                                   |                       |                                    | <sup>7</sup>  <sup>8</sup> Rx |

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 NaviNet® 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.

*Continued on next page*



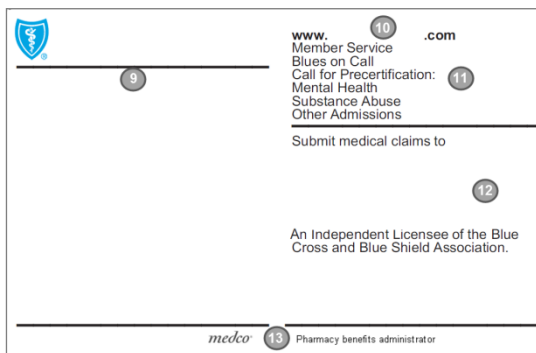
## 1.4 MEMBER IDENTIFICATION CARDS, Continued

### Front of a standard Member ID card

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 2.6: 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.

### The back of the member's 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.



9. **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.
10. **Plan Website:** Identifies the Blue Plan's website address to access Plan information online.
11. **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.
12. **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 located in this space.
13. **Pharmacy Benefits Administrator and Logo:** The name and logo of the pharmacy benefits administrator may appear here if applicable.

*Continued on next page*

## 1.4 MEMBER IDENTIFICATION CARDS, Continued

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### 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:

- [Pennsylvania Western Region ID Card Samples](#)
- [Pennsylvania Central Region ID Card Sample](#)
- [Highmark Delaware ID Card Sample](#)
- [Highmark West Virginia ID Card Samples](#)

[What Is My Service Area?](#)

## 1.4 VERIFYING ELIGIBILITY AND BENEFITS

### Overview

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 NaviNet,<sup>®</sup> performing an electronic HIPAA 270 Eligibility/Benefit Inquiry transaction, or by calling the Provider Service Center.

### NaviNet<sup>®</sup>

NaviNet<sup>®</sup> is our primary resource for providers to obtain their data on Highmark members. This Internet-based service enables you to access enrollment and benefits information, claim status, program allowances, and accounts receivable management as well as many other sources that will help you to find information about your Highmark patients.

This time-saving service is provided free of charge to participating providers in Pennsylvania, Delaware, and West Virginia. If you are NaviNet-enabled, NaviNet is the required method to check benefits and eligibility.

Please visit [Chapter 1.3: Electronic Solutions -- EDI & NaviNet](#) for more information about NaviNet.

[What Is My Service Area?](#)

### 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, select the link titled **Electronic Data Interchange (EDI) Services** from the Provider Resource Center main menu, or by clicking the applicable link below to access the site directly:

- Pennsylvania: [highmark.com/edi](http://highmark.com/edi)
- Delaware: [highmark.com/edi-bcbsde](http://highmark.com/edi-bcbsde)
- West Virginia: [highmark.com/edi-wv](http://highmark.com/edi-wv)

You may contact the EDI Operations support line at **1-800-992-0246**.

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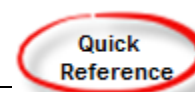
## 1.4 VERIFYING ELIGIBILITY AND BENEFITS, Continued

### Provider Service Center

For those providers who are not NaviNet-enabled or without electronic capabilities, Provider Service Center customer service 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 1.2: Online Resources & Contact Information](#) or access the [Quick Reference](#), which can always be found at the top of the manual's home page.

Please note that the "Quick Reference" icon is placed in key locations throughout the manual to provide easy access to phone numbers for the Provider Service Center and Highmark Clinical Services.



### Verifying eligibility for BlueCard® members

To verify eligibility for BlueCard® members, please use the **Blue Exchange® Eligibility and Benefits Inquiry** on NaviNet, or call **1-800-676-BLUE**.

For additional information about BlueCard, please see the manual's [Chapter 2.6: The BlueCard Program](#). Additional information is also available in the BlueCard Information Center on the Provider Resource Center – select **INTER-PLAN PROGRAMS** from the main menu.

### 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.

## 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 twenty-six (26) years. Effective September 23, 2010, 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.

[What Is My Service Area?](#)

### 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 NaviNet® **Eligibility and Benefits** function. NaviNet is the preferred tool for inquiring about Highmark member information. NaviNet-enabled providers are expected to use this tool for all routine eligibility, benefit, and claim status inquiries.

For those providers not NaviNet-enabled, eligibility can be verified by submitting a HIPAA 270 Eligibility/Benefit Inquiry transaction or by calling the Provider Service Center. Please see [Chapter 1.2: Online Resources & Contact Information](#) for more information on contacting Provider Services in your region.

## 1.4 CONFIDENTIALITY OF MEMBER INFORMATION

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|---------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Confidentiality policy</b>                     | 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.                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Member rights and responsibilities</b>         | Highmark treats members in a manner that respects their rights and will clearly communicate Highmark's expectations of our member responsibilities. Please see <a href="#">Chapter 1.5: Member Rights &amp; Responsibilities</a> to review our members' rights and responsibilities.                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Normal business operation</b>                  | <p>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:</p> <ul style="list-style-type: none"> <li>• Claims management</li> <li>• Certain types of routine audits by Highmark's group customers</li> <li>• Coordination of care</li> <li>• Quality assessment and measurement</li> <li>• Case management</li> <li>• Utilization review</li> <li>• Performance measurement</li> <li>• Customer service</li> <li>• Credentialing</li> <li>• Medical review</li> <li>• Underwriting</li> </ul> |
| <b>Release of information for non-routine use</b> | <p>If member information is needed for reasons other than those listed above, Highmark must obtain the member's consent via an <i>Authorization for Disclosure</i> form.</p> <p>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.</p>                                                                                                                          |
| <b>Internal and external controls</b>             | 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.                                                                                                                                             |

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## 1.4 CONFIDENTIALITY OF MEMBER INFORMATION, Continued

|                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Providers' responsibility to protect PHI</b>    | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Others who have occasion to use member data</b> | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Provider breach notification obligations</b>    | <p>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").</p> <p>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.</p> |
| <b>Member access to PHI</b>                        | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Use of measurement data</b>                     | Through the use of measurement data, Highmark is able to manage members' health care needs through appropriate quality improvement programs such as health, wellness, and disease management programs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

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## 1.4 CONFIDENTIALITY OF MEMBER INFORMATION, Continued

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### **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.

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### **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](https://www.highmark.com). At the bottom of the page, click **Privacy**.

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## 1.4 ADVISING MEMBERS OF TREATMENT OPTIONS

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### 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 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.

[What Is My Service Area?](#)

### 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 fifteen (15) minutes of their scheduled appointment time. A reasonable attempt should be made to notify patients of delays.

[What Is My Service Area?](#)

| PCP AND MEDICAL SPECIALIST EXPECTATIONS                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                               |                                                                                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| Patient's Need:                                                                                                                                                                                                                                                                                                             | Performance Standard:                                                                                                                                                                                                         |                                                                                                                           |
| <b>Emergency/life threatening care</b> <ul style="list-style-type: none"> <li>Sudden, life-threatening symptom(s) or condition requiring immediate medical treatment (e.g., chest pain, shortness of breath)</li> </ul>                                                                                                     | Immediate response                                                                                                                                                                                                            |                                                                                                                           |
| <b>Urgent care appointments</b> <ul style="list-style-type: none"> <li>An urgently needed service is a medical condition that requires rapid clinical intervention as a result of an unforeseen illness, injury, or condition (e.g., high fever, persistent vomiting/diarrhea)</li> </ul>                                   | Office visit within 1 day (24 hours)                                                                                                                                                                                          |                                                                                                                           |
| <b>Regular and routine care appointments</b> <ul style="list-style-type: none"> <li>Non-urgent but in need of attention appointment (e.g., headache, cold, cough, rash, joint/muscle pain)</li> <li>Routine wellness appointments (e.g., asymptomatic/preventive care, well child/patient exams, physical exams)</li> </ul> |                                                        | <ul style="list-style-type: none"> <li>Within 2-7 days (Non-urgent)</li> <li>Within 30 days (Routine wellness)</li> </ul> |
|                                                                                                                                                                                                                                                                                                                             |                                                                                                                                           | Office visit within 3 weeks of member request                                                                             |
| <b>After-hours care</b> <ul style="list-style-type: none"> <li>Access to practitioners after the practice's regular business hours</li> </ul>                                                                                                                                                                               | Acceptable process in place to respond 24 hours per day, 7 days a week to member issues (answering service that pages the practitioner or answering machine message telling caller how to reach the practitioner after hours) |                                                                                                                           |
| <b>In-office waiting times</b> <ul style="list-style-type: none"> <li>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.</li> </ul>                                          | Within 15 minutes                                                                                                                                                                                                             |                                                                                                                           |

*Continued on next page*

## 1.4 MEMBER ACCESS TO PHYSICIANS AND FACILITIES, Continued

| MATERNITY CARE EXPECTATIONS (Obstetrics) |                                              |
|------------------------------------------|----------------------------------------------|
| Patient's Need:                          | Performance Standard:                        |
| • Maternity Emergency                    | Immediate response                           |
| • Maternity 1 <sup>st</sup> Trimester    | Within 3 weeks of first request              |
| • Maternity 2 <sup>nd</sup> Trimester    | Within 7 calendar days of first request      |
| • Maternity 3 <sup>rd</sup> Trimester    | Within 3 calendar days of first request      |
| • Maternity High Risk                    | Within 3 days of identification of high risk |

[What Is My Service Area?](#)

| BEHAVIORAL HEALTH SPECIALIST EXPECTATIONS                                                                                                                                                                                                                                          |                                                                                                                                                                                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Patient's Need:                                                                                                                                                                                                                                                                    | Performance Standard:                                                                                                                                                                                                         |
| <b>Care for a life-threatening emergency</b> <ul style="list-style-type: none"> <li>Immediate intervention is required to prevent death or serious harm to patient or others</li> </ul>                                                                                            | Immediate response                                                                                                                                                                                                            |
| <b>Care for a non-life-threatening emergency</b> <ul style="list-style-type: none"> <li>Rapid intervention is required to prevent acute deterioration of the patient's clinical state that compromises patient safety</li> </ul>                                                   | Care within 6 hours                                                                                                                                                                                                           |
| <b>Urgent care</b> <ul style="list-style-type: none"> <li>Timely evaluation is needed to prevent deterioration of patient condition</li> </ul>                                                                                                                                     | Office visit within 48 hours                                                                                                                                                                                                  |
| <b>Routine office visit</b> <ul style="list-style-type: none"> <li>Patient's condition is considered to be stable</li> </ul>                                                                                                                                                       |   Office visit within 10 business days                 |
|                                                                                                                                                                                                                                                                                    |  Office visit within 7 calendar days                                                                                                      |
| <b>After-hours care</b> <ul style="list-style-type: none"> <li>Access to practitioners after the practice's regular business hours</li> </ul>                                                                                                                                      | Acceptable process in place to respond 24 hours per day, 7 days a week to member issues (answering service that pages the practitioner or answering machine message telling caller how to reach the practitioner after hours) |
| <b>In-office waiting times</b> <ul style="list-style-type: none"> <li>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.</li> </ul> | Within 15 minutes                                                                                                                                                                                                             |

Continued on next page

## 1.4 MEMBER ACCESS TO PHYSICIANS AND FACILITIES, Continued

### 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 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.                                                                                                                                                                                                                           |

### 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 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

*Continued on next page*

## 1.4 MEMBER ACCESS TO PHYSICIANS AND FACILITIES, Continued

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**Equal access  
and non-  
discrimination  
in treatment of  
members**  
(continued)

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 AFTER-HOURS PHYSICIAN ACCESSIBILITY STUDY

### Monitoring accessibility

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

### When the study is performed

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.

### Process

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    | <p>The Highmark representative verifies that the practice has an acceptable after hours process in place to respond to patient calls after regular business hours.</p> <p>Does the physician have an acceptable process?</p> <ul style="list-style-type: none"> <li>• If <b>YES</b>, no further action is necessary.</li> <li>• If <b>NO</b>, go to Step 3.</li> </ul>                                                                                                                                                                                    |
| 3    | <p>A letter is sent to the office informing them of the results and the need for a written corrective action plan. A Highmark representative contacts the office to discuss alternatives that the provider may use to be compliant with the after-hours requirements. Up to two follow-up calls are placed after regular hours to determine if the office has implemented corrective actions. <b>If the practice becomes compliant, a letter is forwarded to the practice acknowledging our appreciation for modifying their after-hours process.</b></p> |

### If you do not meet guidelines

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

# CHAPTER 1: GENERAL INFORMATION

## UNIT 5: MEMBER RIGHTS & RESPONSIBILITIES

### IN THIS UNIT



| TOPIC                                                | SEE PAGE |
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| Medicare Advantage Member Rights & Responsibilities: |          |
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[What Is My Service Area?](#)

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The PA ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The DE ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The WV ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

## 1.5 INTRODUCTION

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### Overview

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.

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### How Highmark communicates member rights and responsibilities

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: PENNSYLVANIA

### Overview



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

[What Is My Service Area?](#)

### Member Rights



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.

### Member Responsibilities



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.

## 1.5 MEMBER RIGHTS & RESPONSIBILITIES: DELAWARE

### Overview



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

[What Is My Service Area?](#)

### Member Rights



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 Delaware (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.

*Continued on next page*

## 1.5 MEMBER RIGHTS & RESPONSIBILITIES: DELAWARE, Continued

### Member Rights

(continued)



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.

[What Is My Service Area?](#)

### Member Responsibilities



Members have the responsibility to:

1. Double-check that any facilities from which they receive care are covered by Highmark Delaware. They can visit [highmarkbcbsde.com](http://highmarkbcbsde.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.

## 1.5 MEMBER RIGHTS & RESPONSIBILITIES: WEST VIRGINIA

### Overview



The member rights and responsibilities for Highmark West Virginia commercial products are outlined below.

[What Is My Service Area?](#)

### Member Rights



Members have the right to:

1. Receive information about 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.

### Member Responsibilities



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. Develop a relationship with their doctor based on trust and cooperation.

*Continued on next page*

## 1.5 MEMBER RIGHTS & RESPONSIBILITIES: WEST VIRGINIA, Continued

### Rights of members receiving case management services



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.

[What Is My Service Area?](#)

## 1.5 MEDICARE ADVANTAGE RIGHTS & RESPONSIBILITIES: PENNSYLVANIA

### Overview



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*.

[What Is My Service Area?](#)

### Medicare Advantage Member Rights



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.

*Continued on next page*

## 1.5 MEDICARE ADVANTAGE RIGHTS & RESPONSIBILITIES: PENNSYLVANIA, Continued

### Medicare Advantage Member Rights (continued)



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:
  - 15.2 How we control the use of medical services.
  - 15.3 The number of appeals and grievances we have received and how these cases were resolved.
  - 15.4 How we pay our participating doctors.
  - 15.5 The financial condition of our Plan.
16. Make suggestions about Medicare Advantage PPO and HMO policies on member rights and responsibilities.

[What Is My Service Area?](#)

### Medicare Advantage Member 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.

*Continued on next page*

## 1.5 MEDICARE ADVANTAGE RIGHTS & RESPONSIBILITIES: PENNSYLVANIA, Continued

[What Is My Service Area?](#)

### Medicare Advantage Member Responsibilities (continued)



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 1-800-935-2583 (Medicare Advantage HMO) or 1-866-306-1061 (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 1-800-988-0668.
15. Understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.



## 1.5 MEDICARE ADVANTAGE RIGHT & RESPONSIBILITIES: WEST VIRGINIA

### Overview



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 Member Rights



[What Is My Service Area?](#)

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 where 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 of 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.

*Continued on next page*

## 1.5 MEDICARE ADVANTAGE RIGHT & RESPONSIBILITIES: WEST VIRGINIA, Continued

### Medicare Advantage Member Rights (continued)



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.

[What Is My Service Area?](#)

### Medicare Advantage Member Responsibilities



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.

## 1.5 PENNSYLVANIA CHIP MEMBER RIGHTS & RESPONSIBILITIES

### Overview



Highmark makes health care programs available to uninsured children in Pennsylvania through the subsidized Children's Health Insurance Program of Pennsylvania (CHIP). Highmark is committed to providing CHIP members 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.

The following provider networks service children covered under CHIP: the Premier Blue Shield preferred provider network 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. 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.

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

[What Is My Service Area?](#)

### CHIP Member Rights



CHIP members/parents have the following rights:

- The right to receive health plan literature and materials for their use, written in a manner that truthfully and accurately provides relevant information that is easily understood by a person of average intelligence. This literature and materials should include information about Highmark, its services, its network practitioners and providers, and member children's rights and responsibilities.
- The right to participate with practitioners in decision making regarding the child's health care.
- The right to a candid discussion of appropriate or medically necessary treatment options for the child's condition, regardless of cost or benefit coverage.
- The right to obtain from the child's physician, unless it is not medically advisable, complete and current information concerning the diagnosis, treatment, and prognosis in terms that they can reasonably be expected to understand.
- The right to be given the name, professional status, and function of any personnel providing health services to the child.
- The right to give informed consent before the start of any procedure or treatment.

*Continued on next page*

## 1.5 PENNSYLVANIA CHIP MEMBER RIGHTS & RESPONSIBILITIES,

Continued

### CHIP Member Rights (continued)



- The right to be advised if a health care facility or any of the providers participating in the child's care propose to engage in or perform human experimentation or research affecting the child's care or treatment. The parent or a legally responsible party on the child's behalf may, at any time, refuse to participate in or continue in any experimentation or research program to which they had previously given informed consent.
- The right to refuse drugs, treatment, or other procedures offered to the child by Highmark or its network providers to the extent permitted by law, and to be informed by a physician of the medical consequences of their refusal of any drugs, treatment, or procedures.
- The right to have records pertaining to the child's medical care treated as confidential unless disclosure is necessary to interpret the application of the contract to the child's care, or unless disclosure is otherwise provided for by law.
- The right to information contained in the child's medical records unless access is specifically restricted by the attending physician for medical reasons.
- The right to obtain emergency services, without unnecessary delay, when the services are necessary.
- The right to be treated with respect and recognition of their dignity and their right to privacy.
- The right to be informed of these rights and responsibilities.
- The right to make recommendations regarding Highmark's members' rights and responsibilities policies.

[What Is My Service Area?](#)

### CHIP Member Responsibilities



CHIP members/parents have the following responsibilities:

- The responsibility to provide, to the extent possible, information that Highmark and its network providers need in order to care for the child. Members/parents should communicate openly with the physician by developing a physician-patient relationship based on trust and cooperation.
- The responsibility to choose a primary care physician (PCP) and keep him/her abreast of the child's medical care.
- The responsibility to maintain the child's health and prevent illness and to follow the plans and instructions for care that were agreed on with the child's practitioner.
- The responsibility to ask questions to make certain they understand the explanations and instructions given to them.

*Continued on next page*

## 1.5 PENNSYLVANIA CHIP MEMBER RIGHTS & RESPONSIBILITIES,

Continued

[What Is My Service Area?](#)

### CHIP Member Responsibilities (continued)



- The responsibility to understand the potential consequences if they refuse to comply with treatment plans or recommendations.
- The responsibility to keep scheduled appointments or give adequate notice of delay or cancellation.
- The responsibility to follow the rules of membership and to read all materials carefully upon enrollment.
- The responsibility to communicate pertinent information to the child's PCP about his/her health and to seek health care before a problem becomes serious.
- The responsibility to express their opinions, concerns, or complaints on the services provided in a constructive manner to the appropriate people within Highmark.
- The responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals to the greatest degree possible.

## CHAPTER 2: PRODUCT INFORMATION

### UNIT 1: PRODUCT OVERVIEW

#### IN THIS UNIT



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#### What Is My Service Area?

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The PA ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The DE ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The WV ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

## 2.1 INTRODUCTION

[What Is My Service Area?](#)

### Overview

Highmark and its affiliates operate health insurance plans in Pennsylvania, Delaware, 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 that are typically covered under one of the following categories:

- National accounts – large employer groups who have employees living in Pennsylvania, Delaware, West Virginia, and in other states
- Local accounts -- large and small groups located in Pennsylvania, Delaware, and West Virginia
- Individual accounts – individuals who do not belong to a group account and who pay for their own coverage. This includes Affordable Care Act (ACA) compliant health care reform products available through the Healthcare Marketplace exchanges or directly through Highmark.
- Federal Employee Program (FEP)
- Children's Health Insurance Plan (CHIP) in Pennsylvania
- Medicare Advantage programs in Pennsylvania and West Virginia\*\*
- Medicare complementary and Medicare supplemental programs

\*Please see [Chapter 3.1: 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 2.2: Medicare Advantage Products & Programs](#) for information on Medicare Advantage.

### Highmark's corporate entities

Highmark is licensed to offer products under various corporate entities in Pennsylvania, Delaware, and West Virginia. With multiple corporate entities, Highmark is able to offer more cost-effective products by establishing region-specific entities that are more reflective and characteristic of the region, product type, market segment, and distribution channels. These corporate entities include, but may not be limited to, the following:

- **Highmark Blue Cross Blue Shield:** Providing integrated Blue Cross and Blue Shield coverage throughout the 42 counties of Pennsylvania's western and northeastern service areas.
- **Highmark Blue Shield:** Serving the twenty-one (21) counties of central Pennsylvania and the Lehigh Valley
- **Highmark Blue Cross Blue Shield of Delaware:** Serving the entire state of Delaware
- **Highmark Blue Cross Blue Shield of West Virginia:** Serving all fifty-five (55) counties of West Virginia and Washington County, Ohio

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## 2.1 INTRODUCTION, Continued

[What Is My Service Area?](#)

- **Highmark Choice Company:** Serves the Western, Central, and Northeastern Regions of Pennsylvania and offers HMO products, including Medicare Advantage HMO plans and the Children's Health Insurance Program (CHIP) in the Western Region
- **Highmark Health Insurance Company:** Serves all forty-nine (49) counties of western and central Pennsylvania and the Lehigh Valley and offers commercial small group off-exchange products and individual market on and off-exchange products
- **Highmark Coverage Advantage:** Serves the twenty-nine (29) counties of western Pennsylvania and offers commercial small group off-exchange products
- **Highmark Benefits Group:** Serves the twenty-one (21) counties of central Pennsylvania and the Lehigh Valley and offers commercial small group off-exchange products
- **Highmark Select Resources:** Serves the twenty-one (21) counties of central Pennsylvania and the Lehigh Valley and offers individual market on and off-exchange products
- **Highmark Senior Health Company:** Serves Pennsylvania's Western, Central, and Northeastern Regions, offering Medicare Advantage Freedom Blue PPO products
- **Highmark Senior Solutions Company:** Serves thirty-three (33) counties of West Virginia, offering Medicare Advantage Freedom Blue PPO products

### Contracts specify covered services

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.

### 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. Highmark has responded by making these plan designs more widely available in the market place.

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 NaviNet.®

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## 2.1 INTRODUCTION, Continued

### 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).

Highmark has many different types of managed care coverage as well as many types of indemnity coverage. Knowing the product helps you to understand which specific managed care rules and guidelines to follow.

[What Is My Service Area?](#)

### 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 to the individual and small group markets, both inside and outside of the Health Insurance Marketplace, a comprehensive package of items and services, known as essential health benefits. These benefits must include items and services within the following categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse 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

Insurance companies, such as Highmark, must cover these benefits in order to be certified and offer products through the Health Insurance Marketplace.

### Medicare Advantage products



Medicare Advantage plans are available in Pennsylvania and West Virginia to individuals who are enrolled in both Medicare Part A and Part B.

For information on Medicare Advantage plans, please see [Chapter 2.2: Medicare Advantage Products & Programs](#).

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## 2.1 INTRODUCTION, Continued

[What Is My Service Area?](#)

### Partnership products



Highmark recognizes that there are specific differences between the different 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])

## 2.1 MANAGED CARE OVERVIEW

### Defining managed care

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 in order to promote and maintain good health while conserving resources.

### Highmark's managed care programs

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)

### Terminology

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 the acronym for primary care physician -- 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).

## 2.1 PREFERRED PROVIDER ORGANIZATION (PPO)

### Overview

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.

Members may also receive care from providers not participating in the network for which the services will be reimbursed at the lower, out-of-network level of benefits. In addition to deductible and coinsurance, the member would be responsible for the difference between the provider's charges and the actual payment provided by Highmark. All services are subject to specific contract coverage and limitations.

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

[What Is My Service Area?](#)

### Components of PPO programs

There are two components of the PPO programs: institutional and medical-surgical.

- The institutional portion typically covers inpatient and outpatient care provided by a Highmark participating facility, such as a hospital or skilled nursing facility.
- The medical/surgical portion typically covers the services of network professional providers, such as physicians, and ancillary providers, such as durable medical equipment suppliers.

Medical-surgical benefits cover a range of preventive care services, including routine annual physical exams, gynecological exams, PAP tests, and mammograms. Covered pediatric care includes routine immunizations and check-ups. The preventive schedule is reviewed periodically using the American Academy of Pediatrics; the U.S. Preventive Services Task Force; the Blue Cross and Blue Shield Association; and medical consultants.

Under PPO plans, members are also covered for emergency and out-of-area care. Although most PPO programs do not require members to select a primary care physician, medical management processes do apply.

### 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, PAYMENT & REIMBURSEMENT** from the main menu, or **REQUIRING AUTHORIZATION** from the **Quicklinks Bar**.

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## 2.1 PREFERRED PROVIDER ORGANIZATION (PPO), Continued

### 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.
- 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 at the group's request).
- All practitioners are paid fee-for-service for care rendered to PPO members.

**Note:** See specific benefit details for the CHIP PPO Plus (in PA) and Medicare Advantage PPO products (PA and WV), 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. The specific percentages of member coinsurance for in-network and out-of-network services are determined by the particular employer group contract or the individual member agreement.

In the case of lower-level payment (for out-of-network services), members can be billed for any deductibles, coinsurances, and/or copayments that apply to the services received in addition to the difference between the approved amount and the provider's charge.

[What Is My Service Area?](#)

### Network providers for Pennsylvania PPO programs



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 twenty-one (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 in this region. The Premier Blue Shield network also serves Highmark members with PPO plans in the Northeastern Region.

In the twenty-nine (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.

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## 2.1 PREFERRED PROVIDER ORGANIZATION (PPO), Continued

### Network providers for Pennsylvania PPO programs (continued)



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. At both levels, they get high-quality care.

**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.

[What Is My Service Area?](#)

### Network providers for Delaware PPO programs



Highmark Delaware’s provider network, which spans all three counties in the state of Delaware and also counties in contiguous states, 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 West Virginia PPO programs



Highmark West Virginia’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 across all fifty-five (55) counties in West Virginia. 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 higher-level reimbursement for services received from network providers and lower-level reimbursement for services received outside the network. The percentage of member coinsurance for in-network and out-of-network services is determined by the specific member contract.

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## 2.1 PREFERRED PROVIDER ORGANIZATION (PPO), Continued

### West Virginia Small Business Plan



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. A company must:

- have between 2-50 employees;
- not have offered company-sponsored health coverage for the past twelve (12) months; and
- be willing to pay at least fifty (50) percent of the premium cost for each employee.

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.

Generally, Highmark West Virginia's WVSBP coverage resembles our standard PPO product, with a high deductible.

[What Is My Service Area?](#)

**REMINDER:**  
Always verify  
benefits!

For inquiries about eligibility, benefits, claim status, or authorizations, Highmark encourages providers to use the electronic resources available to them – NaviNet® and the applicable HIPAA transactions – prior to placing a telephone call to Provider Services.

## 2.1 EXCLUSIVE PROVIDER ORGANIZATION (EPO)

### Overview



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 and also in Delaware.

[What Is My Service Area?](#)

### General characteristics of EPO plans



The following are general characteristics of EPO plans:

- Members utilize the existing managed care networks in:
  - the Western and Central Regions of Pennsylvania and the local Blue Plan PPO providers outside of the 49-county region; and
  - the Delaware service area and the local Blue Plan PPO providers outside of Delaware's three counties.
- 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.
- Members are required to contact Clinical Services to obtain authorization prior to in-network inpatient admissions outside of the Highmark service areas.

Members may be responsible for copayments on such services as, but not limited to, physician office visits, emergency room services, mental health outpatient visits, substance abuse outpatient visits, spinal manipulation, physical therapy, occupational therapy, and speech therapy.



## 2.1 COMMUNITY BLUE (PA ONLY)

### Overview



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.

[What Is My Service Area?](#)

### 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.

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## 2.1 COMMUNITY BLUE (PA ONLY), Continued

### 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.

[What Is My Service Area?](#)

### 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 – NaviNet® and the applicable HIPAA transactions – prior to placing a phone call to Provider Services.

## 2.1 POINT OF SERVICE (POS)

### Overview



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 and West Virginia service areas.

[What Is My Service Area?](#)

### Highmark Delaware POS plans



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 West Virginia POS plans



Providers in Highmark West Virginia's PPO networks also participate in the POS network. In addition, Highmark 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).

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## 2.1 POINT OF SERVICE (POS), Continued

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**REMINDER:**  
**Always verify**  
**benefits!**

All services are subject to specific contract coverage and limitations. Providing to providing service to a POS member, please verify the member's eligibility and benefits via NaviNet® or the applicable HIPAA electronic transaction.

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## 2.1 OPEN ACCESS (PA ONLY)

### Overview



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.

[What Is My Service Area?](#)

### 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:
  - o The 29 counties of western Pennsylvania when they access physicians, hospitals, or other health care providers within the Western Region network.
  - o 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 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.

Blues On Call services, myCare Navigator, and preventive care benefits are integral components.

### 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 twenty-one (21) counties of central Pennsylvania and the Lehigh Valley or the Highmark Managed Care network in the twenty-nine (29) counties of western Pennsylvania, covered services will be reimbursed at the higher, in-network level provided by the group contract.

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## 2.1 OPEN ACCESS (PA ONLY), Continued

### Payment levels correspond to member options (continued)



- If members choose to seek services from a provider outside the twenty-one (21) county Central Region Premier Blue Shield network or the twenty-nine (29) county Highmark Managed Care network in the Western Region, covered services will be reimbursed at the lower, out-of-network level provided by the group contract.

Each employer group that offers an open access plan determines what the higher and lower payment percentages will be 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.

[What Is My Service Area?](#)

## 2.1 VALUE-BASED BENEFITS

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### Introduction

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.

In the ongoing effort to give our members a “greater hand in their health,” Highmark introduced a new feature to the group market PPO and EPO benefit designs starting in January 2011. This benefit design, Value-Based Benefits, supports our network physicians in managing care for members with one or more chronic/ targeted conditions by reducing or removing financial barriers to health care.

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### 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.

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### 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)
  - Depression
  - Diabetes
  - High blood pressure
  - High cholesterol
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## 2.1 VALUE-BASED BENEFITS, Continued

### 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.

| PPOBlue         |          |                     |      |
|-----------------|----------|---------------------|------|
| MEMBER NAME     |          | DEPENDENT           |      |
| FIRSTNAME M     |          | FIRSTNAME M         |      |
| LASTNAME        |          | LASTNAME            |      |
| MEMBER ID       |          |                     |      |
| ZAR109465762001 |          |                     |      |
| Group           | 01234567 | Office Visit        | \$XX |
| BS Plan         | 378      | VB Office Visit     | \$XX |
| RxGrp           | HMRK001  | Specialist Visit    | \$XX |
| RxBin           | 610014   | VB Specialist Visit | \$XX |
|                 |          | Emergency Room      | \$XX |

### 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 through NaviNet.®

NaviNet’s **Eligibility and Benefits** page will provide a **Value Based** link for those members who have Value-Based Benefits. When you click on **Value Based**, you will see the list of conditions covered by the member’s employer group. A list of the specific services that are subject to reduced cost sharing will also be displayed.

### 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.

These various choices, or “packages,” are known as Basic High Value Services,\* Condition Management,\* Ongoing Protocol Compliance,\* Incent for Results, and Incent for Preventive Care and Informed Decision Making. You may see these package names referenced on NaviNet.

*\*Not available to members with Qualified High Deductible Health Plans.*



## 2.1 HEALTH MAINTENANCE ORGANIZATION (HMO)

### Overview



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 Pennsylvania and Delaware. Members must use network participating providers to receive coverage for their care -- *except* for emergency care in Pennsylvania and Delaware, 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.

[What Is My Service Area?](#)

### General characteristics of HMOs



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



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.

*Continued on next page*

## 2.1 HEALTH MAINTENANCE ORGANIZATION (HMO), Continued

### Pennsylvania HMO plans



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.

While you are required to get your preventive care (such as adult and pediatric routine physicals and pediatric immunizations) from your PCP, you can go directly to a network specialist for other covered services - -without a referral.

**Note:** In the individual market, the Pennsylvania Western Region medically-underwritten HMO is closed to new membership; however, newly eligible dependents can be added to existing policies.

[What Is My Service Area?](#)

### Delaware's IPA plans



Highmark Delaware'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).

*Continued on next page*

## 2.1 HEALTH MAINTENANCE ORGANIZATION (HMO), Continued

### Required care definitions for HMO members

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.**


[What Is My Service Area?](#)

| CARE REQUIRED                                   | DEFINITION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|-------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Emergency Care</b>                           | <p>The initial treatment:</p> <ul style="list-style-type: none"> <li>• For bodily injuries resulting from an accident; or</li> <li>• Following the onset of a medical condition; or</li> <li>• 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: <ul style="list-style-type: none"> <li>a) 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</li> <li>b) Serious impairment to bodily functions; or</li> <li>c) Serious dysfunction of any bodily organ or part.</li> </ul> </li> <li>• 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.</li> </ul> |
| <b>Symptomatic Care</b>                         | <p>Medical needs that are symptomatic, but can be treated at the discretion of the physician and patient. Reasonable delays will most likely not affect the outcome of service.</p> <p>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.</p> <p><b>Note:</b> Urgent care requires authorization for Highmark Delaware members.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Routine Asymptomatic and Preventive Care</b> | <p>Medically asymptomatic conditions that can be addressed at the discretion of the physician and patient. Reasonable delays will not affect the outcome of services.</p> <p>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).</p> <p><b>Note:</b> Routine preventive care services such as routine physicals, immunizations, or screening diagnostic tests would not be covered out-of-area as “follow-up care.”</p>                                                                                                                                                                                                                                                                                                                                                                                                                |

## 2.1 AWAY FROM HOME CARE HMO GUEST MEMBERSHIP

### Away From Home Care® (AFHC)



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.

[What Is My Service Area?](#)

### What is guest membership?



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 service area.

**Note:** This program is not available to Medicare Advantage HMO members in Pennsylvania’s Western Region.

### How the Guest Membership Program works



- Guest membership enables HMO members who are residing outside of the service area for at least 90 consecutive days to have an HMO benefit program in another Blue HMO Plan location.
- Members should contact Member Services at least thirty (30) days in advance to determine program availability in the location in which they will be temporarily, or in the case of dependents, permanently residing.
- Once a member is established as a guest member, he or she receives the services covered under the “host” HMO benefit program, which includes the selection of a PCP and coordination of care based on the rules of the local HMO program.
- 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.

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

*Continued on next page*

## 2.1 AWAY FROM HOME CARE HMO GUEST MEMBERSHIP, Continued

### How to set up a guest membership



The process appears here to assist PCP practices in directing our members who need this service.

| STEP | ACTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1    | The member must call the Member Service number on his or her ID card at least 30 days prior to needing a guest membership.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 2    | The Member Service representative forwards the information to the AFHC coordinator at Highmark.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 3    | The AFHC coordinator mails a Guest Application to the member.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 4    | The member must complete, sign and date the application and return it to the AFHC coordinator.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 5    | The AFHC coordinator at Highmark sends the application to the AFHC coordinator at the participating Blue HMO Plan.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 6    | <p>The AFHC coordinator in the participating Blue HMO Plan will assist in the pre-selection of a PCP at the local HMO. The member will then receive a guest "Welcome Kit" with an ID card for the local HMO.</p> <p><b>Note:</b> Highmark will issue ID cards to HMO members who have a guest membership at another Blue HMO. This card should be used when receiving medical care while traveling outside the guest membership area. If prescription drug coverage is part of the member's benefits, this ID card will allow them to access their "home" prescription drug benefits since prescription drug benefits are not included as part of the "host" HMO plan benefit program.</p> |

[What Is My Service Area?](#)

### 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 or Delaware 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: **1-800-249-9579**
- In Delaware: **1-866-835-8977**

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.

*Continued on next page*

## 2.1 AWAY FROM HOME CARE HMO GUEST MEMBERSHIP, Continued

### Members returning to the PA Western Region or to Delaware



When a member who has had a Guest Membership permanently returns to their Highmark service area, he or she must select a PCP from the applicable Highmark network and will then receive the covered services included in their “home” HMO benefit program.

[What Is My Service Area?](#)

### Member questions



If members have questions about how this program works, they should call Member Services at the telephone number listed on the back of their ID card.

## 2.1 VISITING HMO MEMBERS

### Introduction



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 or in Delaware.

### Hosting guest members



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.

### Claims for guest members



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

[What Is My Service Area?](#)

## 2.1 QUICK REFERENCE CHART FOR OUT-OF-AREA CARE

### Out-of-area care

Care for members who receive care out of the service area works differently for each product. The following table presents a quick overview of members' options for out-of-area care categorized by product and care required.

| PRODUCT                                                                                                   | EMERGENCY CARE                                                                                                                                                                                                                   | SYMPTOMATIC CARE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ROUTINE ASYMPTOMATIC AND PREVENTIVE CARE                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>HMO</b>                                                                                                | <p>May seek emergency care immediately from any provider without contacting PCP.</p> <p>Member should notify his or her PCP within 48 hours or as soon as it is reasonably possible to coordinate any needed follow-up care.</p> | <p>May arrange initial visit for "urgent care" (non-emergency care) with participating physicians in other Blue Plan areas through the BlueCard program. Physicians may be located by calling <b>1-800-810-2583</b>, or online at <a href="http://www.bcbs.com">www.bcbs.com</a>.</p> <p>May arrange initial appointment with participating physician without contacting PCP; must coordinate any additional care with PCP before receiving services.</p> <p>May choose to coordinate even initial care through PCP.</p> | <p>Must coordinate "follow-up" care with PCP prior to traveling out-of-area.</p> <p>May arrange "follow-up" care with participating physicians in other Blue Plan areas through BlueCard program. Physicians may be located by calling <b>1-800-810-2583</b>, or online at <a href="http://www.bcbs.com">www.bcbs.com</a>.</p> <p>Once approved by PCP, member may arrange appointment with participating physician.</p> <p>Other routine asymptomatic or preventive care is not covered out of area.</p> |
| <b>PPO</b><br>(including CHIP PPO Plus in PA's Central Region, and also high deductible health plan PPOs) | May seek care immediately and receive high-level coverage.                                                                                                                                                                       | May utilize BlueCard Program by calling <b>1-800-810-BLUE</b> , or online at <a href="http://bcbs.com">bcbs.com</a> to find the names of preferred providers in other Blue Plan areas in order to receive the higher level of benefits while traveling out-of-area. Only some services may be covered at the in-network level.                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |

[What Is My Service Area?](#)

**Note:** Urgent care (non-emergency) requires authorization for Highmark Delaware members.

*Continued on next page*



## 2.1 QUICK REFERENCE CHART FOR OUT-OF-AREA CARE, Continued

### Out-of-area care (continued)

| PRODUCT              | EMERGENCY CARE                                             | SYMPTOMATIC CARE                                                                                                                                                                                                                                                                                                                                   | ROUTINE ASYMPTOMATIC AND PREVENTIVE CARE |
|----------------------|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
| <b>Direct Access</b> | May seek care immediately and receive high-level coverage. | May wait until return home to receive in-network care.                                                                                                                                                                                                                                                                                             |                                          |
| <b>POS</b>           | May seek care immediately and receive high-level coverage. | May wait until return home to receive in-network care.                                                                                                                                                                                                                                                                                             |                                          |
| <b>EPO</b>           | May seek care immediately and receive high-level coverage. | May seek care out-of-area care, but must be from an in-network provider. Services received from providers within the applicable Highmark network or from any local Blue Plan PPO providers are paid at the in-network level. There is no coverage when a member receives services from an out-of-network provider, except in emergency situations. |                                          |

**Note:** Urgent care (non-emergency) requires authorization for Highmark Delaware members.

[What Is My Service Area?](#)

## 2.1 TRADITIONAL FEE-FOR-SERVICE PLANS

### Indemnity programs

Under indemnity programs, Highmark members can seek care directly from any Participating Provider without coordination from a Primary Care Physician (PCP). As long as the service is covered under the member's benefit plan and the services provided are medically necessary, Highmark reimburses the provider.

Participating providers have agreed to accept the plan allowance as payment in full for covered services. The member would be responsible for any applicable copayment, deductible, or coinsurance.

### Providers for indemnity products

The foundation of Highmark's indemnity program is the relationship Highmark has with its participating professional and ancillary providers, along with Highmark's contracted facility providers.

- Facility providers include, but are not limited to, hospitals, skilled nursing facilities, home health agencies, hospices, dialysis centers, psychiatric and substance abuse facilities.
- Professional providers include primary care physicians/practitioners - pediatricians, internists, family practitioners, general practitioners, and Certified Registered Nurse Practitioners (CRNPs) -- who play key roles in managing the care members receive. Specialty providers render services of a more specialized nature for particular conditions a member may have, such as heart disease, a digestive disorder, or a pregnancy.
- Ancillary providers include, but are not limited to, suppliers of home infusion therapy, durable medical equipment, orthotics and prosthetics, and ambulance transportation.

### Payment

Most fee-for-service programs are supported by Highmark's participating and contracted providers. Reimbursement is based on the Plan Allowance. When a member enrolled under one of these programs receives services, Highmark pays the service based on the Plan Allowance applicable to the product and the provider.

When medical/surgical services are rendered by a participating provider, the amount paid constitutes payment-in-full, except when payments are reduced for amounts exceeding the maximum, or reduced based on deductible and coinsurance amounts.

Participating providers agree to not bill the member for the difference between the provider's charge and the Plan Allowance, except for copayments, deductibles, coinsurance, amounts exceeding a maximum, and/or non-covered services -- regardless of the member's income.

*Continued on next page*

## 2.1 TRADITIONAL FEE-FOR-SERVICE PLANS, Continued

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### Billing

These services should be billed to Highmark, instead of asking the patient to pay the full charge at the time the service is performed. Highmark will then make payment directly to the participating provider, who must accept the Plan Allowance as payment-in-full.

If applicable, participating providers may bill the patient for the following:

- Deductible or coinsurance amounts
  - Amounts exceeding the maximum
  - Non-covered services
-

## 2.1 MAJOR MEDICAL (PA ONLY)

### What is Major Medical?



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.

[What Is My Service Area?](#)

### Deductible



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.

### Coinsurance



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.

### Maximum amounts



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 benefits



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

### Claims



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 6.7: Payment/EOBs/Remittances](#) for additional information.

## CHAPTER 2: PRODUCT INFORMATION

### UNIT 2: MEDICARE ADVANTAGE PRODUCTS AND PROGRAMS

#### IN THIS UNIT



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[What Is My Service Area?](#)

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The PA ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The DE ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The WV ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

## 2.2 INTRODUCTION

[What Is My Service Area?](#)

### Background



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).

### Enrollment and benefits



To enroll in a Medicare Advantage plan, members must have both Medicare Part A and Part B and continue to pay their Medicare Part B premium, as well as their Part A premium if they have one (most people receive premium-free Part A because they paid Medicare taxes while working). Additionally, the member cannot have end-stage renal disease at the time of enrollment, unless he or she is a current member of a Highmark commercial product.

Medicare Advantage plans may also have a premium, although Highmark does provide premium-free options. Deductibles, coinsurance, and copayments all vary based on the plan the member has chosen.

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.

*Continued on next page*

## 2.2 INTRODUCTION, Continued

### Enrollment and benefits (continued)



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.

[What Is My Service Area?](#)

### Highmark's compliance commitment to CMS regulations



Highmark complies with all state and federal laws related to Medicare and our Medicare Advantage Products. Medical policies related exclusively to Medicare Advantage are available under the Medical Policy heading on the Provider Resource Center. In cases where Highmark policy, Highmark Medical Policy, settlement provisions, and/or Centers for Medicare & Medicaid (CMS) policy vary, the CMS regulation prevails.

According to CMS' Medicare Managed Care Manual, Highmark's contracts must contain accountability provisions specifying:

- That first tier and downstream entities must comply with Medicare laws, regulations, and CMS instructions (422.504(i)(4)(v)), and agree to audits and inspection by CMS and/or its designees and to cooperate, assist, and provide information as requested, and maintain records a minimum of ten (10) years;
- That the Medicare Advantage organization oversees and is accountable to CMS for any functions and responsibilities described in the Medicare Advantage regulations (422.504(i)(4)(iii)); and
- The person or entity must agree to comply with all State and Federal confidentiality requirements, including the requirements established by the Medicare Advantage organization and the Medicare Advantage program.

For more information on specific CMS regulations, please visit [cms.gov](https://www.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.

*Continued on next page*

## 2.2 INTRODUCTION, Continued

### 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*.

To access the Appendix, scroll down to the bottom of the manual's home page, click on the down arrow in the **ADDITIONAL RESOURCES** box, and then click on the **Appendix** link.

[What Is My Service Area?](#)

### Medicare Advantage HMO Network Sharing for Transplant Services—effective January 1, 2018



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.

### Geriatric Resource Binder



The Geriatric Resource Binder, developed by Highmark's Geriatric Advisory Board Committee, is a comprehensive resource designed to help health care professionals assess problematic areas in the older adult population.

To access the **Geriatric Resource Binder** on the Provider Resource Center, select **EDUCATION/MANUALS** from the main menu.

*Continued on next page*



## 2.2 INTRODUCTION, Continued

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### Highmark Passport



The Highmark Passport is a custom-designed three-ring binder with valuable information provided to Medicare Advantage members to help plan and track their health care needs and services. Members are mailed information specific to their individual needs throughout the year and encouraged to add these materials to their Passport binder.

The Highmark Passport stresses the critical role providers play in helping our members stay well and manage their health conditions. Members are encouraged to take the Highmark Passport to their provider visits to assist them in keeping their health records up to date, including taking notes of your instructions and recommendations.

In addition, the Passport Rewards program rewards our Medicare Advantage members for taking the right steps toward better health and well-being.

You can access a sample online version of the Highmark Passport, as well as additional Medicare Advantage information, on the Provider Resource Center in NaviNet®. Log in to NaviNet, and then select **Resource Center** from the Highmark Plan Central menu. Select **VALUE-BASED REIMBURSEMENT PROGRAMS** from the Provider Resource Center main menu, and then **Medicare Advantage Stars/Medicare Advantage Member and Provider Programs**.

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[What Is My Service Area?](#)

## 2.2 HIGHMARK MEDICARE ADVANTAGE PRODUCTS

### Overview



Highmark offers the following Medicare Advantage products:

- Freedom Blue PPO – offered by Highmark Senior Health Company in the Western, Central, and Northeastern Regions of Pennsylvania, and by Highmark Senior Solutions Company in West Virginia.
- Community Blue Medicare HMO – a select network product administered by Highmark Choice Company is offered in select counties in Pennsylvania’s Western, Central, and Northeastern Regions.
- Community Blue Medicare PPO – these plans are administered by Highmark Senior Health Company and are available in select counties in Pennsylvania’s Western, Central, and Northeastern Regions.
- Community Blue Medicare Plus PPO – this plan, also administered by Highmark Senior Health Company, offers exclusive access to Geisinger Danville facilities and doctors and is offered only to members living in Clinton, Lycoming, Sullivan, and Tioga counties in Pennsylvania.
- Security Blue HMO – offered in 28 counties of Pennsylvania’s Western Region by Highmark Choice Company.

[What Is My Service Area?](#)

### Freedom Blue PPO



Freedom Blue PPO is a Medicare Advantage Preferred Provider Organization plan. To enroll in Freedom Blue PPO, a member must have both Medicare Part A and Part B and must reside in the service area.

- In Pennsylvania, Freedom Blue PPO is administered by Highmark Senior Health Company and is available in a 62-county service area (all Pennsylvania counties *except* Bucks, Chester, Delaware, Montgomery, and Philadelphia).
- In West Virginia, Freedom Blue PPO is offered by Highmark Senior Solutions Company in a 33-county service area.

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. Renal dialysis services are covered at 100 percent, on a temporary basis, while outside the 62-county service area.

*Continued on next page*

## 2.2 HIGHMARK MEDICARE ADVANTAGE PRODUCTS, Continued

### Community Blue Medicare HMO



Community Blue Medicare HMO is a select high-value network product that offers high quality at a lower cost for seniors and administered by Highmark Choice Company. 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.

- Community Blue Medicare HMO is offered in most counties in western Pennsylvania and features a select high value network of Allegheny Health Network and other community doctors and hospitals. Individuals who select this option will have a choice between two plans – Signature and Prestige (both include Part D prescription drug coverage).
- Community Blue Medicare HMO is also available in select counties in central and northeastern Pennsylvania. The product features a local network of 23 hospitals and more than 4,800 physicians. A shared network in select western Pennsylvania locations is available to members traveling across the state.

**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.

[What Is My Service Area?](#)

### Community Blue Medicare PPO

**New in 2018!**



Effective January 1, 2018, Community Blue Medicare PPO plans, administered by Highmark Senior Health Company, are available in 27 counties of western Pennsylvania as well as 27 counties in the Central and Northeastern Regions of 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.

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.

*Continued on next page*

## 2.2 HIGHMARK MEDICARE ADVANTAGE PRODUCTS, Continued

### Community Blue Medicare Plus PPO

**New in 2018!**



Community Blue Medicare Plus PPO, effective January 1, 2018, 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.

Administered by Highmark Senior Health Company, this plan is available to members who reside in the limited service area, which includes Pennsylvania's Clinton, Lycoming, Sullivan, and Tioga counties.

[What Is My Service Area?](#)

### Security Blue HMO--PA Western Region ONLY



The Medicare Advantage HMO product, available only in Pennsylvania's Western Region, covers all Medicare-covered Part A and Part B benefits, including preventive care, doctor visits, hospital stays, and more. In addition, members get added benefits like routine dental, vision, and hearing care. Members have the option to choose a plan that includes Part D Prescription Drug coverage, giving them access to all drugs allowed by Medicare.

Security Blue HMO members choose a primary care physician (PCP) who coordinates care with network participating specialists and facilities when necessary.

To enroll in Highmark's Security Blue HMO, a member must reside in the 28-county Western Region service area. Members are required to receive care from the network of participating providers in the 28 counties, *except* in emergencies.

## 2.2 PRESCRIPTION DRUG COVERAGE UNDER MEDICARE ADVANTAGE

[What Is My Service Area?](#)

### Overview



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 **PHARMACY PROGRAM/FORMULARIES** from the main menu, and then **Pharmacy Information**. Select the third bullet, Medicare Part B Drug Average Sales Price, on the Pharmacy Information page.

### 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 **REQUIRING AUTHORIZATION** from the **Quicklinks Bar**

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## 2.2 PRESCRIPTION DRUG COVERAGE UNDER MEDICARE ADVANTAGE, Continued

### Purchasing Part B prescription drugs



There are several network specialty pharmacies and durable medical equipment (DME) vendors from which members can choose. Participating specialty pharmacies and DME vendors can be located through the provider search function available on the regional member websites accessible via [highmark.com](http://highmark.com) (select the **FOR MEMBERS** tab).

Choose the appropriate region, and then select the link titled **FIND A DOCTOR OR RX**, and then click on **Find a Doctor, Hospital or other Medical Provider**. Once in the *Provider Directory*, select **Medical Supply & Services** as the search option.

Medicare Advantage members are **not** able to purchase any Part B drugs at a retail pharmacy.

[What Is My Service Area?](#)

### IMPORTANT! Verify member cost sharing via NaviNet®

To determine the Medicare Advantage member's Part B prescription drug cost-sharing, verify eligibility and benefits through NaviNet® prior to providing the service.

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 visit the Highmark public website for your service area. Select **FIND A DOCTOR OR RX**, and then click on **Find a Pharmacy**. And you can select **Find a Drug** to quickly access drug formularies.

Additional information is also available to providers on the Provider Resource Center – select **PHARMACY PROGRAM/FORMULARIES** from the main menu.

## 2.2 HOSPICE BENEFIT ELECTION

[What Is My Service Area?](#)

### Background



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 (6) 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.

[Why blue italics?](#)

### 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.

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## 2.2 HOSPICE BENEFIT ELECTION, Continued

[What Is My Service Area?](#)

### **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.

[Why blue italics?](#)

### **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



## 2.2 DUAL ELIGIBILITY UNDER MEDICARE AND MEDICAID

### Dual eligible beneficiaries



“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).

[What Is My Service Area?](#)

### 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 one hundred percent (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

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## 2.2 DUAL ELIGIBILITY UNDER MEDICARE AND MEDICAID, Continued

### QMB Program (continued)



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.

[What Is My Service Area?](#)

### 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.”

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## 2.2 DUAL ELIGIBILITY UNDER MEDICARE AND MEDICAID, Continued

### 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.

[What Is My Service Area?](#)

### 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 beneficiaries :

- 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

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](#).

## 2.2 TRUHEARING HEARING AID BENEFIT PROGRAM

### Introduction



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](mailto:provider.outreach@truhearing.com)
- Phone: **1-855-286-0550**

[What Is My Service Area?](#)

### 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:

- Forty-eight (48) free batteries per hearing aid
- Three year manufacturer's warranty for repair and one-time loss and damage replacement
- Forty-five (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.

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## 2.2 TRUHEARING HEARING AID BENEFIT PROGRAM, Continued

### 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 ten (10) days.

### Questions?

For questions about the billing and payment process, please contact TruHearing's Provider Outreach by email at [provider.outreach@truhearing.com](mailto:provider.outreach@truhearing.com), or by telephone at **1-855-286-0550**.

### 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.

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## 2.2 TRUHEARING HEARING AID BENEFIT PROGRAM, Continued

### 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 **1-855-544-3128**. 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* -- scroll down to the bottom of the manual's home page, and then click on the down arrow in the **ADDITIONAL RESOURCES** box. Select **Appendix** from the available options.

[What Is My Service Area?](#)

## 2.2 HOUSE CALL PROGRAM FOR MEDICARE ADVANTAGE

### Overview



In June 2015, Highmark launched the House Call Program for all Medicare Advantage members. (The program had been in place for a portion of our Medicare Advantage population since 2011.) This free program is aimed at helping members who have chronic conditions or who are frail and 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.

[What Is My Service Area?](#)

### Visit focus



Highmark has contracted with two vendors, Matrix Medical Network and CenseoHealth, to administer the Medicare Advantage 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, 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 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).



## 2.2 ANNUAL WELLNESS VISIT (AWV)

[What Is My Service Area?](#)

### 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 in order 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 (through the Passport Rewards Program) as well as to providers for completing the AWV.

### Billing For AWV’s



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 two 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.”

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 ANNUAL WELLNESS VISIT (AWV), Continued

### FOR MORE INFORMATION



For additional information, please see the **Annual Wellness Visit (AWV) Provider Toolkit** available on the Provider Resource Center. Select **EDUCATION/MANUALS** from the main menu, and then **Geriatric Resource Binder**.

[What Is My Service Area?](#)

## 2.2 SELECT DME NETWORK (PA ONLY)

### Overview



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.

[What Is My Service Area?](#)

### Select DME Network effective January 1, 2017



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.

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.

### FOR MORE INFORMATION



For the most current lists of providers in the Select DME Network, select **CLAIMS, PAYMENT & REIMBURSEMENT** from the main menu on the Provider Resource Center, and then **Select DME Network**. You can select a list of [all participating providers](#) or a [list organized by category](#), which includes telephone numbers.

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

## 2.2 MEDICARE ADVANTAGE PPO NETWORK SHARING

### Overview



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 (in PA and WV) and Community Blue Medicare PPO/Plus PPO (in PA 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.

[What Is My Service Area?](#)

### 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 **1-800-676-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 and/or Community Blue Medicare PPO/Plus 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.

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## 2.2 MEDICARE ADVANTAGE PPO NETWORK SHARING, Continued

### 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 **1-800-676-BLUE** (2583).

[What Is My Service Area?](#)

## CHAPTER 2: PRODUCT INFORMATION

### UNIT 3: OTHER GOVERNMENT PROGRAMS

#### IN THIS UNIT



| TOPIC                                                      | SEE PAGE |
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| Delaware Medicare Supplemental Programs                    | 6        |
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| Children's Health Insurance Program of Pennsylvania (CHIP) | 8        |
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[What Is My Service Area?](#)

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The **PA ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The **DE ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

## 2.3 MEDIGAP BLUE (PA ONLY)

### Introduction



Medigap Blue, Highmark's Medicare supplemental product for individual direct-pay customers on 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.

[What Is My Service Area?](#)

### Standardization among Medigap plans



In the 1990's, 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, H, and I. the plans are detailed in the chart below.

### Benefits available



This chart outlines the benefits provided in each of the six plans:

| SERVICE                                        | PLAN |   |   |   |   |   |
|------------------------------------------------|------|---|---|---|---|---|
|                                                | A    | B | C | E | H | I |
| Basic Benefits (including hospice coinsurance) | X    | X | X | X | X | X |
| Skilled Nursing Facility Coinsurance           |      |   | X | X | X | X |
| Part B Deductible                              |      |   | X |   |   |   |
| Foreign Travel Emergency                       |      |   | X | X | X | X |
| Part B Excess Charges                          |      |   |   |   |   | X |
| Preventive Health Benefits                     |      |   |   | X |   |   |
| At-Home Recovery                               |      |   |   |   |   | X |

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

*Continued on next page*

## 2.3 MEDIGAP BLUE (PA ONLY), Continued

### Highmark plan changes in 2010



In the year 2010, changes were made to the list of Medigap Blue plans that Highmark offers. Plan F and High Deductible (HD) Plan F were added as of January 1, 2010, and Plan N was added as of June 1, 2010.

Also effective June 1, 2010, Plans E, H, and I were closed to new enrollment; however, historic enrollment may still exist in these plans.

### Core benefits for all Medigap Blue plans



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

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

[What Is My Service Area?](#)

### Benefits under Plans A, B, C, F High Deductible, and N



The table below compares the benefits available under the six Medigap Blue plans currently offered by Highmark. Plans that have been closed to new enrollment are not included in this chart, but can be referenced in the previous chart in this section. Plans E, H, and I may still contain historic enrollment. Plans A, B, and C are offered on both charts.

| SERVICE                                        | PLAN |   |   |   |      |               |
|------------------------------------------------|------|---|---|---|------|---------------|
|                                                | A    | B | C | F | F HD | N             |
| Basic Benefits (including hospice coinsurance) | X    | X | X | X | X    | X with copays |
| Part A Deductible                              |      | X | X | X | X    | X             |
| Skilled Nursing Facility Coinsurance           |      |   | X | X | X    | X             |
| Part B Deductible                              |      |   | X | X | X    |               |
| Foreign Travel Emergency                       |      |   | X | X | X    | X             |
| Part B Excess Charges                          |      |   |   | X | X    |               |
| At-Home Recovery                               |      |   |   |   | X    |               |

### 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 NaviNet,<sup>®</sup> performing an electronic HIPAA Eligibility/Benefit Inquiry, or by calling the Provider Service Center.

*Continued on next page*

## 2.3 MEDIGAP BLUE (PA ONLY), Continued

### Medigap supplemental general information



On September 8, 1991, the Medicare Overcharge Measure (MOM) Act was passed. This 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.

[What Is My Service Area?](#)

### Medigap Blue claim submission



If you do not submit claims electronically, and payment under the supplemental coverage has not been received within thirty (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 hand corner of all documents submitted for processing.



## 2.3 SIGNATURE 65 (PA ONLY)

### Overview



Signature 65 is designed to supplement Medicare Part B covered services. Under this contract, Highmark will pay twenty (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:

- Medicare Part A deductible
- Hospital coinsurance for approved Medicare benefits
- Three hundred sixty-five (365) additional hospital days, of which up to thirty (30) can be used for inpatient mental health or substance abuse treatment
- The first three (3) pints of blood per calendar year
- Medicare Part B coinsurance

[What Is My Service Area?](#)

### Carve-out



There are many groups that prefer to purchase the same benefits for their retired employees over age 65 (those with Medicare 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 Basic Blue Shield benefits, even if the service was eligible under Medicare Part B.

## 2.3 DELAWARE MEDICARE SUPPLEMENTAL PROGRAMS

### Overview



Highmark Delaware'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.

[What Is My Service Area?](#)

### Medicfill®



Highmark Delaware's Medicfill® coverage is a health insurance plan designed to supplement Medicare coverage after an individual has retired or become eligible for Medicare as a result of a disability. Medicare is the primary payer; Highmark Delaware is the secondary payer. These are the standardized plans (such as Plan A) and are available as individual direct-pay plans only.

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



Carve-out coverage is a health benefits approach designed to "complement" Medicare coverage after an individual (or spouse), who is still actively working, has reached age 65 and is enrolled in Medicare Parts A and B. It is designed to provide the same benefits the individual had before he or she became eligible for Medicare. Medicare is the primary payer; Highmark Delaware is the secondary payer. These plans are available for groups and individuals.

With this Medicare supplemental product, the benefit is calculated in a way to give an individual who is eligible for Medicare the same benefit as someone in the same employer group who is under age 65 and not eligible for Medicare.

## 2.3 WEST VIRGINIA MEDICARE SUPPLEMENTAL PROGRAMS

### Overview



Highmark West Virginia 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.

[What Is My Service Area?](#)

### Medifil



Medifil is Highmark West Virginia's Medicare supplemental product for individuals who are retired and over age 65, or have become eligible for Medicare as a result of 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 coverage



Carve-out coverage is designed to "complement" Medicare coverage after an individual (or spouse), who is still actively working, has reached age 65 and is enrolled in Medicare Parts A and B. It provides the same benefits the individual had before he or she became eligible for Medicare. Medicare is the primary payer; Highmark West Virginia is the secondary payer.

With this product, the benefit is calculated in a way to give an individual who is eligible for Medicare the same coverage as someone in the same employer group who is under age 65 and not eligible for Medicare.

## 2.3 CHILDREN'S HEALTH INSURANCE PROGRAM OF PENNSYLVANIA (CHIP)

### Introduction



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

[What Is My Service Area?](#)

### Background



The Children's Health Insurance Program (CHIP) is modeled after the Caring Program for Children, which was pioneered by Highmark through its Caring Foundation more than 25 years ago. CHIP expanded in 2007 with the legislation to Cover All Kids. CHIP 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 Insurance Department.

### Health care providers make the programs possible



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 Plan.

### Free, Low-Cost, and Full-Cost CHIP



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.

*Continued on next page*

## 2.3 CHILDREN'S HEALTH INSURANCE PROGRAM OF PENNSYLVANIA (CHIP), Continued

### 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, CHIP uses 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.

Prescription drugs are provided using the Premier Network. Vision coverage is administered by Davis Vision and Dental coverage is provided by United Concordia's network.

[What Is My Service Area?](#)

### Payment directly to participating providers



As with our commercial group programs, Highmark pays Premier Blue Shield, KHPW, and FPH network providers 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 members check the network status of their provider.\*

*\* This does not apply to emergency care.*

### Eligibility requirements for CHIP



The Highmark CHIP Administrative Unit performs eligibility and enrollment functions for children with 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 Public Welfare 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

*Continued on next page*

## 2.3 CHILDREN'S HEALTH INSURANCE PROGRAM OF PENNSYLVANIA (CHIP), Continued

### What Is My Service Area?

#### Eligibility requirements for CHIP (continued)



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).*

#### CHIP ID cards



A child enrolled in CHIP will have the same Highmark insurance card as any commercial or group member. The symbol "Y-18" will appear on ID cards for CHIP members. It can be found in the bottom left-hand corner on the front of the card. You may use NaviNet® to determine eligibility, coverage, and claim status.

#### Central Region:

| HIGHMARK                                                            |          | PPOPlus                                                         |     |
|---------------------------------------------------------------------|----------|-----------------------------------------------------------------|-----|
| MEMBER NAME<br>FIRSTNAME E LASTNAME<br>MEMBER ID<br>ZAR109465162001 |          | PCP INFORMATION<br>PCP PROVIDER NAME<br>412-555-1212 01-01-2012 |     |
| Group                                                               | 02531700 | PCP Visit                                                       | \$0 |
| BS Plan                                                             | 378      | Specialist Visit                                                | \$0 |
| RxGrp                                                               | HMRK001  | Emergency Room                                                  | \$0 |
| RxBIN                                                               | 610014   |                                                                 |     |
| Y-18                                                                |          | Rx                                                              |     |

**www.highmarkblueshield.com**  
 Member Service 1-800-345-3806  
 Mental Health 1-866-727-4936  
 Substance Abuse 1-866-727-4936  
 Pre-Cert 1-800-345-3806  
 BlueCard Service 1-800-810-BLUE

In case of emergency no prior approval is required, go to the nearest medical provider.  
 To receive high level benefits: Receiving non-emergency care through an out-of-network provider will result in a reduced level of benefits.  
 Call Pre-Cert number before you receive non-emergency out-of-network care.  
 For urgent care outside the area, call BlueCard Service to locate a participating provider.

Submit medical claims to the local BC/BS plan. If not filed to the local plan, submit claims to: Highmark Blue Shield P.O. Box 690173, Camp Hill, PA 17089-0173. Highmark Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association.

#### Western Region:

| HIGHMARK                                                       |          | Keystone Blue                                                    |     |
|----------------------------------------------------------------|----------|------------------------------------------------------------------|-----|
| MEMBER NAME<br>FIRSTNAME M LASTNAME<br>MEMBER ID<br>YYRXXXXXXX |          | PCP INFORMATION<br>PCP PROVIDER NAME<br>XXXX-XXX-XXXX 01-01-1900 |     |
| Group                                                          | 05874100 | PCP Visit                                                        | \$0 |
| BC/BS Plan                                                     | 363/865  | Specialist Visit                                                 | \$0 |
| RxGrp                                                          | KHPW001  | Emergency Room                                                   | \$0 |
| RxBIN                                                          | 610014   |                                                                  |     |
| Y-18                                                           |          | Rx                                                               |     |

**www.highmarkbcbs.com**  
 Member Service 1-800-547-9378  
 Blues on Call 1-888-BLUE-428  
 BlueCard Service 1-800-810-BLUE  
 Mental Health 1-800-258-9808  
 Substance Abuse 1-800-258-9808

Blues on Call: 24-hour access to nurses who provide health education and support services.  
 In case of emergency no prior approval is required. Notify your PCP within 48 hours or as soon as reasonably possible for follow-up care.  
 For urgent care outside the area call BlueCard Service to locate a participating provider.  
 Call the Mental Health or Substance Abuse numbers to get help in obtaining services from a network provider.

Providers: File claims to the local BC/BS plan.  
 Members: File claims to: Send written inquiries to: P.O. Box 226, Pittsburgh, PA 15230-0226. Highmark Blue Cross Blue Shield and Highmark Choice Company are Independent Licensees of the Blue Cross and Blue Shield Association.

#### Northeastern Region:

| BlueCross BlueShield                                                  |          | First Priority Health for Kids                                  |     |
|-----------------------------------------------------------------------|----------|-----------------------------------------------------------------|-----|
| MEMBER NAME<br>FIRST NAME M LAST NAME<br>MEMBER ID<br>JUM123456789001 |          | PCP INFORMATION<br>PCP PROVIDER NAME<br>XXX-XXX-XXXX 01-01-2016 |     |
| Group                                                                 | 09735600 | PCP Visit                                                       | \$0 |
| BC/BS Plan                                                            | 363/865  | Specialist Visit                                                | \$0 |
| RxGrp                                                                 | HMRK001  | Emergency Room                                                  | \$0 |
| RxBIN                                                                 | 610014   |                                                                 |     |
| Y-18                                                                  |          | Rx                                                              |     |

**www.highmarkbcbs.com**  
 Member Service 1-800-547-9378  
 Blues on Call 1-888-BLUE-428  
 BlueCard Service 1-800-810-BLUE  
 Mental Health 1-800-258-9808  
 Substance Abuse 1-800-258-9808

Blues on Call: 24-hour access to nurses who provide health education and support services.  
 In case of emergency no prior approval is required. Notify your PCP within 48 hours or as soon as reasonably possible for follow-up care.  
 For urgent care outside the area call BlueCard Service to locate a participating provider.  
 Call the Mental Health or Substance Abuse numbers to get help in obtaining services from a network provider.

Providers: File claims to the local BC/BS plan.  
 Members: File claims to: Send written inquiries to: P.O. Box 226, Pittsburgh, PA 15230-0226. Highmark Blue Cross Blue Shield, Highmark Blue Cross Blue Shield and First Priority Health are independent licensees of the Blue Cross Blue Shield Association.

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## 2.3 CHILDREN'S HEALTH INSURANCE PROGRAM OF PENNSYLVANIA (CHIP), Continued

### CHIP product offerings



**PA Western Region:** CHIP benefits are offered through an HMO product utilizing the KHPW managed care network.

**PA Central Region:** CHIP benefits are offered through *PPO Plus* – a managed care program featuring a PCP component. *PPO Plus* utilizes the Premier Blue Shield network. Unlike traditional PPOs, all Act 68 and Managed Care regulations, including complaint and grievance rights, apply to *PPO Plus*.

**PA Northeastern Region:** CHIP benefits are offered through First Priority Health for Kids -- an HMO product utilizing the FPH managed care network.

### IMPORTANT! PCP required



#### All CHIP members must select a PCP to manage their care.

Routine wellness, preventive care, and immunizations will only be reimbursed if performed by the PCP.

[What Is My Service Area?](#)

### Information for PCPs of CHIP members



Since the CHIP products offered in the Western, Central, and Northeastern Regions are managed care products, all CHIP members must select a PCP to coordinate their care. Routine wellness, preventive care, and immunizations will only be reimbursed if performed by the PCP. All Act 68 and Managed Care regulations, including complaint and grievance rights, apply to the Western Region's Keystone Blue HMO product, the Central Region's PPO Plus product, and the Northeastern Region's First Priority Health for Kids HMO product.

Central Region CHIP members will have an identification card with the PPO Plus product name in the upper right hand corner. For CHIP members residing in the Western Region, the HMO product name, Keystone Blue, will appear in the upper right hand corner on the front of their ID cards. First Priority Health for Kids will be displayed in the upper right corner of the ID card for CHIP members in the 13-county Northeastern Region. The chosen PCP's practice name will also be on the front of all member identification cards (see ID card samples on the previous page).

Although CHIP members are required to select a PCP to oversee their care, traditional "referrals" are not required. If it is necessary to recommend that a CHIP member see a specialist or other provider, PCPs should make every attempt to refer members to providers within the network. Members who go outside of the

*Continued on next page*



## 2.3 CHILDREN'S HEALTH INSURANCE PROGRAM OF PENNSYLVANIA (CHIP), Continued

### Information for PCPs of CHIP members (continued)



network may be responsible for paying any difference between the out-of-network provider's actual charge and the Highmark payment. This occurs even when members are directed to an out-of-network provider by an in-network provider.

- **In the Central Region:** Members can go outside the Premier Blue Shield network and receive care at the lower level of coverage with higher out-of-pocket expenses
- **In the Western Region:** Members must use the Keystone Health Plan West (KHPW) managed care network providers to receive 100 percent coverage unless the care is pre-authorized.
- **In the Northeastern Region:** Members must use First Priority Health (FPH) managed care network providers to receive 100 percent coverage unless the care is pre-authorized.

Member Rights and Responsibilities for CHIP members are available in [Chapter 1.5: Member Rights and Responsibilities](#).

### IMPORTANT!



Providers are reminded that Highmark has eliminated referral requirements in Pennsylvania; however, authorization requirements still exist.

[What Is My Service Area?](#)

### Authorization requirements



Authorization for select services is required for the CHIP HMO products in the Western and Northeastern Regions and also the CHIP *PPO Plus* product in the Central Region. (Please note that CHIP *PPO Plus* authorization requirements differ from traditional PPOs.)

The following services require authorization for CHIP members:

- 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 services (coordinated by National Imaging Associates, Inc. (NIA))
- Durable medical equipment (DME) and orthotics and prosthetics
- Highmark's list of outpatient procedures requiring authorization (available on the Provider Resource Center under **CLAIMS, PAYMENT & REIMBURSEMENT**)

*Continued on next page*



## 2.3 CHILDREN'S HEALTH INSURANCE PROGRAM OF PENNSYLVANIA (CHIP), Continued

[What Is My Service Area?](#)

### Authorization requirements (continued)



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

### Caring Program: Care coordination for special needs



CHIP coverage in the 49-county Western and Central Regions includes the Caring Program-- 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 CHIP members 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. When appropriate, the staff can assist CHIP members at their medical appointments and school meetings.

For questions regarding the Caring Program, please call **1-866-823-0892** and leave a message. All calls are returned within two (2) business days.

The Caring Program Customer Service is available Monday through Friday, 8:30 a.m. to 4:30 p.m. EST. Information regarding the Caring Program can also be accessed at: [caringprogram.com](http://caringprogram.com).

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## 2.3 CHILDREN'S HEALTH INSURANCE PROGRAM OF PENNSYLVANIA (CHIP), Continued

[What Is My Service Area?](#)

### Pediatric Disease Management Program



Highmark's Caring Program offers a pediatric disease management program to assist CHIP members 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 members 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 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 CHIP patients 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.
- 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 patient 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 **1-866-823-0892**.

*Continued on next page*

## 2.3 CHILDREN'S HEALTH INSURANCE PROGRAM OF PENNSYLVANIA (CHIP), Continued

[What Is My Service Area?](#)


**CHIP covered services** CHIP benefits are detailed below:

| AMBULATORY SERVICES (in a non-hospital facility)                                                                                                                                                                                                     | OUTPATIENT HOSPITAL SERVICES                                                                                                                                                                                                                                                                                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Chemotherapy</li> <li>Diagnostic services</li> <li>Emergency accident and medical care</li> <li>Surgery</li> </ul>                                                                                            | <ul style="list-style-type: none"> <li>Clinic services (in a hospital-affiliated clinic)</li> <li>Diagnostic services</li> <li>Emergency accident and medical care</li> <li>Radiation therapy; dialysis treatment; and physical, occupational, and speech therapy</li> </ul>                                                           |
| INPATIENT HOSPITAL SERVICES                                                                                                                                                                                                                          | HOME HEALTH CARE                                                                                                                                                                                                                                                                                                                       |
| <ul style="list-style-type: none"> <li>90 days inpatient care per calendar year (combined limit with mental health and skilled nursing facility care)</li> <li>Pre-admission review is required</li> <li>Transplant services</li> </ul>              | <ul style="list-style-type: none"> <li>Maximum 60 visits per calendar year</li> </ul>                                                                                                                                                                                                                                                  |
| MEDICAL-SURGICAL                                                                                                                                                                                                                                     | DURABLE MEDICAL EQUIPMENT                                                                                                                                                                                                                                                                                                              |
| <ul style="list-style-type: none"> <li>Anesthesia</li> <li>Consultation <ul style="list-style-type: none"> <li>Limited to one per consultant per stay for inpatient</li> <li>Unlimited outpatient</li> </ul> </li> <li>Diagnostic medical</li> </ul> | <ul style="list-style-type: none"> <li>Including wheelchairs, oxygen, and hospital beds</li> </ul>                                                                                                                                                                                                                                     |
| EMERGENCY MEDICAL AND ACCIDENT                                                                                                                                                                                                                       | SECOND SURGICAL OPINION                                                                                                                                                                                                                                                                                                                |
| <ul style="list-style-type: none"> <li>Within 48 hours of emergency</li> <li>Includes follow-up care</li> </ul>                                                                                                                                      | <ul style="list-style-type: none"> <li>Only outpatient consultation eligible</li> </ul>                                                                                                                                                                                                                                                |
| OUTPATIENT MEDICAL VISITS                                                                                                                                                                                                                            | ALLERGY TESTING                                                                                                                                                                                                                                                                                                                        |
| <ul style="list-style-type: none"> <li>50 visits per benefit period</li> <li>Symptomatic</li> </ul>                                                                                                                                                  | <ul style="list-style-type: none"> <li>Consisting of percutaneous, intracutaneous, patch tests, and immunotherapy</li> </ul>                                                                                                                                                                                                           |
| TRANSPLANT SURGERY                                                                                                                                                                                                                                   | MENTAL HEALTH                                                                                                                                                                                                                                                                                                                          |
| ROUTINE LEAD SCREENING                                                                                                                                                                                                                               | <ul style="list-style-type: none"> <li>90 days inpatient care per calendar year (medical/surgical, SNF, and mental health combined)</li> <li>Partial hospitalization (may exchange inpatient days for partials on 2:1 basis to obtain up to 180 partials)</li> <li>50 outpatient visits</li> <li>Emergency psychiatric care</li> </ul> |

*Continued on next page*

## 2.3 CHILDREN'S HEALTH INSURANCE PROGRAM OF PENNSYLVANIA (CHIP), Continued

[What Is My Service Area?](#)


### Other CHIP covered services

| MEDICAL-SURGICAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | DENTAL (administered by United Concordia)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Preventive pediatric – follows the Highmark Preventive Schedule</li> <li>Maternity – including prenatal and postnatal care</li> <li>Routine newborn care – first 31 days</li> <li>Oral surgery for the removal of partial and full bony impacted teeth</li> <li>Surgery</li> <li>Therapy services – chemotherapy; radiation; dialysis treatment; and physical, occupational, and speech therapy (PT, OT, &amp; ST limited to 60 visits combined)</li> <li>Substance abuse – follows mandate</li> </ul> | <b>Diagnostic services:</b> <ul style="list-style-type: none"> <li>Routine exam (one every 6-month period)</li> <li>Bitewing X-rays (once in any 12-month period)</li> <li>Full-mouth X-rays (once every 5-year period)</li> </ul> <b>Restorative services:</b> <ul style="list-style-type: none"> <li>Amalgam and resin restorations to restore diseased or accidentally broken teeth</li> <li>Amalgam and composite restorations for all permanent and deciduous teeth</li> <li>Resin, porcelain, and full-cast single crowns for permanent teeth</li> </ul> |
| PRESCRIPTION DRUGS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Preventive services:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <ul style="list-style-type: none"> <li>Open formulary with soft generic</li> <li>Copayments required for Low-Cost and Full-Cost CHIP</li> <li>First Fill quantity level limit</li> <li>90 days at retail available</li> </ul>                                                                                                                                                                                                                                                                                                                 | <ul style="list-style-type: none"> <li>Routine prophylaxis (one every 6-month period)</li> <li>Topical fluoride application (once every 6-month period)</li> <li>Space-maintainers (within approved limits)</li> <li>Sealants (within approved limits)</li> </ul>                                                                                                                                                                                                                                                                                              |
| HEARING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | General service:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <ul style="list-style-type: none"> <li>Hearing evaluation – once every calendar year</li> <li>Audiometric examination – once every calendar year</li> <li>Hearing aid – not more than one per ear in any two calendar years and \$3,000 limit every 24 consecutive months</li> </ul>                                                                                                                                                                                                                                                          | <ul style="list-style-type: none"> <li>Palliative emergency treatment of an acute condition requiring immediate care</li> <li>Simple extractions (as necessary)</li> <li>Pulpotomies covered for deciduous teeth</li> <li>Administration of anesthesia (within limits)</li> <li>Consultations (within limits and only during inpatient stay)</li> </ul>                                                                                                                                                                                                        |
| VISION (administered by Davis Vision*)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <ul style="list-style-type: none"> <li>Eye examination and refraction – once every 6 months</li> <li>Frame – one every 12 months</li> <li>Lenses – single vision, bifocal, trifocal, aphakic – one pair every 6 months</li> <li>Contact lenses (pair) – covered when medically necessary</li> </ul>                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | * Davis Vision network providers accept reimbursements as payment in full for standard services. Non-Davis network providers are reimbursed at an out-of-network fee schedule.                                                                                                                                                                                                                                                                                                                                                                                 |

Continued on next page

## 2.3 CHILDREN'S HEALTH INSURANCE PROGRAM OF PENNSYLVANIA (CHIP), Continued

[What Is My Service Area?](#)

### 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 CMS-1500 claim form. Please note that in all cases, the child is the member. Report "Patient's relationship to insured" as "self." Do not report the name of the parent.

Electronic claims are preferred. Submit your paper claims to:

| CENTRAL REGION:          | WESTERN AND NORTHEASTERN REGIONS: |
|--------------------------|-----------------------------------|
| Highmark Blue Shield     | Highmark Blue Shield              |
| P.O. Box 890173          | P.O. Box 898819                   |
| Camp Hill, PA 17089-0173 | Camp Hill, PA 17089-8819          |

| DENTAL                           | ROUTINE VISION          |
|----------------------------------|-------------------------|
| United Concordia Companies, Inc. | Davis Vision            |
| Claims Processing                | Vision Care Claims Unit |
| P.O. Box 69421                   | P.O. Box 1501           |
| Harrisburg, PA 17106-9421        | Latham, NY 12110        |

### CHIP enrollment



If you know of children who may qualify for this program, please refer them to the appropriate telephone number:

Highmark CHIP Administrative Unit (PA Western, Central, and Northeastern Regions): **1-800-KIDS-105** (1-800-543-7105); 1-877-323-8480 TTY Service

### FOR MORE INFORMATION



For more information on CHIP, please visit Pennsylvania's "We Cover All Kids" website at <http://www.chipcoverspakids.com>.

## 2.3 THE FEDERAL EMPLOYEE PROGRAM (FEP)

### Overview

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 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 option

Federal employees are offered two Preferred Provider Organization (PPO) benefit packages through FEP -- Standard Option and Basic Option. The same types of services are covered under both options, but at different payment levels.

The **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.

### 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:



*Continued on next page*

## 2.3 THE FEDERAL EMPLOYEE PROGRAM (FEP), Continued

### SAMPLE: Standard Option ID card

#### Front of card:

|                                                                                                                           |                 |                                                                                   |
|---------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------------------------------------------------------------------------|
|  Government-Wide<br>Service Benefit Plan |                 |  |
| Federal Employee Program                                                                                                  |                 |                                                                                   |
| Member Name                                                                                                               | www.fepblue.org |                                                                                   |
| SOUTH CARO IDNEW TEST CARD                                                                                                |                 |                                                                                   |
| Member ID                                                                                                                 | R94665193       |                                                                                   |
| Enrollment Code                                                                                                           | 105             | RxBIN 610415                                                                      |
| Effective Date                                                                                                            | 01/01/2008      | RxPCN PCS                                                                         |
|                                                                                                                           |                 | RxGrp 65006500                                                                    |

#### Back of card:

|                                                                                                                            |                                  |                                                                                     |
|----------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------|
|  Government-Wide<br>Service Benefit Plan |                                  |  |
| Federal Employee Program                                                                                                   |                                  |                                                                                     |
| www.fepblue.org                                                                                                            |                                  |                                                                                     |
| Customer Service:                                                                                                          | 1-800-788-0222<br>1-800-444-0025 |                                                                                     |
| Prescription:                                                                                                              | 1-800-756-8880<br>1-800-327-3239 |                                                                                     |
| Mental Health/<br>Substance Abuse:                                                                                         | 1-800-869-1032                   |                                                                                     |
| Retail Pharmacy:                                                                                                           | 1-800-424-5060                   |                                                                                     |
| Mail Service Pharmacy:                                                                                                     | 1-800-262-7890                   |                                                                                     |
| Assistance Overseas<br>(Call Collect):                                                                                     | 1-804-673-1678                   |                                                                                     |
| Blue Health Connection:                                                                                                    | 1-888-256-3432                   |                                                                                     |
| Blue Cross and Blue Shield of South Carolina<br>An Independent Member of the BlueCross<br>and BlueShield Association.      |                                  |                                                                                     |

### SAMPLE: Basic Option ID card

#### Front of card:

|                                                                                                                           |                 |                                                                                   |
|---------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------------------------------------------------------------------------|
|  Government-Wide<br>Service Benefit Plan |                 |  |
| Federal Employee Program                                                                                                  |                 |                                                                                   |
| Member Name                                                                                                               | www.fepblue.org |                                                                                   |
| TEST I M SAMPLE                                                                                                           |                 |                                                                                   |
| Member ID                                                                                                                 | R94665017       |                                                                                   |
| Enrollment Code                                                                                                           | 112             | RxBIN 610415                                                                      |
| Effective Date                                                                                                            | 01/01/2008      | RxPCN PCS                                                                         |
|                                                                                                                           |                 | RxGrp 65006500                                                                    |

#### Back of card:

|                                                                                                                            |                                  |                                                                                     |
|----------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------|
|  Government-Wide<br>Service Benefit Plan |                                  |  |
| Federal Employee Program                                                                                                   |                                  |                                                                                     |
| www.fepblue.org                                                                                                            |                                  |                                                                                     |
| Customer Service:                                                                                                          | 1-800-484-1680<br>1-800-645-8766 |                                                                                     |
| Prescription:                                                                                                              | 1-800-663-8700                   |                                                                                     |
| Mental Health/<br>Substance Abuse:                                                                                         | 1-877-556-9604                   |                                                                                     |
| Retail Pharmacy:                                                                                                           | 1-800-424-5060                   |                                                                                     |
| Assistance Overseas<br>(Call Collect):                                                                                     | 1-804-673-1678                   |                                                                                     |
| Blue Health Connection:                                                                                                    | 1-888-256-3432                   |                                                                                     |
| CareFirst BlueCross BlueShield<br>An Independent Member of the BlueCross<br>and BlueShield Association.                    |                                  |                                                                                     |

[What Is My Service Area?](#)

### Verifying eligibility & benefits

Eligibility and benefits can be verified through NaviNet® for FEP members residing in Pennsylvania, Delaware, and West Virginia.

For out-of-state FEP members, or FEP members in Highmark's service areas if NaviNet is not available, please call the appropriate FEP Provider Service department:

- Pennsylvania: **1-866-763-3608**
- Delaware: **1-800-721-8005**
- West Virginia: **1-800-535-5266** or **304-424-7792**

Hours are Monday through Friday, 8:30 a.m. to 4 p.m. EST.

*Continued on next page*

## 2.3 THE FEDERAL EMPLOYEE PROGRAM (FEP), Continued

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### 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.

**\* 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.

For special tips on claim submission for FEP members, please see the section on FEP Processing in [Chapter 6.4: Professional \(1500/837P\) Reporting Tips](#).

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### FOR MORE INFORMATION

For more information on the Blue Cross Blue Shield Federal Employee Program, please visit [fepblue.org](http://fepblue.org).

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## CHAPTER 2: PRODUCT INFORMATION

### UNIT 4: BENEFIT PLAN PROGRAMS

#### IN THIS UNIT



| TOPIC                       | SEE PAGE |
|-----------------------------|----------|
| Baby Blueprints             | 2        |
| Blues On Call               | 4        |
| Diabetes Prevention Program | 6        |
| Health Promotion Programs   | 9        |
| Health Spending Accounts    | 12       |
| Highmark Wellness Rewards   | 17       |
| MyCare Navigator            | 19       |
| Patient Experience Review   | 21       |

[What Is My Service Area?](#)

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The **PA ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The **DE ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

## 2.4 BABY BLUEPRINTS

|                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|---------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Overview</b>                             | <p>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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Program details</b>                      | <p>Baby Blueprints is a free program that 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.</p> <p>Baby Blueprints will also provide program participants access to individualized support from a nurse Health Coach.</p> <p>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.”</p> <div style="text-align: right;"> <a href="#">What Is My Service Area?</a> </div> |
| <b>Member fliers</b>                        | <p>Please click on the applicable link for your service area for a printable Baby Blueprints flier for your eligible Highmark members:</p> <ul style="list-style-type: none"> <li>• Pennsylvania:             <ul style="list-style-type: none"> <li>○ <a href="#">Highmark Blue Cross Blue Shield Baby Blueprints Flier</a></li> <li>○ <a href="#">Highmark Blue Shield Baby Blueprints Flier</a></li> </ul> </li> <li>• <a href="#">Highmark Delaware Baby Blueprints Flier</a></li> <li>• <a href="#">Highmark West Virginia Baby Blueprints Flier</a></li> </ul>                                                                                                                                                                                                                       |
| <b>Who is eligible for Baby Blueprints?</b> | <p>Baby Blueprints is available to expectant Highmark members enrolled in a commercial group product, direct pay product, or social mission product.</p> <p>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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>How members can enroll</b>               | <p>Enrollment in Baby Blueprints is simple and convenient. Expectant mothers can enroll at no cost over the phone by calling toll free <b>1-866-918-5267</b>.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

*Continued on next page*

## 2.4 BABY BLUEPRINTS, Continued

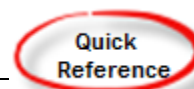
### What can members expect?

Upon enrollment members will receive a confirmation mailing that contains:

- Enrollment confirmation letter
- Information on various educational resources and online support programs found on the Highmark member site
- Information on a childbirth education class reimbursement form, which is available online
- Child immunization and preventive care pamphlet

Members will also receive access to pregnancy-related information on the member website and the *Pregnancy Building Blocks* maternity booklet. The program also includes proactive outreach from a nurse health coach. After delivery, members may also be referred to enroll in a post-partum depression program, if appropriate.

If the member's program includes Blues On Call, she can call the toll-free number at any time to talk to a health coach about any questions/concerns she may have following pregnancy. (For more information on Blues On Call, please see the "Blues On Call" section within this unit.)



### FOR MORE INFORMATION

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.

## 2.4 BLUES ON CALL

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### **What is 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 discuss health information and assist with health care decisions.

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### **Who is eligible?**

Most Highmark members are automatically eligible to make use of Blues On Call services. No registration is required and the service is free.

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### **Chronic condition support**

Blues On Call focuses on helping members manage their chronic illnesses, placing special emphasis on the importance of dealing with the co-morbidities that face many seriously ill individuals. Since most chronically ill members have more than one chronic condition, the Blues On Call “whole patient” approach is a significant improvement over “silo-structured” disease management programs.

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
- 

### **Medical decision support**

Blues On Call Health Coaches educate and support those facing significant medical decisions related to conditions such as:

- Back pain (spinal stenosis, herniated disc, and chronic low back pain)
  - Breast cancer (adjuvant therapy, choosing your surgery, choosing your treatment)
  - Benign uterine problems
  - End-of-life care
  - Prostate issues (benign prostatic hyperplasia, prostate-specific antigen [PSA] decision)
  - Knee osteoarthritis
  - Coronary artery disease
- 

*Continued on next page*

## 2.4 BLUES ON CALL, Continued

### Medical decision support (continued)

Health Coaches provide objective, evidence-based information to help individuals understand their situation, including the potential benefits and potential harms of treatment choices. Health Coaches also help patients gain insights into their choices and provide a framework to think through the decision.

Most importantly, members can incorporate their personal values and preferences into the decision and communicate more effectively with their provider.

### Symptom management support

Blues On Call Health Coaches provide support over the telephone to help members interpret and act on symptoms. Coaches are available 24 hours a day, every day of the year.

Health Coaches use algorithms to educate and support patients to help them make informed decisions about their current situation. This approach provides patients with the opportunity to learn skills that can be used when similar situations arise in the future.

### What Blues On Call is not

Blues On Call does not:

- Address benefit issues
- Address claims issues
- Provide diagnosis or medical advice

### When to refer a patient

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.

### Links to other Highmark resources

Blues On Call Health Coaches can provide information on a variety of health and wellness topics. They also work closely with other Highmark resources for members.

### How to refer to Blues On Call

Encourage your patient to call the Blues On Call phone line (this number is also located on the back of the member ID card): **1-888-BLUE-428** (1-888-258-3428).

### Poster available

The [Blues On Call poster](#) can be printed for your office or to give to a Highmark member. The poster is also available on the Provider Resource Center – select **EDUCATION/MANUALS**, and then **Prevention 101 Awareness Posters**.

## 2.4 DIABETES PREVENTION PROGRAM

### Introduction

Effective January 1, 2018, 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 beginning August 1, 2017.

[What Is My Service Area?](#)

### 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.<sup>SM</sup>

### 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 eighteen (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.

*Continued on next page*

## 2.4 DIABETES PREVENTION PROGRAM, Continued

### 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 sixteen (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 twenty-five (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

[What Is My Service Area?](#)

### Member flier

Please click on the applicable link for your service area for a printable Diabetes Prevention Program flier for your eligible Highmark members:

- Pennsylvania:
  - o [Highmark Blue Cross Blue Shield Diabetes Prevention Program Flier](#)
  - o [Highmark Blue Shield Diabetes Prevention Program Flier](#)
- [Highmark Delaware Diabetes Prevention Program Flier](#)
- [Highmark West Virginia Diabetes Prevention Program Flier](#)

*Continued on next page*

## 2.4 DIABETES PREVENTION PROGRAM, Continued

**Verify  
program  
eligibility  
via NaviNet®**

Providers can verify a member's coverage for the Diabetes Prevention Program in NaviNet's Eligibility and Benefits.

From the main Eligibility and Benefits screen, select **Additional Benefit Provisions**:

Eligibility and Benefits for **JANE M. DOE**  
Female born on 07/10/1956

Highmark: No additional payer information on file

Member ID: [REDACTED] Group: [REDACTED] Service Date: 08/11/2017

**INSURANCE DETAILS**  
View Current Member ID Card

**Group Information**  
Plan Area: [REDACTED]  
Alpha Prefix: [REDACTED]  
Advanced Imaging Ind: YES

**Additional Benefit Provisions** (circled in red)

And then select  
**Routine/Preventive Care**  
from the pop-up box.

**Additional Benefit Provisions** X

- Inpatient Facility Services
- Outpatient Facility Services
- Behavioral Health/Substance Abuse
- Professional Services
- Professional Therapy and Rehabilitation Services
- Routine/Preventive Care** (circled in red)
- Ancillary Services/Supplies
- Other Reproductive Services (non Maternity)
- Oral Surgery/Dental Accident
- Educational & Medical Programs
- Conditions
- Other Services

Close

Scroll down to the **Preventive Care** benefit, "Diabetes Prevention Program" will be listed under the Preventive Schedule categories and will indicate **"Yes"** if the member's plan provides coverage.

| Routine/Preventive Care                               |                                       |
|-------------------------------------------------------|---------------------------------------|
| <b>Preventive Care</b>                                |                                       |
| Coverage                                              | Yes                                   |
| Adult Preventive Schedule                             | State of Delaware Preventive Schedule |
| <b>Pediatric Preventive Schedule</b> (circled in red) | State of Delaware Preventive Schedule |
| <b>Diabetes Prevention Program</b> (circled in red)   | <b>Yes</b> (circled in red)           |



## 2.4 HEALTH PROMOTION PROGRAMS

### Introduction

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 on-line, in the community, at the workplace, and telephonically.

### Health Promotion programs

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 (3) key areas:

- Wellness Profile (health risk and productivity assessments)
- Worksite Health Promotion Programs
- Lifestyle Improvement Programs

### Web-based programs

Web-based programs, powered by Web-MD, are available to all medically insured members. The programs are designed to guide members in developing a personal plan for implementing a healthier lifestyle and reinforce their healthcare provider's instructions for managing chronic conditions.

Members start with the completion of a Wellness Profile. A Digital Health Assistant (DHA) may then provide an online experience emulating one on one personal coaching. The DHA helps members take action, set goals, track progress, and create weekly plans that support longer-term goals.

### 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 and health fairs. Education services include individual coaching in conjunction with the biometric screening experience, live classes pertaining to weight, stress, or nutrition management delivered either on-site or via webinar, and newsletter campaigns.

Engagement is encouraged through a variety of "Reward" programs that track participation for incentive purposes, and activity based "Challenges" that promote increased exercise through friendly competition.

*Continued on next page*

## 2.4 HEALTH PROMOTION PROGRAMS, Continued

|                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|-----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Primary Health Coach Model</b>                   | <p>HMS uses the primary health coach model along with various clinical platforms to support its health promotion programs.</p> <p>Employer groups are given the option to select a model to engage their employees in condition and case management, and wellness activities.</p> <p>In all models, a Primary Health Coach provides a single point of contact for members for both condition and case management to further enhance the seamlessness of the member experience. Members are encouraged to develop collaborative relationships with their Health Coaches.</p>                                                                                                                                                                                                                                                                               |
| <b>Co-morbidities addressed</b>                     | <p>The Health Coach addresses co-morbidities that many seriously ill individuals face. The Primary Health Coach Model uses motivational interviewing and coaching techniques, and focuses on the whole person. These techniques allow the Health Coach to address the member's full spectrum of healthcare issues rather than focusing on a single issue or condition.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Enrollment time period</b>                       | <p>The time period a member is enrolled in a condition management program varies, and is specific to the member's needs. The Health Coach assists the member in developing care goals whose focus is member self-management. Once these goals are accomplished, the program is closed.</p> <p>Members are encouraged to re-engage with the Health Coach at any time that their clinical condition requires, or when they simply want the additional support of the Health Coach to work toward attainment of their goals.</p>                                                                                                                                                                                                                                                                                                                             |
| <b>Components of the Primary Health Coach Model</b> | <p>There are three main components in the Primary Health Coach Model.</p> <p><b>High Risk Member Outreach</b></p> <p>High risk members are coached using motivational interviewing techniques with a focus on self-management. Health coaches assess members using questionnaires then, in collaboration with the member, develop goal directed plans of care.</p> <p>Health coaches individualize the length and frequency of each call based on member need or request.</p> <p><b>Moderate Risk Member Outreach</b></p> <p>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</p> |

*Continued on next page*

## 2.4 HEALTH PROMOTION PROGRAMS, Continued

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### **Components of the Primary Health Coach Model** (continued)

their condition, and to offer the member the opportunity to transfer to speak directly to a Health Coach.

When the member accepts the opportunity to speak to a Health Coach, the member can be enrolled in a condition management program. This enrollment enables the member to have ongoing access to a Primary Health Coach who will assist the member to develop short and long-term self-management goals and to develop strategies for overall health improvement.

The Health Coach uses 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

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### Overview

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)

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.

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### Health Savings Account (HSA)

A Health Savings Account (HSA) can be offered with a federally-qualified high-deductible health plan (QHDHP). The Internal Revenue Service (IRS) determines the annual maximum contribution. HSAs must be linked with a qualified high-deductible health insurance plan, and both the employer and the employee can contribute to it.

Pre-tax income can be set aside to spend on eligible medical expenses and there is no tax on account withdrawals as long as they are used for eligible expenses. The member may invest savings in a variety of mutual funds offered through the HSA. Interest or investment earnings also accumulate tax-free.

The employer may establish payroll deduction for employee contributions and may also opt to contribute to the accounts. The member owns and manages the HSA and decides how and when to use account funds. The account funds accumulate year after year. The funds move with the employee when he/she changes jobs.

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### Health Reimbursement Account (HRA)

A Health Reimbursement Account (HRA) is a health spending account funded by the employer. The employer decides how much to fund the account, which types of expenses may be paid using the account funds, and whether funds roll over at the end of the benefit period.

By offering an HRA along with a health plan that includes employee cost sharing, employers are able to share more of the health care costs while providing employees with health care coverage they value. The employer can designate the funds to be used for the member's cost sharing for covered services and also for expenses not covered by their medical plan such as dental or vision care services. Employees are encouraged to be more involved in their spending decisions and better able to monitor their health care costs.

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*Continued on next page*

## 2.4 HEALTH SPENDING ACCOUNTS, Continued

### **Flexible Spending Account (FSA)**

Flexible Spending Accounts (FSAs) allow members to set aside a specified amount from their paycheck to pay for out-of-pocket medical and health-related expenses not fully reimbursed by their health coverage. An FSA offers a practical solution for those who have additional or special care needs, or for those who would like a vehicle to help budget their medical and health-related costs.

An employer can offer an optional FSA to their employees with any Highmark health plan. A Limited Purpose Medical Care FSA is another option that can be offered with a qualified high deductible health plan in addition to an HSA; however, it can be used for dental, vision, and preventive care expenses only.

The employee determines the amount to contribute to the FSA (up to a maximum set by the IRS), and their pre-tax contributions through payroll deduction are not subject to taxes. The money is the employee's to manage and use during the plan year. Funds must be used by the end of the benefit year since account balances do not carry over; any unused balance at the end of the benefit period is forfeited back to the plan.

### **Plan Activity Statement for members**

Highmark health spending account members can view their account and claims information in a single, user-friendly document. Plan Activity Statements replace Explanation of Benefits (EOB); they capture multiple processed claims and spending account transactions in one document. They are available to members who are enrolled in both a Highmark medical benefit plan and a Highmark health spending account product (HSAs, HRAs, and FSAs).

The statements are written in simple language with clear explanations of claims payments and health spending account activity. The Plan Activity Statement offers many benefits to members, including:

- An easy to use and understand format that gives members a clear, comprehensive view of what services have been performed, what they cost, what has been paid, and the amount they may owe;
- Fewer statements to manage since the Plan Activity Statement consolidates multiple processed medical claims and spending account transactions into one document; and
- One statement for the whole family that clearly outlines the activity for each family member who is covered under the policy holder's plan.

Members who elect to receive the Plan Activity Statements electronically can access them with their logon and password via the secure Highmark member website. Members who request paper copies of their EOBs will receive a paper version of the Plan Activity Statement through the mail.

*Continued on next page*

## 2.4 HEALTH SPENDING ACCOUNTS, Continued

### Payment options

All members with HSA accounts receive a debit card which allows them to make payments at the time of service if they choose. Members with HSAs can also manage payments through the Highmark member website. They can designate payment to providers from their accounts on a claim by claim basis, or they can request payment “to self” and reimburse providers with a personal check.

Another payment option available to members with HSAs is “Direct Payment to Provider” – claims are then automatically submitted for payment to providers directly from their accounts.

For HRAs and FSAs, the employer determines how their employees have access to the funds. The employer can choose from the following options:

- Manual claim submission, with or without a debit card; or
- Automatic submission of claims, with or without “Direct Payment to Provider.”

An employer could choose the manual claim submission option if they would like their employees to have more control of HRA and FSA funds. This would allow their employees to manage payments themselves through the Highmark member website. With this option, members can designate payment from their accounts to providers on a claim by claim basis, or they can elect to pay themselves and reimburse providers with personal checks. And, if the employer chooses to offer a debit card, they would also be able to make payments at the time of service using the debit card.

If an employer chooses automatic submission of claims, they have two options for setting up automatic payment from HRA and FSA accounts. They can choose to have payments sent directly to providers (“Direct Payment to Provider”), or they could choose for payment from the accounts to go to employees who would then be responsible for payment to providers.

### 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.

*Continued on next page*

## 2.4 HEALTH SPENDING ACCOUNTS, Continued

### Explanation of Payment (EOP)

Whenever a full or a partial payment is made to you from a member's health spending account, you will receive an EOP to document the transaction while the member receives notification through their Plan Activity Statement. NaviNet-enabled providers will receive their EOPs via the NaviNet **EOB and Remittance Inquiry** function.

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 NaviNet, that help providers determine member responsibility prior to or at the time of services.

- The *1500 Estimate Submission* 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 *Claim Submission* function 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.

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.

Another helpful tool on NaviNet is the *Benefit Accumulator* which is available on a member's *Eligibility and Benefits Details* page. This tool provides the status of the member's deductible and coinsurance accumulation for the benefit period, if applicable, based on all claims finalized to date.

**Please note that *Benefit Accumulator* and *Real-Time Estimation* 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 NaviNet, please see [Chapter 1.3: Electronic Solutions -- EDI & NaviNet](#).

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## 2.4 HEALTH SPENDING ACCOUNTS, Continued

### Spending account inquiries

For spending account questions or issues in, contact the dedicated Provider Spending Account Information Line:

- Pennsylvania and West Virginia: **1-800-652-9478**
- Delaware: **1-800-346-6262**

[What Is My Service Area?](#)

### 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<br>Attention: Cashier<br>P.O. Box 890150<br>Camp Hill, PA 17001-9774 | Highmark Delaware<br>Attention: Treasury<br>P.O. Box 1991<br>Wilmington, DE 19899-1991 |



## 2.4 HIGHMARK WELLNESS REWARDS

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### Overview

Highmark Wellness Rewards is an optional program available to employer groups which encourages members to take more personal responsibility for their health. It promotes behavior change and provides members with incentives for making real, constructive health and lifestyle changes.

The program is part of a wholly integrated online health platform, developed in conjunction with WebMD®, complete with wellness programs to address issues like tobacco cessation, diet, exercise, and stress management. It is connected to helpful online tools that can help Highmark members identify health risks, track progress, and provide them with information on relevant health issues.

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### Program benefits

The goal of Highmark Wellness Rewards is to affect long-term, healthy behavior change. The program focuses on assessing health risks and identifying unhealthy behaviors. And it gives Highmark members the tools they need to first understand their health status and then take necessary action to maintain or improve their health.

By offering Wellness Rewards in addition to a Highmark medical benefit plan, employers are providing their employees with a proven wellness program delivered through a trusted online resource. Healthy individuals have more energy and feel better physically and mentally. A rewards program enhances the role individuals play in their health so they lead healthier lifestyles and make more informed and appropriate care decisions.

For employers, a healthy workforce can translate into reduced absenteeism and lost time due to illness, better productivity, and happier employees on and off the job. And, by offering a Highmark Wellness Rewards program, employers are demonstrating their commitment and support of their employees' health and well-being.

---

### Wellness Profile

A comprehensive Wellness Profile serves as the foundation of the Highmark Wellness Rewards program. It is a self-health analysis that covers all aspects of an individual's health including nutrition, weight management, and physical activity. The assessment takes only 15-20 minutes to complete and the member receives results online in minutes.

The data entered by the member in the Wellness Profile is used to generate a personalized action plan, or Wellness Profile Report. This is an in-depth, individualized health status report that identifies areas in need of health improvement and includes recommendations for health and wellness programs and activities.

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*Continued on next page*

## 2.4 HIGHMARK WELLNESS REWARDS, Continued

### How it works

Highmark Wellness Rewards engages our members in making healthy lifestyle choices by providing programs to educate and motivate them while their employers provide the incentives for participation. The programs are appropriate for every stage of health -- they address members who are healthy, members with chronic conditions, and those members who have short-term events that are affecting their health.

Because different organizations have different needs, Highmark Wellness Rewards offers two reward structures to match their needs: action-based rewards and points-based rewards. Both options can be chosen in a standard or customized format.

- An action-based program requires members to complete specific activities by a set date and earn rewards for completion.
- A points-based program allows an employer to offer a variety of activities, each with its own point value, and then members can choose which activities best suit their needs. As they complete tasks, they accumulate points to earn rewards as designated by their employer.

Employers are able to choose from a selection of standard program options that best suit their needs. The standard options provide a variety of programs and activities that require various levels of participation. A health awareness program simply requires the completion of the Wellness Profile to identify health risks and inspire healthy changes while other more engaging options require members to participate in worksite health screenings, preventive exams, health coaching, and health and wellness activities.

If an employer is looking for an even more personalized program, a customized program can be created to reward employees based on the company's own health strategy and organizational goals. For completing their program requirements, whether standard or customized, employees receive rewards predetermined by their employer -- such as an extra day off or financial rewards in the form of a gift card -- and, ultimately, better health.

### With your help we can create rewards that last a lifetime

Highmark Wellness Rewards takes the proven data on health behavior change and creates a new opportunity for members, their employers, and Highmark to make a mutual commitment. And, with provider support, Wellness Rewards will proactively encourage healthier lifestyles to help prevent and control chronic illness.

## 2.4 MYCARE NAVIGATOR

### Overview

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.

### Who is eligible?

MyCare Navigator is available to Highmark members and their family members – including spouses and domestic partners, dependent children, parents, and parents-in-law. These family members may use the service even if they do not have their health insurance coverage with Highmark.

### Program objective

The program objective of myCare Navigator focuses on offering services that help Highmark members to effectively navigate through the cumbersome and often confusing health care system. Assistance includes, but is not limited to, offering resource support services and guidance with obtaining provider and pharmacy information.

### Health advocates provide personalized assistance

MyCare Navigator makes it easy for Highmark members and their families to get answers to health care questions and help with their health care needs. By calling a toll-free telephone line, the member is connected to a myCare Navigator health advocate who is most often a registered nurse supported by a physician. The health advocate then provides personalized service until the caller's request is completed.

The myCare Navigator health advocates can assist our members and their families with a variety of health care related questions and tasks including:

- Locating network participating primary care physicians, specialists, hospitals, labs, and other providers and facilities that meet their needs
- Scheduling office visits and other appointments
- Arranging for physician-to-physician consultations
- Assisting with the transfer of medical records
- Seeking and coordinating second opinions

*Continued on next page*

## 2.4 MYCARE NAVIGATOR, Continued

### Health advocates provide personalized assistance (continued)

- Understanding and using their medical benefits and prescription drug coverage to their best advantage
- Directing them to information and resources to help in making informed, appropriate care decisions
- And much more!

There are certain situations when it would be more appropriate to refer a member to Blues On Call rather than myCare Navigator. Those include:

- New clinical diagnosis
- Currently working with a Highmark Health Coach already
- Specialty group conditions
- Critical diagnosis conditions
- Decision support

### Directing members to myCare Navigator

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

**1-888-BLUE-428** (1-888-258-3428), 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”).

### What providers can expect

MyCare 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 Services.

## 2.4 PATIENT EXPERIENCE REVIEW

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Introduction</b>                           | Over the past decade, Highmark has expanded the various online tools available to help support members to make informed decisions on their health care services. In 2012, Highmark added to those tools by launching "Patient Experience Review," a convenient patient review tool developed in collaboration with the Blue Cross and Blue Shield Association (BCBSA).                                                                                                                                                                                                                                                                                                                                          |
| <b>Goal of initiative</b>                     | Highmark's goal is to present meaningful patient review information to our members directly from the member website in order for them to make informed decisions about their care. At the same time, Highmark anticipates that the information shared will be meaningful to providers as feedback for their own quality improvement programs.                                                                                                                                                                                                                                                                                                                                                                   |
| <b>How it works</b>                           | <p>Highmark members have the ability via the member website to post comments and to respond to a core set of five questions for the professional provider survey and up to seven questions for the facility survey, covering their overall experience. The comments and the display of these ratings is pre-password, but only authenticated members (post-password) can post a review. This process helps assure that only authenticated Blue members who attest that they have seen the physician, or received care at the facility, can contribute to the review process.</p> <p><b>Note:</b> Comments are checked for appropriateness before being displayed on the Highmark Online Provider Directory.</p> |
| <b>Reviews restricted to Highmark members</b> | <p>All Highmark members have the ability to post a review once they log into our secure member website and sign an electronic attestation verifying that they have received services in the past two years from the provider they are rating.</p> <p>Also, members of other Blue Plans have the ability to rate providers, including our network, using their own patient review tool. This functionality is being coordinated on the national level through the Blue Cross and Blue Shield Association.</p>                                                                                                                                                                                                    |
| <b>Reviews available for public view</b>      | <p>Anyone, including members and prospective members, can access the reviews by viewing the Highmark Provider Directory, which is accessible pre-password on our member website.</p> <p>Providers may also read any reviews by visiting the online Highmark Provider Directory accessible from our regional websites.</p>                                                                                                                                                                                                                                                                                                                                                                                       |

*Continued on next page*

## 2.4 PATIENT EXPERIENCE REVIEW, Continued

### Types of providers that members can review

Through Patient Experience Review, members can rate and post comments about professional providers, certain ancillary providers, and the following facility provider types:

- Acute-care hospitals
- Children's hospitals
- Inpatient rehabilitation facilities
- Outpatient rehabilitation facilities
- Ambulatory surgery centers
- Freestanding hospices
- Birthing centers
- Urgent care centers
- Retail health clinics
- Diagnostic imaging centers

### Survey questions for providers

The survey tool for providers focuses on five broad categories, with a specific question in each. Members are asked to respond by selecting "yes/no" or from within a five-star range, where one star is "low" and five stars is "high." Responses to the last two questions are required before a member can submit a review.

Members are also given the option to write additional comments, if desired.

**REVIEW PROVIDER**

**\* Required Responses**

**Availability**  
How would you rate the provider's availability for your appointment? ☆☆☆☆☆

**Communication**  
How well did the provider communicate with you about your health concerns? ☆☆☆☆☆

**Environment**  
How would you rate the provider's overall office environment? ☆☆☆☆☆

**Experience**  
\*How would you rate your overall experience and satisfaction with this provider? ☆☆☆☆☆

**Recommend**  
\*Would you recommend this provider to your family/friends? Yes No

### Providers can monitor reviews

Providers can monitor the ratings and comments being posted about their services. Through NaviNet®, practitioners and facilities can register an email address and receive an automated alert each time a review is posted. In addition, providers are able to respond to all reviews that are posted, with the ability to remove from public view up to two comments posted in a rolling twenty-four (24) month period.

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## 2.4 PATIENT EXPERIENCE REVIEW, Continued

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**Instructional  
tip sheet  
available**

[TIP SHEET](#)

Click on the Tip Sheet icon for instructions on registering an email address. You will receive an email alert when a member rating or comment about your practice or facility is posted in the Highmark Provider Directory. Instructions are also provided on how a practitioner or an individual appointed to monitor facility reviews can read and respond to reviews received.

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## CHAPTER 2: PRODUCT INFORMATION

### UNIT 5: TELEMEDICINE SERVICES

#### IN THIS UNIT



| TOPIC                                                               | SEE PAGE |
|---------------------------------------------------------------------|----------|
| Introduction to Telemedicine                                        | 2        |
| Telemedicine Services Benefit and Approved Vendors                  | 4        |
| Virtual PCP Visits and Virtual Retail Clinic Visits <b>Updated!</b> | 9        |
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[What Is My Service Area?](#)

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The PA ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The DE ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The WV ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.



## 2.5 INTRODUCTION TO TELEMEDICINE

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### Overview

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 growing 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.

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### 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.

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### Highmark provides coverage and options for telemedicine services

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.
- 

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## 2.5 INTRODUCTION TO TELEMEDICINE, Continued

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### 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.

In 2015, the State of Delaware enacted legislation 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**.

In Pennsylvania, proposed legislation for telehealth coverage by commercial insurance plans is under consideration. Proposed legislation in West Virginia amends physician practice standards regarding telemedicine.

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[What Is My Service Area?](#)

## 2.5 TELEMEDICINE SERVICE BENEFIT AND APPROVED VENDORS

### Overview

In August 2012, Highmark introduced the “Telemedicine Service” benefit to certain members. This benefit provided access to 24/7 virtual PCP-type care through our approved vendor – Teladoc.™ Teladoc is a national network of U.S. board-certified doctors who are available 24 hours a day, 7 days a week and 365 days a year via phone and online video consultations. This benefit has provided our members with an affordable, convenient alternative to urgent care and emergency room visits for non-emergent medical issues.

As demand continues to grow, Highmark now provides a telemedicine service benefit for most of our members and is giving them a choice through two new vendors.

**Effective January 1, 2016, American Well™ (Amwell) and Doctor On Demand™ are the Highmark-approved vendors for our members’ Telemedicine Service benefit.** Amwell and Doctor On Demand are both direct-to-consumer models, which means that anyone can register with them and use their services. Since this approach requires no administrative fees, Highmark can continue to provide our members with a telemedicine services benefit option while reducing administrative costs.

### Services provided by Amwell and Doctor On Demand

Amwell and Doctor On Demand both provide national coverage by certified providers via real-time interactive video and audio telecommunications technology:

- **24/7/365 acute care for minor illnesses provided by both Amwell and Doctor On Demand:** PCP-type care, such as, but not limited to the following: cough, sinus infection, sore throat, vomiting, diarrhea, fever, pinkeye, flu/cold, headache. Amwell and Doctor On Demand both have nationwide networks of licensed, board-certified physicians, including family practitioners, internists, and pediatricians for acute care for minor illness.  
  
If a member uses Amwell or Doctor On Demand for treatment, member cost sharing applies and can vary in the form of a copay or subject to network deductible and/or coinsurance as per their **Telemedicine Service** benefit.
- **Virtual behavioral health provided by Amwell only:** Scheduled 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. Psychiatrists, psychologists, and therapists are available to provide services.

*Continued on next page*

## 2.5 TELEMEDICINE SERVICE BENEFIT AND APPROVED VENDORS,

Continued

### Services provided by Amwell and Doctor On Demand (continued)

If a member elects to use Amwell for virtual behavioral health services, the member's benefit plan must have both the **Telemedicine Service** benefit and coverage for **Outpatient Mental Health** services. Virtual behavioral health services are subject to member cost sharing in accordance with their **Outpatient Mental Health** benefit. If a self-insured group plan does not include outpatient mental health benefits, this service will not be covered.

Each vendor operates 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 Telemedicine Service benefit to obtain these services from Amwell or Doctor On Demand.**

The technology used is private, secure, and HIPAA-compliant in order to provide a safe and confidential consult with a doctor online. Both platforms can be accessed via mobile app or online (i.e., smart phone, tablet, laptop/PC with a webcam).

### How members access and use this service

Highmark members must have the Telemedicine Service benefit for coverage of services obtained through Amwell or Doctor On Demand. Highmark member portals provide links to each vendor's website. Members must first register with either or both vendors, providing the following information:

- Highmark Member ID number
- Medical and prescription history
- PCP information
- Pharmacy of choice

Once the member is registered and connected, the doctor can review their history, answer questions, and, at their discretion, diagnose, treat, and even prescribe medication. If the member receives a prescription, it will be sent straight to the member's pharmacy.

The member will have access to records of their consultation and can provide a copy to their PCP. Both vendors send follow-up emails that sum up the service, contain a survey, and offer contact information for any questions they may have regarding the service they received.

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## 2.5 TELEMEDICINE SERVICE BENEFIT AND APPROVED VENDORS,

Continued

### Member eligibility

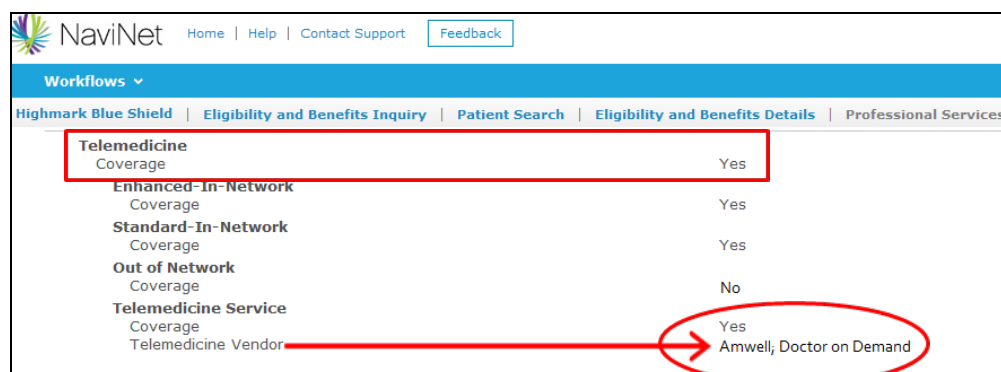
The Telemedicine Service benefit provides coverage for Amwell and Doctor On Demand services to most Highmark members with individual health plans and employer group coverage, both fully insured and self-insured.

**Telemedicine coverage for services provided by Amwell and Doctor On Demand are not available for members with Medicare Advantage and Medicare supplemental plans.**

**Please Note:** Certain self-insured employer groups will continue to retain Teledoc as their telemedicine vendor.

### Using NaviNet® 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 using NaviNet's Eligibility and Benefits Inquiry. If a member has coverage for telemedicine services, the **Telemedicine** benefit category under Professional Services will indicate "Yes."



| NaviNet                                                                                                                             |                          |
|-------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
| Home   Help   Contact Support   Feedback                                                                                            |                          |
| Workflows ▾                                                                                                                         |                          |
| Highmark Blue Shield   Eligibility and Benefits Inquiry   Patient Search   Eligibility and Benefits Details   Professional Services |                          |
| Telemedicine Coverage                                                                                                               | Yes                      |
| Enhanced-In-Network Coverage                                                                                                        | Yes                      |
| Standard-In-Network Coverage                                                                                                        | Yes                      |
| Out of Network Coverage                                                                                                             | No                       |
| Telemedicine Service Coverage                                                                                                       | Yes                      |
| Telemedicine Vendor                                                                                                                 | Amwell; Doctor on Demand |

### FOR MORE INFORMATION

To learn more about the services Amwell and Doctor On Demand provide to Highmark members through the Telemedicine Service benefit, you can visit their user friendly websites at:

- [amwell.com](http://amwell.com)
- [doctorondemand.com](http://doctorondemand.com)

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## 2.5 TELEMEDICINE SERVICE BENEFIT AND APPROVED VENDORS,

Continued

### **Additional services offered by American Well**

In addition to online consultations with Amwell's nationwide network of providers, which are available to Highmark members through their Telemedicine Service benefit, 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 American Well website at [www.americanwell.com](http://www.americanwell.com).

### **ATTENTION: Providers using the AmWell technology platform for their private practices**

**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, 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.

**Behavioral Health Providers:** 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

*Continued on next page*

## 2.5 TELEMEDICINE SERVICE BENEFIT AND APPROVED VENDORS,

Continued

**ATTENTION:**  
**Providers**  
**using the**  
**AmWell**  
**technology**  
**platform for**  
**their private**  
**practices**  
(continued)

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. For example, Medicare Advantage plans do not include the Telemedicine Service benefit or benefit enhancements for virtual visits. 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.**

## 2.5 VIRTUAL PCP VISITS AND VIRTUAL RETAIL CLINIC VISITS

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### Overview

Primary care is traditionally the point of first contact for the patient when a medical illness, issue, or concern arises; however, primary care providers treat patients not only when they are ill. Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses, as well as coordination of care within the broader health care system. By regularly seeing a trusted primary care practitioner, a patient's minor health problems can be identified and controlled before they become serious ones.

Because we recognize the important role of the primary care provider, Highmark strives to make primary care more accessible for our members. **Effective for dates of service on and after January 1, 2016, Highmark is providing our members another option for accessing outpatient primary care services – Virtual PCP Visits and Virtual Retail Clinic Visits.**

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.

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### What are Virtual PCP Visits and Virtual Retail Clinic Visits?

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.

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### Why Virtual PCP Visits and Virtual Retail Clinic Visits?

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, any time, 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.
- 

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## 2.5 VIRTUAL PCP VISITS AND VIRTUAL RETAIL CLINIC VISITS,

Continued

### Non-covered services

Services that are not covered include, but are not limited to, the following:

- Mental health counseling and therapy \*
- Asynchronous (online) medical evaluations (e-Visits)
- Remote critical care services (0188T, 0189T)
- Unsecured and unstructured services such as, but not limited to, Skype and instant messaging
- Provider to provider consultations, telephone conversations, facsimile, or email communications

*\*For information on behavioral health virtual services, please see the Virtual Behavioral Health section in this unit.*

### Eligible providers

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

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.**

*Continued on next page*

## 2.5 VIRTUAL PCP VISITS AND VIRTUAL RETAIL CLINIC VISITS,

Continued

**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 NaviNet's Eligibility and Benefits Inquiry or by submitting a HIPAA 270 transaction.

In NaviNet, select **Additional Benefit Provisions** from the Eligibility and Benefits Details page, and then **Professional Services** from the pop-up box to determine coverage for **PCP Office/Outpatient Visit and Consultation, Physician Office/Outpatient Visit and Consultation**, and/or **Retail Clinic**. If the member has coverage for Virtual PCP Visits and/or Virtual Retail Clinic Visits, the benefit category will indicate "Virtual Visits – Yes."

|                                                                                                                                                                                                                     |                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|
|  NaviNet <a href="#">Home</a>   <a href="#">Help</a>   <a href="#">Contact Support</a>   <a href="#">Feedback</a>                  |                                |
| Workflows ▾                                                                                                                                                                                                         |                                |
| <a href="#">Highmark Blue Shield</a>   <a href="#">Eligibility and Benefits Inquiry</a>   <a href="#">Patient Search</a>   <a href="#">Eligibility and Benefits Details</a>   <a href="#">Professional Services</a> |                                |
| <b>PCP Office/Outpatient Visit and Consultation</b>                                                                                                                                                                 |                                |
| Coverage                                                                                                                                                                                                            | Yes                            |
| Virtual Visits                                                                                                                                                                                                      | Yes                            |
| <b>Enhanced-In-Network</b>                                                                                                                                                                                          |                                |
| Coverage                                                                                                                                                                                                            | Yes                            |
| <b>Standard-In-Network</b>                                                                                                                                                                                          |                                |
| Coverage                                                                                                                                                                                                            | Yes                            |
| <b>Out of Network</b>                                                                                                                                                                                               |                                |
| Coverage                                                                                                                                                                                                            | Yes                            |
| <b>Physician Office/Outpatient Visit and Consultation</b>                                                                                                                                                           |                                |
| Coverage                                                                                                                                                                                                            | Yes                            |
| Virtual Visits                                                                                                                                                                                                      | Yes                            |
| <b>Enhanced-In-Network</b>                                                                                                                                                                                          |                                |
| Coverage                                                                                                                                                                                                            | Yes                            |
| <b>Standard-In-Network</b>                                                                                                                                                                                          |                                |
| Coverage                                                                                                                                                                                                            | Yes                            |
| <b>Out of Network</b>                                                                                                                                                                                               |                                |
| Coverage                                                                                                                                                                                                            | Yes                            |
| <b>Retail Clinic</b>                                                                                                                                                                                                |                                |
| Coverage                                                                                                                                                                                                            | Yes                            |
| Virtual Visits                                                                                                                                                                                                      | Yes                            |
| <b>Enhanced-In-Network</b>                                                                                                                                                                                          |                                |
| Coverage                                                                                                                                                                                                            | Yes                            |
| <b>Standard-In-Network</b>                                                                                                                                                                                          |                                |
| Coverage                                                                                                                                                                                                            | Yes                            |
| Deductible                                                                                                                                                                                                          | Subject to Enhanced Deductible |
| Coinsurance - Insurer                                                                                                                                                                                               | 90 Percent up to               |
|                                                                                                                                                                                                                     | Out-of-Pocket                  |
|                                                                                                                                                                                                                     | 100 Percent thereafter         |
| <b>Out of Network</b>                                                                                                                                                                                               |                                |
| Coverage                                                                                                                                                                                                            | Yes                            |

*Continued on next page*

## 2.5 VIRTUAL PCP VISITS AND VIRTUAL RETAIL CLINIC VISITS,

Continued

**IMPORTANT:**  
Telemedicine  
Service benefit  
category is for  
Amwell, Doctor  
On Demand, &  
Teladoc  
services only

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, Doctor on Demand, and Teladoc, which are independent companies that provide online medical consultation services for patients through their network of practitioners.

In the NaviNet Eligibility and Benefits Inquiry, the “Telemedicine Service” benefit category under Professional Services is an indicator for Amwell, Doctor on Demand, 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**.

[What Is My Service Area?](#)

**Member  
fliers  
available**

The fliers accessible below can be customized with your practice information and instructions, and then printed and given to your Highmark patients with coverage that includes Virtual PCP Visits and Virtual Retail Clinic Visits.

### Virtual PCP Visits Member Flier:

- [PA Western and Northeastern Regions](#)
- [PA Central Region](#)
- [Delaware](#)
- [West Virginia](#)

### Virtual Retail Clinic Visits Member Flier:

- [PA Western and Northeastern Regions](#)
- [PA Central Region](#)
- [Delaware](#)
- [West Virginia](#)

These fliers are also available on the Provider Resource Center – select **FORMS**, and then choose **Miscellaneous Forms**.

**Technology  
requirements**

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.

*Continued on next page*

## 2.5 VIRTUAL PCP VISITS AND VIRTUAL RETAIL CLINIC VISITS,

Continued

### Technology requirements (continued)

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 512 X 512 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.

### Security guidelines

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

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:

- Any telecommunications technology used **must provide both audio and video streams** that meet Highmark's technology and security guidelines.
- All services provided must be medically necessary.
- Services performed must fall under the scope of the provider's licensure.

*Continued on next page*

## 2.5 VIRTUAL PCP VISITS AND VIRTUAL RETAIL CLINIC VISITS,

Continued

### Guidelines for providing services (continued)

- 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.

*Why blue italics?*

### Billing and reimbursement

*Claims for Virtual PCP Visits and Virtual Retail Clinic Visits are submitted based on how you are contracted with Highmark. Claims must include the following:*

- **Professional claims (1500/837P):**
  - o Outpatient Evaluation & Management (E&M) CPT codes *(99201-99205; 99211-99215)* applicable to the services.
  - o **GT or 95 modifier** indicating the use of interactive audio and video telecommunications technology.
  - o Place of Service "02" (Telehealth) must be used when reporting the GT or 95 modifier.
- **Outpatient Facility Claims (UB-04/837I):**
  - o Appropriate procedure code (99201-99205; 99211-99215 or G0463).
  - o **GT or 95 modifier** indicating the use of interactive audio and video telecommunications technology.
  - o Appropriate revenue code.

Reimbursement will be based on the current plan allowance in place at the time services were rendered. Member cost-sharing (copay, deductible and/or coinsurance) and visit limits apply if applicable.

*Continued on next page*

## 2.5 VIRTUAL PCP VISITS AND VIRTUAL RETAIL CLINIC VISITS,

Continued

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### **PCPs: Updating your information for the online Provider Directory**

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**.

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### **Delaware House Bill 69**



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**.

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[What Is My Service Area?](#)

## 2.5 VIRTUAL BEHAVIORAL HEALTH

### Overview

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.

### Why Virtual Behavioral Health?

Virtual behavioral health is about more than 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.

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## 2.5 VIRTUAL BEHAVIORAL HEALTH, Continued

### Non-covered services

Services that are not covered include, but are not limited to, the following:

- Asynchronous (online) medical evaluations (e-Visits)
- Remote critical care services (0188T, 0189T)
- Unsecured and unstructured services such as, but not limited to, Skype and instant messaging
- Provider to provider consultations, telephone conversations, facsimile, or email communications

### 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 Advantage and Medicare supplemental plans.**

**Note:** This is also available for Federal Employee Program (FEP) members.

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## 2.5 VIRTUAL BEHAVIORAL HEALTH, Continued

**IMPORTANT:**  
Telemedicine  
Service benefit  
category is for  
Amwell, Doctor  
On Demand, &  
Teladoc  
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, Doctor On Demand, and Teladoc -- under the Telemedicine Service benefit. Amwell, Doctor On Demand, and Teladoc are independent companies that provide online medical consultation services for patients through their network of practitioners.

In the NaviNet Eligibility and Benefits Inquiry, the **Telemedicine Service** benefit category under Professional Services is an indicator for **Amwell, Doctor On Demand, 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**.

**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 NaviNet's Eligibility and Benefits Inquiry or by submitting a HIPAA 270 transaction.

**Member flier  
available**

The [Virtual Behavioral Health Member Flier](#) can be customized with your practice information and instructions, and then printed and given to your Highmark patients with coverage that includes virtual behavioral health services.

The flier is also available on the Provider Resource Center – select **FORMS**, and then choose **Miscellaneous Forms**.

**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 512 X 512 at 8-bit pixel depth.

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## 2.5 VIRTUAL BEHAVIORAL HEALTH, Continued

### Technology requirements (continued)

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.

### 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.

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## 2.5 VIRTUAL BEHAVIORAL HEALTH, Continued

### Guidelines for providing services (continued)

- 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.

[Why blue italics?](#)

### Billing and reimbursement

*Claims for virtual behavioral health services are submitted based on how you are contracted with Highmark. Claims must include the following:*

- **Professional claims (1500/837P):**
  - o Appropriate existing outpatient mental health CPT codes.
  - o *Appropriate license-level modifier for the clinician who provided the service.*
  - o **GT or 95 modifier** indicating the use of interactive audio and video telecommunications technology.
  - o Place of Service "02" (Telehealth) must be used when reporting the GT or 95 modifier.
- **Outpatient Facility Claims (UB-04/837I):**
  - o Appropriate existing outpatient mental health CPT codes.
  - o *Appropriate license-level modifier for the clinician who provided the service.*
  - o **GT or 95 modifier** indicating the use of interactive audio and video telecommunications technology.
  - o Appropriate behavioral health revenue code (900-919).

Reimbursement will be based on the current fee schedule in place at the time services were rendered. Member cost-sharing (copay, deductible, and/or coinsurance) would apply if applicable.

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## 2.5 VIRTUAL BEHAVIORAL HEALTH, Continued

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### **Updating your information for the online Provider Directory**

If you are able to 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

### Overview

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.

[What Is My Service Area?](#)

### Applicable products

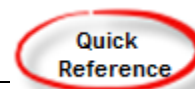
The specialist virtual visit benefit enhancement is applicable to all Highmark group products and to most individual products.

This benefit enhancement **does not apply** to the following:

- All Medicare Advantages products in Pennsylvania and West Virginia
- Medicare supplemental products in all service areas
- Individual HMO product available in Pennsylvania’s Western Region
- *Complete Care* in Pennsylvania

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## 2.5 SPECIALIST VIRTUAL VISIT, Continued



### Verifying member eligibility

Participating providers should use the *Eligibility and Benefits Inquiry* in NaviNet® to verify a member's coverage for specialist virtual visits. On the *Eligibility and Benefits Details* page, select **Additional Benefit Provisions**, and then the **Professional Services** category -- scroll to the **Specialist Office/Outpatient Visit and Consultation** service provision. If NaviNet is not available, please call the Provider Service Center.

"Specialist Virtual Visit" and "Originating Site Access Fee" (access fee applicable only when the originating site is a **medical site**) will be displayed with a "Yes" if the member is eligible for the service. If services are not covered under the member's benefit plan, the services will not be displayed under the provision.

|                                                            |                                               |
|------------------------------------------------------------|-----------------------------------------------|
| <b>Specialist Office/Outpatient Visit and Consultation</b> |                                               |
| Coverage                                                   | Yes                                           |
| Services Include                                           | Specialist Virtual Visit                      |
| Originating Site Access Fee                                | Yes for Specialist Virtual Visit              |
|                                                            | Subject to Program Deductible and Coinsurance |

Highmark members can be directed to call the Member Services telephone number on their ID cards to inquire about coverage for specialist virtual visits under their benefit plan.

[What Is My Service Area?](#)

### Member flier available

The flier available below can be given to your Highmark patients with coverage that includes the specialist virtual visit benefit enhancement. Click on the applicable link for your service area:

- Pennsylvania:
  - [Highmark BCBS Specialist Virtual Visit Member Flier](#)
  - [Highmark Blue Shield Specialist Virtual Visit Member Flier](#)
- [Highmark Delaware Specialist Virtual Visit Member Flier](#)
- [Highmark West Virginia Specialist Virtual Visit Member Flier](#)

These fliers are also available on the Provider Resource Center – select **FORMS**, and then choose **Miscellaneous Forms**.

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## 2.5 SPECIALIST VIRTUAL VISIT, Continued

**IMPORTANT:**  
Telemedicine  
Service benefit  
category is for  
Amwell, Doctor  
On Demand, &  
Teladoc  
services only

Specialist virtual visits are a benefit enhancement and separate from the services provided by our approved vendors -- Amwell, Doctor On Demand, and Teladoc -- under the Telemedicine Service benefit. Amwell, Doctor On Demand, and Teladoc are independent companies that provide online medical consultation services for patients through their network of practitioners.

In the NaviNet *Eligibility and Benefits Inquiry*, the **Telemedicine Service** benefit category under Professional Services is an indicator for **Amwell, Doctor On Demand, 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**.

### 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.

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## 2.5 SPECIALIST VIRTUAL VISIT, Continued

### Requirements (continued)

- 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.

### Non-covered services

Services that are not covered under the specialist virtual visit benefit enhancement include, but are not limited to, the following:

- Mental health counseling and therapy\*
- Asynchronous (online) medical evaluations (e-Visits)
- Remote critical care services (0188T, 0189T)
- Unsecured and unstructured services such as, but not limited to, Skype and instant messaging
- Provider to provider consultations, telephone conversations, facsimile, or email communications

*\* For information on behavioral health virtual services, please see the section of this unit on **Virtual Behavioral Health**.*

### 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.

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## 2.5 SPECIALIST VIRTUAL VISIT, Continued

### 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.

### 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.** Highmark will accept HCPCS code Q3014 ("telehealth originating site facility fee") for the service. Claims for the medical originating site's access fee will be accepted as either professional (1500/837P) or outpatient facility (UB-04/837I using Revenue Code 780). **No other services reported on the medical originating site claim will be eligible for payment by Highmark or the member.**

The access fee is an all-inclusive fee that includes all medical originating site fees including, without limitation, providing a physical location for the virtual visit as well as providing all equipment to be utilized for the secure connection. 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. **Highmark will accept and reimburse only one claim per encounter for the medical originating site access fee. Procedure code Q3014 will be reimbursed according to the current 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.

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## 2.5 SPECIALIST VIRTUAL VISIT, Continued

### 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.

- Evaluation and management (E&M) visits (99201-99205; 99211-99215) and consultation services (99241-99245) are eligible codes for the specialist's services rendered at the distant site.
- The procedure code representing the specialist's services must be billed with a **GT or 95 modifier** indicating the use of an interactive audio and video telecommunications system. The GT or 95 modifier is only billed by the specialty practitioner.
- Place of Service "02" (Telehealth) must be used when reporting the GT or 95 modifier.

Reimbursement will be based on the current 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.

### Updating your information for the online Provider Directory

If you are able to 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**.

## 2.5 TELEDERMATOLOGY

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### Overview

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.

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### 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.

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### 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.

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## 2.5 TELEDERMATOLOGY, Continued

### 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 Advantage and Medicare supplemental plans.**

**Note:** This is also available for Federal Employee Program (FEP) members.

**IMPORTANT:**  
Telemedicine  
Service benefit  
category is for  
Amwell, Doctor  
On Demand, &  
Teladoc  
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, Doctor On Demand, and Teladoc -- under the Telemedicine Service benefit. Amwell, Doctor On Demand, and Teladoc are independent companies that provide online medical consultation services for patients through their network of practitioners.

In the NaviNet *Eligibility and Benefits Inquiry*, the **Telemedicine Service** benefit category under Professional Services is an indicator for **Amwell, Doctor On Demand, 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**.

### 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 NaviNet's *Eligibility and Benefits Inquiry* or by submitting a HIPAA 270 transaction.

### Member flier available

The [Teledermatology Member Flier](#) can be customized with your practice information and instructions, and then printed and given to your Highmark patients with coverage that includes teledermatology services.

The flier is also available on the Provider Resource Center – select **FORMS**, and then choose **Miscellaneous Forms**.

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## 2.5 TELEDERMATOLOGY, Continued

### 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 current 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 current medical policies are accessible on the Provider Resource Center under **CLAIMS, PAYMENT & REIMBURSEMENT**.

### 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.

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## 2.5 TELEDERMATOLOGY, Continued

### Guidelines for providing services (continued)

- 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

Highmark will accept claims for teledermatology services from dermatologists billing on a 1500 (02/12) claim form or 837P electronic format. Services should be billed using procedure code 99444:

**99444** – Online evaluation and management service provided by a physician to an established patient, guardian, or health care provider not originating from a related E/M service provided within the previous seven (7) days, using the Internet or similar electronic communication network.

Outpatient facility claims (UB-04/837I) should be billed using procedure code 99444 and Revenue Code 780.

**Note:** A telehealth modifier is not needed with the 99444 code as the description of the code already indicates that the service is "online."

Reimbursement will be based on the current fee schedule in place at the time services were rendered. Member cost-sharing (copay, deductible, and/or coinsurance) would apply if applicable.

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## 2.5 TELEDERMATOLOGY, Continued

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### **Updating your information for the online Provider Directory**

If you are able to 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

### 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 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). This is self-reporting and up to you to supply us with this information.

### Updating your practice information via NaviNet

If you are able to provide virtual visits/telemedicine services, you can notify Highmark by updating your practice information via NaviNet:

1. Select **Provider File Management** from the main menu on NaviNet Plan Central.
2. Choose the applicable **Billing Provider**.
3. Check the box in front of the address of the location where the service can be provided, and then click on the **Edit** button above the list of addresses.
4. Click on the arrow in front of **Office Accessibility and Services** to expand the category, and then click the **Edit** button for **Services offered at this location**.
5. Check the box for **Telemedicine** in the list of services, and then click **OK**.
6. Click on the **Submit** button to update your files.

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:

|                       |                                                                                       |
|-----------------------|---------------------------------------------------------------------------------------|
| PLANS ACCEPTED        | Practice Information                                                                  |
| PRACTICE INFORMATION  | Evening Hours: Yes                                                                    |
| HOSPITAL AFFILIATIONS | Weekend Hours Available: No                                                           |
| BACKGROUND            | Specialties: Internal Medicine                                                        |
| PATIENT RATING        | Accepting New Patients: Yes                                                           |
| QUALITY MEASURES      | Patient Age Range Accepted: 14–125 Years                                              |
|                       | Electronic Capabilities:                                                              |
|                       | Other Professionals Onsite:                                                           |
|                       | Handicap Accessible: Yes                                                              |
|                       | Assistive Aids: Handicapped Accessible, Public Transportation, Qualified Interpreters |
|                       | Languages Spoken: Info N/A                                                            |
|                       | Parking Details: Free                                                                 |
|                       | Services Onsite: Allergy Injections, Drawing Blood, <b>OKG, Telemedicine</b>          |



## 2.5 DELAWARE TELEMEDICINE MANDATE – HOUSE BILL 69

### Overview

In addition to the telemedicine programs discussed in the previous sections of this unit, effective January 1, 2016, Highmark Delaware 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.

[What Is My Service Area?](#)

### 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.

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## 2.5 DELAWARE TELEMEDICINE MANDATE – HOUSE BILL 69,

Continued

### 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.

[What Is My Service Area?](#)

### 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 NaviNet's Eligibility and Benefits Inquiry or by submitting a HIPAA 270 transaction. If NaviNet is not available, please call the Highmark Delaware Provider Service Center at 1-800-346-6262.

Highmark Delaware 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 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 Delaware 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 Delaware 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.

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## 2.5 DELAWARE TELEMEDICINE MANDATE – HOUSE BILL 69,

Continued

[What Is My Service Area?](#)

### 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 Delaware 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.

*Continued on next page*

## 2.5 DELAWARE TELEMEDICINE MANDATE – HOUSE BILL 69,

Continued

[What Is My Service Area?](#)

### Billing and reimbursement

**Reimbursement for all services described below will be based on the current 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.**

Highmark Delaware will accept claims from medical provider covered under Delaware House Bill 69 as follows:

- **Real-time audio:**

Professional services claims (1500/837P) should be billed using CPT codes 99441-99443 & 98966- 98968.

Outpatient facility claims (UB-04/837I) should be billed using CPT codes 99441-99443 & 98966- 98968 and the appropriate revenue code.

- **Real-time audio & visual:**

Professional service claims (1500/837P) should be billed using existing outpatient evaluation & management Level I CPT codes or CMS Level II office visit codes applicable to the services provided with a GT or 95 modifier indicating the use of an interactive audio and video telecommunications system. **Note:** Place of Service “02” (Telehealth) must be used when reporting the GT or 95 modifier for professional claims.

Outpatient facility claims (UB-04/837I) should be billed with existing outpatient evaluation & management Level I CPT codes or CMS Level II office visit codes applicable to the services provided with a GT or 95 modifier, indicating the use of an interactive audio and video telecommunications system, and the appropriate revenue code.

- **Store and forward:**

Professional service claims (1500/837P) should be billed using existing evaluation & management Level I CPT codes or CMS Level II office visit codes applicable to the services provided with a GQ modifier indicating the use of asynchronous telecommunications system. **Note:** Place of Service “02” (Telehealth) must be used when reporting the GT or 95 modifier for professional claims.

Outpatient facility claims (UB-04/837I) should be billed using existing evaluation & management Level I CPT codes or CMS Level II office visit codes applicable to the services provided with a GQ modifier, indicating the use of asynchronous telecommunications system, and the appropriate revenue code.

*Continued on next page*

## 2.5 DELAWARE TELEMEDICINE MANDATE – HOUSE BILL 69,

Continued

[What Is My Service Area?](#)

### Billing and reimbursement (continued)

- **Originating Site:**

The originating medical site (i.e., provider's office, outpatient facility) is the location of an eligible member at the time the service is performed. Highmark Delaware will accept only one claim for the originating site access fee per visit that involves both an originating medical site and a distant site. Only the originating medical site will receive payment for an access fee. (Access fee not applicable for non-medical sites, i.e., member's home.)

Professional service claims (1500/837P) should be billed using CMS Level II code Q3014, indicating the telehealth origination site fee, when applicable.

Outpatient facility claims (UB-04/837I) should be billed using CMS Level II code Q3014 and Revenue Code 780, when applicable.

- **Distant Site:**

The distant site is the location from where the provider is rendering the service is located.

Highmark Delaware will not accept or reimburse claims submitted for an access fee by the distant site.

- **Telehealth Transmission:**

Professional service claims (1500/837P) should be billed using CMS Level II code T1014 indicating the telehealth transmission, if appropriate.

Outpatient facility claims (UB-04/837I) should be billed using CMS Level II code T1014 and the appropriate revenue code.

Highmark Delaware will accept only one telehealth transmission code per encounter, per provider; if both a medical originating and distant site were involved, Highmark Delaware will accept one from each site, when applicable.

### Updating your information for the online Provider Directory

If you are able to 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**.

## 2.5 TELESTROKE

### 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. Highmark's current medical policies are accessible on the Provider Resource Center under **CLAIMS, PAYMENT & REIMBURSEMENT**.

### 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 NaviNet's Eligibility and Benefits Inquiry or by submitting a HIPAA 270/271 transaction.

## CHAPTER 2: PRODUCT INFORMATION

### UNIT 6: THE BLUECARD PROGRAM

#### IN THIS UNIT



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[What Is My Service Area?](#)

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The PA ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The DE ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The WV ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

## 2.6 INTRODUCTION

---

### Overview

The 36 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.

Throughout BCBSA's more than 80-year history, the Blue Cross and Blue Shield companies have provided millions of families with top-quality, affordable health insurance. As a participating provider of Highmark, you may render services to patients who are national account members of other Blue Plans traveling to or living in Pennsylvania, Delaware, and West Virginia. The BlueCard® Program makes it easier for you to service these out-of-area Blue Plan members.

---

### In this unit

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
-



## 2.6 WHAT IS THE BLUECARD PROGRAM?

### Definition

**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.

### Advantages for providers

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.

[What Is My Service Area?](#)

### Highmark networks supporting BlueCard

The BlueCard Program is supported by Highmark's networks as follows:

#### 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.

**DELAWARE:** The Delaware Provider Network supports the BlueCard Program.

*\*Keystone Health Plan West is Highmark's managed care provider network in the 29-county Western Region of Pennsylvania.*

*Continued on next page*

## 2.6 WHAT IS THE BLUECARD PROGRAM?, Continued

### Highmark networks supporting BlueCard (continued)

#### 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.

[What Is My 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\*\*

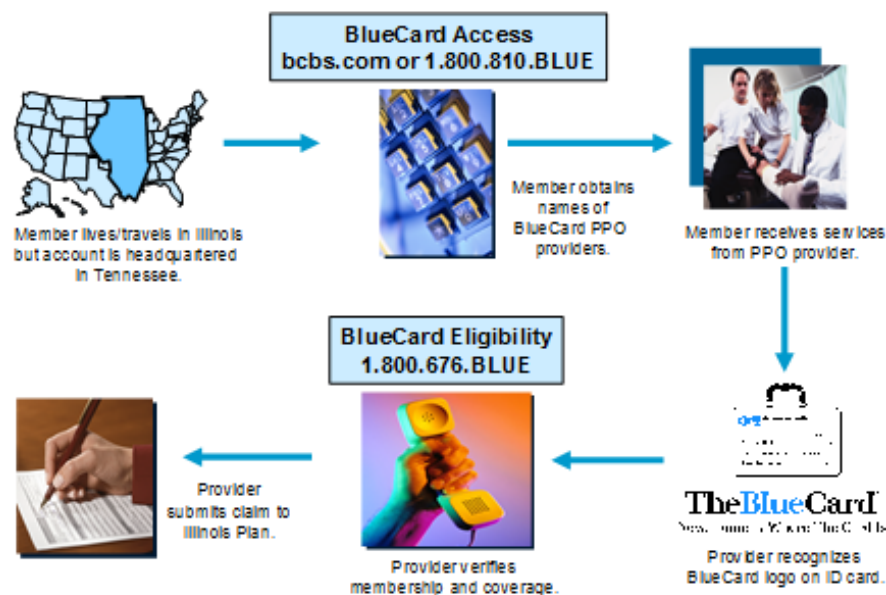
\*For more information on FEP, please visit the manual's [Chapter 2.3: Other Government Programs](#) and for billing tips, see [Chapter 6.4: Professional \(1500/837P\) Reporting Tips](#).

**\*\*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.**

## 2.6 HOW THE PROGRAM WORKS: AN EXAMPLE

### Example situation

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 **1-800-810-BLUE (2583)**.

The member also can obtain information online by using the *BlueCard National Doctor and Hospital Finder* available at [bcbs.com](http://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.

*Continued on next page*

## 2.6 HOW THE PROGRAM WORKS: AN EXAMPLE, Continued

### 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 **1-800-676-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.

## 2.6 HOW TO IDENTIFY BLUECARD MEMBERS

### Member identification numbers

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) will issue alphanumeric "prefixes" to Blue Plans since the options for 3-character all alpha combinations are running low. The examples below illustrate the alpha and alphanumeric prefixes on the Member ID card (A = alpha; N = numeric):



*Continued on next page*

## 2.6 HOW TO IDENTIFY BLUECARD MEMBERS, Continued

### Prefix (formerly “alpha prefix”) (continued)

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.

Initially, the ANA (alpha-numeric-alpha) format will be issued, with a designated sequence of alpha/numeric patterns to follow as needed. Please note the following guidelines the BCBSA will use in creating alphanumeric prefixes:

- Zero (0) and one (1) will **not** be used in prefixes; only the numerals two (2) through nine (9) will be used.
- Numeric-only prefixes (NNN) will not be used.
- R22 – R99 will not be issued as they overlap with Federal Employee Program (FEP) identification numbers.
- Other alphanumeric combinations may be excluded for various reasons.

### Examples of Member ID numbers

The following examples represent various numeral/letter combinations that may be seen as Member IDs for Blue Plan members:

AAA1234567  
Prefix

ANA1234H567  
Prefix

AAA12345678901234  
Prefix

**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.

### Helpful tips

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 1-800-676-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.

*Continued on next page*

## 2.6 HOW TO IDENTIFY BLUECARD MEMBERS, Continued

### 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.

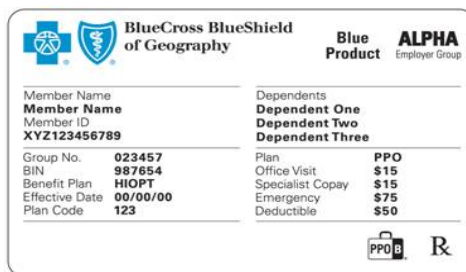


The 3-character prefix.

The "PPO in a suitcase" logo may appear in the lower right corner.

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 (see *Page 3 of this unit*). You will be reimbursed for covered services in accordance with your PPO contract with Highmark.



*Continued on next page*

## 2.6 HOW TO IDENTIFY BLUECARD MEMBERS, Continued

### Suitcase Logos (continued)

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.

*Continued on next page*



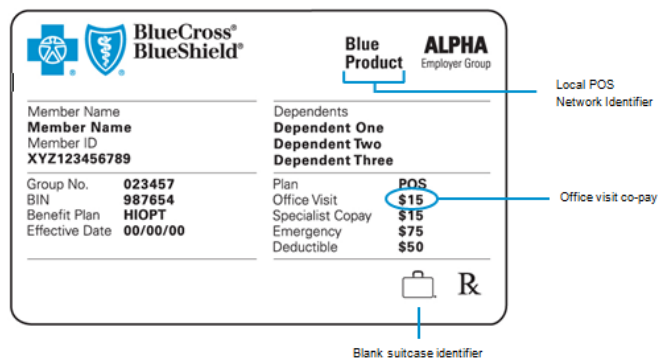
## 2.6 HOW TO IDENTIFY BLUECARD MEMBERS, Continued

### 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



## 2.6 MEDICAID PROGRAMS ADMINISTERED BY BLUE PLANS

---

### Background

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 the NaviNet® BlueExchange® function;
- Submit a HIPAA 270/271 electronic eligibility inquiry; or
- Call the BlueCard Eligibility line at **1-800-676-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 **1-800-676-BLUE** (2583); and
  - Electronic Provider Access (EPA) tool for pre-service review, including prior authorization.
- 

*Continued on next page*

## 2.6 MEDICAID PROGRAMS ADMINISTERED BY BLUE PLANS,

Continued

### Claim submission and reimbursement

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 copayment, 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 services to a Medicaid 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.)

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.

*Continued on next page*

## 2.6 MEDICAID PROGRAMS ADMINISTERED BY BLUE PLANS,

Continued

### 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 pending 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                         |                                                                                                                                   |
| (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                              |                                                                                                                                   |
| (Service) Laboratory or Facility State or Province Code         | Service Facility Name and Location Information                                                                                    |
| 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 |                                                                                                                                   |

*Continued on next page*

## 2.6 MEDICAID PROGRAMS ADMINISTERED BY BLUE PLANS,

Continued

### IMPORTANT: NDC reporting requirements

National Drug Codes (NDC s) 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           | <u>0</u> 9999-9999-99   | 0002-7597-01<br>Zyprexa® 10mg Vial | <u>0</u> 0002759701            |
| 5-3-2                                       | 99999-999-99            | 5-4-2           | 99999- <u>0</u> 999-99  | 50242-040-62<br>Xolair® 150mg vial | 50242 <u>0</u> 04062           |
| 5-4-1                                       | 99999-9999-9            | 5-4-2           | 99999-9999- <u>0</u> 9  | 60575-4112-1<br>Synagis® 50mg vial | 605754112 <u>0</u> 1           |

## 2.6 INTERNATIONAL BLUE PLANS

### Overview

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:

|                                                                                                                                |                                |
|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------|
|  <b>BlueCross &amp; BlueShield de Uruguay</b> |                                |
| MEMBER NAME                                                                                                                    | Plan                           |
| Member Name                                                                                                                    | 1400                           |
| MEMBER ID                                                                                                                      | RPA PREMIUM                    |
| XYZ 0123456789                                                                                                                 | Expiration Date: May. 31, 2011 |
| Plan                                                                                                                           | PPO                            |
| GROUP                                                                                                                          | URU038                         |
| BC/BS Plan Codes: 154/654                                                                                                      |                                |
| CREDENCIAL PARA USO EXCLUSIVO FUERA DE URUGUAY                                                                                 |                                |

#### Back of card:

|                                                                                                                                                                                                                                           |                                                                                                                                                                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  <b>BlueCross &amp; BlueShield de Uruguay</b>                                                                                                           | <a href="http://www.bcbsu.com.uy">www.bcbsu.com.uy</a>                                                                                                                  |
| <b>Cientes:</b> Por beneficios consulte su contrato. La posesión de esta tarjeta no garantiza la elegibilidad de los beneficios.                                                                                                          | <b>Uruguay</b><br>Atención al Cliente: (596-2) 707-7575                                                                                                                 |
| <b>Proveedores en Uruguay:</b> Para verificar elegibilidad y beneficios, por favor llamar a nuestras oficinas. Dirija facturas por servicios médicos a nuestra dirección.                                                                 | <b>United States (E.E.U.U.)</b><br>Customer Service: (596-2) 707-7575<br>Provider Finder: 1-800-810-2583<br>Eligibility: 1-800-676-2583                                 |
| <b>Providers in the United States:</b> To verify membership eligibility, please call Eligibility line. Providers should file all claims to the local BlueCross and/or BlueShield Plan in whose Service Area the member received services. | <b>BlueCross &amp; BlueShield de Uruguay</b><br>Lord Ponsonby 2456<br>11600 Montevideo, Uruguay<br>An Independent Licensee of the BlueCross and BlueShield Association. |

### 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

## 2.6 GEOBLUE TRAVEL INSURANCE

### Overview

GeoBlue<sup>SM</sup> 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.

### Group plans

Employers can obtain group plans for their employees that provide either long-term or short-term coverage.

- GeoBlue Expat<sup>SM</sup> combines comprehensive global benefits with medical assistance services. This plan is designed for international assignees and their families when they leave their home countries for six months or more.
- GeoBlue Traveler<sup>SM</sup> is offered for international business travelers who are outside their home country for trips lasting up to one hundred eighty (180) days. It provides group supplemental medical benefits and services for international business travelers.

### Individual plans

GeoBlue also offers a full array of travel and international medical plans for individuals with global lifestyles whether for just a two week leisure trip or a two year work assignment. General plans include:

- **Voyager** offers coverage in addition to a primary health plan for a single trip of international travel for up to six months.
- **Trekker** provides coverage for unlimited trips within a 12-month period with a limit to the number of days per trip and also requires a primary health plan.
- **Xplorer** is long-term international health insurance for expatriates that provides coverage both inside and outside the United States.

GeoBlue specialty plans are also available that provide discounted coverage for a single trip for a group of five or more and long-term coverage for students and faculty, maritime crews, and missionaries.



## 2.6 LIMITED BENEFIT PRODUCTS

### Overview

Verifying Blue Plan patients' 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., \$1million or more), you may now see patients whose annual benefits are limited to \$50,000 or less.

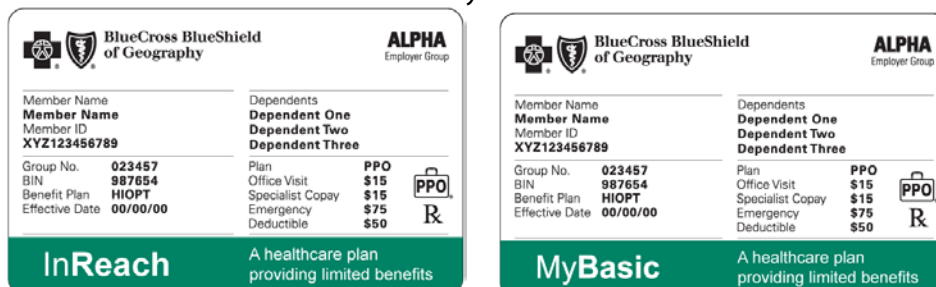
Currently, Highmark does not offer the limited benefit plans described here to our members; however, you may see patients with these limited benefit plans who are covered by another Blue Plan.

### 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 **1-800-676-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.

*Continued on next page*



## 2.6 LIMITED BENEFIT PRODUCTS, Continued

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**If benefits  
are exhausted  
before the end  
of treatment**

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

### Overview

With health costs increasing, employers are considering alternative approaches to control health care expenses by placing a greater emphasis on employee accountability by encouraging members to take a more active role in making health care decisions. Blue Plans have begun to introduce 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:

**1-800-676-BLUE** (1-800-676-2583)

*Continued on next page*

## 2.6 REFERENCED BASED BENEFITS, Continued

### Claims, payment, and member responsibility

Reference Based Benefits will not modify the current contracting amount agreed on between you and Highmark. You should submit claims to Highmark under your current billing practices. When you receive payment for services, the claim will pay per the member's benefits. Providers can expect to receive their contract rate on all procedures 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.

**Quick  
Reference**

## 2.6 CONSUMER DIRECTED HEALTHCARE AND HEALTH CARE DEBIT CARDS

### Overview

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

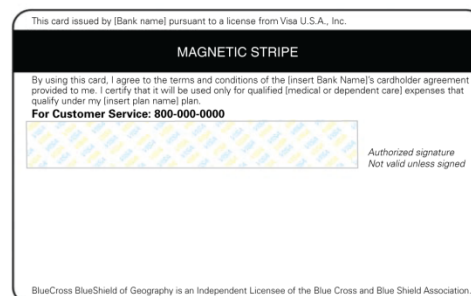
In some cases, the card will display the Blue Cross and Blue Shield trademarks along with the logo from a major debit card such as MasterCard® or Visa®.

### Example: Stand-alone health care debit card

#### Front of card:



#### Back of card:



*Continued on next page*

## 2.6 CONSUMER DIRECTED HEALTHCARE AND HEALTH CARE DEBIT CARDS, Continued

### Example: Combined health care debit card and Member ID card



### Health care debit card details

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 **1-800-676-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.

*Continued on next page*

## 2.6 CONSUMER DIRECTED HEALTHCARE AND HEALTH CARE DEBIT CARDS, Continued

### Helpful

### Tips

(continued)

- 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 **1-800-676-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.

## 2.6 HEALTH INSURANCE MARKETPLACES

### Overview

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.

[What Is My Service Area?](#)

### 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.

*Continued on next page*

## 2.6 HEALTH INSURANCE MARKETPLACES, Continued

### Marketplace options (continued)

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.

[What Is My Service Area?](#)

### 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.



## 2.6 BLUE EXCHANGE FOR INQUIRIES AND AUTHORIZATIONS

### Overview

We understand you need the right tools and resources to provide the best care to out-of-area Blue Plan members. To help you obtain information for out-of-area Blue Plan members, Highmark offers several options to assist you with administrative processes, including BlueExchange.®

BlueExchange 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. BlueExchange transactions submitted through Highmark are routed to the member's Blue Plan based on the prefix.

BlueExchange 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 BlueExchange via NaviNet

Highmark provides you with convenient, easy-to-use access to BlueExchange via NaviNet®. Each of these transactions can be initiated through Highmark's BlueExchange portal within NaviNet.

The **BlueExchange (Out-of-Area)** option in the Plan Central menu allows you to choose from the three transactions.

**Workflows for this Plan**

- Eligibility and Benefits Inquiry
- Auth Inquiry and Reports
- Authorization Submission
- Claim Status Inquiry
- Claim Investigation Inquiry
- Claim Submission
- Estimate Submission
- Diagnosis Code Inquiry
- Allowance
- Procedure Code Inquiry
- Network Provider Inquiry
- Network Facility Inquiry
- Provider Information
- AR Management
- BlueExchange® Out of Area**
- Resource Center

**Welcome to Plan Central**

| HEADLINE                                                                                                      | AUDIENCE     | DATE POSTED |
|---------------------------------------------------------------------------------------------------------------|--------------|-------------|
| <a href="#">ENHANCEMENT TO NAVINET PROVIDER FILE MANAGEMENT</a>                                               | ALL          | 04/16/2018  |
| <a href="#">HIGHMARK SUPPORTS NATIONAL INFANT IMMUNIZATION WEEK, APRIL 21-28, 2018</a>                        | PROFESSIONAL | 04/11/2018  |
| <a href="#">HIGHMARK SEEKING NEW MEMBERS FOR MEDICAL REVIEW COMMITTEE FOR 2019-2020 TERM</a>                  | PROFESSIONAL | 04/10/2018  |
| <a href="#">LOCUM TENENS PROCESS CHANGES EFFECTIVE JUNE 1, 2018</a>                                           | PROFESSIONAL | 04/09/2018  |
| <a href="#">IMMEDIATE ACTION REQUIRED: PROVIDERS TO ENSURE THEIR INFORMATION IS ACCURATE IN THE DIRECTORY</a> | ALL          | 04/05/2018  |
| <a href="#">FRAUD AND ABUSE: AUDITS DISCLOSE ACCOMPLISHMENTS AND FUTURE</a>                                   | ALL          | 04/03/2018  |

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## 2.6 BLUE EXCHANGE FOR INQUIRIES AND AUTHORIZATIONS,

Continued

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### **NaviNet User Guides**

NaviNet User Guides can provide helpful tips on using the BlueExchange transactions. To access, click on **Help** in the navigation panel at the top of the NaviNet screen to open the NaviNet Support window. Select the applicable Highmark plan for your service area to access all available User Guides.

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### **Electronic transactions routed via BlueExchange**

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 BlueExchange:

- 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 BlueExchange.

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## 2.6 BLUECARD ELIGIBILITY AND BENEFITS VERIFICATION

### Overview

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 BlueExchange® inquiry within NaviNet®; or
- Call the BlueCard® Eligibility line at **1-800-676-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 very quick turnaround -- with responses in seconds. 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 BlueExchange inquiry from within NaviNet:** The *BlueExchange Eligibility and Benefits Inquiry* transaction allows users to access up-to-date eligibility and benefits information for out-of-area members.

### 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 **1-800-676-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.

*Continued on next page*

## 2.6 BLUECARD ELIGIBILITY AND BENEFITS VERIFICATION, Continued

### 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:

| Front of card                                                                                                                                                                              |                                                                                                             | Back of card                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  <b>BlueCross BlueShield of Geography</b><br><b>Blue Product ALPHA</b><br><small>Employer Group</small> |                                                                                                             | <a href="http://www.BluePlan.com">www.BluePlan.com</a><br> <b>BlueCross BlueShield of Geography</b>                                                                                                                                                             |                                                                                                                                                                  |
| Member Name<br><b>Member Name</b><br>Member ID<br><b>XYZ123456789</b>                                                                                                                      | Dependents<br><b>Dependent One</b><br><b>Dependent Two</b><br><b>Dependent Three</b>                        | Customer Service: 1-800-234-5678 x1234<br>Behavioral Health: 1-800-987-6543 x1234<br>Outside of Area: 1-800-810-2583 x1234<br>Eligibility: 1-800-676-2583 x1234<br>Pharmacy Benefits*: 1-800-888-1234                                                                                                                                               | <b>BlueCross and BlueShield of Geography</b><br>P.O. Box 01234<br>City, State 01234-1234<br>An independent licensee of the BlueCross and BlueShield Association. |
| Plan<br><b>PPO</b><br>Plan Code<br><b>123</b>                                                                                                                                              | Office Visit <b>\$15</b><br>Specialist Copay <b>\$15</b><br>Emergency <b>\$75</b><br>Deductible <b>\$50</b> | Members: See your benefit booklet for covered services. Possession of this card does not guarantee eligibility for benefits.<br>Hospitals or physicians: file claims with your local BlueCross and/or BlueShield Plan.<br>BlueCross and BlueShield of Geography provides administrative services and does not assume any financial risk for claims. | <b>BETA</b><br>Pharmacy Management<br>Pharmacy benefits administrator—not a BlueCross BlueShield product.                                                        |

## 2.6 UTILIZATION REVIEW

|                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|-----------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Introduction</b>               | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Pre-service review defined</b> | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Inpatient services</b>         | <p>Effective July 1, 2014, under a new 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).</p> <p>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.</p> <p>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.</p> <p>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 forty-eight (48) hours when a change to the original pre-service review occurs, and within seventy-two (72) hours for emergency and/or urgent admissions.</p> <p><b>Note:</b> 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.</p> |

*Continued on next page*

## 2.6 UTILIZATION REVIEW, Continued

### 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.

### 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 **INTER-PLAN PROGRAMS** from the main menu, and then choose **Medical Policy and Pre-Certification/Pre-Authorization Router for Out-of-Area Members**. 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.
- **Initiate a BlueExchange authorization request submission via NaviNet.** Select the **BlueExchange (Out-of-Area)** option from NaviNet's Plan Central menu, and then click on **BX Referral/Auth Submission** on the fly-out menu.
- **Use the new Electronic Provider Access (EPA) function available in NaviNet.** Select **Authorization Submission** from NaviNet's Plan Central menu, and then click on **PreService Review for Out of Area Members** on the fly-out menu. This option will take you directly to the member's Home Plan provider portal to conduct electronic pre-service review. **Note:** This function is not yet available for access to all Blue Plans. Please see the next section of this unit for more information.
- **Call BlueCard Eligibility at 1-800-676-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.

*Continued on next page*

## 2.6 UTILIZATION REVIEW, Continued

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### **How to obtain authorization** (continued)

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)

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### Overview

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.

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### Implementation schedule

The availability of EPA will vary depending on the capabilities of each Home Plan. Some Home Plans are fully implemented and have electronic pre-service review for many services, while others have not yet implemented electronic pre-service review capabilities.

Highmark has already implemented EPA and the EPA tool is ready for your use through NaviNet.® To determine if another Blue Plan has already implemented electronic pre-service review, please reference the [Plan Implementation Schedule](#). This schedule is also available in the BlueCard Information Center on the Provider Resource Center (in Pennsylvania and Delaware).

**Note:** The schedule reflects anticipated EPA implementation by Home Plan, indicating the date which electronic pre-service review will be available for inpatient, high-tech radiology, and other services. Providers should keep in mind that, although this schedule reflects planned implementation to date, some Plans may experience delays.

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### Determine if precertification is required

You can first check whether precertification is required by the member's Home Plan by either:

- Sending a service-specific request through NaviNet's *BlueExchange*®; or
  - Accessing the Home Plan's precertification requirements pages by using the Medical Policy Router available on the Provider Resource Center. (Select **INTER-PLAN PROGRAMS** 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 ELECTRONIC PROVIDER ACCESS (EPA), Continued

### Using the EPA tool

As a Highmark provider, you will initiate this process by logging into NaviNet as you normally would for other purposes. From **Authorization Submission** in NaviNet's main menu, select **Pre-Service Review for Out of Area Members** from the fly-out menu.

|                                    | AUDIENCE     | DATE POSTED |
|------------------------------------|--------------|-------------|
| MANAGEMENT                         | ALL          | 04/16/2018  |
| MANAGEMENT WEEK, APRIL 21-28, 2018 | PROFESSIONAL | 04/11/2018  |
|                                    | PROFESSIONAL | 04/10/2018  |

You will be asked to enter the prefix from the member's ID card. (The prefix is the first three characters of the Member ID.)

Pre-Service Review For Out of Area Members

Pre-Service Review for Out-of-Area Members includes notification, pre-certification, pre-authorization and prior approval. Entering a 3-digit Member Alpha prefix below allows you to conduct any available pre-service review through The Blue Cross and Blue Shield Association's Electronic Provider Access process for an out-of-area member.

**Pre-Service Review**

Member ID Alpha Prefix:

Provider:

Please verify that the contact information populated in the fields below is your current contact information.

**Contact Information**

First Name:  Last Name:

Middle Initial:

Email:

Phone Number:

After entering the prefix, you will be automatically routed to the member's Home Plan EPA landing page. This page will welcome you to the member's Home Plan portal and indicate that you have left Highmark's portal. The landing page will allow you to connect to the available electronic pre-service review processes.

*Continued on next page*

## 2.6 ELECTRONIC PROVIDER ACCESS (EPA), Continued

### Using the EPA tool (continued)

Because the screens and functionality of Home Plan pre-service review processes vary widely, Home Plans may include instructional documents or e-learning tools on the Home Plan landing page to provide instruction on how to conduct an electronic pre-service review. The page will also include instructions for conducting pre-service review for services where the electronic function is not available.

**Note:** Electronic Provider Access (EPA) for pre-service review does not support the Federal Employee Program (FEP). Please contact Highmark for FEP members, whose identification numbers begin with an “R.”

### FOR MORE INFORMATION



Additional resources are available in the **BlueCard Information Center** on the Provider Resource Centers in Pennsylvania and Delaware, including the following:

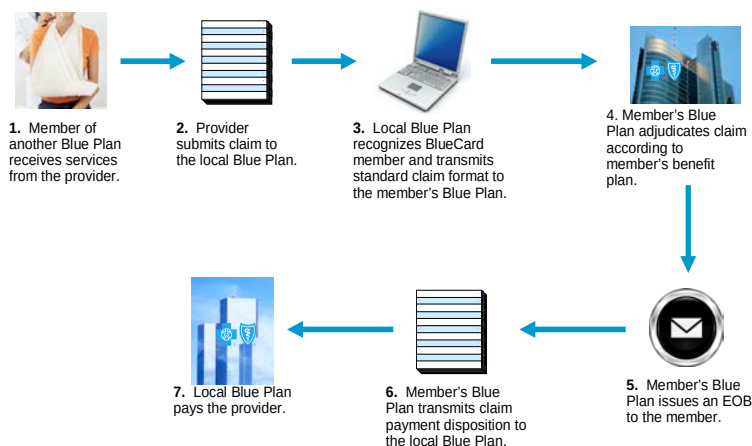
- [EPA Tip Sheet](#)
- [Blue Plan Implementation Schedule](#)

[What Is My Service Area?](#)

## 2.6 CLAIM SUBMISSION AND CLAIM STATUS INQUIRY

### How claims flow through BlueCard®

The diagram below illustrates how claims flow through BlueCard:



### Submit BlueCard claims to Highmark

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 next section of this unit – **NAIC Codes** -- for complete information on all Highmark NAIC payer codes.

### Helpful 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 **1-800-676-BLUE** (2583) and ask to be connected with the utilization review area.

*Continued on next page*

## 2.6 CLAIM SUBMISSION AND CLAIM STATUS INQUIRY, Continued

### Helpful Tips

(continued)

- 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.
  - o On the 837I and the 837P electronic claim submission, use the Patient Amount Paid Segment (AMT01=F5 patient paid amount).
  - o 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.
  - o 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 NaviNet'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.

- NaviNet's *Claim Status Inquiry*, 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.
- BlueExchange® is another option Highmark offers through NaviNet for obtaining BlueCard claim status. The claim status inquiry option in BlueExchange even allows you to search for the status of out-of-area Medicare cross-over claims or those filed directly to the member's Home Plan.

*Continued on next page*

## 2.6 CLAIM SUBMISSION AND CLAIM STATUS INQUIRY, Continued

### 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 the *Claim Status Inquiry* within NaviNet, and then initiate an adjustment request via the *Claims Investigation Inquiry*.
- Providers who are not NaviNet-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 thirty (30) days, please visit NaviNet, 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

*Continued on next page*

## 2.6 CLAIM SUBMISSION AND CLAIM STATUS INQUIRY, Continued

### Coordination of benefits (continued)

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.

[What Is My Service Area?](#)

### 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.

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## 2.6 CLAIM SUBMISSION AND CLAIM STATUS INQUIRY, Continued

### Calls from BlueCard members

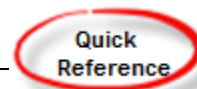
If BlueCard members contact you with questions about claims, advise them to contact their Blue Plan and refer them to their ID card for a customer service number.

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

For more information:

- Visit the **BlueCard Information Center** on the Provider Resource Center – select **INTER-PLAN PROGRAMS** from the main menu to access.
- Call Highmark Provider Services



## 2.6 NAIC CODES

### Overview

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.

[What Is My Service Area?](#)

### Pennsylvania



| PENNSYLVANIA  |                                                     |                                                                                                                                                                                                                                                                                                                |
|---------------|-----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| NAIC CODE     | PROVIDER TYPE                                       | PRODUCTS                                                                                                                                                                                                                                                                                                       |
| <b>54771W</b> | Western Region facility type providers (UB-04/837I) | <ul style="list-style-type: none"> <li>All Highmark commercial products;</li> <li>Medicare Advantage Security Blue HMO and Medicare Advantage Community Blue HMO administered by Highmark Choice Company; and</li> <li>All BlueCard products and Medicare Advantage claims for any other Blue Plan.</li> </ul> |
| <b>54771C</b> | Central Region facility type providers (UB-04/837I) | <ul style="list-style-type: none"> <li>All Highmark commercial products;</li> <li>Medicare Advantage Community Blue HMO administered by Highmark Choice Company; and</li> <li>All BlueCard products and Medicare Advantage claims for any other Blue Plan.</li> </ul>                                          |

*Continued on next page*



## 2.6 NAIC CODES, Continued

[What Is My Service Area?](#)

### Pennsylvania (continued)



| PENNSYLVANIA (cont.) |                                      |                                                                                                                                                                                                                                                                                                                                            |
|----------------------|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| NAIC CODE            | PROVIDER TYPE                        | PRODUCTS                                                                                                                                                                                                                                                                                                                                   |
| <b>54771</b>         | All other provider types (1500/837P) | <ul style="list-style-type: none"> <li>All Highmark commercial products;</li> <li>Medicare Advantage Security Blue HMO (Western Region only) and Medicare Advantage Community Blue HMO, both administered by Highmark Choice Company; and</li> <li>All BlueCard products and Medicare Advantage claims for any other Blue Plan.</li> </ul> |
| <b>15460</b>         | All provider types                   | Medicare Advantage Freedom Blue PPO administered by Highmark Senior Health Company (Pennsylvania plans only with prefixes <b>HRT</b> , <b>TDM</b> , <b>USK</b> , <b>HRF</b> ).                                                                                                                                                             |

### Highmark Delaware



| DELAWARE     |                          |                                                                                                         |
|--------------|--------------------------|---------------------------------------------------------------------------------------------------------|
| NAIC CODE    | PROVIDER TYPE            | PRODUCTS                                                                                                |
| <b>00070</b> | Facility provider types  | All Highmark Delaware products; BlueCard claims; and Medicare Advantage claims for any other Blue Plan. |
| <b>00570</b> | All other provider types | All Highmark Delaware products; BlueCard claims; and Medicare Advantage claims for any other Blue Plan. |

### Highmark West Virginia



| WEST VIRGINIA |                    |                                                                                                                          |
|---------------|--------------------|--------------------------------------------------------------------------------------------------------------------------|
| NAIC CODE     | PROVIDER TYPE      | PRODUCTS                                                                                                                 |
| <b>54828</b>  | All provider types | All Highmark West Virginia products; BlueCard claims; and Medicare Advantage claims for any other Blue Plan.             |
| <b>15459</b>  | All provider types | Highmark Senior Solutions Company Medicare Advantage Freedom Blue PPO (West Virginia plan only with prefix <b>HSR</b> ). |

## 2.6 SPECIAL CONSIDERATIONS FOR CLAIMS FILING

### Providers contracting with more than one Blue Plan

If you have a contract with the member's Home Plan that matches the member's product (Traditional, PPO, etc.), file the claim with that Blue Plan. Otherwise, submit all claims to Highmark.

**Note:** Within the 21-county central Pennsylvania and Lehigh Valley area, Highmark Blue Shield markets in the same region as another Blue Plan. If you treat a Highmark Blue Shield member who resides within those 21 counties, you must send your claim to Highmark even if you also contract with the other Blue Plan.

[What Is My Service Area?](#)

### Contiguous counties

Claims filing rules for contiguous area providers are based on the permitted terms of the provider contract which may include:

- Provider location (i.e., which Blue Plan service area is the provider's office located in)
- Provider contract with the two contiguous counties (i.e., is the provider contracted with only one or both service areas)
- The member's Home Plan and where the member works and resides (i.e., is the member's Home Plan with one of the contiguous county's plans)
- The location of where the services were received (i.e., does the member work and reside in one contiguous county and see a provider in another contiguous county)

**Note:** Contiguous counties' guidelines do not apply to ancillary claims filings. Please see the next page for information on submission of ancillary claims.

### Overlapping service areas

Submission of claims in overlapping service areas is dependent on what Blue Plan(s) the provider contracts within 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.

**Note:** Overlapping service area guidelines do not apply to ancillary claims.

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## 2.6 SPECIAL CONSIDERATIONS FOR CLAIMS FILING, Continued

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### Ancillary claims

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

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### Overview

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.

---

### Requests for medical 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 1-866-251-9601**. 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.

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*Continued on next page*

## 2.6 MEDICAL RECORDS REQUESTS, Continued

**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.

## 2.6 BLUECARD QUICK TIPS

### 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:
  - Submit a BlueExchange® Inquiry via NaviNet®; or
  - Submit a HIPAA 270 transaction to Highmark.
4. Or, call BlueCard Eligibility **1-800-676-BLUE** (2583) for eligibility inquiries:
  - English and Spanish speaking operators are available;
  - 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.
  - **Pennsylvania:** Western Region Facility – 54771W; Central Region Facility – 54771C; all other provider types – 54771.
  - **Delaware:** Facility – 00070; all other provider types – 00570.
  - **West Virginia:** All provider types – 54828
6. Always report the patient's complete identification number, including the 3-character prefix.
7. Consider electronic means for claim inquiries:
  - BlueCard claims can often be found within the Claim Status Inquiry transaction in NaviNet. Remember to enter the entire identification number including the 3-character prefix; or
  - Submit a BlueExchange Inquiry via NaviNet; or
  - Initiate a HIPAA 276 transaction to Highmark.
8. Consider electronic means for utilization review inquiries:
  - Submit a BlueExchange Inquiry via NaviNet; or
  - Submit a HIPAA 278 transaction to Highmark.
9. Or, call BlueCard Eligibility **1-800-676-BLUE** (2583) for utilization inquiries. Ask to be transferred to the Utilization Review area.

[What Is My Service Area?](#)

## 2.6 MEDICARE ADVANTAGE PRODUCTS

### Introduction

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 overview

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 **1-800-676-BLUE** (2583) for all Medicare Advantage members.

[What Is My Service Area?](#)

### Highmark's Medicare Advantage products

Highmark offers the following Medicare Advantage products:

- Freedom Blue PPO – offered by Highmark Senior Health Company in the Western, Central, and Northeastern Regions of Pennsylvania, and by Highmark Senior Solutions Company in West Virginia.
- Community Blue Medicare HMO – a select network product administered by Highmark Choice Company is offered in select counties in Pennsylvania's Western, Central, and Northeastern Regions.
- Community Blue Medicare PPO -- these plans are administered by Highmark Senior Health Company and are available in select counties in Pennsylvania's Western, Central, and Northeastern Regions.
- Community Blue Medicare Plus PPO – this plan, also administered by Highmark Senior Health Company, offers exclusive access to Geisinger Danville facilities and doctors and is offered only to members living in Clinton, Lycoming, Sullivan, and Tioga counties in Pennsylvania.

*Continued on next page*

## 2.6 MEDICARE ADVANTAGE PRODUCTS, Continued

[What Is My Service Area?](#)

### Highmark's Medicare Advantage products (continued)

- Security Blue HMO – offered in 28 counties of Pennsylvania's Western Region by Highmark Choice Company.

Medicare Advantage products are not currently available in Delaware.

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:** Effective January 1, 2018, the Medicare Advantage HMO Network Sharing for Transplant Services program will provide 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

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."

*Continued on next page*



## 2.6 MEDICARE ADVANTAGE PRODUCTS, Continued

### 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.

## 2.6 MEDICARE ADVANTAGE PPO NETWORK SHARING

### Overview

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 benefits verification

To verify eligibility and benefits for a Medicare Advantage PPO member, you can initiate a BlueExchange® Eligibility and Benefits Inquiry via NaviNet®; submit an electronic inquiry to Highmark via a HIPAA 270/271 transaction; or call the BlueCard® Eligibility Line at **1-800-676-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.

[What Is My Service Area?](#)

### 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.

*Continued on next page*

## 2.6 MEDICARE ADVANTAGE PPO NETWORK SHARING, Continued

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### 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 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 **1-800-676-BLUE (2583)**.

[What Is My Service Area?](#)

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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:

MEDICARE ADVANTAGE | **HMO**

MEDICARE ADVANTAGE | **PFFS**

**MA** | **PPO**  
MEDICARE ADVANTAGE

MEDICARE ADVANTAGE | **POS**

MEDICARE ADVANTAGE | **MSA**

### Medicare Advantage eligibility verification

To verify eligibility and benefits for an out-of-area Medicare Advantage member, you can initiate a BlueExchange® Eligibility and Benefits Inquiry via NaviNet®; submit an electronic inquiry to Highmark via a HIPAA 270/271 transaction; or call the BlueCard® Eligibility Line at **1-800-676-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.**

*Continued on next page*

## 2.6 MEDICARE ADVANTAGE ELIGIBILITY, CLAIMS, AND PAYMENT,

Continued

### 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:

[What Is My Service Area?](#)

| PENNSYLVANIA  |                                                     |                                                                                                                                                                                                                                                                       |
|---------------|-----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| NAIC CODE     | PROVIDER TYPE                                       | PRODUCTS                                                                                                                                                                                                                                                              |
| <b>54471W</b> | Western Region facility type providers (UB-04/837I) | <ul style="list-style-type: none"> <li>Medicare Advantage Security Blue HMO and Medicare Advantage Community Blue HMO administered by Highmark Choice Company; and</li> <li>All Medicare Advantage claims for any other Blue Plans.</li> </ul>                        |
| <b>54771C</b> | Central Region facility type providers (UB-04/837I) | <ul style="list-style-type: none"> <li>Medicare Advantage Community Blue HMO administered by Highmark Choice Company.</li> <li>All Medicare Advantage claims for any other Blue Plans.</li> </ul>                                                                     |
| <b>54771</b>  | All other provider types (1500/837P)                | <ul style="list-style-type: none"> <li>Medicare Advantage Security Blue HMO (Western Region only) and Medicare Advantage Community Blue HMO, both administered by Highmark Choice Company.</li> <li>All Medicare Advantage claims for any other Blue Plan.</li> </ul> |
| <b>15460</b>  | All provider types                                  | Medicare Advantage Freedom Blue PPO administered by Highmark Senior Health Company (Pennsylvania plans only with prefixes <b>HRT, TDM, USK, HRF</b> ).                                                                                                                |

*Continued on next page*

## 2.6 MEDICARE ADVANTAGE ELIGIBILITY, CLAIMS, AND PAYMENT,

Continued

**NAIC codes  
for Medicare  
Advantage  
claims  
submission  
(continued)**

| DELAWARE     |                                      |                                                  |
|--------------|--------------------------------------|--------------------------------------------------|
| NAIC CODE    | PROVIDER TYPE                        | PRODUCTS                                         |
| <b>00070</b> | Facility provider types (UB-04/837I) | All Medicare Advantage claims for any Blue Plan. |
| <b>00570</b> | All other provider types (1500/837P) | All Medicare Advantage claims for any Blue Plan. |

| WEST VIRGINIA |                    |                                                                                                                          |
|---------------|--------------------|--------------------------------------------------------------------------------------------------------------------------|
| NAIC CODE     | PROVIDER TYPE      | PRODUCTS                                                                                                                 |
| <b>54828</b>  | All provider types | All Medicare Advantage claims for any other Blue Plan.                                                                   |
| <b>15459</b>  | All provider types | Highmark Senior Solutions Company Medicare Advantage Freedom Blue PPO (West Virginia plan only with prefix <b>HSR</b> ). |

### FOR MORE INFORMATION

For complete information on all Highmark NAIC payer codes, please see the section of this unit titled “NAIC Codes.”

[What Is My Service Area?](#)

**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<br>P.O. Box 890062<br>Camp Hill, PA<br>17089-0062 | Highmark Blue Cross<br>Blue Shield Delaware<br>P.O. Box 8830<br>Wilmington, DE 19899 | Highmark Blue Cross<br>Blue Shield West Virginia<br>P.O. Box 7026<br>Wheeling, WV 26003 |

*Continued on next page*

## 2.6 MEDICARE ADVANTAGE ELIGIBILITY, CLAIMS, AND PAYMENT,

Continued

[What Is My Service Area?](#)

### Reimbursement for Medicare Advantage HMO, POS, and PPO -- with a Plan contract



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— effective January 1, 2018



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

*Continued on next page*

## 2.6 MEDICARE ADVANTAGE ELIGIBILITY, CLAIMS, AND PAYMENT,

Continued

### Medicare Advantage HMO Network Sharing for Transplant Services (continued)



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.

[What Is My Service Area?](#)

### 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.

*Continued on next page*



## 2.6 MEDICARE ADVANTAGE ELIGIBILITY, CLAIMS, AND PAYMENT,

Continued

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**Reimbursement  
for Medicare  
Advantage  
PFFS members**  
(continued)

A link is provided on the Provider Resource Center to access the Medicare Advantage PFFS Terms and Conditions for all Blue Plans -- select **INTER-PLAN PROGRAMS** from the main menu.

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

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Overview</b>                                                    | <p>The following are guidelines for the processing of traditional Medicare-related claims:</p> <ul style="list-style-type: none"> <li>• When Medicare is the primary payer, submit claims to your local Medicare carrier or intermediary.</li> <li>• Most Blue Plan claims are set up to automatically cross over to the member's Blue Plan after being adjudicated by the Medicare intermediary.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>How to submit Medicare primary / Blue Plan secondary claims</b> | <p>For members with Medicare primary coverage and Blue Plan secondary coverage, submit claims to your Medicare intermediary and/or Medicare carrier.</p> <p>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.</p> <p>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.</p>                                                                                                                                                                                                                                |
| <b>Review the remittance advice for confirmation</b>               | <p>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:</p> <ul style="list-style-type: none"> <li>• 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. <b>Do not submit the claim to Highmark.</b></li> <li>• If the remittance advice indicates that the claim was not crossed over, submit the claim to Highmark with the Medicare remittance advice.</li> <li>• 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.</li> <li>• For claim status inquiries, contact Highmark.</li> </ul> |
| <b>When you can expect payment</b>                                 | <p>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 fourteen (14) business days.</p> <p>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.</p>                                                                                                                                                                                                                                                                                                                                                                                |

*Continued on next page*

## 2.6 TRADITIONAL MEDICARE-RELATED CLAIMS, Continued

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### **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 thirty (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.

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### **Questions?**

If you have questions, please contact Highmark Provider Services.

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**Quick  
Reference**

## CHAPTER 3: PROVIDER NETWORK PARTICIPATION

### UNIT 1: NETWORK PARTICIPATION OVERVIEW

#### IN THIS UNIT



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[What Is My Service Area?](#)

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The **PA ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The **DE ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

## 3.1 INTRODUCTION TO NETWORK PARTICIPATION

### Overview

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, non-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.

*Why blue italics?*

### 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. If you have questions about MHPAEA, you can email your questions to [HPMeditor@highmark.com](mailto:HPMeditor@highmark.com).*

*Continued on next page*

### 3.1 INTRODUCTION TO NETWORK PARTICIPATION, Continued

#### Eligible organizational providers (facility and ancillary)

Highmark holds contracts with organizational providers (facility and ancillary) and credentials them in order 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 in the specialties 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 3.4: Organizational Provider Participation](#).

#### Who is an eligible professional provider?

Eligible professional providers include:

- Doctors of Medicine (MD)
- Doctors of Osteopathy (DO)
- Doctors of Dentistry (DDS/DMD)
- Doctors of Podiatry (DPM)
- Doctors of Optometry (OD)
- Doctors of Chiropractic (DC)
- Nurse midwives
- Licensed physical therapist
- Licensed psychologist
- Certain certified registered nurses
- Licensed audiologist
- Licensed speech-language pathologist
- Licensed clinical social workers
- Licensed occupational therapists
- Licensed marriage and family therapists
- Licensed professional counselors
- Licensed dietitian – nutritionist

[What Is My Service Area?](#)

#### Additional providers eligible in WV



Highmark West Virginia also contracts with the following provider types for networks and/or programs as indicated:

- Acupuncturists -- for Federal Employee Program (FEP) 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

*Continued on next page*

### 3.1 INTRODUCTION TO NETWORK PARTICIPATION, Continued

#### Physician assistants & acupuncturists



Practitioners who are not eligible to contract with Highmark to participate in Highmark's networks in Pennsylvania and Delaware may be eligible to provide services for certain government programs only (e.g., FEP and Medicare Advantage).

**Acupuncturists:** Although acupuncturists are not eligible to contract with Highmark for our commercial and Medicare Advantage networks in Pennsylvania and Delaware, they are fully credentialed and contracted to provide services to FEP members only.

**Physician Assistants (PAs):** In Pennsylvania and Delaware, Physician Assistants are not eligible to participate in Highmark's commercial networks as independent practitioners; the services they perform are recognized only when they are employed by and acting under the personal supervision of a physician. However, Physician Assistants are eligible to contract with Highmark to provide services to Medicare Advantage members in Pennsylvania.

#### 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 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 serving as a PCP in another group practice.

In West Virginia 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.

*Continued on next page*

### 3.1 INTRODUCTION TO NETWORK PARTICIPATION, Continued

#### 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 maybe 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 network 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.

*Continued on next page*



### 3.1 INTRODUCTION TO NETWORK PARTICIPATION, Continued

#### **Mutual roles and obligations for network participating providers and Highmark** (continued)

- Highmark will make payment directly to network providers and will notify the member 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 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.

#### **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.

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### 3.1 INTRODUCTION TO NETWORK PARTICIPATION, Continued

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**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.

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## 3.1 NETWORK COMPLIANCE

|                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|---------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Policy</b>                               | <p>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 in order 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.</p> <p>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.</p> |
| <b>Categories of non-compliance</b>         | <p>Non-compliance can be divided into three categories:</p> <ol style="list-style-type: none"> <li>1. Quality of care concerns</li> <li>2. Unacceptable resource utilization</li> <li>3. Administrative non-compliance</li> </ol>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Quality of care concerns</b>             | <p>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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Examples of quality of care concerns</b> | <p>Examples of quality of care concerns include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Actions or omissions that result or may result in an adverse effect on a patient's well-being</li> <li>• Delayed services/referrals</li> <li>• Missed diagnoses</li> <li>• Medication errors</li> <li>• Delayed diagnosis/treatment</li> <li>• Unexpected operative complications</li> <li>• Invasive procedure complications</li> <li>• Inappropriate procedures</li> <li>• Unanticipated, unexplainable death</li> <li>• Actions requiring a report to the National Practitioner Data Bank (NPDB) or other adverse actions</li> </ul>                                                                                                                                                |

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### 3.1 NETWORK COMPLIANCE, Continued

**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

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### 3.1 NETWORK COMPLIANCE, Continued

**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:

- (a) 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");
- (b) Disclose the Provider Data to Highmark's contracted vendors and agents to assist in the review, analysis, and reporting of the Provider Data;
- (c) Report the Provider Data to other providers to assist such providers in the management of care costs, quality outcomes, and other efficiencies;
- (d) Report the Provider Data to Members and customers (including third parties who supply information and analysis services to group customers); and
- (e) 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

### Overview

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 NaviNet, EFT, & paperless EOBs/remittances required for all participating providers

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

NaviNet is an easy online solution linking physician offices and facilities with Highmark and other health plans. NaviNet 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.
- 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 NaviNet --which is two days earlier than receiving them by mail.

### How to sign up for NaviNet

To sign up for NaviNet, you can call Highmark's Provider Service Center or go to [navinet.net](http://navinet.net), and then click on the **PROVIDERS: SIGN UP FOR NAVINET** button.



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### 3.1 ELECTRONIC TRANSACTION REQUIREMENTS, Continued

#### Enrolling in EFT and paperless EOBs & remittances

After becoming NaviNet-enabled, providers must also enroll in electronic funds transfer (EFT) and paperless EOB statements and remittances. This is done through the **EFT Attestation and Registration** transaction on NaviNet. To use this transaction, the provider's NaviNet Security Officer must enable the function for the EFT Responsible Party. Your NaviNet Security Officer is an employee of your practice or health system who has been assigned to serve as the primary contact with NaviNet.

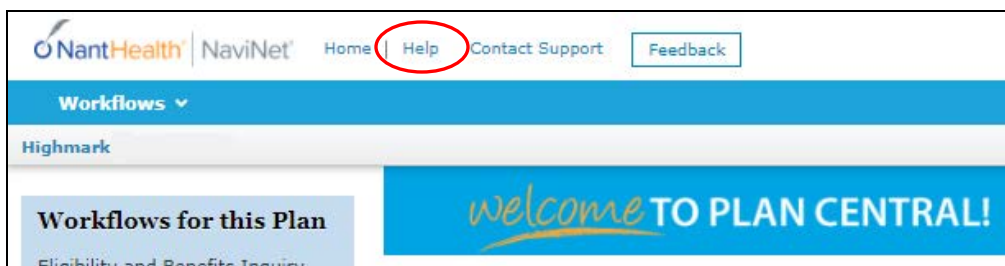
The EFT Attestation and Registration transaction allows the person who is designated as the provider's "EFT Responsible Party" to electronically attest, register, and/or maintain banking information on behalf of the practice. Once you are enrolled and start receiving EFT payments, you will no longer receive paper EOB statements or remittances. You can view your electronic EOBs and remittances via NaviNet. To access EFT payment detail and EOBs and remittances, select the **AR Management** transaction from the Highmark Plan Central menu.

Helpful instructions for using the EFT Attestation and Registration transaction are available on the Provider Resource Center in both video and PDF formats.

- Pennsylvania: Select **PROVIDER TRAINING** from the main menu, and then **Provider Training** from the submenu. Please see the **NAVINET SELF SERVICE GUIDES** category.
- Delaware and West Virginia: Select **EDUCATION/MANUALS** from the main menu, and then **Provider Training**. Please see the **NAVINET SELF SERVICE GUIDES** category.

The [EFT Attestation and Registration Guide](#), a helpful, printable PDF document, is available in that location.

In addition, NaviNet provides support for available transactions – just click on **Help** at the top of Highmark Plan Central to access NaviNet Support. Select the Highmark Health Plan for your location, and then click **Go**. You'll find a User Guide for EFT Attestation and Registration under the **Office & Provider Management** heading.



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### 3.1 ELECTRONIC TRANSACTION REQUIREMENTS, Continued

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**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.

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## 3.1 PROVIDER NETWORKS

### Overview of Pennsylvania networks



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

[What Is My Service Area?](#)

### Participating Provider Network



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



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.

*Continued on next page*

### 3.1 PROVIDER NETWORKS, Continued

#### Premier Blue Shield Network (continued)



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 made 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.

[What Is My Service Area?](#)

#### Western Region KHPW managed care network



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.

#### Community Blue commercial network



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 the regional member websites by selecting **Find a Doctor or RX**.

*Continued on next page*

### 3.1 PROVIDER NETWORKS, Continued

[What Is My Service Area?](#)

#### First Priority Health Network



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 also 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



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 2.2: Medicare Advantage Products and Programs](#).

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

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## 3.1 PROVIDER NETWORKS, Continued

### ACA Select Network



Effective January 1, 2018, 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.

The [ACA Select Network Map](#) identifies participating hospitals by county. 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.

[What Is My Service Area?](#)

### Delaware



The Delaware Provider Network spans all three counties in the state of Delaware and also contiguous counties of neighboring states. Highmark Delaware 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



Highmark West Virginia 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

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### 3.1 PROVIDER NETWORKS, Continued

[What Is My Service Area?](#)

#### West Virginia (continued)



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)

### Overview



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.

[What Is My Service Area?](#)

### Select DME Network effective January 1, 2017



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 the most current lists of providers in the Select DME Network, select **CLAIMS, PAYMENT & REIMBURSEMENT** from the main menu on the Provider Resource Center, and then click on **Select DME Network**. You can select a list of [all participating providers](#) or a [list organized by category with phone numbers](#).

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

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**Overview** 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 non-network provider.

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**Background** Many of Highmark's products have a requirement that members have all of 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 non-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.

Please see the units of the *Highmark Provider Manual's* Chapter 2, Product Information, for additional program and product information.

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**Participating provider responsibilities** 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 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.

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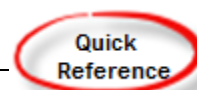
### 3.1 DIRECTING CARE TO NETWORK PROVIDERS, Continued

#### Locating network providers

The online Highmark Provider Directory allows providers and members to search for Highmark network participating providers. It can be accessed from our public websites. For members who have BlueCard® benefits, this tool can be used to search for any provider within the nationwide Blue Cross Blue Shield system.

Providers and members can access the Highmark Provider Directory from the home page of each of Highmark's regional public websites. Access to all Highmark regional websites is available at [highmark.com](http://highmark.com). Click on the orange **CONSUMERS/MEMBERS/PROVIDERS** tab, and then select the appropriate link under **FOR MEMBERS** for the Highmark service area in which you are located. The Provider Directory is accessed by clicking on **FIND A DOCTOR OR RX**.

Providers can also search for participating providers through NaviNet's **Network Provider Inquiry** and **Network Facility Inquiry** functions.



#### 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 that 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 that 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 that services 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

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### Overview

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)."

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### 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 : **1-800-236-8641**
  - 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)

### Overview



Highmark's Participating Provider Network in Pennsylvania services Highmark's traditional programs as well as BlueCard® traditional, point of service (POS), and health maintenance organization (HMO) programs. 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."

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.

[What Is My Service Area?](#)

### Participating Provider Agreement form



To become a Participating Provider, you must complete a "Participating Provider Agreement." By submitting the completed form, a solo practitioner is entering into the agreement as both "Participating Provider" and "Practitioner." If 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 "Participating Provider Agreement" can be found on Highmark's Provider Resource Center. The Provider Resource Center can be accessed via NaviNet® or [highmark.com](http://highmark.com) (click on the orange **CONSUMERS/MEMBERS/ PROVIDERS** tab, and then select the link for the Highmark plan in your service area from the options under the **FOR PROVIDERS** heading).

To reach the link for the participating provider agreement form, select **FORMS** from the main menu on the Provider Resource Center, and then click on **Provider Information Management Forms**. In this location, you will also find the [Regulations for Participating Providers and Premier Blue Shield Providers](#).

The completed Participating Provider Agreement can be sent to Highmark along with a copy of your current license as follows:\*

- Fax to : **1-800-236-8641**
- Mail to: Highmark Blue Shield  
Provider Information Management  
P.O. Box 898842  
Camp Hill, PA 17089-8842

Once the completed agreement is received and processed, you will be notified in writing of the effective date of your participation.

*\*If a group practice, submit a copy of the license of each practitioner.*

## 3.1 PARTICIPATION IN HIGHMARK CREDENTIALED NETWORKS

### Overview

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



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).

[What Is My Service Area?](#)

### FOR MORE INFORMATION

For complete details on CAQH ProView and the credentialing process, please see [Chapter 3.2: Professional Credentialing](#).

## 3.1 DUAL NETWORKS (PA ONLY)

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### Overview



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 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.

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[What Is My Service Area?](#)

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## 3.1 ASSIGNMENT ACCOUNTS

### Overview

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:

- 1) The billing entity must be arranged in one of these manners:
  - a. **Incorporated solo practitioner** – An incorporated solo practitioner who desires to have the corporation recognized as the entity or to use a tax identification number to receive payment from Highmark.
  - b. **Sole proprietorship** – A sole proprietorship is unincorporated, owned by one individual, and its liabilities are the sole proprietor's personal liabilities. The sole proprietor takes the risks of the business for all assets owned. For legal and tax purposes, the business does not exist separately from the owner.
  - c. **Group practice** – Two or more providers practicing as a group may establish an assignment account to have the group recognized as a single entity for purposes of billing and payment. Examples of a typical group practice arrangement are:
    - Two or more providers practice as a partnership;
    - A group of providers form a professional corporation and the corporation becomes the employer of the providers;
    - A provider employs one or more other providers as associates in his or her practice.
- 2) Limited license providers may not be included in a Highmark assignment account which also contains health service doctors (MDs and DOs)\*;
- 3) A provider not participating in a Highmark provider network may not be included in a Highmark assignment account which also contains participating providers.

*\*Exceptions apply in the Medicare Advantage networks in Pennsylvania and West Virginia for MD and DO groups only.*

*Continued on next page*

## 3.1 ASSIGNMENT ACCOUNTS, Continued

### 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 **FORMS**, and then **Provider Information Management Forms**.

**Note:** To establish a Medicare assignment account, call Medicare Provider Enrollment Services at **1-866-488-0549**.

### 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 new assignment accounts are required to enroll in NaviNet®, Electronic Funds Transfer (EFT), and paperless Explanation of Benefits (EOB) statements.**

NaviNet 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 NaviNet, 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

*Continued on next page*

### 3.1 ASSIGNMENT ACCOUNTS, Continued

#### 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 be sure to 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.

NaviNet is the preferred method for notifying Highmark of practitioner changes. Select **Provider File Management** from the main menu on Highmark Plan Central. Please see the next page for additional information on making changes to an existing assignment account.

#### Restrictions

Highmark has the right to deny a request to add to 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 NaviNet, Highmark's preferred method for updating your assignment account information. Select **Provider File Management** from the main menu on Highmark Plan Central.

- **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 NaviNet-enabled, complete the applicable form as follows:

- **Practitioner Updates:** For practitioner changes, use the [Request for Addition/Deletion to an Existing Assignment Account](#) electronic form.
- **Address Updates:** For adding new practice locations or to make changes to an existing location, complete the [Provider File Maintenance Request](#) form.

These forms are also available on the Provider Resource Center – select **Forms**, and then **Provider Information Management Forms**.

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## 3.1 ASSIGNMENT ACCOUNTS, Continued

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### How to make changes to an existing assignment account (continued)

The completed **Provider File Maintenance Request** form can be faxed or mailed as follows:

- Fax to : **1-800-236-8641**
- Mail to: Highmark Blue Shield  
Provider Information Management  
P.O. Box 898842  
Camp Hill, PA 17089-8842

**Note:** Changes to your electronic funds transfer (EFT) account can be completed in NaviNet by your practice's "EFT Responsible Party." Your NaviNet Security Officer must first enable the transaction for the EFT Responsible Party in order for the EFT Attestation and Registration button to display on the Highmark Plan Central menu.

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### IMPORTANT!

**If going from a solo practice to adding additional practitioners, you will need to create a new assignment account.**

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## 3.1 PROVIDER TAX IDENTIFICATION NUMBERS

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### 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.**

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### 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](https://www.irs.gov).

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## 3.1 NATIONAL PROVIDER NUMBER (NPI)

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### Background

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.

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### 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.

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### 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 at:  
<https://nppes.cms.hhs.gov>
  - Download and complete a paper application from the NPPES website and mail to NPPES.
  - Call NPPES for a paper application: **1-800-465-3203** (TTY: 1-800-692-2326)
-

## CHAPTER 3: PROVIDER NETWORK PARTICIPATION

### UNIT 2: PROFESSIONAL PROVIDER CREDENTIALING

#### IN THIS UNIT



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[What Is My Service Area?](#)

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The PA ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The DE ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The WV ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

## 3.2 INTRODUCTION TO CREDENTIALING

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### Overview

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); Commonwealth of Pennsylvania Department of Health (DOH) regulations; State of Delaware Regulation 1403 Managed Care Organizations; 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 Pennsylvania's Western, Central, and Northeastern Regions; Delaware; and West Virginia, unless otherwise noted.

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### 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.

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### 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.

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### Initial credentialing

Highmark staff follows an established process to credential professional providers for the Premier Blue Shield, Western Region managed care, and Medicare Advantage networks in Pennsylvania; the Commercial Exclusive Provider Organization (EPO) and Independent Practice Association (IPA) networks in Delaware; 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.

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## 3.2 INTRODUCTION TO CREDENTIALING, Continued

### Initial credentialing (continued)

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 in Pennsylvania and West Virginia, 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.

[What Is My Service Area?](#)

### Recredentialing

Highmark completes the recredentialing process at least once every three years with any applicable physicians and allied health professionals in the Premier Blue Shield, Western Region managed care, and Medicare Advantage networks in Pennsylvania; the Commercial EPO and IPA networks in Delaware; 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, Pennsylvania DOH, State of Delaware, 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.

*Continued on next page*

## 3.2 INTRODUCTION TO CREDENTIALING, Continued

### Ongoing monitoring

Highmark's Provider Information Management 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, and other federal health programs) (monthly);
- Licensing Board queries (monthly); and
- Medicare Part B Opt Out List (quarterly).

If it is determined or suspected that a provider no longer complies credentialing, recredentialing, or contracting requirements (e.g., revocation or suspension of a license, OIG sanction), the matter will be investigated and presented to the applicable Highmark Network Quality and Credentials Committee (or the medical director in urgent situations) for appropriate action.

**Note:** Effective November 1, 2015, the ongoing monitoring process applies to practitioners in Highmark Blue Cross Blue Shield's northeastern Pennsylvania service area.

[What Is My Service Area?](#)

### Network Quality and Credentials Committee

The Highmark Network Quality and Credentials Committee (PA/DE/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 (also practicing physicians), 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.

*Continued on next page*

## 3.2 INTRODUCTION TO CREDENTIALING, Continued

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### **Network Quality and Credentials Committee** (continued)

**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.

[What Is My Service Area?](#)

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## 3.2 HIGHMARK NETWORK CREDENTIALING POLICY

### Overview

Physicians and any applicable allied health professionals must be credentialed by Highmark to participate in the Premier Blue Shield, Western Region managed care, and Medicare Advantage networks in Pennsylvania; the Commercial EPO and IPA networks in Delaware; and the Commercial PPO and POS networks and the Medicare Advantage network in West Virginia.

[What Is My Service Area?](#)

### Types of professional providers credentialed

Highmark currently credentials the following types of professional providers:

| PHYSICIANS                                                       | ALLIED HEALTH PROFESSIONALS       |
|------------------------------------------------------------------|-----------------------------------|
| Medical Doctors (MD)                                             | Audiologists                      |
| Doctors of Osteopathic Medicine (DO)                             | Clinical Social Workers           |
| Podiatrists (DPM)                                                | Counselors and Therapists         |
| Doctors of Chiropractic (DC)                                     | Occupational Therapists           |
| Doctors of Dental Surgery/Dental Medicine (DDS/DMD):             | Optometrists                      |
| • Oral & maxillofacial surgeons                                  | Physical Therapists               |
| • Oral & maxillofacial radiologists                              | Psychologists                     |
| • Oral and maxillofacial pathologists                            | Registered Dietitians             |
| • Orthodontists                                                  | Registered Nurse Anesthetists     |
| • General dentists who provide covered medical/surgical services | Registered Nurse Midwives         |
|                                                                  | Registered Nurse Practitioners    |
|                                                                  | Speech Pathologists & Therapists  |
|                                                                  | Licensed dietitian – nutritionist |
|                                                                  | Acupuncturists*                   |
|                                                                  | Massage Therapists*               |
|                                                                  | Certified Diabetic Educators*     |
|                                                                  | Licensed Physician Assistants*    |
|                                                                  | Clinical Nurse Specialists**      |

\*Highmark West Virginia only

\*\*Highmark West Virginia and Highmark Delaware only

*Continued on next page*



## 3.2 HIGHMARK NETWORK CREDENTIALING POLICY, Continued

### 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 thirty (30) days.
- The practitioner was terminated by Highmark during the recredentialing process, and there has been a break in service/contract of greater than thirty (30) days.

**Note:** A practitioner returning to the network(s) may also be required to execute a new agreement.

If a network(s) credentialed practitioner moves from one network practice to another, no further credentialing is required if the notification from the practitioner is received within thirty (30) days and is ninety (90) days prior to the recredentialing due date.

If the notification from a practitioner is received more than thirty (30) days after the move to another network practice or is not within ninety (90) days of the practitioner's recredentialing date, the practitioner will not be terminated; however, initial credentialing will be required.

### 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 thirty (30) days.

NaviNet®-enabled providers can make those changes through the *Provider File Management* function on NaviNet. For those providers not NaviNet-enabled, the [Request for Addition/Deletion to an Existing Assignment Account](#) electronic form can be used to notify us. This form is also available on the Provider Resource Center -- select **FORMS**, and then **Provider Information Management Forms**.

*Continued on next page*

## 3.2 HIGHMARK NETWORK CREDENTIALING POLICY, Continued

### General credentialing criteria

The following is a general summary of Highmark's credentialing criteria for all practitioners.

- Active state license in each state in which 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;
- Written proof of Medicare eligibility and have not opted out of the Medicare Part B program for the Medicare Advantage network(s) (PA and WV); and
- No Medicare or Medicaid sanctions.

In addition, physicians (MDs, DOs, DDSs/DMDs, DPMs, and DCs) and Physician Assistants for West Virginia only, must furnish proof of the following:

- Active Drug Enforcement Agency (DEA) certificate in each state in which the practitioner is prescribing controlled substances;
- Privileges at a network or participating Blue Cross Blue Shield hospital, as applicable; and
- Availability to see Highmark members at least twenty (20) hours a week (for primary care practitioners).

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 only) must have 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.

*Continued on next page*

## 3.2 HIGHMARK NETWORK CREDENTIALING POLICY, Continued

### 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).

*Continued on next page*

## 3.2 HIGHMARK NETWORK CREDENTIALING POLICY, Continued

### Malpractice information

Credentialing representatives may ask detailed questions regarding malpractice cases. If physicians do not submit the requested information, they could be denied or terminated from the network(s). In order to receive an accurate score, please submit the requested information regarding malpractice.

[What Is My Service Area?](#)

### Proof of Medicare eligibility

All new practitioners must supply a Medicare welcome (participation) letter as proof of Medicare eligibility during the credentialing process. Practitioners who have opted out of Medicare are not eligible to see Medicare Advantage members.

Individual proof of Medicare eligibility is not required of physical therapists, speech/language pathologists, and occupational therapists wishing to be part of the Medicare Advantage networks in Pennsylvania and West Virginia if they are contracted with a Medicare approved outpatient physical therapy group.

### 24/7 availability requirements

Highmark requires that all credentialed network practitioners provide coverage for members twenty-four (24) hours a day, seven (7) 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 designee can be contacted is acceptable. A referral to a crisis line is NOT acceptable unless a prior arrangement has been made with the crisis line whereby the practitioner (or his/her designee) can be contacted directly, if needed.

The following specialties are exempt from this requirement:

- Audiologists
- Dermatopathologists
- Dietitians/nutritionists
- Occupational therapists
- Pathologists (only if working outside of the acute care setting)
- Oral and maxillofacial pathologists (only if working outside of the acute care setting)
- Physical therapists
- Preventive medicine specialists
- Speech/language pathologists

*Continued on next page*

## 3.2 HIGHMARK NETWORK CREDENTIALING POLICY, Continued

### Availability for urgent and routine care

At the time of initial credentialing, Primary Care Practitioners (PCPs) not joining an existing group must provide office hours at each practice location accessible to members a minimum of twenty (20) hours a week at each practice site. (Applies to the Keystone Health Plan West [KHPW]\* and Premier Blue Shield networks in Pennsylvania, and to the Delaware participating provider network.)

PCP practice sites not meeting this requirement will be subject to an on-site review every three (3) years. In addition, for PCP practices participating in Pennsylvania's KHPW and Premier Blue Shield networks, practice sites not meeting the requirement will be noted in the provider directory as having limited hours.

*\*Keystone Health Plan West is Highmark's managed care provider network in the Western Region of Pennsylvania.*

[What Is My Service Area?](#)

### Admitting and clinical privilege requirements

Primary care physicians (family practitioners, pediatricians, internists, and general practitioners) and Primary Care Physician Assistants (West Virginia only) are required to have admitting privileges in good standing at a network participating hospital. Applicable physician specialists and Physician Assistant Specialists (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
- Oral maxillofacial surgery
- Oral maxillofacial pathology
- Oral maxillofacial radiology
- Pathology
- Non-surgical podiatry
- Physiatry/physical medicine
- 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.

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## 3.2 HIGHMARK NETWORK CREDENTIALING POLICY, Continued

### Admitting and clinical privilege requirements (continued)

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.)

[What Is My Service Area?](#)

### First Priority Health network admitting and clinical privilege requirements



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 one hundred eighty (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 the one hundred eighty (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.

*Continued on next page*

## 3.2 HIGHMARK NETWORK CREDENTIALING POLICY, Continued

### Time frame – Highmark West Virginia participating practitioners



Highmark West Virginia'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 Highmark West Virginia and whose primary site of service is located in Ohio are required to be credentialed and notified of their credentialing status within ninety (90) days of Highmark West Virginia receiving a complete or incomplete credentialing application.

All other providers will be initially credentialed within one hundred twenty (120) days following the submission of the provider's completed credentialing application, in compliance with W.Va. Code § 30-45-2(11).

[What Is My Service Area?](#)

### 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 sixty (60) days or longer will be required to undergo initial credentialing and, if applicable, recredentialing at least every three (3) years.

## 3.2 PRACTITIONER CREDENTIALING RIGHTS

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|               |                                                                                                                                                                                                                                                                                                     |
|---------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Policy</b> | 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. |
|---------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

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|                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Primary sources</b> | <p>Primary sources that may be contacted as part of the credentialing process include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>• State Licensing Bureau</li> <li>• Drug Enforcement Agency</li> <li>• Educational program(s) the practitioner completed</li> <li>• American Board of Medical Specialties, or American Osteopathic Association, if applicable</li> <li>• National Practitioner Data Bank</li> <li>• Office of the Inspector General participation/sanction data</li> <li>• Federation of Chiropractic Licensing Board, if applicable</li> <li>• Federation of Podiatric Medical Board, if applicable</li> </ul> |
|------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

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|                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|---------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Additional sources</b> | <p>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:</p> <ul style="list-style-type: none"> <li>• Convictions, criminal and civil proceedings;</li> <li>• Substance abuse impairment;</li> <li>• Fraud, inappropriate or excessive billing;</li> <li>• Complaints;</li> <li>• Non-cooperation/non-compliance with Highmark contract terms, administrative requirement, or health services management programs;</li> <li>• Completeness, timeliness, and accuracy of credentialing information;</li> <li>• Quality of care or utilizations issues.</li> </ul> |
|---------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

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|                                    |                                                                                                                                                                                                                                                                                                                                |
|------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Right to review information</b> | 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. |
|------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

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## 3.2 PRACTITIONER CREDENTIALING RIGHTS, Continued

### Right to review information (continued)

The request for information should be made in writing and directed to:

Highmark Provider Information Management (PIM)  
P.O. Box 898842  
Camp Hill, PA 17089-8842

**or**

Fax: **1-800-236-5907**

Within thirty (30) calendar days of receipt of the request, the information, except for references, recommendations, or other peer review protected information and any other data that is prohibited from being disclosed by law, will be mailed with a cover letter in an envelope marked "Personal and Confidential."

As documentation of receipt of request, a copy of the communication will be maintained in the provider's credentialing file.

### Notification of discrepancy

In the event information from a source varies substantially from that which was submitted by the provider, Provider Information Management (PIM) will initiate notification and communication via phone, fax, email, or certified returned receipt requested letter within thirty (30) calendar days of discovery.

As documentation of receipt of discrepancy notification, a copy of the communication will be provided in the provider's credentialing file.

### Right to correct erroneous information

Within thirty (30) calendar days of request to correct information, the provider should submit any corrections in writing to PIM:

Highmark Provider Information Management (PIM)  
P.O. Box 898842  
Camp Hill, PA 17089-8842

**or**

Fax: **1-800-236-5907**

**or**

Email address provided by staff assigned

This information is reviewed with the Medical Director to make a decision on a case by case basis. The information received from the provider may be presented to the Network Quality and Credentials Committee, if applicable.

Any differences in demographic information, education, work history, and/or Drug Enforcement Agency (DEA) certificate/license expiration dates may be handled via telephone.

As documentation of receipt of corrections, the communication will be maintained in the provider's credentialing file.

*Continued on next page*

## 3.2 PRACTITIONER CREDENTIALING RIGHTS, Continued

### Right to be informed of credentialing status

Providers can view network status and effective dates via the Provider File Management selection in NaviNet.® Select **Provider File Management** from the main menu on the left on Highmark's NaviNet Plan Central, and then click on the **Review credentialing status** link at the top of your Provider File Management page.

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

### Communication of practitioner rights

Communication regarding provider rights to review, to be notified of and correct erroneous information, and to receive notice of application status is made via inclusion of this information in this manual, the *Highmark Provider Manual*. This online manual is available to network participating providers electronically on the Provider Resource Center, which is accessible via NaviNet and also Highmark's regional websites in Pennsylvania, Delaware, and West Virginia.

Annual notifications of the availability of this information in the *Highmark Provider Manual* are published in the *Provider News* newsletters, which are published bi-monthly. Providers are notified when *Provider News* is published online via e-Subscribe email notifications. Providers not subscribed to e-Subscribe email notifications receive an annual postcard indicating newsletter publication dates for the calendar year.

## 3.2 THE CREDENTIALING PROCESS

### Overview

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 Pennsylvania and Delaware service areas must use CAQH for credentialing and recredentialing.

### IMPORTANT: Mandated WV Uniform Credentialing Form



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 see the next page 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](http://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 1-800-236-5907**.

Providers without access to a fax machine can mail the application to:

Provider Information Management  
Highmark  
P.O. Box 898842  
Camp Hill, PA 17001-9937

[What Is My Service Area?](#)

### IMPORTANT!

For an overview of the Highmark credentialing process, select **CREDENTIALING** from the main menu on the Provider Resource Center, and then click on ***Professional Initial Credentialing Set Up***. The process is also explained on the next page.

[Why blue italics?](#)

*Continued on next page*

## 3.2 THE CREDENTIALING PROCESS, Continued

### 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 Provider Credentialing Request Form**, which is available on Highmark's Provider Resource Center via NaviNet® or [www.highmark.com](http://www.highmark.com) (click on the orange **CONSUMERS/MEMBERS/PROVIDERS** tab, and then select the link for the Highmark plan in your service area from the options under the **FOR PROVIDERS** heading). Select **CREDENTIALING** from the main menu on the left of the Provider Resource Center, and then click on **Professional Initial Credentialing Set Up** from the submenu. *The link to the form is embedded in the second bullet in the section for providers who are already participating with CAQH.*

Complete the required fields on the form, including your CAQH ID, and then click on **Submit**. Highmark will retain an electronic copy of your CAQH ProView profile in its database and send you a confirmation email.

[Why blue italics?](#)

### 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 by selecting **CREDENTIALING** from the main menu on the Provider Resource Center, and then **Professional Initial Credentialing Set Up** from the submenu. *The link to the form is embedded in the second bullet in the section for providers who are NOT currently participating with CAQH ProView.*

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.

### Form also available in NaviNet

The **Initial Provider Credentialing Request** form is also available from Highmark's NaviNet Plan Central. To access the form via NaviNet Plan Central, select **Provider File Management**, and then click on the **Request Credentialing** button.

*Continued on next page*

## 3.2 THE CREDENTIALING PROCESS, Continued

### Check the status of your request

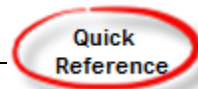
To ensure your application has been received, please visit NaviNet and follow these steps:

- Select **Provider File Management** from the Highmark Plan Central menu (if there is more than one group, select the applicable group from the dropdown, and then click on **Go**).
- 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 **1-888-599-1771** 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 | ACTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1    | To begin the process, the practitioner must submit all information requested through CAQH ProView. Highmark will then provide additional information and instructions.                                                                                                                                                                                                                                                                                                                                                                   |
| 2    | The Highmark Credentialing Department representative reviews the application. If the application is incomplete, the representative contacts the practice to request the missing information.                                                                                                                                                                                                                                                                                                                                             |
| 3    | The credentialing process will include, but is not limited to, verification or confirmation of the following: <ul style="list-style-type: none"> <li>• Unrestricted licensing in the state(s) where practicing*</li> <li>• Drug Enforcement Agency (DEA) certificate issued by each state where practicing*</li> <li>• Medical education and training (as applicable)*</li> <li>• Board certification (if applicable)*</li> <li>• History of liability claims</li> <li>• Malpractice coverage amounts</li> <li>• Work history</li> </ul> |

*Continued on next page*

## 3.2 THE CREDENTIALING PROCESS, Continued

### Steps in the initial credentialing process (continued)

| STEP         | ACTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|--------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 3<br>(cont.) | <ul style="list-style-type: none"> <li>• Medicare participating status</li> <li>• National Practitioner Data Bank (NPDB)*</li> <li>• Office of the Inspector General (OIG) Medicare and Medicaid sanction lists*</li> </ul> <p><b>Note:</b> 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.</p> <p><i>* These elements are verified through primary sources.</i></p> |
| 4            | <p>The Credentialing Department will also review the application for the following:</p> <ul style="list-style-type: none"> <li>• Ability to enroll new members</li> <li>• Ability to provide urgent/routine care</li> <li>• 24/7 coverage (if applicable)</li> <li>• Office hour availability of at least 20 hours/week (PCP)</li> </ul>                                                                                                                                                               |
| 5            | <p>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.</p> <p><b>Note:</b> 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.</p>                      |
| 6            | <p>If the credentials file elements meet all Highmark credentialing criteria, the Medical Director will review the application and render a decision.</p> <p>If the application does not meet Highmark credentialing criteria, the Highmark Network Quality and Credentials Committee reviews the application. In some instances, the Committee may request additional information before rendering a decision.</p>                                                                                    |
| 7            | <ul style="list-style-type: none"> <li>• Upon approval of the Highmark Network Quality and Credentials Committee or the Medical Director, practitioners will receive written notification.</li> <li>• If denied initial credentialing status, the practitioner will receive written notification within sixty (60) calendar days and will be offered an opportunity to have the decision reconsidered.</li> </ul>                                                                                      |

*Continued on next page*

## 3.2 THE CREDENTIALING PROCESS, Continued

[What Is My Service Area?](#)

### Steps in the initial credentialing process (continued)

| STEP | ACTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 8    | <ul style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>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.</li> </ul> |

#### 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 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.**

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## 3.2 THE CREDENTIALING PROCESS, Continued

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**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](https://www.irs.gov).

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## 3.2 THE RECREDENTIALING PROCESS

|                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Overview</b>                                | <p>The process for credentialing new practitioners and recredentialing existing network practitioners is essentially the same. Network practitioners must be recredentialed at least every three (3) years.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Notification to complete online process</b> | <p>Highmark uses the standardized online credentialing system developed by the Council for Affordable Quality Healthcare (CAQH) exclusively for initial credentialing and also for recredentialing of existing network practitioners for applicable networks.</p> <p>All Highmark network providers must use CAQH ProView™ for recredentialing. Paper applications and NaviNet® functionality for recredentialing have been eliminated.</p> <p>Several months prior to the end of the three-year credentialing cycle, the practitioner will receive notification that the recredentialing application is due.</p> <ul style="list-style-type: none"> <li>• <b>For Practitioners Registered with CAQH:</b> Highmark will send a letter to notify the practitioner that it is time for recredentialing. The practitioner will then log into CAQH ProView at <a href="https://proview.caqh.org">https://proview.caqh.org</a> to review and re-attest to their CAQH application.</li> <li>• <b>For Practitioners Not Yet Registered with CAQH:</b> Highmark will send you a notification to log into CAQH ProView at <a href="https://proview.caqh.org">https://proview.caqh.org</a>. Complete the online application. Be sure to add Highmark as an authorized plan, or grant global authorization.</li> <li>• <b>For West Virginia Practitioners Not Registered with CAQH:</b> Generally, six (6) 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.</li> </ul> |
| <b>If you do not have Internet access...</b>   | <p>If you do not have internet access, please contact the CAQH Help Desk for other options by calling <b>1-888-599-1771</b>.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Assessment of clinical quality</b>          | <p>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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |

*Continued on next page*

## 3.2 THE RECREDENTIALING PROCESS, Continued

### Office site reviews

For all PCPs, OB/GYNs, and potential high-volume behavioral health practitioners, Quality Management nurses will conduct Practitioner Office/Facility Site Quality and Medical/Treatment Record Evaluations for any practitioner in the network.

These evaluations will be based on the following:

- 1) Member dissatisfactions received about the quality of any practitioner office where care is delivered that is related to physical accessibility, physical appearance, or adequacy of waiting room and examining/treatment room space; or
- 2) Annual random sampling with practice sites selected using a statistically valid sampling methodology.
- 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;
- 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;
- 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 (6) 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](#).

*Continued on next page*

## 3.2 THE RECREDENTIALING PROCESS, Continued

### Assessment of data completeness

Highmark must include an evaluation of a practitioner's data completeness in the recredentialing process in order to comply with the standards of various accrediting and regulatory entities such as the Centers for Medicare & Medicaid Services (CMS). The Data Completeness Evaluation occurs in concert with the Healthcare Effectiveness Data and Information Set (HEDIS®) and Risk Adjustment Data Validation (RADV) chart audits.

Data Completeness Evaluations are incorporated into the recredentialing process as follows:

- **Year One:** If a Data Completeness deficiency or deficiencies are noted by one of 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 (5) 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 (5) or more feedback sheets are given to the practice for a third consecutive year.
- **Year Three:** If a practice receives five (5) or more feedback sheets **for three (3) consecutive years**, the practitioners at that office will be evaluated as "exceptions" at the time of their next recredentialing review, which could potentially lead to termination from the network(s).

For the basic elements reviewed during this assessment, please see the measures related to documentation in the Professional/Facility Medical Record Evaluation tables in the Clinical Quality section of [Chapter 5.6: Quality Management](#).

*Continued on next page*

## 3.2 THE RECREDENTIALING PROCESS, Continued

### Step-by-step process

The recredentialing process is essentially the same as the initial process for credentialing new practitioners.

| STEP | ACTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1    | <p>Notification is sent to the practitioner that the recredentialing application is due several months prior to the end of the three-year credentialing period.</p> <ul style="list-style-type: none"> <li>CAQH registered practitioners receive a letter from Highmark, and then log into CAQH ProView to review and re-attest to their CAQH application.</li> <li>Practitioners not yet registered with CAQH ProView will receive a letter from Highmark notifying you to log into CAQH ProView at <a href="https://proview.caqh.org">https://proview.caqh.org</a>. Complete the online application and add Highmark as an authorized plan or grant global authorization.</li> </ul> |
| 2    | <p>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.</p>                                                                                                                                                                                                                                                                                                                                                            |
| 3    | <p>The Credentials Committee or the Medical Director reviews the practitioner's qualifications and renders a decision.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 4    | <p>The practitioner is notified of any adverse decision through a letter within sixty (60) calendar days.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

## 3.2 CREDENTIALING REQUIREMENTS FOR FACILITY-BASED PROVIDERS

[What Is My Service Area?](#)

### Facility-based practitioner credentialing policy

**Highmark does not require practitioners to complete the credentialing or recredentialing process for the network(s) if they are strictly facility-based and practice exclusively in a network participating acute care hospital setting.** This includes, but is not limited to, the following provider types:

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

Highmark policy does not require credentialing or recredentialing for the network(s) when the following requirements are met. The practitioner must:

- Provide one hundred (100) percent of his or her services to members exclusively in the acute care or general hospital setting.
- Have a current, valid unrestricted license (i.e., absence of a current Prothonotary report or consent order) to practice in the state(s) where he/she provides care for the organization's members. 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 Pennsylvania and/or Delaware state requirements.
- Actively participate with Medicare/Medicaid and have never been debarred from or excluded from participation in any Medicare or Medicaid government programs.
- Sign an *Affirmation of Medical Practice Statement* (Form No. 282). (See *PARE Attestation information below*.)

**These practitioners, however, must complete the appropriate provider agreements to participate with Highmark's participating provider network(s).**

### PARE Attestation

The PARE Attestation, or [Hospital Based Provider Affirmation Statement](#) form, can be also be accessed from the Provider Resource Center -- select **FORMS**, and then **Provider Information Management Forms**.

### IMPORTANT!

If a practitioner begins to provide medical services to members outside of a network-participating acute care facility, the practitioner will be required to complete the initial credentialing and contracting processes.

## 3.2 EMERGENCY MEDICINE CREDENTIALING REQUIREMENTS

### Board certification requirements

Emergency department 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 (6<sup>th</sup>) year of completing approved, applicable residency training or a contiguous subsequent fellowship training program in the specialty in which he/she practices. The intent is the provider is 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), Pediatric Advanced Life Support (PALS), and Advanced Trauma Life Support (ATLS) certification.

### General Practice Specialist



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.

In order to maintain the recredentialing status as a General Practice Specialist, the practitioner must maintain ATLS, ACLS, and PALS certifications and obtain ten (10) Pediatric CMEs (continuing medical education credits) per year (for a total of thirty [30] Pediatric CMEs per credentialing cycle).

[What Is My Service Area?](#)

## 3.2 CREDENTIALING REQUIREMENTS FOR BEHAVIORAL HEALTH

|                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|-----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Overview</b>                                     | <p>Behavioral health practitioners considered for participation must provide evidence of a current license in their specialty at the highest level in the state in which they practice. Licensure must be for independent practice, if applicable.</p> <p>A behavioral health practitioner must carry professional liability insurance in compliance with regulations in the state(s) in which he/she practices. Please see the section in this unit titled “Malpractice Insurance Requirements” for additional information on requirements in Pennsylvania, Delaware, and West Virginia.</p> |
| <b>Licensed clinical social worker requirements</b> | <p>Licensed clinical social workers (LCSWs) must hold a master’s degree or doctoral degree in social work from a school accredited by the Council on Social Work Education (CSWE). Additionally, they must be licensed at the highest level for independent practice in the state in which they practice.</p>                                                                                                                                                                                                                                                                                 |
| <b>Clinical nurse specialist requirements</b>       | <p>Clinical nurse specialists must be licensed as a registered nurse in the state in which they practice. They must hold a certificate of Clinical Nurse Specialty in psychiatric mental health nursing as issued by the American Nurses’ Association (ANA)/American Nurses Credentialing Center (ANCC).</p>                                                                                                                                                                                                                                                                                  |
| <b>Psychiatric-certified CRNP requirements</b>      | <p>Psychiatric certified registered nurse practitioners (CRNPs) must be licensed as a registered nurse and a CRNP in the state in which they practice.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Master’s-prepared therapist criteria</b>         | <p>Master’s-prepared therapists (other than clinical social workers or nurses) must hold licensure or certification in the state in which they practice at an independent practice level in an accepted human services specialty, such as one of the following:</p> <ul style="list-style-type: none"> <li>• Licensed professional counselor (LPC)</li> <li>• Marriage and family therapists (MPT)</li> </ul>                                                                                                                                                                                 |

[What Is My Service Area?](#)

## 3.2 DUAL CREDENTIALING/REREDENTIALING AS BOTH PCP AND SPECIALIST

### Physician categories

Highmark contracts with network physicians as either:

- Primary Care Physicians (PCPs) -- family practitioners, general practitioners, internists, and pediatricians; or
- Specialists -- all other MDs or DOs.

An individual practitioner may participate as both PCP and specialist if the practitioner meets network credentialing standards for each category.

### Criteria

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

- Demonstrate that the practice adequately provides primary care services to Highmark members;
- Meet the standards for PCPs; and

Must be board certified or meet one of the board certification exceptions for each specialty requested. Each specialty not boarded/meets exception will be "Process discontinued".

### Recredentialing

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

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

### Policy

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 August 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 August 15, 2016, will be grandfathered and processed as routine. Please note that these exceptions do not apply to practitioners practicing in Emergency Departments or Urgent Care Centers/Medical Aid Units (MAUs); board certification is required.

### Highmark 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)

*\* If ABPM or ABFAS boards not available to practitioner*

[What Is My Service Area?](#)

### Exceptions to board certification requirements

Effective August 15, 2016, all applicable practitioners who are not board certified and are applying to participate in a Highmark credentialed network must meet one of the following exception criteria to be considered eligible for credentialed network participation:

#### **Exception 1: Completed training prior to December 31, 1987**

Practitioners must have graduated from an accredited medical osteopathic, or podiatric medical school, or dental school; completed an applicable accredited residency or fellowship acceptable to the Highmark Network Quality and Credentials Committee in the specialty in which the practitioner practices; **and** completed training prior to December 31, 1987.

#### **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.

*Continued on next page*

## 3.2 PRACTITIONER QUALITY AND BOARD CERTIFICATION, Continued

### Exceptions to board certification requirements (continued)

#### Exception 3: Geo Access Deficiency

An annual Geo Access report will be generated and practitioners who are not board certified will be evaluated using network access requirements for specialty and practice location(s). If there is an access deficiency for any location, the practitioner's file will meet the exception. If it is determined that there are no access deficiencies in any location, initial applicants will be "Process Discontinued"; recredentialing applicants will be reviewed by the Medical Director.

### 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 after August 15, 2016, 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.

### Northeastern Pennsylvania certification requirements



Effective November 1, 2015, current Highmark credentialing policies and procedures will apply to practitioners in Highmark's northeastern Pennsylvania service area.

[What Is My Service Area?](#)

## 3.2 MALPRACTICE INSURANCE REQUIREMENTS

### Overview

A provider must carry, at their own expense, the minimum required amount of malpractice insurance at all times to maintain credentialing.

### Network malpractice insurance criteria

Providers must carry and maintain at all times liability and professional liability (malpractice) insurance to insure the group provider and each individual practitioner against any claim or claims for damages arising by reason of personal injury or death occasioned, directly or indirectly, in connection with the performance or omission of any provider service. The amount of coverage carried should not be less than the amounts required by any applicable state laws or less than those coverage levels required by Highmark.

Network providers must provide evidence of coverage to the network upon request. Providers must also notify Highmark at least thirty (30) days in advance of any reduction or termination of malpractice coverage.

[What Is My Service Area?](#)

### Pennsylvania requirements: If you are Mcare Fund eligible



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).

### Pennsylvania requirements: If you are not Mcare Fund eligible



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) are required to carry \$1 million per incident and \$3 million in annual aggregate.

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## 3.2 MALPRACTICE INSURANCE REQUIREMENTS, Continued

### Delaware requirements



All participating practitioners in Delaware are required to carry \$1 million per medical incident and \$3 million in annual aggregate.

[What Is My Service Area?](#)

### West Virginia requirements



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.

## 3.2 TERMINATION FROM THE NETWORKS

### Overview

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.

[What Is My Service Area?](#)

### Valid reasons for termination

Professional network providers shall be terminated in accordance with the relevant terms of their provider contracts for failure to satisfy the following criteria which includes but is not limited to:

1. Maintain an active license to practice.
2. Maintain an active Drug Enforcement Agency (DEA) certificate, where applicable.
3. Maintain coverage for malpractice insurance in the minimum amounts required 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.

*Continued on next page*

## 3.2 TERMINATION FROM THE NETWORKS, Continued

### Invalid reasons for termination

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

1. Advocating for medically necessary and appropriate health care consistent with the degree of learning and skill possessed by a reputable health care practitioner practicing according to the applicable legal standard of care.
2. Filing a grievance against 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.

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## 3.2 TERMINATION FROM THE NETWORKS, Continued

### **Continuation of care throughout a contract termination (continued)**

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 ninety (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).

## 3.2 RECONSIDERATIONS AND APPEALS

[What Is My Service Area?](#)

### **Reconsideration of a Credentials Committee decision**

A reconsideration hearing is available to a professional network practitioner in the event that a denial or termination action or a limited or modified decision is made by the Highmark Network Quality and Credentials Committee due to:

1. The lack of required qualifications at the time of recredentialing.  
(This includes, but is not limited to, loss of an unrestricted state license; loss of Drug Enforcement Agency (DEA )license; failure to obtain or keep appropriate board certification; lack of adequate clinical hospital privileges; and/or insufficient malpractice insurance coverage.)
2. Any reason reportable to the National Practitioner Data Bank (NPDB).

The practitioner must request the reconsideration in writing within thirty (30) days of notice of the termination. The provider shall be given the opportunity to present information to the Highmark Network Quality and Credentials Committee by one or any of the following options:

1. In writing, to the Credentials Committee for consideration, which shall take place during a Credentials Committee meeting.
2. 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 Network Quality and Credentials Committee.

After the meeting, the provider shall receive written notice of the final decision of the Highmark Network Quality and Credentials Committee which will include the basis for the decision, the appeal process, and the practitioner's right to an appeal to the Medical Review Committee (for Pennsylvania practitioners) or to the Appeals Review Committee (for Delaware and West Virginia practitioners) within thirty (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.

*Continued on next page*



## 3.2 RECONSIDERATIONS AND APPEALS, Continued

### Appeals of Credentials Committee decisions

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

- The specific time period for submitting the request
- The appointment of a hearing officer or a panel of individuals to review the appeal
- Practitioners are allowed at least thirty (30) calendar days after receipt of the notification to request a hearing
- Practitioners may be represented by an attorney or another person of their choice
- Written notification of the appeal decision will be provided that contains the specific reasons for the decision

In the event of an appeal, the panel of individuals to review the appeal will be the Highmark Medical Review Committee (comprised of professional peers) for Pennsylvania practitioners. The Appeals Review Committee, which is comprised of professional peers including representatives from Delaware and West Virginia, will review appeals for Delaware and West Virginia practitioners. Highmark's Medical Review Committee and Appeals Review Committee decisions are final and not subject to further appeal.

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### 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 thirty (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.

## CHAPTER 3: PROVIDER NETWORK PARTICIPATION

### UNIT 3: PROFESSIONAL PROVIDER GUIDELINES

#### IN THIS UNIT



| TOPIC                                            | SEE PAGE |
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The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The PA ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The DE ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The WV ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

### 3.3 PROVIDER DATA UPDATES FOR THE PROVIDER DIRECTORY

|                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Overview</b>                          | <p>Highmark is committed to ensuring that the information in the Highmark Provider Directory meets Centers for Medicare &amp; Medicaid Services (CMS) regulations and National Committee for Quality Assurance (NCQA) standards, as well as our own standards of quality.</p> <p>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.</p>                                                                                                                                                         |
| <b>CMS requirements</b>                  | <p>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 to confirm:</p> <ul style="list-style-type: none"> <li>• The provider name is correct.</li> <li>• The practice name is correct.</li> <li>• The provider's practicing specialties are correctly listed.</li> <li>• Providers are not listed at practice locations where they do not actually accept appointments and see patients.</li> <li>• The provider is accepting new patients, or not accepting new patients, at the location.</li> <li>• The provider's street address and phone number are correct.</li> </ul> |
| <b>NCQA requirements</b>                 | <p>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.</p>                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Policy</b>                            | <p>Providers are required to review and update their information in NaviNet® as soon as a change occurs. All data should be reviewed once a quarter, at a minimum, to ensure accuracy. <b>Providers who do not verify or update their data in a timely manner will be removed from the Highmark Provider Directory.</b> In addition, your status within Highmark's networks may be impacted.</p>                                                                                                                                                                                                                                                                                                             |
| <b>NaviNet® Provider File Management</b> | <p>You may review your detailed, real-time billing provider information in Provider File Management in NaviNet®. Select <b>Provider File Management</b> from the menu under <b>Workflows for this Plan</b> on Highmark Plan Central.</p> <p>Please see the section of this unit on <b>Reporting Changes in Your Practice</b> for additional information on reviewing your information and instructions for making necessary changes via NaviNet or forms, if necessary.</p>                                                                                                                                                                                                                                  |

### 3.3 MEDICAL RECORDS DOCUMENTATION AND MAINTENANCE

#### Overview

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;

*Continued on next page*

### 3.3 MEDICAL RECORDS DOCUMENTATION AND MAINTENANCE,

Continued

#### Standards of documentation (continued)

- 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

#### Overview

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 medical records to Highmark, unless otherwise provided.

*Continued on next page*

### 3.3 MEDICAL RECORDS REVIEW, Continued

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**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.

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**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.

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### 3.3 LOCUM TENENS POLICY

#### Overview

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.

[Why blue italics?](#)

#### Service time frame

Locum tenens service time frames **may not exceed sixty (60) consecutive days** for Medicare Advantage or Commercial networks.

If a regular physician is absent longer than sixty (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 3.2: Professional Provider Credentialing](#).

#### Process change effective June 1, 2018

*Effective June 1, 2018, Highmark’s locum tenens process has changed. Highmark will no longer enumerate substitute physicians and has discontinued the use of the Locum Tenens Form.*

*Providers should follow the requirements and billing guidelines outlined below. This process is applicable to both Commercial and Medicare Advantage.*

#### Requirements

*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;*

*Continued on next page*



### 3.3 LOCUM TENENS POLICY, Continued

#### **Requirements** (continued)

- 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 sixty (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.

Why blue italics?

#### **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

---

### Overview

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 : **1-800-236-8641**
- 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 fifteen (15) business days to process. Please allow ample time for processing before checking the request status.

---

### 3.3 REPORTING CHANGES IN YOUR PRACTICE

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#### 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 (ten [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
- 

*Continued on next page*

### 3.3 REPORTING CHANGES IN YOUR PRACTICE, Continued

#### Type of changes to report (continued)

- Changes in practice locations where practitioners see and treat patients
- Languages spoken by the physician or clinical staff
- Board certification change
- Specialty change

#### Using NaviNet® to report updated practice information

All NaviNet®-enabled practitioners should make their practice information changes via Provider File Management on NaviNet. 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.

Select **Provider File Management** from the main menu on NaviNet's Plan Central, 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 File Management NaviNet Guide](#), which is available on the **Provider Resource Center** under **EDUCATION/MANUALS**.

#### How to use NaviNet to add or delete practitioners

NaviNet-enabled practices can use NaviNet's Provider File Management to add practitioners to 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 NaviNet Security Officer can generate a username for a practitioner new to your assignment account. From the NaviNet toolbar, select **NaviNet Central**, and then select **NaviNet Administration**. Click on **User Management**, and then **Create New User**.

*Continued on next page*

### 3.3 REPORTING CHANGES IN YOUR PRACTICE, Continued

#### How to update practice information for non-NaviNet enabled practitioners

Practitioners who are not NaviNet-enabled must notify Highmark in writing of any change to their practices. The [Request for Addition/Deletion to an Existing Assignment Account](#) form can be completed for practitioner changes.

For additional practice addresses or for address changes, complete the [Provider File Maintenance Request](#) form.

- Fax to: **1-800-236-8641**
- Mail to: Highmark Blue Shield  
Provider Information Management  
P.O. Box 898842  
Camp Hill, PA 17089-8842

These forms are also available on the Provider Resource Center – 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 sixty (60) days before the event.**

#### Updating “Accepts Appointments?”

The “Accepts Appointments?” question requires a response in NaviNet’s Provider File Management. 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:

|                                     | Address       | City     | State | Zip   | Type                                       | E-<br>Prescribe?         | Accepts Appointments? *                                       |
|-------------------------------------|---------------|----------|-------|-------|--------------------------------------------|--------------------------|---------------------------------------------------------------|
| <input type="checkbox"/>            | 123 Main St.  | Any Town | USA   | xxxxx | Practice                                   | <input type="checkbox"/> | <input type="radio"/> Yes <input type="radio"/> No            |
| <input checked="" type="checkbox"/> | 321 First St. | Any Town | USA   | xxxxx | Main, Practice, Check, Credential, Mailing | <input type="checkbox"/> | <input checked="" type="radio"/> Yes <input type="radio"/> No |

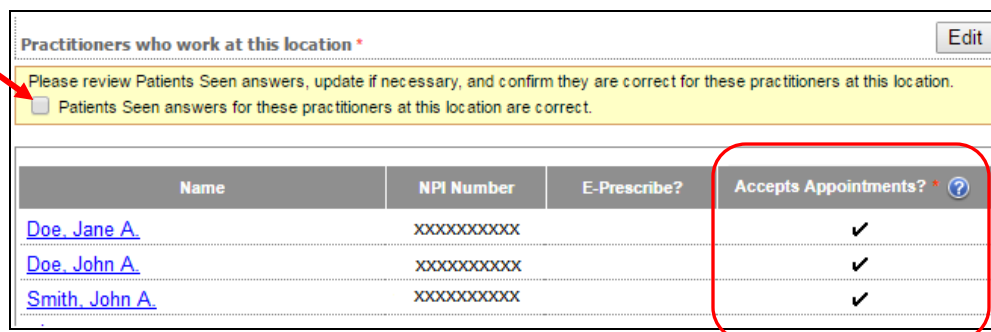
OK Cancel

*Continued on next page*

### 3.3 REPORTING CHANGES IN YOUR PRACTICE, Continued

#### Updating “Accepts Appointments?” (continued)

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.



**Practitioners who work at this location \*** Edit

Please review Patients Seen answers, update if necessary, and confirm they are correct for these practitioners at this location.

☐ Patients Seen answers for these practitioners at this location are correct.

| Name                           | NPI Number | E-Prescribe? | Accepts Appointments? * ? |
|--------------------------------|------------|--------------|---------------------------|
| <a href="#">Doe, Jane A.</a>   | XXXXXXXXXX |              | ✓                         |
| <a href="#">Doe, John A.</a>   | XXXXXXXXXX |              | ✓                         |
| <a href="#">Smith, John A.</a> | XXXXXXXXXX |              | ✓                         |

#### 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: **1-800-236-8641**
- Mail to: Highmark Blue Shield  
Provider Information Management  
P.O. Box 898842  
Camp Hill, PA 17089-8842

### 3.3 MERGERS AND ACQUISITIONS

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#### Notification to Highmark

You must send written notification on your practice letterhead of anticipated mergers, acquisitions, etc., at least forty-five (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: **1-800-236-8641**
- 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 **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.

*Continued on next page*

### 3.3 MERGERS AND ACQUISITIONS, Continued

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**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

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#### To resign from the Participating Provider Network



To resign from participation with the Participating Provider Network in Pennsylvania, a signed, written request must be submitted. A resignation may be submitted at any time. It is effective in accordance with the termination provision in the agreement the provider has executed. A letter will be sent to you advising you of the effective date of your resignation.

- Fax to : **1-800-236-8641**
- Mail to: Highmark Blue Shield  
Provider Information Management  
P.O. Box 898842  
Camp Hill, PA 17089-8842

[What Is My Service Area?](#)

#### To resign from Highmark's credentialed networks

To resign from participation with Highmark's credentialed network(s) in all service areas, fax or mail a signed, written request as follows:

- Fax to : **1-800-236-8641**
- Mail to: Highmark Blue Shield  
Provider Information Management  
P.O. Box 898842  
Camp Hill, PA 17089-8842

A resignation may be submitted at any time and is effective in accordance with the termination provision in the agreement the provider has executed. A letter will be sent to you advising of the effective date of your resignation.

---

### 3.3 CORRECTIVE ACTION

#### Overview

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

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 in order 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.

#### 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
- Monitor and observe the provider subject to corrective action
- Termination or suspension

*Continued on next page*

### 3.3 CORRECTIVE ACTION, Continued

**Forms of  
corrective  
action**  
(continued)

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 fourteen (14) days, the provider will be notified that he/she can request a hearing. The request must be made in writing within thirty (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**

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**

An appeal shall be made available to a professional network provider before a subcommittee of the applicable Highmark credentials committee if the practitioner is placed under corrective action.

*Continued on next page*

### 3.3 CORRECTIVE ACTION, Continued

#### Corrective action appeals (continued)

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 thirty (30) days of receipt of the notice of the action.                                                                                        |
| 2    | If the provider requests an appeal on a timely basis, the Highmark will notify the provider of the time and date of the Subcommittee meeting.                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 3    | <p>The appeal shall be held before a subcommittee of the applicable Credentials Committee which is comprised of network practicing providers who will review the information presented and render a decision. The members of the subcommittee shall not be in direct economic competition with the provider.</p> <p>The provider has the right during the meeting to have representation by an attorney or other person of the provider's choice. For any appeal, the Credentials Subcommittee may consider the report of a specialist regarding the issue at hand.</p> |
| 4    | After completion of the appeal, the provider has the right to receive the written decision of the Credentials Subcommittee from the Medical Director, including a statement of the basis for the decision. The decision of the Credentials Subcommittee is not subject to further appeal.                                                                                                                                                                                                                                                                               |

## CHAPTER 3: PROVIDER NETWORK PARTICIPATION

### UNIT 4: ORGANIZATIONAL PROVIDER PARTICIPATION (FACILITY/ANCILLARY)

#### IN THIS UNIT



| TOPIC                                                 | SEE PAGE |
|-------------------------------------------------------|----------|
| Participation and Credentialing <b>Updated!</b>       | 2        |
| Applications <b>Updated!</b>                          | 4        |
| Reporting Mergers, Acquisitions, and Changes          | 5        |
| Electronic Transaction Requirements                   | 7        |
| Urgent Care Centers/Medical Aid Units <b>Updated!</b> | 8        |

[What Is My Service Area?](#)

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The PA ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The DE ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The WV ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

## 3.4 PARTICIPATION AND CREDENTIALING

|                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|--------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Overview</b>                | <p>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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Requirements</b>            | <p>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. Providers that are eligible for accreditation must also maintain an active accreditation status.</p> <p>For requirements for specific organizational provider types, click on the link below:<br/> <a href="#">Organizational Provider Participation, Credentialing, and Contracting Requirements</a></p> <p>This document is also available on the Provider Resource Center – select <b>CREDENTIALING</b>, and then <b>Organizational Initial Credentialing Set Up</b>.</p>                                                     |
| <b>Facility provider types</b> | <p>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:</p> <ul style="list-style-type: none"> <li>• Acute care hospitals</li> <li>• Psychiatric facilities</li> <li>• Substance abuse treatment centers</li> <li>• Skilled nursing facilities (SNFs)</li> <li>• State-owned psychiatric hospitals</li> <li>• Ambulatory surgical centers (ASCs)</li> <li>• Renal dialysis facilities</li> <li>• Hospice</li> <li>• Home health</li> <li>• Comprehensive outpatient rehabilitation facilities (CORFs)</li> <li>• Rehabilitation hospitals</li> <li>• Long-term acute care facilities (LTACs)</li> <li>• Long-term services and supports (LTSS)/home and community-based service options (HCBS)</li> </ul> |

[Why blue italics?](#)

*Continued on next page*

### 3.4 PARTICIPATION AND CREDENTIALING, Continued

#### 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 twenty-four (24) hour per day, seven (7) 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 [Chapter 3.1: 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 [Application for Facility and Ancillary Providers](#). This application is also accessible on the Provider Resource Center -- select **CREDENTIALING** from the main menu, and then **Organizational Initial Credentialing Set Up**.

**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. Please see the **Provider Application for Facility and Ancillary Providers** page on the Provider Resource Center for current provider types with closed networks. In addition, closed network status will be noted on the [Organizational Provider Participation, Credentialing, and Contracting Requirements](#) document.

[Why blue italics?](#)

### 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 **CREDENTIALING**, and then **Organizational Initial Credentialing Set Up**.

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 -- select **CREDENTIALING**, and then **Behavioral Health Initial Credentialing Set Up**. In this location on the Provider Resource Center, you will also find the following documents for freestanding behavioral health providers:

- [Behavioral Health Services Grid](#)
- [Freestanding Behavioral Health Provider Autism Spectrum Disorder Services Grid](#)

**Please fax the completed application and all supporting documentation to the applicable fax number for your service area as indicated on the application.**



### 3.4 REPORTING MERGERS, ACQUISITIONS, AND CHANGES

---

#### Overview

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 thirty to sixty (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:

[Highmark Facility/Ancillary Change Form](#)

The **Highmark Facility/Ancillary Change Form** is also available on the Provider Resource Center -- select **FORMS**, and then **Miscellaneous Forms**.

The completed form must be faxed to the appropriate regional fax number noted on the last page of the form. Upon receipt of the completed form and required documents, Highmark will review the submitted information and notify the facility if additional information is needed.

#### 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).

*Continued on next page*

### 3.4 REPORTING MERGERS, ACQUISITIONS, AND CHANGES, Continued

#### Highmark approval required (continued)

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

For address and phone number changes unrelated to a Facility Event, please use the [Address/Phone Number Change Form For Facility & Ancillary Providers](#).

This form is also available on the Provider Resource Center – select **FORMS**, and then **Miscellaneous Forms**.

## 3.4 ELECTRONIC TRANSACTION REQUIREMENTS

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### Overview

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 NaviNet and Electronic Funds Transfer (EFT), and will receive paperless Remittance Advices.

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.

---

### NaviNet® and EFT enrollment required

**All Highmark network participating providers are required to enroll in NaviNet® and Electronic Funds Transfer (EFT).**

NaviNet 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.
  - Paperless Remittance Advices reduce the amount of paper flowing into the facility's office. Remittance Advices are available for viewing via NaviNet, which is earlier than receiving them by mail.
- 

### FOR MORE INFORMATION

For guidance on enrolling in NaviNet and EFT and paperless remittances, please see the section on **Electronic Transaction Requirements** in [Chapter 3.1: Network Participation Overview](#).

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## 3.4 URGENT CARE CENTERS/MEDICAL AID UNITS

### Introduction

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.

[What Is My Service Area?](#)

### Delaware regulations for UCCs and MAUs



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; use of the term “urgent care” in signage or advertising identifies a facility to be a “free standing emergency center” that treats all life-threatening emergencies.

Delaware law defines “Free Standing Emergency Center” as a facility physically separate from a hospital which uses in its title or in its advertising, 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. The facility rendering such care is capable of treating all medical emergencies that have life-threatening potential. While not a trauma center, a free standing emergency center is open 24 hours a day, seven days a week and is generally able to treat most emergencies.

In Delaware, a facility is considered to be an “Urgent Care Center (UCC)” only if they are licensed as a Free Standing Emergency Center. Facilities providing urgent care that are not licensed are called “Medical Aid Units (MAUs).”

*Continued on next page*

### 3.4 URGENT CARE CENTERS/MEDICAL AID UNITS, Continued

*Why blue italics?*

#### 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 **CREDENTIALING**, and then **Organizational Initial Credentialing Set Up**.

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.

**Please Note:** You must also complete the National Imaging Associates (NIA) privileging application, as necessary, to apply for privileging for radiology services that may be provided. For the application and additional information, select **CARE MANAGEMENT PROGRAMS** from the main menu on the Provider Resource Center, and then **Radiology Management Program**.

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.

Effective August 1, 2017, Highmark eliminated the requirement that practitioners in network participating Urgent Care Centers and Medical Aid Units need to be credentialed by Highmark. Although this professional credentialing by Highmark is no longer required, 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 **FORMS**, and then **Provider Information Management Forms**.

The Medicare Welcome Letter will also still be required for those practitioners practicing in a Medicare Advantage network.

*Continued on next page*

### 3.4 URGENT CARE CENTERS/MEDICAL AID UNITS, Continued

#### 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. Initial applicants that are not accredited must obtain accreditation by a Highmark recognized accrediting organization within eighteen (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 Free Standing Emergency Center. Medical Aid Units do not require licensing.

#### 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:
  - o Monday-Friday: Minimum twelve (12) hours per day
  - o Saturday and Sunday: Minimum eight (8) 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.

*Continued on next page*

### 3.4 URGENT CARE CENTERS/MEDICAL AID UNITS, Continued

#### Additional participation requirements (continued)

- 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 NaviNet® 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.

To confirm coverage for urgent care provided by Urgent Care Centers in Pennsylvania and West Virginia, and Medical Aid Units in Delaware, select **Additional Benefit Provisions** (upper right) from the NaviNet Eligibility and Benefits page. Select **Professional Services** (from the pop-up box), and then scroll until you reach the **Urgent Care** category.

[What Is My Service Area?](#)

#### IMPORTANT! Verifying Highmark Delaware UCC benefit



To verify a Highmark Delaware member's benefits for services in an Urgent Care Center (a "Free Standing Emergency Center"), select **Additional Benefit Provisions** from the NaviNet Eligibility and Benefits page, and then select **Outpatient Facility Services** (from the pop-up box). Scroll to the **Emergency Room Care** category – differences between coverage for Emergency Room and Freestanding Urgent Care will be noted.

Please note that member cost-sharing may be different for services at Urgent Care Centers and Medical Aid Units.

*Continued on next page*

### 3.4 URGENT CARE CENTERS/MEDICAL AID UNITS, Continued

#### 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)

**Please Note:** Medicare Advantage members do not have coverage for S9088. 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.



## CHAPTER 3: PROVIDER NETWORK PARTICIPATION

### UNIT 5: OHIO HEALTHCARE SIMPLIFICATION ACT



FOR PROVIDERS LOCATED IN OHIO AND PARTICIPATING WITH HIGHMARK PLANS IN WEST VIRGINIA AND PENNSYLVANIA

#### IN THIS UNIT



| TOPIC                                     | SEE PAGE |
|-------------------------------------------|----------|
| Introduction                              | 2        |
| Products and Network                      | 3        |
| Termination for Cause Contract Provisions | 4        |
| Amendments                                | 5        |
| Credentialing                             | 6        |
| Most Favored Nation Clauses Prohibited    | 7        |
| Arbitration                               | 8        |

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The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The **PA ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The **DE ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

## 3.5 INTRODUCTION

### Overview



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.

[What Is My Service Area?](#)

## 3.5 PRODUCTS AND NETWORK

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### Products



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.

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### Networks



Except as permitted by OHSA, Highmark will not rent or sell networks involving Ohio providers.

[What Is My Service Area?](#)

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## 3.5 TERMINATION FOR CAUSE CONTRACT PROVISIONS

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### 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 sixty (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.

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## 3.5 AMENDMENTS

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### Notification of material changes to terms of agreement



Highmark shall furnish providers with ninety (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.

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[What Is My Service Area?](#)

## 3.5 CREDENTIALING

### Applicability



This section on credentialing applies to all providers subject to the Ohio Healthcare Simplification Act (OHSA).

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### Forms



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 twenty-one (21) days of receipt of application.

### Time frames



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 ninety (90) days of Highmark receiving a complete **or** incomplete credentialing application.

### State Medical Board



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



Please see Chapter 3's Units, 1, 2, and 4 of this *Highmark Provider Manual* for additional credentialing information.

## 3.5 MOST FAVORED NATION CLAUSES PROHIBITED

### Policy



Highmark may not include most favored nation clauses in professional provider and non-hospital facility provider contracts.

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### 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

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**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.

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## CHAPTER 4: PROVIDER RESPONSIBILITIES AND GUIDELINES

### UNIT 1: PCPS AND SPECIALISTS

#### IN THIS UNIT



| TOPIC                                                       | SEE PAGE |
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| PCP and Medical Specialist Accessibility Expectations       | 4        |
| Primary Care Practitioner Overview                          | 6        |
| Primary Care Practitioner Role and Responsibilities         | 8        |
| How Members Select and Change PCPs                          | 10       |
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#### [What Is My Service Area?](#)

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The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

## 4.1 PRIMARY CARE/SPECIALIST ESSENTIALS

### Introduction

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 in order 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.

### 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).

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## 4.1 PRIMARY CARE/SPECIALIST ESSENTIALS, Continued

### Advising members of treatment options policy (continued)

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, unless required by law or regulation.

## 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.

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| PCP AND MEDICAL SPECIALIST ACCESSIBILITY EXPECTATIONS                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                               |                                                                                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| Patient's Need:                                                                                                                                                                                                                                                                                                             | Performance Standard:                                                                                                                                                                                                         |                                                                                                                           |
| <b>Emergency/life threatening care</b> <ul style="list-style-type: none"> <li>Sudden, life-threatening symptom(s) or condition requiring immediate medical treatment (e.g., chest pain, shortness of breath)</li> </ul>                                                                                                     | Immediate response                                                                                                                                                                                                            |                                                                                                                           |
| <b>Urgent care appointments</b> <ul style="list-style-type: none"> <li>An urgently needed service is a medical condition that requires rapid clinical intervention as a result of an unforeseen illness, injury, or condition (e.g., high fever, persistent vomiting/diarrhea)</li> </ul>                                   | Office visit within 1 day (24 hours)                                                                                                                                                                                          |                                                                                                                           |
| <b>Regular and routine care appointments</b> <ul style="list-style-type: none"> <li>Non-urgent but in need of attention appointment (e.g., headache, cold, cough, rash, joint/muscle pain)</li> <li>Routine wellness appointments (e.g., asymptomatic/preventive care, well child/patient exams, physical exams)</li> </ul> |                                                        | <ul style="list-style-type: none"> <li>Within 2-7 days (Non-urgent)</li> <li>Within 30 days (Routine wellness)</li> </ul> |
|                                                                                                                                                                                                                                                                                                                             |                                                                                                                                           | Office visit within 3 weeks of member request                                                                             |
| <b>After-hours care</b> <ul style="list-style-type: none"> <li>Access to practitioners after the practice's regular business hours</li> </ul>                                                                                                                                                                               | Acceptable process in place to respond 24 hours per day, 7 days a week to member issues (answering service that pages the practitioner or answering machine message telling caller how to reach the practitioner after hours) |                                                                                                                           |
| <b>In-office waiting times</b> <ul style="list-style-type: none"> <li>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.</li> </ul>                                          | Within 15 minutes                                                                                                                                                                                                             |                                                                                                                           |

Continued on next page

## 4.1 PCP AND MEDICAL SPECIALIST ACCESSIBILITY EXPECTATIONS,

Continued

| MATERNITY CARE EXPECTATIONS (Obstetrics) |                                              |
|------------------------------------------|----------------------------------------------|
| Patient's Need:                          | Performance Standard:                        |
| • Maternity Emergency                    | Immediate response                           |
| • Maternity 1 <sup>st</sup> Trimester    | Within 3 weeks of first request              |
| • Maternity 2 <sup>nd</sup> Trimester    | Within 7 calendar days of first request      |
| • Maternity 3 <sup>rd</sup> 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<br>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.                                                                                                                                                                                                                           |

## 4.1 PRIMARY CARE PRACTITIONER OVERVIEW

|                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|--------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Introduction</b>                        | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Definition of PCP</b>                   | A primary care physician or practitioner (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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Practitioners who may serve as PCPs</b> | <p>A physician (MD or DO) who is a family practitioner, general practitioner, internal medicine practitioner, or pediatrician is entitled to participate as a primary care physician (PCP). The physician must complete the credentialing process.</p> <p>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 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.</p> |
| <b>How PCPs are reimbursed</b>             | <p>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.</p> <p>Please see the section in this unit on <b>First Priority Health Network PCP Payment Methodology</b> for more information on FPH network payment methodology.</p>                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>PCP selection requirements</b>          | <p>Highmark members enrolled in the following products are required to select a PCP to manage their care:</p> <ul style="list-style-type: none"> <li>• <b>Pennsylvania:</b> <ul style="list-style-type: none"> <li>o Commercial HMO plans in the Western and Northeastern Regions</li> <li>o Medicare Advantage HMO plans -- Security Blue HMO, offered only in the Western Region, and Community Blue Medicare HMO</li> <li>o Children's Health Insurance Program (CHIP) plans, including CHIP HMO plans in the Western and Northeastern Regions and also the CHIP PPO Plus product, a gatekeeper Preferred Provider Organization (PPO) product, in the Central Region</li> </ul> </li> </ul>                                                                                                          |

[What Is My Service Area?](#)

*Continued on next page*

## 4.1 PRIMARY CARE PRACTITIONER OVERVIEW, Continued

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### PCP selection requirements (continued)

- **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.**

[What Is My Service Area?](#)

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## 4.1 PRIMARY CARE PRACTITIONER ROLE AND RESPONSIBILITIES

### Overview

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.

### 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\*
- Providing 24-hour telephone availability year round
- Providing physician coverage at all times
- 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:
  - o Clinical initiatives
  - o Condition management and shared decision making
  - o Credentialing
  - o Clinical studies
  - o Health Plan Employer Data and Information Set (HEDIS®)
  - o Providing access to members' medical records
  - o Risk Adjustment Data Verification (RADV)

*Continued on next page*



## 4.1 PRIMARY CARE PRACTITIONER ROLE AND RESPONSIBILITIES,

Continued

### PCP responsibilities (continued)

**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).*

### 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.

## 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 Children's Health Insurance Plan (CHIP) HMO and PPO Plus plans are required to select a PCP.
- **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.

[What Is My Service Area?](#)

### 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 1 <sup>st</sup> through the 15 <sup>th</sup> day of the month, | the first of the next month following the date of the call.   |
| after the 15 <sup>th</sup> day of the month,                            | the first of the second month following the date of the call. |

For example, if the member calls to select a new PCP on:

- January 4, the change will be effective February 1.
- January 20, the change will be effective March 1.

### 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).

## 4.1 ARRANGING FOR PCP ABSENCE

### Introduction

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 or her office staff of the arrangements.
4. Be sure that your answering service informs patients of the arrangement.

### PCP back-up physician form – WV



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](#).

This form is also accessible from the *Highmark Provider Manual's Tip Sheet Index* available under **ADDITIONAL RESOURCES** at the bottom of the manual's home page.

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 **1-800-798-7768**.

[What Is My Service Area?](#)

### 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 or 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 or 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.

*Continued on next page*

## 4.1 ARRANGING FOR PCP ABSENCE, Continued

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**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.

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**Informing the  
office staff**

It is imperative that both the regular and the covering physicians' office staffs be aware of any temporary coverage arrangements. Failing to notify the office staffs may decrease continuity of care to members.

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## 4.1 MEMBER REMOVAL POLICY AND PROCEDURE

|                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Policy</b>                                | 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 or her practice.                                                                                                                                                                                                                                                                                                                                               |
| <b>Background</b>                            | The relationship between a PCP and his or 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 or her effort to remove the member from the practice.                                                                                                                                                                                              |
| <b>Invalid reasons for removing a member</b> | <p>Invalid reasons for removing a member include:</p> <ul style="list-style-type: none"> <li>• Race</li> <li>• Sexual orientation</li> <li>• Age (unless the member's age is outside of the scope of the practice, e.g., an adult patient in a pediatric practice)</li> <li>• National origin</li> <li>• Diagnosis</li> <li>• Physical disability</li> <li>• Religion</li> <li>• Gender</li> <li>• Health status factors (e.g., medical condition, claims experience, receipt of health care medical history, genetic information, or evidence of insurability)</li> <li>• Health care insurance coverage</li> </ul> |
| <b>Before you request removal...</b>         | 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 or her removal. Your efforts must be documented in the member's chart.                                                                                                                                                                                                                                                                                                                                                                        |

*Continued on next page*

## 4.1 MEMBER REMOVAL POLICY AND PROCEDURE, Continued

### 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<br>Fifth Avenue Place, Suite 721<br>120 Fifth Avenue<br>Pittsburgh, PA 15222-3099<br>Fax: 1-717-635-4219 | Highmark West Virginia<br>Provider Services Department<br>614 Market Street<br>Parkersburg, WV 26102 |

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**NOTE: It is not necessary to send a written request for members with coverage that does not require 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 thirty (30) days.

## 4.1 HOW TO CLOSE AND RE-OPEN YOUR PRACTICE TO MEMBERS

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**Introduction** This section is intended to explain how to close and re-open your practice to new members.

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**Definition:** When a practice is “closed to new members,” it means that the PCP practice is temporarily not available for selection by new members.

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**Definition:** A new member is one who has:

**New member**

- Never been seen by a physician of the practice.
- Not been seen by a physician of the practice within the past 36 months.

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**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.

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**Guidelines**

- Your practice must provide written notice to Highmark sixty (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 to : 1-800-236-8641
  - Mail to: Highmark Blue Shield  
Provider Information Management  
P.O. Box 898842  
Camp Hill, PA 17089-8842
-

## 4.1 FIRST PRIORITY HEALTH NETWORK PCP PAYMENT METHODOLOGY

### Introduction



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 Children's Health Insurance Program (CHIP). There are several reimbursement methodologies available to primary care physicians (PCPs) participating in the FPH network. These include: capitation, billables, and copayments.

[What Is My Service Area?](#)

### FPH PCP capitation



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 [Chapter 4.5: 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 twelve (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.

*Continued on next page*



## 4.1 FIRST PRIORITY HEALTH NETWORK PCP PAYMENT METHODOLOGY, Continued

[What Is My Service Area?](#)

### FPH PCP capitation (continued)



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 in order 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



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 Highmark Blue Shield NaviNet®. It is accessed from the **Workflows for this Plan** menu on Highmark Plan Central by hovering over **AR Management**, and then selecting **PCP CAP Rosters** from the fly-out menu. The roster is mailed to PCPs without access to NaviNet.

- The roster is generated by "provider group," not by "physicians within the group."
- The roster can be downloaded to a PDF or text file.

*Continued on next page*

## 4.1 FIRST PRIORITY HEALTH NETWORK PCP PAYMENT METHODOLOGY, Continued

### Capitation roster (continued)



- A 13-month history of rosters will be available at all times within NaviNet.
- Providers receiving Highmark capitation via electronic funds transfer (EFT) will only receive the roster via NaviNet.
- Providers receiving a paper check will receive the roster by mail in addition to the ability to access the roster via NaviNet.

[What Is My Service Area?](#)

### FPH PCP billables



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. This list is also available on the Highmark Blue Shield Provider Resource Centers on the Highmark Blue Shield website and also via NaviNet® – select **EDUCATION/MANUALS**, and then click on **First Priority Health Network Resources**.

### FPH PCP copayments



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 NaviNet’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.

## 4.1 UNCONFIRMED DIAGNOSIS CODE (UDC) PROGRAM

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### Introduction

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.

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### Program overview

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.

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### FOR MORE INFORMATION

Complete program information is available on the NaviNet® Provider Resource Center – select **EDUCATION/MANUALS** from the main menu, and then **Risk Adjustment Programs**.

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## 4.1 PCP AND SPECIALIST COMMUNICATION

|                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|-------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Overview</b>                     | Network personal physicians and specialists, including medical, surgical, and behavioral health, must communicate with one another in order to assure continuity and coordination of care for members. The communication procedure is documented below.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Purpose</b>                      | The goal is to ensure the exchange of information in an effective, timely, and confidential manner to promote appropriate diagnosis and treatment for members.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Requirements</b>                 | <p>PCPs and specialists, including medical, surgical, and behavioral health specialists, must communicate in each of the following ways to ensure continuity of patient care:</p> <ul style="list-style-type: none"> <li>• 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 <a href="#">Patient Treatment Summary Communication Form</a> is available on the Provider Resource Centers in Pennsylvania and West Virginia -- select <b>FORMS</b>, and then <b>Miscellaneous Forms</b>.</li> <li>• Within ten (10) business days of the first visit, the specialist must provide the PCP with information about his or 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.</li> <li>• 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.</li> <li>• The PCP must document his or 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 or she has reviewed the information (e.g., by initialing each page).</li> </ul> |
| <b>Member role in communication</b> | <b>Highmark members should not be asked by PCPs or specialists to communicate findings, reports, lab results, etc. to another practitioner.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

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## 4.1 PCP AND SPECIALIST COMMUNICATION, Continued

### PCP/behavioral health form



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**.

[What Is My Service Area?](#)

### 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.

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## 4.1 PCP AND SPECIALIST COMMUNICATION, Continued

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**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

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|-----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Introduction</b>                           | As a specialist, you play the important role of providing specialty services to our Highmark members.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>How specialists are reimbursed</b>         | Network specialists are paid fee-for-service. For more information on reimbursement methods, see <a href="#">Chapter 6.7: Payment/EOBs/Remittances</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>How auxiliary personnel are reimbursed</b> | <p>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.</p> <p>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.</p> <p>Highmark’s Medical Policies are available on the Provider Resource Center under <b>CLAIMS, PAYMENT &amp; REIMBURSEMENT</b>.</p> |
| <b>If network participation is terminated</b> | <p>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.</p> <p>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.</p>                                                                                                                                                                                                                                                                                      |
| <b>Directing care to network providers</b>    | <p>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.</p> <p>For more information on directing care to network providers, please see <a href="#">Chapter 3.1: Network Participation Overview</a>.</p>                                                                                                                                                                                                                                         |

## 4.1 PREVENTIVE CARE RESPONSIBILITIES FOR ALL NETWORK PHYSICIANS

### Preventive care

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 (7) days and no later than thirty (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.

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## 4.1 PREVENTIVE CARE RESPONSIBILITIES FOR ALL NETWORK PHYSICIANS, Continued

### 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 **EDUCATION/MANUALS** 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.

## 4.1 OB/GYN REQUIREMENTS AND PROCEDURES

|                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|--------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Overview</b>                | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Direct access</b>           | <p>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).</p> <p>Direct access offers the following advantages for members seeing a credentialed network OB/GYN:</p> <ul style="list-style-type: none"> <li>• No referral for annual routine gynecological exam</li> <li>• No referral for sick visits</li> <li>• No referral for follow-up care</li> <li>• No referral for maternity services</li> </ul> <p>Direct access does not extend to services provided by OB/GYN residents or to gynecological services provided in a hospital clinic setting.</p>  |
| <b>Communication procedure</b> | <p>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.</p> <p>The following should be faxed or mailed within thirty (30) days to the member's PCP for each office visit:</p> <ul style="list-style-type: none"> <li>• Clinical findings</li> <li>• Test results</li> <li>• Treatment plans</li> <li>• A summary report at the conclusion of the treatment period</li> <li>• Acceptable formats include typed letters, physician forms, and progress notes</li> </ul> |
| <b>OB/GYN referrals</b>        | <p>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.</p> <p>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.</p>                                                                                                                                                                                                                                                                     |

## 4.1 OBSTETRICAL SERVICES

### Overview

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, you are reminded to be sure to verify benefits for 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 on NaviNet.® If you do not have access to NaviNet, please call Provider Services for your service area to speak to a customer service representative:

- PA Western Region: **1-800-547-3627**
- PA Central, Eastern, and Northeastern Regions: **1-866-731-8080**
- Delaware: **1-800-346-6262**
- West Virginia: **1-800-543-7822**

**Note:** Maternity authorizations are not necessary unless the care is provided out-of-network.

[What Is My Service Area?](#)

### 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: **1-800-596-9443**
- Delaware: **1-800-572-2872**
- West Virginia: **1-800-344-5245**

*Continued on next page*

## 4.1 OBSTETRICAL SERVICES, Continued

### **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 [Chapter 2.4: 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 [Chapter 3.3: Professional Provider Guidelines](#).

## 4.1 GYNECOLOGICAL SERVICES

|                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|---------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Overview</b>                                         | <p>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:</p> <ul style="list-style-type: none"> <li>• No referral for annual routine gynecological exam</li> <li>• No referral for sick visits</li> <li>• No referral for follow-up care</li> </ul>                                                                                                                    |
| <b>Annual routine gynecological exams</b>               | <p>Annual routine gynecological exams include, but are not limited to, the following services:</p> <ul style="list-style-type: none"> <li>• Pelvic exam</li> <li>• Pap test</li> <li>• Clinical breast exam</li> <li>• Interval history</li> </ul>                                                                                                                                                                                                                                                                                                                                                       |
| <b>Follow-up visits</b>                                 | <p>Follow-up visits may include the following services:</p> <ul style="list-style-type: none"> <li>• Screening mammography</li> <li>• Diagnostic mammography</li> <li>• Selected diagnostic and surgical procedures, <b>only</b> if not on the list of procedures requiring pre-authorization</li> <li>• Lab services referred by the OB/GYN</li> <li>• Additional office visits, if necessary</li> </ul>                                                                                                                                                                                                |
| <b>Mammography</b>                                      | A prescription is required to order a mammogram.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Mammography screening vs. diagnostic mammography</b> | <p>A <b>screening mammogram</b> is an ordinary check-up intended to detect any problems. A <b>diagnostic mammogram</b> is a test intended to follow-up on a confirmed or suspected irregularity or diagnosis.</p> <div style="text-align: right;"> <a href="#">What Is My Service Area?</a> </div>                                                                                                                                                                                                                                                                                                       |
| <b>Infertility services require a benefit</b>           | <p>Not all members have a benefit to cover testing and/or treatment for infertility and/or assisted fertilization. To verify coverage, please use the <b>Eligibility and Benefits</b> feature on NaviNet.® For inquiries that cannot be handled via NaviNet, please call the Provider Service Center for your service area:</p> <ul style="list-style-type: none"> <li>• PA Western Region: <b>1-800- 547-3627</b></li> <li>• PA Central, Eastern, and Northeastern Regions: <b>1-866-731-8080</b></li> <li>• Delaware: <b>1-800-346-6262</b></li> <li>• West Virginia: <b>1-800-543-7822</b></li> </ul> |

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## 4.1 GYNECOLOGICAL SERVICES, Continued

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**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.

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**OB/GYN  
network  
participation**

For Highmark network participation requirements and procedures, please see [Chapter 3.3: Professional Provider Guidelines](#).

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## 4.1 BREAST PUMPS AND LACTATION COUNSELING

### Introduction

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 NaviNet® or the applicable HIPAA electronic transactions. In NaviNet's **Eligibility and Benefits Inquiry**, select **Additional Benefit Provisions**, and then select Other Services from the pop-up box. Scroll to **Women's Health Services** to determine if your patient is covered under the federal mandate.

### 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                                                                    |
|---------------|------------------------------------------------------------|------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| <b>Ameda</b>  | Purely Yours Electric Breast Pump with Dual Collection Kit | <a href="http://www.insured.amedadirect.com">www.insured.amedadirect.com</a> | <b>Phone:</b> 1-877-791-0064<br><b>Hours:</b> 8 a.m. - 6 p.m.                  |
| <b>Medela</b> | Pump in Style Advanced Breast Pump Starter Set             | <a href="http://www.medeladelivers.com">www.medeladelivers.com</a>           | <b>Phone:</b> 1-800-866-2825<br><b>Hours:</b> Monday – Friday, 9 a.m. - 6 p.m. |

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## 4.1 BREAST PUMPS AND LACTATION COUNSELING, Continued

### 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 NaviNet for benefit coverage.

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## 4.1 BREAST PUMPS AND LACTATION COUNSELING, Continued

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### 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 **CLAIMS, PAYMENT & REIMBURSEMENT** from the main menu.

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## 4.1 DOCTOR MATCH

### Introduction



In western Pennsylvania and Delaware, an online compatibility tool is available to help Highmark members choose a PCP or OB/GYN. Doctor Match is designed to match prospective patients with doctors who share a similar health care philosophy. By participating in Doctor Match, you can help new patients find you and grow your practice.

[What Is My Service Area?](#)

### How it works

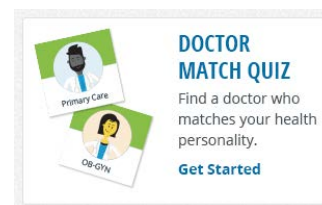


To participate in Doctor Match, PCPs and OB/GYNs complete a physician survey that asks about their personal treatment philosophy and communication style. Highmark members who are looking for a new PCP or OB/GYN answer similar questions to identify the qualities they are looking for in a doctor. And then the member is provided with a list of physicians whose perspectives on health care are closest to theirs.

### Member access to tool



Highmark members can access the Doctor Match Quiz from the home page on the public website or when they log in to their secure member account. They just click on “Get Started” and answer the questions presented.



They will be presented with a list of prospective doctors with your detailed practice profile information from the Highmark Provider Directory.

### Provider access to survey



PCPs and OB/GYNs can access the Doctor Match Quiz in NaviNet®. From Highmark Plan Central, select **Doctor Match Quiz** from the options under **Workflows for this Plan** (you may have to click on the down arrow to view all menu options).

The quiz is quick and easy – it takes only 5 to 7 minutes to complete. And it can be retaken at any time if you feel some of your answers may differ over time.

**Reminder!** Including a photo in your online directory profile is important to many potential patients. Your photo can be easily uploaded through **Provider File Management** in NaviNet.® For complete instructions for uploading your photo, click on the **Tip Sheet** icon.

#### Workflows for this Plan

- Eligibility and Benefits Inquiry >
- Auth Inquiry and Reports >
- Authorization Submission >
- Claim Status Inquiry >
- Claim Investigation Inquiry >
- Claim Submission >
- Estimate Submission >
- Diagnosis Code Inquiry >
- Allowance >
- Procedure Code Inquiry >
- Network Provider Inquiry >
- Network Facility Inquiry >
- Provider File Management >
- AR Management >
- BlueExchange (Out-of-Area) >
- Resource Center >
- Claims Dashboard >
- Quality Blue >
- Doctor Match Quiz >**

[TIP SHEET](#)

## CHAPTER 4: PROVIDER RESPONSIBILITIES AND GUIDELINES

### UNIT 2: BEHAVIORAL HEALTH PROVIDERS

#### IN THIS UNIT



| TOPIC                                                                     | SEE PAGE |
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#### What Is My Service Area?

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The **PA ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The **DE ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

## 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 NaviNet® 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.

### NaviNet® Eligibility and Benefits Inquiry

To verify behavioral health benefits via NaviNet, select the **Eligibility and Benefits Inquiry** transaction from the main menu on Highmark Plan Central. Click on the **Additional Benefit Provisions** link on the Eligibility and Benefits Detail page. From the pop-up box, select **Behavioral Health/Substance Abuse** for detailed behavioral health benefits.

[What Is My Service Area?](#)

### Contact information

To reach Highmark's Behavioral Health Services, please call:

- PA Western & Northeastern Regions: **1-800-258-9808**
- PA Central Region: **1-800-628-0816**
- Delaware: **1-800-421-4577**
- West Virginia: **1-800-344-5245**; for Medicare Advantage Freedom Blue PPO, please call **1-800-269-6389**

Standard business hours for the Behavioral Health Services department are:

- Monday through Friday from 8:30 a.m. to 7 p.m.
- Saturday and Sunday from 8:30 a.m. to 4:30 p.m. (limited staffing for urgent requests)

### Medical management services

Highmark Behavioral Health Services provides behavioral health medical management services for members enrolled in Highmark programs.

*Continued on next page*

## 4.2 GENERAL INFORMATION, Continued

### 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. In addition, authorization is required for partial hospitalization and for intensive outpatient services.

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 5.4: 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 2.5: 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.

## 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 five levels of care for mental health and substance abuse treatment services:

1. Inpatient hospitalization
2. Psychiatric residential treatment and substance abuse residential treatment
3. Partial hospitalization programs (PHPs)
4. Intensive outpatient programs (IOPs)
5. Traditional outpatient treatment

### 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 NaviNet® 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.

*Continued on next page*

## 4.2 LEVELS OF CARE, Continued

### 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 (4) hours per day, three (3) 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 (3) hours per day, five (5) 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 two and one-half (2.5) hours per day, two (2) or more days per week
- Psychiatric/medication evaluation as needed
- Toxicology screen/self-help, 12-step, or education groups as needed

*Continued on next page*

## 4.2 LEVELS OF CARE, Continued

### Intensive outpatient programs (IOPs) (continued)

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. Claims for services provided are submitted under the 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 fifteen (15) minutes (e.g., medication checks) to fifty (50) minutes (e.g., individual or family psychotherapy) and can extend as long as two (2) hours (e.g., group psychotherapy).

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## 4.2 LEVELS OF CARE, Continued

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**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 DELAWARE SENATE BILLS 41 AND 109 – DRUG AND ALCOHOL DEPENDENCY TREATMENT

[What Is My Service Area?](#)

### Overview



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



Effective **January 1, 2018**, 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



**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



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).

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## 4.2 DELAWARE SENATE BILLS 41 AND 109 – DRUG AND ALCOHOL DEPENDENCY TREATMENT, Continued

### Prescription drug coverage for a 5-day emergency supply



If a health plan's coverage includes prescription drugs, the plan must provide immediate access, without prior authorization, to a five (5) 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.

[What Is My Service Area?](#)

### Benefit management restrictions



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 fourteen (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; thirty (30) days of Intensive Outpatient Program treatment; or five (5) 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 forty-eight (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.

*Continued on next page*

## 4.2 DELAWARE SENATE BILLS 41 AND 109 – DRUG AND ALCOHOL DEPENDENCY TREATMENT, Continued

### Retrospective review



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.

[What Is My Service Area?](#)

### REMINDER: Verify Benefits



You can verify benefits, including whether the member's benefit plan follows the mandate, via NaviNet's Eligibility and Benefits Inquiry or by submitting a HIPAA 270 transaction.

If NaviNet is not available, please call the Highmark Delaware Provider Service Center at **1-800-346-6262**.

## 4.2 HIGHMARK BEHAVIORAL HEALTH PROGRAMS

|                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|-------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Overview</b>                                 | <p>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.</p>                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Case and condition management programs</b>   | <p>Highmark offers health coaching through behavioral health case management and chronic condition management approaches. The objective of the programs are 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.</p> <p>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.</p>                                    |
| <b>Role of the behavioral health specialist</b> | <p>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.</p> <p>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.</p> |
| <b>Utilization management team's role</b>       | <p>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.</p>                                                                                                                                                                                                                                                                                                                                                 |

*Continued on next page*

## 4.2 HIGHMARK BEHAVIORAL HEALTH PROGRAMS, Continued

### 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 NaviNet.®

To recommend patients to Highmark behavioral health programs, providers should call Highmark Behavioral Health Services at:

- Pennsylvania Western & Northeastern Regions: **1-800-258-9808**
- Pennsylvania Central Region: **1-800-628-0816**
- Delaware: **1-800-421-4577**
- West Virginia: **1-800-344-5245**

The Behavioral Health Services department is available:

- Monday through Friday from 8:30 a.m. to 7 p.m.
- Saturday and Sunday from 8:30 a.m. to 4:30 p.m.

[What Is My Service Area?](#)

## 4.2 ACCESSIBILITY EXPECTATIONS FOR BEHAVIORAL HEALTH

### Accessibility expectations

To stay healthy, members must be able to see their providers when needed. To support this goal, we are sharing with you 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.

[What Is My Service Area?](#)

| BEHAVIORAL HEALTH PROVIDER EXPECTATIONS                                                                                                                                                                                                                                        |                                                                                                                                                                                                                       |                                      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|
| Patient's Need:                                                                                                                                                                                                                                                                | Performance Standard:                                                                                                                                                                                                 |                                      |
| <b>Care for a life-threatening emergency</b> <ul style="list-style-type: none"> <li>Immediate intervention is required to prevent death or serious harm to patient or others</li> </ul>                                                                                        | Immediate response                                                                                                                                                                                                    |                                      |
| <b>Care for a non-life-threatening emergency</b> <ul style="list-style-type: none"> <li>Rapid intervention is required to prevent acute deterioration of the patient's clinical state that compromises patient safety</li> </ul>                                               | Care within 6 hours                                                                                                                                                                                                   |                                      |
| <b>Urgent care</b> <ul style="list-style-type: none"> <li>Timely evaluation is needed to prevent deterioration of patient condition</li> </ul>                                                                                                                                 | Office visit within 48 hours                                                                                                                                                                                          |                                      |
| <b>Routine office visit</b> <ul style="list-style-type: none"> <li>Patient's condition is considered to be stable</li> </ul>                                                                                                                                                   |                                                | Office visit within 10 business days |
|                                                                                                                                                                                                                                                                                |                                                                                                                                   | Office visit within 7 calendar days  |
| <b>After-hours care</b> <ul style="list-style-type: none"> <li>Access to providers after the practice's regular business hours</li> </ul>                                                                                                                                      | Acceptable process in place to respond 24 hours per day, 7 days a week to member issues (answering service that pages the provider or answering machine message telling caller how to reach the provider after hours) |                                      |
| <b>In-office waiting times</b> <ul style="list-style-type: none"> <li>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.</li> </ul> | Within 15 minutes                                                                                                                                                                                                     |                                      |

*Continued on next page*

## 4.2 ACCESSIBILITY EXPECTATIONS FOR BEHAVIORAL HEALTH,

Continued

### 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<br>or Hospital Service | Caller transferred directly to 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.                                                                                                                                                                                                                           |



## 4.2 TREATMENT INFORMATION AND PATIENT PRIVACY

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### **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.

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### **Restrictions on substance abuse information**

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.

When practicing in any of Highmark's service areas, contracted providers are expected to be compliant with any applicable federal or state regulations.

---

## 4.2 BEHAVIORAL HEALTH PROVIDER AND PCP COMMUNICATION

### Introduction

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.

### Behavioral health provider and PCP communication

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.

### 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.

### Communication procedure

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 directed the member, 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.

*Continued on next page*

## 4.2 BEHAVIORAL HEALTH PROVIDER AND PCP COMMUNICATION,

Continued

### What should be communicated?

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

[What Is My Service Area?](#)

### Form available for PCP communication



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 Centers in Pennsylvania – select **FORMS**, and then **Behavioral Health Forms**.

The form is not required. Behavioral health providers can choose to communicate all of the information included on the form via another written format. Acceptable formats include typed letters, physician forms, and progress notes.

## 4.2 DOCUMENTATION STANDARDS FOR OUTPATIENT SERVICES

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Overview</b>                                                     | 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.                                                                                                                                                                             |
| <b>Initial evaluations</b>                                          | 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.                                                                                                               |
| <b>Minimum documentation standards for outpatient office visits</b> | <p>The provider's progress notes for outpatient office visits should, at a minimum, include the following information:</p> <ul style="list-style-type: none"> <li>• Member's name</li> <li>• Date of service</li> <li>• Length of session (if billing code submitted is time dependent)</li> <li>• Therapy/modality utilized</li> <li>• Appropriate subjective and objective data</li> <li>• Assessment</li> <li>• Treatment plan</li> </ul> |

## 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 <b>NOT</b> required |
| Psychologist                                     | Authorization is required            |

[What Is My Service Area?](#)

### Process

| STEP | ACTION                                                                                                                                                                                                                                                                                                                                                                                                                 |
|------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1    | To request authorization for psychiatric consultation with a patient in an acute care medical unit, the provider calls Highmark Behavioral Health Services at: <ul style="list-style-type: none"> <li>PA Western &amp; Northeastern Regions: <b>1-800-258-9808</b></li> <li>PA Central Region: <b>1-800-628-0816</b></li> <li>Delaware: <b>1-800-421-4577</b></li> <li>West Virginia: <b>1-800-344-5245</b></li> </ul> |
| 2    | The Highmark Behavioral Health Care Manager gathers the following data about the request: <ul style="list-style-type: none"> <li>Patient's location</li> <li>Source of the referral for the psychiatric consultation</li> <li>Reason for the consultation</li> </ul>                                                                                                                                                   |
| 3    | The Highmark Care Manager enters an authorization for CPT code 99254.                                                                                                                                                                                                                                                                                                                                                  |

## 4.2 FOLLOW-UP APPOINTMENTS AFTER HOSPITALIZATION

|                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|-------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Overview</b>                                 | <p>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.</p> <p>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.</p>                                                                                                                                                                                                           |
| <b>Discharge planning</b>                       | <p>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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Follow-up appointment important</b>          | <p>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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Member contact after inpatient discharge</b> | <p>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.</p> <p>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.</p> |
| <b>When medication is prescribed</b>            | <p>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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>If a follow-up appointment is not made</b>   | <p>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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

*Continued on next page*

## 4.2 FOLLOW-UP APPOINTMENTS AFTER HOSPITALIZATION,

Continued

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**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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## CHAPTER 4: PROVIDER RESPONSIBILITIES AND GUIDELINES

### UNIT 3: FACILITY-SPECIFIC GUIDELINES

#### IN THIS UNIT



| TOPIC                                                                          | SEE PAGE |
|--------------------------------------------------------------------------------|----------|
| Overview of Facility-Specific Guidelines                                       | 2        |
| Member Access to Facilities                                                    | 3        |
| Status of Patient vs. Place of Service                                         | 4        |
| Observation Services                                                           | 5        |
| Purchased Services Provided to Members Registered as Inpatients or Outpatients | 10       |
| Post-Exposure Rabies Treatment                                                 | 12       |
| Early Maternity Discharge and Home Health Evaluation                           | 14       |
| Breast Pumps and Lactation Counseling                                          | 17       |

[What Is My Service Area?](#)

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The **PA ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The **DE ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.



## 4.3 OVERVIEW OF FACILITY-SPECIFIC GUIDELINES

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### Introduction

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.

[What Is My Service Area?](#)

### Facility Bulletins

In the past, Highmark published Facility Bulletins to communicate policies and procedures to facilities. Although the publication of newly created Facility Bulletins was discontinued in 2015, Highmark has reviewed previously published bulletins in Pennsylvania to evaluate their content. As the bulletins were evaluated, Highmark determined if the information was still current and valid, or if the information was outdated and/or superseded in a more recent bulletin (or communication). Those bulletins deemed to be outdated, or superseded in a more recent communication, were marked as obsolete and added to the Facility Bulletin Archive.

Facility Bulletins continue to be available online to providers as resources and for historical reference in all service areas. The *Highmark Provider Manual*, provider newsletters, Special Bulletins, and other communications (e.g., Plan Central Messages) should be referenced for the most up-to-date information.

Facility Bulletins can be accessed from the Provider Resource Center by selecting **NEWSLETTERS/NOTICES** from the main menu.

### Medicare Advantage

For guidelines related to care management of Medicare Advantage members, please see [Chapter 5.3: Medicare Advantage Procedures](#).

## 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 the 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.

## 4.3 STATUS OF PATIENT VS. PLACE OF SERVICE

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### 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 who is admitted as an overnight bed patient 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.

---

## 4.3 OBSERVATION SERVICES

### Introduction

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 **forty-eight (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.

*Continued on next page*

## 4.3 OBSERVATION SERVICES, Continued

### 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 twenty-four (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 thirty-six (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 at:

<https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html?redirect=/bni>

### 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 forty-eight (48) hours.
- The clinical diagnosis and necessity of inpatient admission are unclear, but the hospital expects to determine these in less than forty-eight (48) hours.

*Continued on next page*

## 4.3 OBSERVATION SERVICES, Continued

### 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

### 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 InterQual® admission criteria 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.

*Continued on next page*

## 4.3 OBSERVATION SERVICES, Continued

### Outpatient cost-sharing applies (continued)

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 forty-eight (48) hours have elapsed.

The request for the inpatient authorization should ordinarily be made using the NaviNet® Automated Care Management function. If NaviNet is unavailable, contact Highmark Clinical Services at:

- In the PA Western Region, call **1-800-242-0514**.
- In the PA Central & Northeastern Regions, call **1-866-803-3708**.
- In the Delaware, call **1-800-572-2872**.
- In the West Virginia, call **1-800-344-5245**.

[What Is My Service Area?](#)

### 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 function on NaviNet®. If NaviNet is unavailable, providers may contact the appropriate Highmark Provider Service unit by telephone:

- In the PA Western Region, call **1-800-242-0514**.
- In the PA Central & Northeastern Regions, call **1-866-803-3708**.
- In the Delaware, call **1-800-346-6262**.
- In the West Virginia, call **1-800-543-7822**.

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## 4.3 OBSERVATION SERVICES, Continued

### Reporting observation services



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  |

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.**

[What Is My Service Area?](#)

### IMPORTANT!



Highmark Delaware providers need to follow their current reimbursement method and continue to submit claims according to their contract.



## 4.3 PURCHASED SERVICES PROVIDED TO MEMBERS REGISTERED AS INPATIENTS OR OUTPATIENTS

### Overview

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.

*Continued on next page*

## 4.3 PURCHASED SERVICES PROVIDED TO MEMBERS REGISTERED AS INPATIENTS OR OUTPATIENTS, Continued

### Using vendors (continued)

**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, **certain 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.

[What Is My Service Area?](#)

### Exceptions for Medicare Advantage



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.

## 4.3 POST-EXPOSURE RABIES TREATMENT

### Background

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:
  - o 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
  - o Rabies Vaccine
    - **90675** – Rabies vaccine, for intramuscular use; **or**
    - **90676** – Rabies vaccine, for intradermal use
- Appropriate ICD-10 diagnosis code(s) for the exposure.

*Continued on next page*

## 4.3 POST-EXPOSURE RABIES TREATMENT, Continued

### Reporting services (continued)

#### 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.

## 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 forty-eight (48) hours following a vaginal delivery or ninety-six (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.

[What Is My Service Area?](#)

### **Pennsylvania Health Security Act 85 of 1996**



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 forty-eight (48) hours of inpatient care following normal vaginal delivery and ninety-six (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 (1) home health care visit within forty-eight (48) hours after discharge when discharge occurs prior to forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following cesarean delivery. The visit must be provided by a licensed health care provider whose scope of practice includes postpartum care.

*Continued on next page*

## 4.3 EARLY MATERNITY DISCHARGE AND HOME HEALTH EVALUATION, Continued

### Pennsylvania Health Security Act 85 of 1996 (continued)



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).**

[What Is My Service Area?](#)

### Eligibility and benefits



When coordinating a home health visit following an early maternity discharge, providers should first check the member's eligibility and benefits to determine if their coverage follows the mandate.

Pennsylvania's Act 85 is tied directly to the maternity benefit. In NaviNet's *Eligibility and Benefits Inquiry*, select the **Inpatient Facility Services** category to determine if Act 85 applies to the member's Maternity coverage:

|                         |     |
|-------------------------|-----|
| Maternity               |     |
| Coverage                | Yes |
| State Mandated Benefits | Yes |
| Home Health Care Visit  | Yes |

### Authorization requirements



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.

*Continued on next page*

## 4.3 EARLY MATERNITY DISCHARGE AND HOME HEALTH EVALUATION, Continued

### Scenarios



The table below reviews several scenarios and clarifies when authorization is required for home health visits following a maternity stay:

[What Is My Service Area?](#)

| 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<br>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



If a claim is rejected for no authorization when an authorization is **not** required based on the scenarios above, the HHA should submit a claim investigation via NaviNet's Claim Investigation Inquiry.

## 4.3 BREAST PUMPS AND LACTATION COUNSELING

### Introduction

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 NaviNet® or the applicable HIPAA electronic transactions. In NaviNet's **Eligibility and Benefits Inquiry**, select **Additional Benefit Provisions**, and then select Other Services from the pop-up box. Scroll to **Women's Health Services** to determine if your patient is covered under the federal mandate.

### 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                                                                    |
|---------------|------------------------------------------------------------|------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| <b>Ameda</b>  | Purely Yours Electric Breast Pump with Dual Collection Kit | <a href="http://www.insured.amedadirect.com">www.insured.amedadirect.com</a> | <b>Phone:</b> 1-877-791-0064<br><b>Hours:</b> 8 a.m. - 6 p.m.                  |
| <b>Medela</b> | Pump in Style Advanced Breast Pump Starter Set             | <a href="http://www.medeladelivers.com">www.medeladelivers.com</a>           | <b>Phone:</b> 1-800-866-2825<br><b>Hours:</b> Monday – Friday, 9 a.m. - 6 p.m. |

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## 4.3 BREAST PUMPS AND LACTATION COUNSELING, Continued

### 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 NaviNet for benefit coverage.

*Continued on next page*

## 4.3 BREAST PUMPS AND LACTATION COUNSELING, Continued

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### 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 **CLAIMS, PAYMENT & REIMBURSEMENT** from the main menu.

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## CHAPTER 4: PROVIDER RESPONSIBILITIES AND GUIDELINES

### UNIT 4: ANCILLARY PROVIDERS

#### IN THIS UNIT



| TOPIC                                                                                        | SEE PAGE |
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#### What Is My Service Area?

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The **PA ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The **DE ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

## 4.4 INTRODUCTION

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### Overview

An ancillary provider is a supplier of health care related equipment or services, such as durable medical equipment, prosthetics, orthotics, drugs, medical supplies, and diagnostic services.

To supplement the professional provider and facility networks, Highmark contracts with a network of ancillary providers. These include freestanding and facility-based providers in the specialties including, but not limited to:

- Durable medical equipment
- Orthotics/prosthetics
- Home infusion
- Ambulance
- Independent laboratories

Because the services and supplies provided by ancillary providers addressed in this unit bill in the professional 1500/837P format, this unit is labeled as for professional providers.

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### In this unit

This unit provides information and guidelines for providers of durable medical equipment and supplies, orthotics, prosthetics, and home infusion.

For diagnostic services, please see [Chapter 4.5: Outpatient Radiology and Laboratory](#).

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### 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 DME/RESPIRATORY SUPPLIES MANAGEMENT PROGRAM

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### Overview

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 NaviNet® *Eligibility and Benefit 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. However, some groups, such as the Pennsylvania Employees Benefit Trust Fund (PEBTF), contract with DMEnsion Benefit Management Inc. for management of DME services for their members. Please verify benefits via NaviNet for a member's specific coverage.

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### DME requiring authorization

Highmark maintains a **List of Procedures/DME Requiring Authorization**. This list is available on the Provider Resource Center. To access the list quickly, select **REQUIRING AUTHORIZATION** from the **Quicklinks Bar**.

The list is also available by selecting **CLAIMS, PAYMENT & REIMBURSEMENT** from the main menu on the Provider Resource Center, and then **Procedures/Service Requiring Prior Authorization**.

The authorization process for DME and supplies furnished through a stand-alone, Highmark participating ancillary DME supplier for the items on the list is managed by Highmark's Clinical Services. Ordering physicians may initiate authorization requests. In Pennsylvania, DME vendors may also initiate authorization requests (after obtaining a physician order). NaviNet-enabled providers must submit the authorization request via NaviNet.

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### IMPORTANT!

**DME that does not require authorization simply requires a prescription written by the ordering physician.**

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*Continued on next page*

## 4.4 DME/RESPIRATORY SUPPLIES MANAGEMENT PROGRAM,

Continued

[What Is My Service Area?](#)

### Medicare Advantage



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 by selecting **CLAIMS, PAYMENT & REIMBURSEMENT** on the Provider Resource Center. Or call EDI Operations toll-free at **1-800-992-0246**, Monday through Friday, 8 a.m. to 5 p.m. EST.

You can also submit claims electronically through NaviNet's HIPAA- approved claims submission transaction – just select **Claim Submission** from Highmark Plan Central. Once your claims are submitted to Highmark, whether through NaviNet or a HIPAA 837 electronic transaction, you are able to view the claim status and perform claim investigations in NaviNet.

### 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.

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## 4.4 DME/RESPIRATORY SUPPLIES MANAGEMENT PROGRAM,

Continued

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**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

### Process

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. In Pennsylvania, DME vendors may also initiate authorization requests (after obtaining a physician order).

**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 | ACTION                                                                                                                                                                                                                                                                                                                                                                                                               |
|------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1    | The requesting provider determines whether the request must be authorized by Highmark's Clinical Services. <b>Please gather all pertinent information, including a Certificate of Medical Necessity (CMN) if required, prior to submitting the request.</b>                                                                                                                                                          |
| 2    | If required, the requesting provider submits the request for authorization to Clinical Services through one of the following methods: <ul style="list-style-type: none"> <li>• If NaviNet®-enabled, the request <b>must</b> be submitted via NaviNet.</li> <li>• For those practices not yet NaviNet-enabled, <b>fax</b> an authorization request form to <b>1-412-544-2921</b> or <b>1-888-236-6321</b>.</li> </ul> |
| 3    | Clinical Services will review the request. <ul style="list-style-type: none"> <li>• If benefits are not available, go to Step 4.</li> <li>• If medical appropriateness cannot be determined, go to Step 5.</li> <li>• If the request meets criteria, Clinical Services will approve the authorization request and notify the requester.</li> </ul>                                                                   |
| 4    | If benefits are not available for the requested item or service, Clinical Services will deny the authorization request and notify the requesting provider.<br><br>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.                                                                 |
| 5    | If medical appropriateness cannot be determined from the documentation provided, Clinical Services will contact the requesting provider for additional information.<br><br>This information must be returned to Clinical Services in a timely manner, preferably within forty-eight (48) hours, as regulatory time frames must be met.<br><br>Proceed to Step 6.                                                     |
| 6    | <ul style="list-style-type: none"> <li>• If medical necessity cannot be determined, the authorization request is pended and sent to a Highmark physician reviewer for review. Proceed to Step 7.</li> <li>• If the documentation substantiates the request, the service will be approved and the requesting provider will be notified.</li> </ul>                                                                    |

*Continued on next page*



## 4.4 AUTHORIZING DURABLE MEDICAL EQUIPMENT, Continued

### Process (continued)

| STEP | ACTION                                                                                    |                                                                                                                                                                                                |
|------|-------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 7    | If the Highmark physician reviewer determines that the authorization:                     |                                                                                                                                                                                                |
|      | Is medically appropriate. . .                                                             | Is not medically appropriate. . .                                                                                                                                                              |
|      | Clinical Services will approve the pended authorization request and notify the requester. | 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. |

## 4.4 SELECT DME NETWORK (PA ONLY)

### Overview



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.

[What Is My Service Area?](#)

### Select DME Network effective January 1, 2017



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 the most current lists of providers in the Select DME Network, select **CLAIMS, PAYMENT & REIMBURSEMENT** from the main menu on the Provider Resource Center, and then click on **Select DME Network**. You can select a list of [all participating providers](#) or a [list organized by category with phone numbers](#).

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.

## 4.4 BILLING FOR DMEPOS PROVIDED TO MEMBERS REGISTERED AS INPATIENTS OR OUTPATIENTS AT A FACILITY

### Overview

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



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.

[What Is My Service Area?](#)

## 4.4 PAP DEVICE PROGRAM

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### Introduction

Highmark is committed to providing our members with access to high quality health care. To meet that commitment, we are building partnerships with providers and developing innovative programs that encourage improvement in quality of care. These programs reward those providers who achieve high levels of performance.

Highmark has been evaluating reimbursement of ancillary services in order to build programs based on quality and value. As a result, the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Program was developed. The goal of the DMEPOS Quality Program is to positively impact four areas of patient care: quality, access, patient experience, and cost.

Highmark expects to see improved medical outcomes for our members through measuring performance, monitoring quality of care, and defining best practices while also managing rising health care costs for our members and employer groups. The PAP Device Program is summarized below. The DMEPOS Quality Program will be expanded over time to include additional incentive programs for other DMEPOS product categories.

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### PAP Device Program

Suppliers participating in the PAP Device Program are eligible to receive enhanced reimbursement for their efforts to help improve member compliance when using positive airway pressure (PAP) devices.

Under the PAP Device Program, participating suppliers are required to monitor and measure device usage compliance for members to whom they supply continuous positive airway pressure (CPAP) devices, respiratory assist devices (RADs), and/or accessories for those devices. Participating suppliers who meet program requirements and compliance criteria will be reimbursed at a higher rate than those who do not satisfy the requirements.

All Highmark commercial network participating suppliers who provide members with PAP devices and/or accessories for PAP devices are eligible to participate in the program.

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### FOR MORE INFORMATION

To learn more about program participation and requirements, please visit the Provider Resource Center. Select **CLAIMS, PAYMENT & REIMBURSEMENT** from the main menu, and then click on **PAP Device Program**.

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## 4.4 HOME INFUSION THERAPY GUIDELINES

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### Overview

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 agree 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
- 

*Continued on next page*

## 4.4 HOME INFUSION THERAPY GUIDELINES, Continued

### 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 **CLAIMS, PAYMENT & REIMBURSEMENT** on the Provider Resource Center.

## 4.4 DME SUPPLIES PROVIDED IN A PHYSICIAN'S OFFICE FOR MEDICARE ADVANTAGE (PA ONLY)

### Overview



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 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.

[What Is My Service Area?](#)

### IMPORTANT! Always verify benefits



Please verify the member's benefits through NaviNet® 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.

## 4.4 MEDICARE ADVANTAGE GUIDELINES FOR DMEPOS UPGRADES

### Overview



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.

[What Is My Service Area?](#)

### Claim submission and reimbursement



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.



## 4.4 MEDICARE ADVANTAGE CAPPED RENTALS

### Overview



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.

[What Is My Service Area?](#)

### Payment methodology and required modifiers for capped rentals



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<br>(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.

[Why blue italics?](#)

### List of capped rental items

**TIP SHEET**



*For a complete list of procedure codes for DMEPOS items that fall into this capped rental classification, click on the link in the Tip Sheet icon to the left.*

*This list is also available in the manual's **Tip Sheet Index**, which can be accessed from **ADDITIONAL RESOURCES** at the bottom of the Highmark Provider Manual's home page.*

## 4.4 MEDICARE ADVANTAGE HOME OXYGEN THERAPY

### Introduction



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.

[What Is My Service Area?](#)

### Oxygen equipment limited to 36-month rental period



Reimbursement for oxygen equipment is limited to thirty-six (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 (6) months. Ownership of the oxygen delivery equipment will remain with the equipment supplier.

### Supplier responsibilities



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.

*Continued on next page*

## 4.4 MEDICARE ADVANTAGE HOME OXYGEN THERAPY, Continued

### Reasonable useful lifetime (RUL)



After thirty-six (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 (5) 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 thirty-six (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.

[What Is My Service Area?](#)

### Payment for oxygen content



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



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.

*Continued on next page*

## 4.4 MEDICARE ADVANTAGE HOME OXYGEN THERAPY, Continued

### Conditions for which coverage is not available



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 PO<sub>2</sub> will improve the oxygenation of tissues with impaired circulation.
4. Terminal illnesses that do not affect the respiratory system.

### Portable oxygen systems



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.

[What Is My Service Area?](#)

### Spare tanks or emergency inhalators



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



Initial orders for oxygen therapy must also include the results of a blood gas study, usually a measurement of the partial pressure of oxygen (PO<sub>2</sub>) in arterial blood.

**The study must be performed within thirty (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.

*Continued on next page*

## 4.4 MEDICARE ADVANTAGE HOME OXYGEN THERAPY, Continued

### Conditions of blood gas studies



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.

[What Is My Service Area?](#)

### Blood gas level criteria



The table below describes three groups of blood gas levels for which coverage is provided.

| GROUP                                  | BLOOD GAS LEVEL CRITERIA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|----------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>GROUP 1:</b><br>Medically necessary | <p>Arterial PO<sub>2</sub> is at or below 55 mm Hg, or arterial oxygen saturation is at or below 88% taken at rest.</p> <p>OR</p> <p>Arterial PO<sub>2</sub> 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 PO<sub>2</sub> at or above 56 mm Hg or arterial oxygen saturation at or above 89% while awake.</p> <p>OR</p> <p>A greater than normal fall in oxygen level during sleep (arterial PO<sub>2</sub> 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).</p> <p>OR</p> <p>Arterial PO<sub>2</sub> is at or below 55 mm Hg or arterial oxygen saturation at or below 88%, taken during activity for a patient who demonstrates arterial PO<sub>2</sub> 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.</p> |

*Continued on next page*

## 4.4 MEDICARE ADVANTAGE HOME OXYGEN THERAPY, Continued

### Blood gas level criteria (continued)



|                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|--------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>GROUP 2:</b><br>Medically necessary     | Arterial PO <sub>2</sub> is 56 to 59 mm Hg or arterial blood oxygen saturation is 89% if any of the following are documented: <ul style="list-style-type: none"> <li>• Dependent edema suggesting congestive heart failure</li> <li>• 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)</li> <li>• Erythrocythemia with a hematocrit greater than 56%</li> </ul> |
| <b>GROUP 3:</b><br>Not medically necessary | Home use of oxygen is not medically necessary for members with PO <sub>2</sub> levels at or above 60 mm Hg, or arterial blood oxygen saturation at or above 90%.                                                                                                                                                                                                                                                                                                                                                                               |

### Additional studies



Retesting between the 61<sup>st</sup> and 90<sup>th</sup> 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<sub>2</sub> was 56 mm Hg or greater
- Oxygen saturation was 89% or greater

[What Is My Service Area?](#)

### Certificate of Medical Necessity (CMN)



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.

*Continued on next page*

## 4.4 MEDICARE ADVANTAGE HOME OXYGEN THERAPY, Continued

### Obtaining authorization



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    | <p>If NaviNet®-enabled, the vendor or physician <b>must</b> enter an authorization request for oxygen into NaviNet.</p> <p><b>A Certificate of Medical Necessity (CMN) must be completed for the situations indicated above.</b></p> <p>If not NaviNet-enabled, the vendor or physician should fax a CMN form to Clinical Services at 412-544-2921 or 1-888-236-6321.</p> |
| 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 Pages 7-8 of this unit).                                                                                                                                                                                                                                        |

### Recertification



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 PO<sub>2</sub> 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.

[What Is My Service Area?](#)



## 4.4 DIABETIC TESTING DEVICES FOR MEDICARE ADVANTAGE MEMBERS

### Overview



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.

[What Is My Service Area?](#)

### Purchasing diabetic testing devices



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



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



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.

*Continued on next page*



## 4.4 DIABETIC TESTING DEVICES FOR MEDICARE ADVANTAGE MEMBERS, Continued

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### FOR MORE INFORMATION



If you have specific questions about diabetic testing devices for Medicare Advantage members, please contact the Provider Service Center.

[What Is My Service Area?](#)

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## CHAPTER 4: PROVIDER RESPONSIBILITIES AND GUIDELINES

### UNIT 5: OUTPATIENT RADIOLOGY AND LABORATORY

#### IN THIS UNIT



| TOPIC                                                         | SEE PAGE |
|---------------------------------------------------------------|----------|
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| • Prior Authorization for Diagnostic Imaging Services         | 5        |
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| Outpatient Laboratory Overview                                | 11       |
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#### What Is My Service Area?

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The PA ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The DE ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The WV ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

## 4.5 RADIOLOGY MANAGEMENT PROGRAM OVERVIEW

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### Introduction

Highmark's Radiology Management Program is designed to improve the quality and appropriateness of outpatient advanced imaging services delivered to our members. With the expansion of imaging technology, increasing concern over the levels of radiation exposure, and spiraling health care costs, radiology utilization management programs are common.

The Highmark Radiology Management Program consists of two components: privileging diagnostic imaging providers and prior authorization of select procedures. The privileging process helps to ensure that outpatient imaging services are being performed by qualified providers who demonstrate competency in administration of these services, thus improving quality and safety to our members. The prior authorization process ensures that select outpatient advanced diagnostic imaging services are used only when they are clinically appropriate. The program components are discussed in more detail in the next two sections of this unit.

This program applies to all Highmark products, *except* indemnity products.

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### National Imaging Associates (NIA)

Highmark retains the services of National Imaging Associates, Inc. (NIA), a wholly-owned subsidiary of Magellan Health Services, to assist with the Radiology Management Program. NIA pioneered the radiology benefits management industry and has long-standing experience grounded in clinical research, innovative technology, and proven results. NIA is URAC accredited, NCQA certified in utilization management, and is compliant with all state regulations applicable to their services.

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## 4.5 PRIVILEGING FOR RADIOLOGY SERVICES

### What is privileging?

**Privileging** is a process that assesses the quality of imaging services performed at an imaging center or in a physician's office. All professional providers who perform imaging services must be privileged. Non-privileged providers are not eligible for reimbursement of imaging services.

### Privileging Requirements

Highmark's privileging requirements are intended to promote reasonable and consistent quality and safety standards for the provision of imaging services. The *Highmark Radiology Management Program Privileging Requirements* can be accessed from the **Radiology Management Program** page on the Provider Resource Centers via NaviNet® or Highmark's public websites -- select **CARE MANAGEMENT PROGRAMS** from the main menu, and then **Radiology Management Program**.

Highmark will not reimburse providers for imaging services performed for Highmark members if they do not satisfy the privileging requirements. Any denied services will not be billable to the member.

### How to become a privileged provider

Any contracted professional provider who performs diagnostic imaging services can apply to become a privileged provider. The online *Highmark Privileging Application* must be completed. A separate privileging application is required for each practice location where diagnostic imaging services are performed as well as for each billing methodology used (global, professional, technical).

**To obtain a login for the application, you will need to contact National Imaging Associates, Inc. (NIA) by calling 1-888-972-9642 or by sending an email to [RADPrivilege@Magellanhealth.com](mailto:RADPrivilege@Magellanhealth.com).** NIA will need the following information in order to assign a login:

- Provider name
- Address of diagnostic imaging location
- Tax identification number

Once you obtain your login/MIS number from NIA, you can access the *Highmark Privileging Application* from the Provider Resource Center. From the main menu, select **CARE MANAGEMENT PROGRAMS**, and then **Radiology Management Program**. Next, select **Privileging Application and Requirements**, and then scroll down the page to the link for the **Highmark Privileging Application**.

For questions regarding the application, contact NIA at **1-888-972-9642**.

*Continued on next page*

## 4.5 PRIVILEGING FOR RADIOLOGY SERVICES, Continued

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**IMPORTANT:**  
You may  
require more  
than one login  
& application

A separate login and privileging application will be required for each practice location, each modality, and if more than one billing methodology is used (global, professional or technical).

Providers must complete an application for each addition or expansion of services and also when adding additional sites. Practitioners will not be reimbursed for services provided on transferred or new equipment without being privileged.

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## 4.5 PRIOR AUTHORIZATION FOR DIAGNOSTIC IMAGING SERVICES

### Overview

Under the Highmark Radiology Management Program, prior authorization is intended to ensure quality and proper use of diagnostic imaging consistent with clinical guidelines. Providers are required to use NaviNet® to request authorizations from National Imaging Associates, Inc. (NIA) prior to ordering any services on the program's list of procedures requiring authorization.

Using Highmark medical policy and nationally accepted clinical criteria, Highmark and NIA work closely with imaging providers and ordering physicians. This is to ensure our members receive the most appropriate imaging tests, avoid the inconvenience and expense of unnecessary and/or duplicate services, and reduce their exposure to unnecessary radiation. NIA will issue authorization numbers that will be required for reimbursement. Denials may be issued based on medical necessity and/or appropriateness determinations.

### Verifying eligibility and benefits

Highmark's Radiology Management Program applies to members enrolled in most Highmark health plans; however, some employer groups may choose to opt out of the program. Prior to ordering or performing any procedures included in the program, providers should always verify the member's eligibility and benefits.

You can determine if a member's benefit plan requires prior authorization on the **Eligibility and Benefits Details** screen in NaviNet. In the **Group Information** section, the **Advanced Imaging Ind** will show "YES" if the Radiology Management Program applies to the member's plan and prior authorization is required:

| Member ID: XXXXXXXXXX    Group: XXXXXXXX ABC COMPANY    Service Date: 03/06/2018                                                                                                                                                                                                                                                                                                                  |                              |                                                                                                                                                                                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>INSURANCE DETAILS</b><br><a href="#">View Current Member ID Card</a><br><br><b>Group Information</b><br>Plan Area: XXX<br>Alpha Prefix: XXX<br><b>Advanced Imaging Ind: YES</b><br>Radiation Therapy Management: YES<br>Physical Medicine Management: YES<br>Genetic Testing: NO<br><br><b>Products:</b><br>Connect Blue HDHP EPO<br><br><b>Type:</b><br>Preferred Provider Organization (PPO) | <b>PRIMARY CARE PROVIDER</b> | <a href="#">Connect Blue HDHP EPO Provisions</a><br><br><a href="#">View Previous Coverage</a><br><br><a href="#">Additional Benefit Provisions</a><br><br><a href="#">Benefit Accumulator</a> |

*Continued on next page*

## 4.5 PRIOR AUTHORIZATION FOR DIAGNOSTIC IMAGING SERVICES,

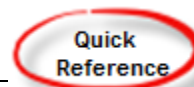
Continued

### Requesting authorization

The ordering physician's office should use NaviNet's **Authorization Submission** transaction to submit an authorization request to NIA before scheduling the test. NaviNet is the preferred method of submitting NIA authorization requests.

Providers who are not NaviNet-enabled should call the **NIA Call Center**, which can be reached by calling your Highmark Provider Service Center. Listen carefully to the options and select the option for requesting authorization for advanced imaging.

NIA Call Center hours are from 8 a.m. to 8 p.m. EST, Monday through Friday. Saturday hours are from 8 a.m. to 1 p.m. EST. If necessary, NIA can be contacted directly at **1-888-972-9642**.



### Services that require prior authorization

The prior authorization process applies only to certain outpatient, non-emergent advanced diagnostic imaging services. The prior authorization process **does not apply** to imaging services ordered in an emergency room, urgent care centers, ambulatory surgery centers, or during inpatient or observation stays.

#### Prior authorization applies to selected procedures of the following types of imaging tests:

- Computed tomography (CT);
- Magnetic resonance imaging (MRI);
- Magnetic resonance angiography (MRA);
- Positron emission tomography (PET);
- Myocardial perfusion imaging (MPI) scans; and
- Stress echocardiography.\*

*\* Effective with dates of service on or after October 3, 2016, requirements for stress echocardiography under the program changed from prior notification to prior authorization. Please note, however, that stress echocardiography will continue to require prior notification for certain self-funded employer groups.*

*Continued on next page*

## 4.5 PRIOR AUTHORIZATION FOR DIAGNOSTIC IMAGING SERVICES,

Continued

### Procedures requiring authorization

To access the most current list of specific procedure codes that require authorization, please see the [Prior Authorization Quick Reference Guide for Ordering Providers](#).

This Quick Reference Guide is also available on the program's page on the Provider Resource Center. Select **CARE MANAGEMENT PROGRAMS** from the main menu on the Provider Resource Center, and then **Radiology Management Program**. Select **Prior Authorization/ Notification Information (Prior Authorization in Delaware)**, and then scroll to the **ADDITIONAL RESOURCES** category.

**Note:** For procedure codes in these categories that are not on the list requiring prior authorization, please refer to Highmark Medical Policy for clinical guidelines to determine coverage based on medical necessity.

### Clinical Validation of Records (CVR)

Effective October 3, 2016, NIA implemented a Clinical Validation of Records (CVR) process for all codes that are part of Highmark's Radiology Management Program. As part of the prior authorization process, NIA will **request and review clinical documentation from the member's medical record** to help ensure Highmark members receive the most appropriate and effective care.

If your authorization request is pended for additional clinical information, you will immediately receive a fax specifying clinical documentation from the member's medical record that is needed for review. Providers must fax the requested information to NIA before a final determination can be made.

NIA will validate the clinical criteria within the patient's medical records, ensuring that the clinical criteria support the requested procedure and are clearly documented in the medical records. All reviews are processed under NCQA and regulatory guidelines. Urgent requests can continue to be called into NIA and clinical validation will not be required under those circumstances.

### 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 the service. Highmark recommends that providers confirm a member's eligibility on

*Continued on next page*



## 4.5 PRIOR AUTHORIZATION FOR DIAGNOSTIC IMAGING SERVICES,

Continued

### Authorization is not a guarantee of payment (continued)

either the anticipated date of service or one business day prior to the anticipated date of service. Some benefit plans may also impose deductibles, coinsurance, copayments, and/or maximums that may impact the payment. Providers may consult NaviNet to obtain benefit information.

**Note:** Authorization numbers do not need to be entered on a claim. However, Highmark strongly recommends that the provider performing the diagnostic test documents and archives the imaging authorization number in the event it is needed for future reference.

### When NIA is contacted post-service

When the ordering physician contacts the National Imaging Associates, Inc. (NIA), an affiliate of Magellan Health, Inc., for authorization **after** one of the select outpatient advanced imaging services was performed but **prior to** claim submission, a retrospective review is necessary.

In such cases, if NIA determines that:

- The service **was medically necessary**, an authorization number is issued. The rendering provider can obtain the authorization number from the **Referral/Authorization Inquiry** transaction in NaviNet®, and then is free to submit a claim to Highmark.
- The service **did not meet medical necessity criteria**, a denial letter is sent to both the ordering physician and the rendering provider. When this is the case, the facility will **not be reimbursed** for the service.

### When a claim rejects for lack of NIA authorization

A retrospective review is also necessary when a claim for one of the selected advanced imaging services is received by Highmark and subsequently denied because no NIA authorization is on file. Under these circumstances, the rendering provider can **contact NIA** via telephone to initiate a retrospective review. NIA will then contact the ordering physician to obtain all the necessary information to complete the retrospective review.

Another option for the rendering provider is to **contact the ordering physician directly** to request that he or she initiate the retrospective review process.

If, upon review, NIA determines that the service billed on the rejected claim **did not meet medical necessity criteria**, a denial letter is sent to both the ordering physician and the rendering provider. In this situation, the facility will not be reimbursed and is not permitted to bill the member for the service.

*Continued on next page*

## 4.5 PRIOR AUTHORIZATION FOR DIAGNOSTIC IMAGING SERVICES,

Continued

**When a claim rejects for lack of NIA authorization**  
(continued)

If NIA determines that the service was **medically necessary**, an authorization is issued. The rendering provider can obtain the authorization number from the **Referral/Authorization Inquiry** transaction in NaviNet.

To have the previously denied claim adjusted, the provider can then open a NaviNet Investigation, reporting the newly obtained authorization number. ("NRR-NIA Retrospective Review" should be selected from the NaviNet drop-down selections as the reason for adjustment.)

Providers who are not NaviNet-enabled can call the appropriate Highmark Provider Service Center to request the adjustment with the new NIA authorization number.

**FOR MORE INFORMATION**

For more detailed information on the components of the Highmark Radiology Management Program, please refer to the documents available on the Provider Resource Center. Select **CARE MANAGEMENT PROGRAMS** from the main menu on the left, and then **Radiology Management Program**.

## 4.5 DIAGNOSTIC IMAGING PROCESS FOR FACILITIES

### Process overview for facilities

The following table outlines the proper process that facilities should follow when a provider orders outpatient, non-emergent diagnostic imaging services:

| STEP                                           | DESCRIPTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Provider orders diagnostic imaging test</b> | <ol style="list-style-type: none"> <li>1. Ordering provider contacts NIA for prior authorization.</li> <li>2. Authorization number is given by NIA, if approved, to ordering provider.</li> <li>3. Authorization number is valid for 60 days from the day the authorization number is issued.</li> <li>4. Facilities are not permitted to obtain an authorization directly from NIA.</li> </ol>                                                                                                                                                                                                                                               |
| <b>Ordering provider schedules test</b>        | <ol style="list-style-type: none"> <li>1. Ordering provider contacts facility to schedule an appointment.</li> <li>2. Authorization number is provided to facility at the time appointment is made.</li> <li>3. Facilities should not schedule an appointment without the NIA authorization number.</li> </ol>                                                                                                                                                                                                                                                                                                                                |
| <b>When additional authorization is needed</b> | <ol style="list-style-type: none"> <li>1. In urgent, non-emergent situations, facilities are permitted to <b>initiate</b> an authorization by contacting NIA directly. However, NIA will provide additional authorization back to the ordering provider.</li> <li>2. Additional, related procedures should be performed by the facility at the time the initial authorized procedure is done. Facilities must immediately notify the ordering provider, and NIA must be contacted within two (2) business days for additional authorization.</li> <li>3. Ordering provider contacts facility with additional authorization number.</li> </ol> |

## 4.5 OUTPATIENT LABORATORY OVERVIEW

|                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|-----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Overview</b>                                     | Providers must refer members to participating laboratory vendors when lab services are needed and are not performed in the provider's office.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prescription necessary</b>                       | PCPs and specialists need only give their members a prescription for the necessary lab tests and direct them to a network-participating lab.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Communication between the PCP and specialist</b> | Specialty practitioners should communicate with a member's PCP after a consultation visit so that laboratory services can be appropriately coordinated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Pass-through billing not permitted</b>           | <p>Pass-through billing occurs when ordering practitioners bill for clinical laboratory tests that were not performed in their offices. Highmark does not permit pass-through billing.</p> <p>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.</p> <p>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.</p> |

*Continued on next page*

## 4.5 OUTPATIENT LABORATORY OVERVIEW, Continued

### Designated outpatient lab providers

Network-participating hospitals provide outpatient lab services. In addition, there are several freestanding labs and specialty labs that are designated outpatient lab providers. NaviNet® is the fastest method for accessing real-time lists of network participating providers.

| STEP | ACTION                                                                                                                                                                                                                                       |
|------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1    | Log in to NaviNet by accessing <a href="https://navinet.navimedix.com/sign-in?ReturnUrl=/Main.asp">https://navinet.navimedix.com/sign-in?ReturnUrl=/Main.asp</a> .                                                                           |
| 2    | From Plan Central, select <b>Network Facility Inquiry</b> .                                                                                                                                                                                  |
| 3    | Use the descriptive fields to narrow your search requirements by network, facility number, specialty description, etc.<br><b>Note:</b> Laboratories can be found by selecting <b>Laboratory Medicine</b> in the specialty description field. |
| 4    | Click <b>Search</b> to return requested information.                                                                                                                                                                                         |

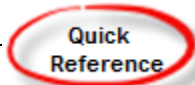
[What Is My Service Area?](#)

### Participating independent laboratory lists

NaviNet is the preferred Highmark tool for inquiring about participating providers; however, if you are not NaviNet-enabled, please click the links below for a list of designated independent lab providers. Please select the appropriate region-specific link below:

- [Pennsylvania Western Region Independent Labs](#)
- [Pennsylvania Central Region Independent Labs](#)
- [Pennsylvania Northeastern Region Independent Labs](#)
- [Delaware Independent Labs](#)
- [West Virginia Independent Labs](#)

If you are a provider who participates with Highmark and are interested or want more information about NaviNet, call the Provider Service Center for your service area.



## 4.5 LABORATORY MANAGEMENT PROGRAM

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### Overview

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 genetic counselors 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

Effective for dates of service beginning August 1, 2016, 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 [eviCore.com](http://eviCore.com), under **Online Forms and Resources**.

**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.
- 

*Continued on next page*

## 4.5 LABORATORY MANAGEMENT PROGRAM, Continued

### 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), and 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 **1-888-564-5492** 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.

NaviNet-enabled providers should use the NaviNet Authorization Submission transaction 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 NaviNet-enabled for authorization submission, you may use the eviCore Web Portal, available 24/7 at [evicore.com](http://evicore.com), to request authorizations.

Authorizations are valid for sixty (60) 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 **1-888-564-5492** 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.

*Continued on next page*

## 4.5 LABORATORY MANAGEMENT PROGRAM, Continued

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### Claims review requirements

Beginning August 1, 2016, 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](http://eviCore.com).

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### FOR MORE INFORMATION

For complete program information, please see the Laboratory Management Program page on the Provider Resource Center – select **CARE MANAGEMENT PROGRAMS**, and then **Laboratory Management Program**.

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## 4.5 SPECIAL PROGRAMS IN LUZERNE AND LACKAWANNA COUNTIES (PA ONLY)

[What Is My Service Area?](#)

### Introduction



Highmark recognizes the need to address regional community needs while maintaining provider network continuity and balance. The goal is to meet the needs of members through innovative programming within the network.

For members with HMO plans serviced by providers in the First Priority Health (FPH) network in Pennsylvania's Luzerne and Lackawanna counties, special programs for outpatient laboratory and radiology services meet their needs for access to high quality, cost-effective services.

For all other counties in the 13-county Northeastern Region service area, radiology and laboratory services for members with HMO plans serviced by the FPH provider network can be performed at any participating facility with a script from the ordering physician.

### Outpatient Laboratory Program



The outpatient laboratory program with Commonwealth Health Laboratory Services is for members whose FPH network primary care physician (PCP) is located within Lackawanna or Luzerne counties. Care must be coordinated with the member's FPH network PCP. The member needs only to take a physician's orders to a Commonwealth Health Laboratory for services.

Services included in this program are:

- Pre-admission testing;
- House calls; and
- Services associated with skilled nursing/personal care facilities.

Please see the [Commonwealth Health Laboratory Services](#) listing of laboratory sites, which includes addresses, hours, and telephone and fax numbers. This list is also available on the **Highmark Blue Shield Provider Resource Center** – select **EDUCATION/MANUALS**, and then **First Priority Health Network Resources**.

### Outpatient Radiology Program



For members with HMO coverage whose FPH network PCP is located within Luzerne County (excluding the Berwick and Hazelton areas), an outpatient radiology program provided in conjunction with Wilkes-Barre General Hospital renders integrated, high quality, and cost-effective care.

Care must be coordinated with the member's FPH network PCP. The member needs only to take a physician's orders to Wilkes-Barre General Hospital or one of

*Continued on next page*

## 4.5 SPECIAL PROGRAMS IN LUZERNE AND LACKAWANNA COUNTIES (PA ONLY), Continued

### Outpatient Radiology Program (continued)



its affiliated sites for services. For site locations, hours, and telephone numbers, please see the [Wilkes-Barre General Radiology Sites](#) list. This list is also available on the **Highmark Blue Shield Provider Resource Center** – select **EDUCATION/MANUALS**, and then **First Priority Health Network Resources**. Services for members in the remaining Luzerne County region can be obtained from any participating hospital facility.

Magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), and positron emission tomography (PET) scans are excluded from the capitated radiology program; however, they do require prior authorization. For a complete listing of radiology procedures that require authorization, please refer to the [Wilkes-Barre General Radiology Sites](#) list.

[What Is My Service Area?](#)

## 4.5 REPORTING PLACE OF SERVICE

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### **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

**Overview** 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 NaviNet® or by contacting Provider Service if you are not a NaviNet-enabled provider.

**Five categories of outpatient diagnostic services**

| ADVANCED IMAGING SERVICES: |                                                                                                                                                                                                                                                                                                                    |
|----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1                          | 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: |                                                                                                                                                                                                                                                                                                                    |
| 2                          | Standard Imaging Services – procedures such as skeletal X-rays, ultrasound, and fluoroscopy.                                                                                                                                                                                                                       |
| 3                          | 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.                                                      |
| 4                          | Laboratory and Pathology Services – procedures such as non-routine Papanicolaou (Pap) smears, blood tests, urinalysis, biopsies, and cultures.                                                                                                                                                                     |
| 5                          | Allergy Testing Services - allergy testing procedures such as percutaneous tests, intracutaneous tests, and patch tests.                                                                                                                                                                                           |

*Continued on next page*

## 4.5 COST SHARING ON OUTPATIENT DIAGNOSTIC SERVICES,

Continued

### 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 previous page), 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 also 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.

*Continued on next page*

## 4.5 COST SHARING ON OUTPATIENT DIAGNOSTIC SERVICES,

Continued

### Examples of multiple copayments and/or coinsurance (continued)

- 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 his 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), he 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.

**Quick Reference**

### Determining if members have cost sharing

More information on outpatient radiology and other diagnostic services cost sharing can be easily accessed through NaviNet, or by contacting the Provider Service Center if you are not a NaviNet-enabled provider.

To verify outpatient diagnostic benefits in NaviNet, select **Additional Benefit Provisions** from the Eligibility and Benefits detail page, and then **Outpatient Facility Services** from the pop-up box.

The screenshot displays the NaviNet member portal interface. At the top, it shows 'Member ID: XXXXXXXXXX', 'Group: XXXXXXXX ABC COMPANY', and 'Service Date: 03/06/2018'. The main content area is divided into three sections: 'INSURANCE DETAILS' (with a link to 'View Current Member ID Card'), 'PRIMARY CARE PROVIDER', and a list of links including 'Connect Blue HDHP EPO Provisions', 'View Previous Coverage', 'Additional Benefit Provisions' (highlighted with a red box), and 'Benefit Accumulator'. A pop-up box titled 'Additional Benefit Provisions' is open, showing a list of services: 'Inpatient Facility Services', 'Outpatient Facility Services' (highlighted in yellow), 'Behavioral Health/Substance Abuse', 'Professional Services', 'Professional Therapy and Rehabilitation Services', 'Routine/Preventive Care', 'Ancillary Services/Supplies', 'Other Reproductive Services (non Maternity)', 'Oral Surgery/Dental Accident', 'Educational & Medical Programs', 'Conditions', and 'Other Services'. A 'Close' button is at the bottom right of the pop-up.

## CHAPTER 4: PROVIDER RESPONSIBILITIES AND GUIDELINES

### UNIT 6: PRESCRIPTION DRUG PROGRAMS

#### IN THIS UNIT



| TOPIC                                                      | SEE PAGE |
|------------------------------------------------------------|----------|
| Pharmaceutical Overview                                    | 2        |
| Pharmaceutical Home Delivery                               | 4        |
| Drug Management                                            | 5        |
| Medical Injectable Drugs Program                           | 7        |
| Prescription Drugs for Medicare Advantage Hospice Patients | 9        |

[What Is My Service Area?](#)

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The PA ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The DE ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The WV ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

## 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](http://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 supply at the pharmacy and also through home delivery mail service.*

[What Is My Service Area?](#)

### 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 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.

*Continued on next page*



## 4.6 PHARMACEUTICAL OVERVIEW, Continued

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**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.

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**Telephone  
contact**

For pharmacy benefit questions, the Highmark Prescription Drug Department can be contacted at **1-800-600-2227** between 8:30 a.m. and 4:30 p.m., Monday through Friday.

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**FOR MORE  
INFORMATION**

This unit provides a brief overview of Highmark pharmacy benefit programs. To access all policies and updates, select **PHARMACY PROGRAM/FORMULARIES** from the main menu on the Provider Resource Center.

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## 4.6 PHARMACEUTICAL HOME DELIVERY

### Mail 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.*

[What Is My Service Area?](#)

### 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](http://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 **1-800-903-6228**.

## 4.6 DRUG MANAGEMENT

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### 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 **PHARMACY PROGRAM/FORMULARIES** from the main menu on the Provider Resource Center to access all policies and updates.

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*Continued on next page*

## 4.6 DRUG MANAGEMENT, Continued

### **Medical necessity 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:

- a. in accordance with generally accepted standards of medical practice;
- 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 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.

## 4.6 MEDICAL INJECTABLES DRUG PROGRAM

|                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Introduction</b>                        | Highmark has a streamlined program through which network physicians must obtain certain medical injectable drugs exclusively through Walgreens Specialty Pharmacy. In addition, Highmark has also delegated Walgreens Specialty Pharmacy to manage Highmark's authorization process required for certain drugs in the program.                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Drugs included in the program</b>       | <p>Highmark provides a <a href="#">list of drugs included in the program</a> that is reviewed regularly and updated as needed.</p> <p>This list is also available on the Provider Resource Center by selecting <b>PHARMACY PROGRAM/FORMULARIES</b> from the main menu, and then <b>Pharmacy Information</b>. On the program page, you will also find additional information, including referral forms by therapy/drug and the necessary information that you will need to provide to Walgreens Specialty Pharmacy when ordering.</p>                                                                                                                                                                                                         |
| <b>Certain drugs require authorization</b> | <p>Certain drugs on the Medical Injectable Drugs Program list require authorization.</p> <p>To determine if a drug from the program's list of drugs requires authorization, please refer to Highmark's <a href="#">List of Procedures/DME Requiring Authorization</a>.</p> <p>This list is also available on the Provider Resource Center under <b>CLAIMS, PAYMENT &amp; REIMBURSEMENT</b>. It can also be accessed quickly from the <b>Quicklinks Bar</b> by selecting <b>REQUIRING AUTHORIZATION</b>.</p>                                                                                                                                                                                                                                  |
| <b>Ordering drugs</b>                      | <p>Walgreens Specialty Pharmacy can be reached by calling <b>1-888-347-3416</b> to place an order. Walgreens Specialty Pharmacy bills Highmark and ships to the medical provider. Highmark does not reimburse network physicians for products included in the Medical Injectable Drugs Program. <b>Note:</b> Financial assistance resources are available to patients who qualify; delivery of the drug may be delayed if a patient seeks financial assistance.</p> <p>Walgreens Specialty Pharmacy is open seven days a week and offers several delivery options, monitoring of your refill needs, patient education and support, and has clinical pharmacists available 24 hours a day, seven days a week to answer patient questions.</p> |
| <b>BlueCard® patients</b>                  | 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.                                                                                                                                                                                                                                                                                                                                                                                                                  |

*Continued on next page*

## 4.6 MEDICAL INJECTABLES DRUG PROGRAM, Continued

### Obtaining authorization

**Authorizations must be obtained by the prescribing physician.** Walgreens Specialty Pharmacy will only accept authorizations by fax.

To obtain information and the authorization request form, physicians can call Walgreens Specialty Pharmacy's authorization department at **1-888-347-4894**.

### 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 Walgreens Specialty Pharmacy, regardless of where the drug is administered.  
Physicians are instructed to notify Walgreens Specialty pharmacy 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 the **Referral/Auth Inquiry** in NaviNet® to determine if the physician has obtained authorization.
- If an authorization is not present, please contact the ordering physician who must contact Walgreens Specialty Pharmacy 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 **Medical Injectable Drugs Program** page on the Provider Resource Center for additional information specific to your service area. From the main menu, select **PHARMACY PROGRAM/FORMULARIES**, and then click on **Medical Injectable Drugs Program**.

## 4.6 PRESCRIPTION DRUGS FOR MEDICARE ADVANTAGE HOSPICE PATIENTS

[What Is My Service Area?](#)

### Overview



As per guidance from the Centers for Medicare & Medicaid (CMS), Highmark requires authorization for select prescription medications for the treatment of a condition that is completely unrelated to a Medicare Advantage member's terminal illness or related condition when in a hospice election period.

### Drug list & authorization request form



Highmark maintains a [Hospice Drug List](#) of the prescription medications that require authorization for coverage under Medicare Part D during the hospice election period. **This list is applicable to prescription drugs provided for Medicare Advantage members for treatment of a condition that is unrelated to the member's terminal illness or related condition while in a hospice election period.**

Forms are also provided to complete and fax or mail your authorization requests:

- [PA Western Region Medicare Part D Prior Authorization Form](#)
- [PA Central Region Medicare Part D Prior Authorization Form](#)
- [West Virginia Medicare Part D Prior Authorization Form](#)

This list and authorization request forms are also available on the Provider Resource Center in your service area. To access, select **PHARMACY PROGRAM/FORMULARIES** from the main menu, and then **Pharmacy Information**.

### Documentation requirements



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. 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.

### IMPORTANT!



Per CMS guidelines, a hospice provider cannot request a coverage determination on behalf of the member.

## CHAPTER 5: CARE AND QUALITY MANAGEMENT

### UNIT 1: CARE MANAGEMENT OVERVIEW

#### IN THIS UNIT



| TOPIC                                          | SEE PAGE |
|------------------------------------------------|----------|
| Introduction to Care Management                | 2        |
| Components of the Care Management Program      | 3        |
| Partnership Vendors                            | 4        |
| Utilization Management <b>Updated!</b>         | 5        |
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| Case Management                                | 22       |
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#### What Is My Service Area?

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The PA ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The DE ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The WV ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.



## 5.1 INTRODUCTION TO CARE MANAGEMENT

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### Overview

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)
- Health Promotion
- 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.

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### 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.

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### Behavioral health

Additional information on the utilization processes and procedures specific to behavioral health can be located in [Chapter 5.4: Behavioral Health](#). For requirements and guidelines for behavioral health providers, please see [Chapter 4.2: Behavioral Health Providers](#).

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## 5.1 COMPONENTS OF THE CARE MANAGEMENT PROGRAM

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### 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.

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## 5.1 PARTNERSHIP VENDORS

### Partnerships enhance services

By partnering with vendors who provide expertise in specific care management services, Highmark is able to enhance the services provided to members. These vendors work in coordination with Highmark to provide a seamless, integrated program for Highmark members.

### eviCore Healthcare

Highmark's Radiation Therapy Authorization Program and Highmark's Laboratory Management Program are both administered by eviCore Healthcare, a specialty benefit management company.

Additional information on both programs can be found on the Provider Resource Center by selecting **CARE MANAGEMENT PROGRAMS** from the main menu.

### WholeHealth Networks, Inc.

Highmark has contracted with WholeHealth Networks, Inc. (WHN), a subsidiary of Tivity Health Support, LLC., (formerly "Healthways") to administer Highmark's Physical Medicine Management Program.

Additional information on Highmark's Physical Medicine Management Program can be located under **CARE MANAGEMENT PROGRAMS** on the Provider Resource Center.

[What Is My Service Area?](#)

### naviHealth



Highmark has partnered with naviHealth 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 naviHealth can be located on the Provider Resource Center – select **CARE MANAGEMENT PROGRAMS**, and then **Post-Acute Care Management for Medicare Advantage Members**.

### National Imaging Associates Inc. (NIA)

Highmark's Radiology Management Program is administered by National Imaging Associates Inc. (NIA), an affiliate of Magellan Health, Inc., and an accredited and certified radiology management organization.

Additional information on the program can be found on the Provider Resource Center under **CARE MANAGEMENT PROGRAMS**. In addition, limited information is also located in the Highmark Provider Manual's [Chapter 4.5: Outpatient Radiology and Laboratory](#).

## 5.1 UTILIZATION MANAGEMENT

|                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|-----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Overview</b>             | <p>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.</p> <p>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.</p> <p>Components of the utilization management process are described below.</p> |
| <b>Authorization</b>        | <p>An <b>authorization</b> 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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prior authorization</b>  | <p><b>Prior authorization</b> (also known as preservice review or precertification review) is the process by which <u>services requiring authorization</u> are evaluated against criteria for medical necessity and appropriateness prior to the receipt of services.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Pre-determination</b>    | <p><b>Pre-determination</b> is the process in which members or providers may request that <u>selected services that do not require authorization</u>, 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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Inpatient admissions</b> | <p>Requests for inpatient services are evaluated according to criteria for medical necessity, appropriateness, the most appropriate setting, and according to benefit availability. Authorization is required for all in-network inpatient services and required under all Highmark products whenever a member is admitted as an inpatient to any of the following facilities:</p> <ul style="list-style-type: none"> <li>• Acute Care</li> <li>• Long-Term Acute Care (LTAC)</li> <li>• Inpatient Rehabilitation Facility</li> <li>• Mental Health or Substance Abuse Treatment Facility</li> <li>• Skilled Nursing Facility(SNF)</li> </ul>                                                                                                                                                                                                                                                                                                                                                      |

*Continued on next page*

## 5.1 UTILIZATION MANAGEMENT, Continued

### 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 twenty-four (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 InterQual® criteria, 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.

*Continued on next page*

## 5.1 UTILIZATION MANAGEMENT, Continued

### 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. The provider has two (2) business days after notification of an authorization denial to initiate a peer-to-peer review for authorizations that are not Medicare Advantage. We will make the peer-to-peer conversation available within one (1) business day after receiving a request. 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, we will inform the provider and member of their appeal rights and procedures.

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.

Effective September 12, 2017, the peer-to-peer review option prior to a pending denial decision is no longer available for Medicare Advantage. Elimination of the Medicare Advantage peer-to-peer review process will result in more timely and efficient processing of authorization requests. With notification of a denial decision, providers and members will continue to be informed of their appeal rights and procedures.

**Note:** For additional information on initiating a peer-to-peer conversation, please see the manual's [\*\*Chapter 5.5: Denials, Grievances, and Appeals\*\*](#).

[Why blue italics?](#)

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## 5.1 UTILIZATION MANAGEMENT, Continued

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### 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.

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### 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 to consulting psychiatrists for consultation on individual cases.

For more information on behavioral health authorizations, please see [Chapter 5.4: Behavioral Health](#).

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## 5.1 ACCESS TO MEDICAL MANAGEMENT SERVICES

### Overview

**NaviNet®** 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 through the Automated Care Management (ACM) application. Other functionality available in NaviNet related to utilization management includes discharge planning, referrals to Case Management, and inquiry functions to confirm status of your authorization requests.

When NaviNet is not available or for non-routine inquiries that cannot be handled through NaviNet, Clinical Services can be contacted.

[What Is My Service Area?](#)

### Clinical Services telephone availability

Clinical Services may be contacted by telephone when NaviNet is unavailable or for questions/issues that cannot be handled through NaviNet.

#### PENNSYLVANIA

- Medical Services:
  - o Western Region
    - Facilities: **1-800-242-0514**
    - Professional Providers: **1-800-547-3627**
  - o Central Region
    - Facilities: **1-866-803-3708**
    - Professional Providers: **1-866-731-8080**
  - o Northeastern Region: **1-800-452-8507**
- Behavioral Health Services:
  - o Western & Northeastern Regions: **1-800-258-9808**
  - o Central Region: **1-800-628-0816**
- Medicare Advantage:
  - o Freedom Blue PPO: **1-866-588-6967**
  - o Community Blue Medicare HMO: **1-888-234-5374**
  - o Community Blue Medicare PPO and Plus PPO: **1-866-588-6967**
  - o Security Blue HMO (Western Region only): **1-866-517-8585**

#### DELAWARE

- Medical Services: **1-800-572-2872**
- Behavioral Health Services: **1-800-572-2872**

#### WEST VIRGINIA

- Medical Services: **1-800-344-5245**
- Behavioral Health Services: **1-800-344-5245**
- Medicare Advantage Freedom Blue PPO: **1-800-269-6389**

#### Hours of Availability:

- Monday through Friday -- 8:30 a.m. to 7 p.m.
- Saturday and Sunday -- 8:30 a.m. to 4:30 p.m. (limited staffing for urgent requests)



## 5.1 CRITERIA FOR MEDICAL MANAGEMENT DECISIONS

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### Introduction

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, corporate 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.

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### Definition: Medically necessary

Except where any applicable law, regulation, or government body requires a different definition (i.e., the Federal Employees Health Benefits Program, 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 in any provider contract shall mean health care services (or such similar term as contained in the applicable benefit agreement or plan document to include, but not be limited to, “health services and supplies,” “services and supplies,” and/or “medications and 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;
  - 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 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.
- 

### 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.

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## 5.1 CRITERIA FOR MEDICAL MANAGEMENT DECISIONS, Continued

### Criteria used

The Medical Utilization Management staff uses the following criteria, guidelines and policies:

- InterQual® Level of Care Criteria
- Highmark Medical Policy
- Highmark Medicare Advantage Medical Policy
- American Society of Addiction Medicine (ASAM) criteria

### InterQual®

The InterQual Levels of Care provide 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 InterQual Criteria. The InterQual Criteria are embedded into the Automated Care Management (ACM) application in NaviNet.

**Note:** For more information on the ACM application via NaviNet, please see the applicable section in [Chapter 5.2: Authorizations](#).

### 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.

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## 5.1 CRITERIA FOR MEDICAL MANAGEMENT DECISIONS, Continued

### Highmark Medical Policy (continued)

Both Highmark Medical Policies and Highmark Medicare Advantage Medical Policies are available on the Provider Resource Center under **CLAIMS, PAYMENT & REIMBURSEMENT**.

Additional information regarding Medical Policy may also be found in the **Highmark Medical Policy** section of this unit.

### Clinical judgment

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 Committee (CMC). The CMC 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 at [www.fepblue.org](http://www.fepblue.org). Select the **Benefit Plans** tab, and then click on **Brochures & Forms** to access the *FEP Medical Policy Manual*.

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 DECISIONS

### 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 InterQual® Criteria 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.

### FOR MORE INFORMATION

Please see [Chapter 5.4: Behavioral Health](#) for additional information on medical necessity criteria for behavioral health services.

## 5.1 HIGHMARK MEDICAL POLICY

### Overview

Medical policies are documents that provide medical necessity and coverage guidelines for all of 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 in Pennsylvania and West Virginia. Please see [Chapter 5.3: Medicare Advantage Procedures](#) for additional information.

[What Is My Service Area?](#)

### 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

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## 5.1 HIGHMARK MEDICAL POLICY, Continued

### Medical Policy development (continued)

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 of these sources.

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.

### 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 the Centers for Medicare & Medicaid Services.

### Determining medical policy criteria

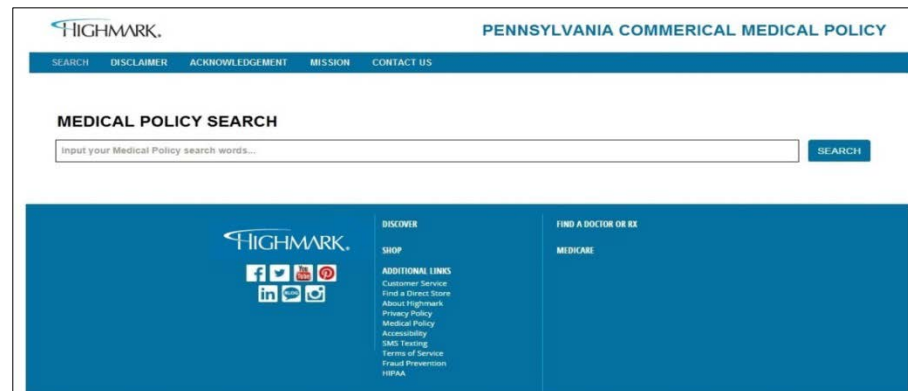
Facilities must coordinate with the ordering and/or performing provider before the date of service. The facility should work with the ordering and/or performing provider, as necessary, to ensure medical policy criteria are met. Alternatively, the facility can initiate an inquiry through the Provider Service Center if there are concerns about whether the facility services to be performed meet applicable Highmark medical policy criteria.

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## 5.1 HIGHMARK MEDICAL POLICY, Continued

### Accessing Highmark's medical policies

Highmark's commercial and Medicare Advantage medical policies are accessed on the Provider Resource Center under **CLAIMS, PAYMENT & REIMBURSEMENT**. Select **Medical Policy**, and then the medical policy type – **Highmark Medical Policy** or **Medicare Advantage Medical Policy**. And then click on the **Medical Policy Search** link to access the search feature:



Medical policy may differ in our 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 **NEWSLETTERS/NOTICES** on the Provider Resource Center.

In addition, you can sign up for "e-Subscribe" and receive a monthly email notification when the latest issue of Medical Policy Update is published. To subscribe, select **NEWSLETTERS/NOTICES** from the main menu on the Provider Resource Center, and then click on **E-Subscribe For Publications And Notifications**.

### 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.

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## 5.1 HIGHMARK MEDICAL POLICY, Continued

### 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.

### Conflicts

In 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 at [fepblue.org](http://fepblue.org). Select the **Benefit Plans** tab, and then click on **Brochures & Forms** to access the FEP Medical Policy Manual.

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

### Policy

**Non-covered services include those 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, at all times, 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 into 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 REQUEST

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|-----------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Introduction</b>                           | 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.                                                                                                                                                                                                                                                                                                                  |
| <b>When medical records are requested</b>     | <p>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.</p> <p>The medical record requests are made in writing. The request is addressed to the attention of the hospital's Medical Records Department.</p>                                          |
| <b>Minimum necessary standards</b>            | 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.                                                                                                                                                                                                                                                                         |
| <b>Confidentiality</b>                        | 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.                                                                                                                                                                                                         |
| <b>Provider responsibility for timeliness</b> | <p>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.</p> <p>For this reason, it is important for providers to provide all relevant medical records within the time frame stipulated in the written request. <b>Lack of response or a late response to the request for medical records may result in a denial of payment.</b></p> |
| <b>Non-reimbursement policy</b>               | According to Highmark policy, Highmark does <b>not</b> reimburse participating network providers for supplying medical records to Highmark.                                                                                                                                                                                                                                                                                                                                                    |

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## 5.1 MEDICAL RECORDS REQUEST, Continued

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### **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 (10) 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 [Chapter 2.6: The BlueCard Program](#).

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## 5.1 MEMBER CONSENT FOR RELEASE OF MEDICAL RECORDS

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**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.

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**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

### Overview

Highmark's Health Management Services (HMS) 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 Health Coaches, 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.

[What Is My Service Area?](#)

### 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 HMS health coaching staff at:

- Pennsylvania: **1-800-596-9443**
- Delaware: **1-800-572-2872**
- West Virginia: **1-800-344-5245**; for Medicare Advantage Freedom Blue PPO, please call **1-800-269-6389**

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

*Continued on next page*

## 5.1 CASE MANAGEMENT, Continued

### Provider referrals for case management (continued)

- 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 health coaching staff uses clinical, utilization, and predictive modeling 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 Health Coach. Case management is a voluntary program and requires the member's consent. If the member is accepted into the program, the assigned Health Coach will contact the member and/or the member's family, when necessary, to obtain permission for 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.

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## 5.1 CASE MANAGEMENT, Continued

### Health Coach responsibilities

The Health Coach is responsible for the following:

- Contacting the member and his or 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 or her providers

Health Coaches 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 Health Coaches 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 amongst providers
- Communication of adverse situations to the physician or service provider
- Evaluation and assistance with financial concerns
- Assessment and assistance with advanced care planning
- Information related to available community resources such as self-help support groups and other similar services

## 5.1 CONDITION MANAGEMENT

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### **What is condition management?**

Condition management programs focus on improving the outcomes of members identified with chronic illnesses by improving their self-management skills and understanding of their illness and treatment options.

Once the member chooses to participate, they are enrolled in a program specific to their needs. Members may provide consent to allow the Health Coach 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 Health Coaches**

Health Coaches are available to receive inbound calls twenty-four (24) hours a day, seven (7) days a week. Health Coaches 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.

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## 5.1 CONDITION MANAGEMENT, Continued

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### **Primary goals of condition managment**

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 BLUE DISTINCTION PROGRAMS

### Overview

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

Blue Distinction Center

Blue Distinction Center+

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+.

*Continued on next page*

## 5.1 BLUE DISTINCTION PROGRAMS, Continued

### Blue Distinction Specialty Care (continued)



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
- Cardiac care
- Cancer care
- Knee and hip replacement
- Maternity care
- Spine surgery
- Transplants

In 2019, new fertility care and gene therapy programs will be launched.

### 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.

*Continued on next page*

## 5.1 BLUE DISTINCTION PROGRAMS, Continued

### Blue Distinction Specialty Care benefit designs (continued)

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.

To verify in NaviNet®, select **Additional Benefit Provisions** on the *Eligibility and Benefits Detail* page, and then select the **Other Services** benefit category from the pop-up box.

### 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's public websites. 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](#).

## CHAPTER 5: CARE AND QUALITY MANAGEMENT

### UNIT 2: AUTHORIZATIONS

#### IN THIS UNIT



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[What Is My Service Area?](#)

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The PA ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The DE ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The WV ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

## 5.2 INTRODUCTION

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### Overview

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 and, when applicable, is in the highest benefit tier.

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.

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### 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. 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.

---

## 5.2 AUTHORIZATION GUIDELINES

### Introduction

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."

### 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.

[What Is My Service Area?](#)

### 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 McKesson Health Solution's InterQual® criteria in the processes for assessing medical necessity and appropriateness of services. The InterQual criteria are applied to assessment of 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 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](#).

*\* Medicare Advantage products are available only in Pennsylvania and West Virginia.*

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## 5.2 AUTHORIZATION GUIDELINES, Continued

### Electronic authorization requests

NaviNet® is the preferred method for submitting authorization requests to Highmark. Authorizations may be requested through NaviNet or by submitting a HIPAA 278 electronic transaction. Electronic authorization requests are the preferred method and are quick and easy to perform.

To learn more about how to request authorizations via NaviNet, access the **NaviNet Support** page by clicking on **Help** on the toolbar at the top of the NaviNet screen.

For a HIPAA 278 transaction, refer to the **Provider EDI Reference Guide** accessible from the Provider Resource Center:

- Select **CLAIMS, PAYMENT & REIMBURSEMENT** from the main menu, and then **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 NaviNet 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.

*Continued on next page*



## 5.2 AUTHORIZATION GUIDELINES, Continued

### 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 NaviNet® 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

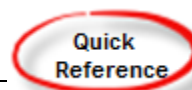
Highmark reserves the right to request and review medical records for visits whether or not authorization is required. If such review determines that any or all treatments were not medically necessary, were not billed appropriately, or were not performed, a refund will be requested. If a refund is requested, the provider may not bill the member for the services.

*Continued on next page*

## 5.2 AUTHORIZATION GUIDELINES, Continued

### **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 and authorization inquiry in NaviNet. If not NaviNet-enabled, call Clinical Services at the phone number for your service area.



### **Failure to obtain an authorization**

Failure to preauthorize or precertify 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).

## 5.2 SERVICES REQUIRING AUTHORIZATION

### Introduction

Highmark products, including Medicare Advantage, require authorization for all inpatient admissions and select outpatient services, drugs, and equipment. The following circumstances are representative of those 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



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](#).

[What Is My Service Area?](#)

### Inpatient admissions

Authorization is required for all in-network 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 forty-eight (48) hours for vaginal delivery and ninety-six (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 nonroutine or emergency admissions for maternity care, such as admissions for hyperemesis, preterm labor, placenta previa, and preeclampsia.

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## 5.2 SERVICES REQUIRING AUTHORIZATION, Continued

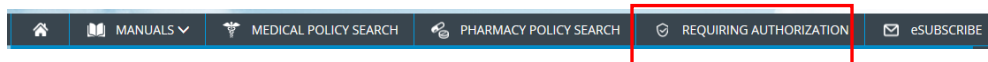
### List of Procedures/ DME Requiring Authorization

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 through **Special Bulletins**. The list includes services such as:

- Behavioral health intensive outpatient and partial hospitalization
- 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, PAYMENT & REIMBURSEMENT** from the main menu, and then **Procedure/Service Requiring Prior Authorization**.

For quick access to The List of Procedures/DME Requiring Authorization, click on the **REQUIRING AUTHORIZATION** tab on the Quicklinks Bar at the top on the Provider Resource Center:



**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 NaviNet® **Eligibility and Benefits Inquiry** or the applicable HIPAA electronic transaction for benefit verification.

[What Is My Service Area?](#)

### 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 **CARE MANAGEMENT PROGRAMS**, and then click on the **Physical Medicine Management Program** link for details on this program. The program applies to physical and occupational therapy and manipulation services in Pennsylvania and West Virginia. In Delaware, the program is for physical and occupational therapy services.

*Continued on next page*

## 5.2 SERVICES REQUIRING AUTHORIZATION, Continued

### Outpatient non-emergent diagnostic imaging

Additional information on select advanced outpatient diagnostic imaging procedures that require authorization can be found on the Provider Resource Center – select **CARE MANAGEMENT PROGRAMS** from the main menu on the left, and then **Radiology Management Program**.

### Radiation Therapy Authorization Program

Additional information on radiation therapy services that require prior authorization can be found on the Provider Resource Center. Select **CARE MANAGEMENT PROGRAMS**, and then **Radiation Therapy Authorization Program**.

[What Is My Service Area?](#)

### Post-acute care management for Medicare Advantage members



Highmark has a partnership with naviHealth, a national post-acute care management company, to bring a personalized approach to support its Medicare Advantage members. According to patient needs, naviHealth 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 **CARE MANAGEMENT PROGRAMS**, and then **Post-Acute Care Management For Medicare Advantage Members**.

### Laboratory Management Program for molecular and genomic testing

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 **CARE MANAGEMENT PROGRAMS**, and then **Laboratory Management Program**.

## 5.2 AUTHORIZATION REQUEST PROCESS

### Introduction

Authorization requests should be submitted at least fourteen (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 and admissions related to childbirth, the provider or member must contact Highmark within forty-eight (48) hours after the emergency admission or for lengths of stay longer than forty-eight (48) hours after a vaginal delivery or ninety-six (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 NaviNet'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.

*Continued on next page*

## 5.2 AUTHORIZATION REQUEST PROCESS, Continued

### Electronic submission preferred

**Electronic submission is the preferred method for requesting authorization.** If NaviNet®-enabled, the request must be submitted via NaviNet.

[What Is My Service Area?](#)

### Process

The authorization request process is as follows:

| STEP                    | ACTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>1<br/>Submission</b> | Submit the required information via NaviNet or HIPAA 278. <ul style="list-style-type: none"> <li>• <b>NaviNet:</b> The user is guided through the steps.</li> <li>• <b>HIPAA 278 transaction:</b> For information about using the transaction, refer to the <b>Provider EDI Reference Guide</b>.*</li> </ul>                                                                                                                                                                                                                                                                                                |
| <b>2<br/>Review</b>     | 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.                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>3<br/>Decision</b>   | Following review, Clinical Services either authorizes or denies coverage for the request. <ul style="list-style-type: none"> <li>• If the request is approved, you will be notified through the <b>Referral/Authorization Inquiry</b> in NaviNet or through your practice's software. If you do not have access to NaviNet, you will receive a paper report through the mail.</li> <li>• 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.</li> </ul> |

\* 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

In Pennsylvania, home health care providers must use NaviNet to submit authorization requests. Please see the next section of this unit -- **NaviNet Home Health Authorization Submission (PA Only)**.

In Delaware and West Virginia, 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 from the **Faxable Authorization Request Forms** section of this unit. And it is also available on the Provider Resource Center – select **FORMS** from the main menu, and then **Miscellaneous Forms**.

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## 5.2 AUTHORIZATION REQUEST PROCESS, Continued

[What Is My Service Area?](#)

### Telephone requests

If you are not electronically-enabled, you may contact Clinical Services by calling the applicable phone number for your service area.

#### PENNSYLVANIA:

- Western Region:
  - o Facilities: **1-800-242-0514**
  - o Professional Providers: **1-800-547-3627**
- PA Central & Northeastern Regions:
  - o Facilities: **1-866-803-3708**
  - o Professional Providers: **1-866-731-8080**
- Medicare Advantage:
  - o PA Medicare Advantage Freedom Blue PPO: **1-866-588-6967**
  - o Community Blue Medicare HMO: **1-888-234-5374**
  - o Community Blue Medicare PPO and Plus PPO: **1-866-588-6967**
  - o Security Blue HMO (Western Region only): **1-866-517-8585**

**DELAWARE: 1-800-572-2872**

**WEST VIRGINIA: 1-800-344-5245; Freedom Blue PPO: 1-800-269-6389**

#### BEHAVIORAL HEALTH SERVICES:

- PA Western Region: **1-800-258-9808**
- PA Central, Eastern, & Northeastern Region: **1-800-628-0816**
- Delaware: **1-800-421-4577**
- West Virginia: **1-800-344-5245; Freedom Blue PPO: 1-800-269-6389**

### IMPORTANT! Federal Employee Program (FEP)

**Authorization requests for Federal Employee Program (FEP) members cannot be submitted via NaviNet.** Please follow the guidance below for calling 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:
  - o **Pennsylvania's Western & Northeastern Regions, Delaware, and West Virginia** – Highmark participating providers should contact their local Highmark plan for authorization for inpatient admissions.
  - o **Pennsylvania's 21-county Central Region** – providers participating with Capitol Blue Cross would request authorization for inpatient admissions from Capitol Blue Cross.

FEP applies a \$500 penalty if an authorization is not obtained for an inpatient hospital admission. However, the penalty is imposed on the provider – in the form of reduced payment. The provider may not bill this amount to the member.



## 5.2 HOME HEALTH NAVINET AUTHORIZATION SUBMISSIONS (PA ONLY)

[What Is My Service Area?](#)

### Overview



Effective August 1, 2016, participating home health care providers in Pennsylvania must use the home health care authorization request submission process through Highmark's NaviNet® provider portal. This process is applicable **for all Pennsylvania commercial and Medicare Advantage products.**

### Provider advantages



The advantages of the home health care authorization process in NaviNet include:

- **Automation:** The interactive application allows for more “automation” as compared to the previous home health authorization process.
- **Consistency:** The use of clinical quality outcomes data provides consistency in how criteria are applied across all network home health agencies.
- **Reduced Response Time:** The approval response occurs within minutes rather than days.
- **Efficiencies:** The average submission time has been reduced from a thirty (30) minute average to a five (5) minute average submission time.

### Requirements



Using NaviNet, the following is required to be submitted:

- An Outcome and Assessment Information Set (OASIS) File upload
- The CMS-485 form

**Note:** Highmark no longer requires providers to complete the Home Health Survey.

### Helpful resources available



Please review the following webinar and helpful documents for additional information:

- [Home Health Prior Authorization Process Change](#) - Providers are highly encouraged to view this online webinar.
- [Home Health Process Change Guide](#)
- [Home Health Authorization FAQs](#)
- [Home Health Authorization Tips: OASIS File Overview](#)

These resources are also available on the Provider Resource Center. Select **Provider Training** from the main menu, and then **Provider Training** again. Scroll to the **Informational Training and Documentation** section -- **Home Health Authorizations** is the third bullet in this category.

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## 5.2 HOME HEALTH NAVINET AUTHORIZATION SUBMISSIONS (PA ONLY), Continued

**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 the NaviNet **Eligibility and Benefits Inquiry** or through the applicable HIPAA electronic transactions.

**NaviNet  
Customer  
Care**



For technical process issues pertaining to home health care authorization submissions, please telephone a NaviNet Customer Care Representative at **1-888-482-8057**.

[What Is My Service Area?](#)

**Provider  
Service  
Center**



For general questions and inquiries about the new home health care authorization process, please contact the facility Provider Service Center:

- Pennsylvania Western Region: **1-800-242-0514**
- Pennsylvania Central & Northeastern Regions: **1-866-803-3708**

## 5.2 INPATIENT ADMISSIONS

### Introduction

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 fourteen (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.

**For emergency (urgent, unplanned) admissions, the provider or member must contact Highmark no later than forty-eight (48) hours after admission to be considered timely notification.**

### Submitting a request for authorization

Facilities should submit authorization requests for medical and behavioral health inpatient admissions via the Automated Care Management (ACM) application in NaviNet®. **Please see the next section of this unit for information on the ACM application in NaviNet.**

If either NaviNet 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 the **Eligibility and Benefits** transaction via NaviNet.

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## 5.2 INPATIENT ADMISSIONS, Continued

### 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, step-by-step instructions for submitting behavioral health authorization requests via NaviNet are available in the [Behavioral Health ACM Authorization Submission Manual](#). This manual is also available on the Provider Resource Center under **EDUCATION/MANUALS**.

[What Is My Service Area?](#)

### 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 AUTOMATED CARE MANAGEMENT (ACM)

### **What is Automated Care Management (ACM)?**

Automated Care Management (ACM) is an automated process which allows facilities to submit authorization requests for medical and behavioral health inpatient care and inpatient/post-acute transfers via NaviNet® using interactive InterQual® Criteria. NaviNet can also be used for submitting behavioral health intensive outpatient and partial hospitalization authorization requests.

Certain authorization requests for acute inpatient care meeting InterQual criteria may be authorized immediately, via the system. Other inpatient requests will pend for additional review by Clinical Services.

### **Important: Observation services**

ACM is not to be used for observation services. Do not submit admission requests until it is clear that the patient requires inpatient admission.

### **ACM exclusions**

ACM cannot be used to submit authorization requests for members with coverage under the Federal Employee Program (FEP), or members from another Blue Plan (BlueCard).

### **Highmark's expectation of facilities**

Highmark expects that NaviNet-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 ACM.

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.

### **Interventions triggered by the ACM surveys**

ACM is designed to simplify the administrative process while continuing to collect relevant clinical data for post-discharge and case management activities. Some of the interventions triggered by the survey information include referrals to Health Coaches.

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## 5.2 AUTOMATED CARE MANAGEMENT (ACM), Continued

### Admission Survey

The Admission Survey is presented immediately following the InterQual section of the ACM application on NaviNet during the initial request for authorization of an acute inpatient admission. At that time, the facility should be prepared to provide the following information:

- Patient history and any co-morbid conditions
- Re-admissions within thirty (30) days
- Social situation
- Any special needs
- Any assistance needed from Clinical Services in discharge planning

### Accessing the Admission Survey

After submission, the Admission Survey can be viewed through the NaviNet **Referral/Authorization Inquiry** application. Identify the admission in question, and then click on the **Survey** button.

### 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 (5) or more days, and also 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 through ACM via NaviNet for **post-acute transfers** to long-term acute care hospitals, acute rehabilitation hospitals, and skilled nursing facilities.

Submitting authorization requests through NaviNet for these transfers follows a similar process to the steps which are used for acute inpatient hospital admissions. There are two main differences:

1. The Clinical Comments section on the NaviNet screen **must** be completed for post-acute transfers.
2. All authorization requests for post-acute transfers will pend for review by a Highmark Care Manager, regardless of whether or not post-acute InterQual criteria have been met.

*Continued on next page*

## 5.2 AUTOMATED CARE MANAGEMENT (ACM), Continued

### 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.

[What Is My Service Area?](#)

### 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 resources for ACM

Detailed information on how to use the ACM tool via NaviNet is available on the Provider Resource Centers in Pennsylvania and West Virginia.

- Pennsylvania: Select **Provider Training**, and then **Provider Training** again.
- West Virginia: Select **EDUCATION/MANUALS**, and then **Provider Training**.

On the Provider Training page, scroll to the **Informational Training and Documentation** section, and then to **Introduction to Automated Care Management**.

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## 5.2 AUTOMATED CARE MANAGEMENT (ACM), Continued

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### **Additional resources for ACM** (continued)

In addition, the [Behavioral Health ACM Authorization Submission Manual](#) provides instruction for submitting authorization requests through NaviNet for behavioral health inpatient, intensive outpatient, and partial hospitalization services. This manual is available under **EDUCATION/MANUALS** on the Provider Resource Center in all service areas.

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## 5.2 DISCHARGE PLANNING

|                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|---------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Definition:<br/>Discharge<br/>planning</b>     | Highmark initiates discharge planning at the beginning of an admission in order to facilitate a coordinated transition to the next level of care. Discharge planning involves coordination and collaboration among providers, the health plan, the member, and/or the member's family.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>When<br/>discharge<br/>planning<br/>begins</b> | The discharge planning process ideally begins prior to a scheduled admission or at the time of an emergency admission. The initial discharge plan is reassessed throughout the member's stay.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Objectives<br/>of discharge<br/>planning</b>   | <p>The objectives of discharge planning are to:</p> <ul style="list-style-type: none"> <li>• Promote a safe and effective transition of care, especially when the transition is to home</li> <li>• Promote, when appropriate, the use of alternative levels of care</li> <li>• Direct members within the participating provider network</li> <li>• Arrange for the provision of care in an appropriate alternative cost-effective setting (e.g., skilled nursing or inpatient rehabilitation facility, home care, outpatient services) with an ongoing assessment of continued need</li> <li>• Provide early identification of members who may be candidates for case management or condition management programs</li> <li>• Collaboratively develop and implement appropriate discharge plans with the treating provider</li> </ul> |
| <b>Discharge<br/>planning<br/>tool</b>            | <p>The Discharge Planning Information survey is available through the Automated Care Management (ACM) function via NaviNet®. Acute care facilities are required to complete the tool for members at the time of the initial inpatient authorization request and with subsequent continued stay reviews.</p> <p>The purpose of the Discharge Planning Information survey is to assess the need for assistance in discharge planning. It also provides feedback which can help to identify members who may benefit from referrals to Case Management or Condition Management programs.</p>                                                                                                                                                                                                                                             |
| <b>Completing<br/>the Discharge<br/>Survey</b>    | <p>The ACM Discharge Survey is to be completed at or immediately following discharge. The facility should be prepared to provide the following information:</p> <ul style="list-style-type: none"> <li>• Discharge date</li> <li>• Discharge Disposition</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

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## 5.2 DISCHARGE PLANNING, Continued

### Coordinating the discharge plan

The hospital is normally responsible for coordinating the discharge plan for the member. Facilities are encouraged to contact Clinical Services for assistance whenever complex cases are identified.

Clinical Services can assist in: coordinating services, including transfers to other facilities; referrals to Case Management and Condition Management programs; and evaluation of available community resources, as appropriate.

### When Clinical Services assists

When Clinical Services is asked to assist in the discharge planning process, the facility should be able to provide and discuss the following information as it pertains to the member:

- Level of function, pre- and post-service
- Ability to perform self-care activities
- Primary caregiver and support system
- Living arrangements, pre- and post-service
- Psychosocial needs of the member and the member's caregiver
- Special equipment, medication, dietary needs, safety needs, and/or obstacles to care
- Needs requiring referral to Case Management or Condition Management

### Behavioral health

For additional information on discharge planning for behavioral health, please see [Chapter 5.4: Behavioral Health](#).

[What Is My Service Area?](#)

### Additional requirements 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.

**Note:** For more information on these special processes for Medicare Advantage members, please refer to [Chapter 5.3: Medicare Advantage Procedures](#).

## 5.2 CONCURRENT REVIEW

### When is concurrent (continued stay) 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 NaviNet®-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.

*Continued on next page*

## 5.2 CONCURRENT REVIEW, Continued

### 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](#).

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### Time frame

Decisions regarding inpatient concurrent review are made **within twenty-four (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, if 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.

*Continued on next page*

## 5.2 CONCURRENT REVIEW, Continued

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**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.

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**Behavioral health**

For more information on concurrent review for behavioral health, please see [Chapter 5.4: Behavioral Health](#).

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## 5.2 RETROSPECTIVE REVIEW

### Introduction

**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:

[What Is My Service Area?](#)

| 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 <b>will reject</b> this claim.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 2    | <p>When the claim denial notification is received (via the remittance advice), submit pertinent clinical information with a cover letter explaining the circumstances to the following address:</p> <p><b>PENNSYLVANIA:</b><br/> Highmark<br/> Medical Review<br/> P.O. Box 890392<br/> Camp Hill, PA 17089-0392</p> <p>PA Central Region outpatient claims only:<br/> Medical Review<br/> P.O. Box 890035<br/> Camp Hill, PA 17089-0035</p> <p><b>DELAWARE:</b><br/> Highmark BCBSDE, Inc.<br/> Medical Management<br/> Retrospective Reviews<br/> P.O. Box 1991<br/> Del Code 1-8-40<br/> Wilmington, DE 19899-1991</p> <p><b>WEST VIRGINIA:</b><br/> Highmark West Virginia<br/> Attn.: Medical Review<br/> P.O. Box 1948<br/> Parkersburg, WV 26102</p> <p><b>Behavioral Health</b> (all service areas):<br/> Highmark Clinical Services<br/> Attn.: Behavioral Health<br/> 120 Fifth Ave., Suite P4205<br/> Pittsburgh, PA 15222</p> |

*Continued on next page*

## 5.2 RETROSPECTIVE REVIEW, Continued

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**Time  
frame**

Retrospective reviews are completed **within thirty (30) calendar days** of receipt of the facility's request. If MM&Q requires additional information, the request will be made within forty-eight (48) hours after receiving the request for retrospective review.

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**Behavioral  
health**

For more information on retrospective review specific to behavioral health services, please refer to [Chapter 5.4: Behavioral Health](#).

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## 5.2 TIME FRAMES FOR AUTHORIZATIONS

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### **Preservice determinations**

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:

- Seventy-two (72) hours after receipt of the request in cases involving urgent care; or
- Fourteen (14) 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 fourteen (14) days. 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 forty-five (45) days to provide the specified information.

---

### **Concurrent review determinations**

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:

- Twenty-four (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
- Seventy-two (72) hours after receipt of the request if it is a case involving urgent care and the request was received fewer than 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.

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*Continued on next page*



## 5.2 TIME FRAMES FOR AUTHORIZATIONS, Continued

### Retrospective review determinations

For retrospective reviews, Highmark will provide notification of our determination within thirty (30) calendar days of receipt of the request. If Medical Management & Quality (MM&Q) requires additional information, the request will be made within forty-eight (48) hours after receiving the request for retrospective review.

This 30-day time frame may be extended one time for up to fifteen (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 forty-five (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. The 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;
- 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

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### Overview

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 NaviNet®, there are certain instances when Highmark allows requests to be made via fax.

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### Forms

The following faxable precertification/authorization forms are available:

- [Bariatric Surgery Precertification Worksheet](#)
- [Discharge Notification Form](#)
- [Discharge Summary Fax Template](#) (Behavioral health)
- [Home Health Precertification Worksheet](#)
- [Inpatient Authorization Request Form](#) (Hospital)
- [Long-Term Acute Care Facility Precertification Worksheet](#)
- [Outpatient Authorization Request Form](#)
- [Rehabilitation Precertification Worksheet](#) (Inpatient)
- [Skilled Nursing Facility Precertification Worksheet](#)

Completed authorization request forms should be **faxed** to the fax numbers designated on the forms. Please take note that some forms have designated fax numbers for specific service areas – be careful to fax to the correct number to avoid any delays.

These forms are also available on the Provider Resource Center – select **FORMS**, and then **Miscellaneous Forms**. For the Behavioral Health fax template, select **FORMS**, and then **Behavioral Health 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.

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*Continued on next page*

## 5.2 FAXABLE AUTHORIZATION REQUEST FORMS, Continued

### 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** requests are completed within seventy-two (72) hours of receipt.
- **Urgent concurrent** requests are completed within twenty-four (24) hours of receipt.
- **Non-urgent** requests are completed within fourteen (14) days of receipt.

### 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 NaviNet first to see if an authorization is still required.
- Outpatient authorization requests have a sixty (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 NaviNet for status updates!

Please use NaviNet to check on the status of your authorization request, as the most up-to-date status will be viewable in NaviNet.

If you are not yet NaviNet-enabled, visit [navinet.net](http://navinet.net) to learn more about obtaining access to the system.

## 5.2 PRESERVICE DENIALS

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**Introduction** 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.

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**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 it is 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.

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*Continued on next page*

## 5.2 PRESERVICE DENIALS, Continued

### 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.

[What Is My Service Area?](#)

### 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

### Emergency medical care defined

Emergency medical care is the treatment of bodily injuries resulting from an accident, following the sudden onset of a medical condition or following, in the case of a chronic condition, a sudden or unexpected medical event that manifests itself with 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 that the absence of immediate medical attention to result in one or more of the following:

- a. placing the health of the member or, with respect to a pregnant woman, the health of the woman or the unborn child, in serious jeopardy;
- b. causing other serious medical consequences;
- c. causing serious impairment to bodily functions; or
- d. causing serious dysfunction of any bodily organ or part.

### 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, authorization is required within forty-eight (48) hours of the admission.

### 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

|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Introduction</b>                                      | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Definition:<br/>Experimental/<br/>investigational</b> | The term <b>experimental/investigational</b> 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Highmark<br/>Medical<br/>Policy</b>                   | <p>Highmark determines an intervention to be experimental/investigational based on one or more of the following reasons:</p> <ul style="list-style-type: none"> <li>• The service does not have FDA approval;</li> <li>• Based on scientific evidence, the service does not impact or improve health outcomes;</li> <li>• Scientific evidence does not demonstrate the efficacy of the service; and/or</li> <li>• The service is still being performed in a clinical trial setting with no long-term outcomes available.</li> </ul> <p><b>Note:</b> Providers need to always follow Highmark Medical Policy. To access medical policies, select <b>CLAIMS, PAYMENT &amp; REIMBURSEMENT</b> from the main menu on the Resource Center, and then <b>Medical Policy</b>.</p> |
| <b>Definition:<br/>Cosmetic</b>                          | The term <b>cosmetic</b> applies to procedures performed to improve an individual's appearance and not to improve or restore bodily function.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Precertification<br/>requirements</b>                 | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Physician<br/>review</b>                              | <p>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.</p> <p>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.</p>                                                                                                                                                                                                                                                                                   |

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## 5.2 EXPERIMENTAL/INVESTIGATIONAL AND COSMETIC SERVICES,

Continued

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### 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

|                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Definition</b>              | <b>Clinical trials</b> 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.                                                                                                                                                                                                                                                                                                                                                      |
| <b>Verify benefits</b>         | <p>Certain clinical trials may be covered under a member's benefit plan. Others are covered under the Medicare program.</p> <p>To determine if benefits are available for a particular clinical trial, providers should check the member's benefits through NaviNet. If NaviNet is unavailable, facilities should contact the Provider Service Center.</p> <div data-bbox="1156 667 1351 751" data-label="Image"> </div>                                                                                                                                     |
| <b>Provider responsibility</b> | <p>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.</p> <p>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).</p> |

## 5.2 PCP REFERRAL AUTHORIZATIONS IN DELAWARE

### Overview



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



Requests for referral authorizations must be submitted to Highmark's Medical Clinical Services department.

- Telephone: **1-800-572-2872**
- Fax: **1-800-670-4862**

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.

[What Is My Service Area?](#)

### Non-network referral authorization



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.

*Continued on next page*

## 5.2 PCP REFERRAL AUTHORIZATIONS IN DELAWARE, Continued

### Additional services



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.

[What Is My Service Area?](#)

## 5.2 PRIOR AUTHORIZATIONS FOR NON-PARTICIPATING PROVIDERS (PA-FHP)

[What Is My Service Area?](#)

### Overview



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



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 (2) weeks prior to the member's target service date.

### Requesting prior authorization



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. This form is also available on the Highmark Blue Shield Provider Resource Center – select **EDUCATION/MANUALS**, and then click on **First Priority Health Network Resources**.

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.

Quick  
Reference

## CHAPTER 5: CARE AND QUALITY MANAGEMENT

### UNIT 3: MEDICARE ADVANTAGE PROCEDURES



#### FOR PENNSYLVANIA AND WEST VIRGINIA PROVIDERS ONLY

#### IN THIS UNIT



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#### What Is My Service Area?

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The **PA ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The **DE ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

## 5.3 INTRODUCTION AND OVERVIEW

### Introduction



This unit outlines Highmark and Centers for Medicare & Medicaid Services (CMS) procedures and processes specifically for Medicare Advantage members. This information is applicable to all Highmark Medicare Advantage products in Pennsylvania and West Virginia.

[What Is My Service Area?](#)

### 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 twenty-four (24) hours.

### Compliance terms



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, 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.

- [Pennsylvania Medicare Advantage Compliance Language](#)
- [West Virginia Medicare Advantage Compliance Language](#)

*Continued on next page*

## 5.3 INTRODUCTION AND OVERVIEW, Continued

### FOR MORE INFORMATION



To learn more about Highmark's Medicare Advantage products, please see [Chapter 2.2: 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 explain their rights, benefits, and responsibilities as a member of our Plan.

To access the manual's Appendix, scroll down to the bottom of the manual's home page, and then click on the arrow in the **ADDITIONAL RESOURCES** box. Select **Appendix** from the options. You will also find **Medicare Advantage Compliance Language** in this location.

[What Is My Service Area?](#)

## 5.3 EXPEDITED REVIEW OF INITIAL DETERMINATIONS AND APPEALS

[What Is My Service Area?](#)

### Policy



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. As 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 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.

### What these processes do not apply to



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.

*Continued on next page*



## 5.3 EXPEDITED REVIEW OF INITIAL DETERMINATIONS AND APPEALS, Continued

### Your role



You may be contacted by a Highmark Clinical Services care manager 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 physician advisor about an expedited appeal, you must return his or her call. Failure to do so could result in corrective action and/or sanctioning.

[What Is My Service Area?](#)

### 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 you choose to initiate the appeal on behalf of the member, then the appeal is automatically considered an expedited appeal.

### If a denial decision is upheld



If a denial decision is upheld, the network is required to forward the case to the CMS appeals contractor within twenty-four (24) hours of the decision.

The appeals contractor may request additional information. In such cases, a Medicare Advantage appeals administrator may contact your office for additional information. If you are contacted, please respond to the request immediately.

### Process for expedited review or appeals



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? <ul style="list-style-type: none"> <li>• If the member is pursuing the review, go to <b>Step 4</b>.</li> <li>• If the member is appointing a representative, go to <b>Step 3</b>.</li> </ul> |

*Continued on next page*

## 5.3 EXPEDITED REVIEW OF INITIAL DETERMINATIONS AND APPEALS, Continued



### Process for expedited review or appeals (continued)

[What Is My Service Area?](#)

| STEP | WHO DOES IT...                                           | WHAT HAPPENS...                                                                                                                                                                                                                                                                                                                                                                                                                               |
|------|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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.<br><br>If an appeal request does not meet expedited criteria, it will be processed as a standard appeal and then a representative statement will be requested for a physician or other appointed representative request only. |
| 3b   | OR<br>An appointed representative                        | 3b. The appointed representative may submit a <a href="#">Representative Statement Document</a> 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: <b>1-800-485-9610</b><br>May send a physician's statement supporting the urgent need for services to:<br>Fax: 1-800-894-7947<br>Mail: Expedited Review Department<br>P.O. Box 535073<br>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.)<br><br>Is there enough information to render a decision?<br><ul style="list-style-type: none"> <li>• If yes, go to <b>Step 7</b>.</li> <li>• If no, request additional information from provider of care and go to <b>Step 6</b>.</li> </ul>                                                                                                               |
| 6    | Care provider                                            | Forwards member's medical records to care manager or physician advisor.                                                                                                                                                                                                                                                                                                                                                                       |
| 7    | Clinical Services care manager and/or physician reviewer | <ul style="list-style-type: none"> <li>• Renders decision.</li> <li>• Notifies member by telephone and letter.</li> <li>• Notifies physician.</li> </ul>                                                                                                                                                                                                                                                                                      |

#### Where can I get forms?

A current copy of the **Representative Statement Form** is available under the CMS' forms section of the CMS website at:

<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf>

## 5.3 MEDICARE ADVANTAGE MEDICAL POLICY

[What Is My Service Area?](#)

### Overview



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.

Highmark maintains medical policy guidelines for our Medicare Advantage products based on National and Local Coverage Determinations. Medicare Advantage Medical Policy 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., 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.

### Accessing Medicare Advantage Medical Policy



You can access Highmark's Medicare Advantage Medical Policy from the Provider Resource Center under **CLAIMS, PAYMENT & REIMBURSEMENT**.

Prior to rendering service, it is important to review medical necessity criteria outlined in our medical policy guidelines.

## 5.3 ADVISING MEMBERS OF THEIR INPATIENT RIGHTS AT DISCHARGE

[What Is My Service Area?](#)

### Policy



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 (2) days after admission** to the inpatient level of care. A follow-up copy must also be delivered to the patient **no more than two (2) days prior to discharge**.

The member will need to sign and date the *Important Message* to indicate that he or 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 or 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 <i>Important Message From Medicare</i> at or near the time of admission, but no later than two (2) days after admission to the inpatient level of care.                                                                                                                                                                                                     |
| 2    | Provide a follow-up signed copy of the <i>Important Message From Medicare</i> to all Medicare Advantage patients (or, if necessary, to their representative) prior to discharge, but no more than two (2) days before discharge. Retain a copy of the signed document in the member's medical record or in some other location/format in order to be able to demonstrate that the requirement was met. |

### Member must comprehend



The member must be able to understand the purpose and contents of the notice in order 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.

*Continued on next page*

## 5.3 ADVISING MEMBERS OF THEIR INPATIENT RIGHTS AT DISCHARGE, Continued

### Member must comprehend (continued)



If the facility determines that the patient does not understand that he or 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 or she leaves the facility and goes home or to an alternative level of care.

[What Is My Service Area?](#)

### Member disagrees with discharge decision



If the member disagrees with the discharge decision, he or she has until midnight on the day of the scheduled discharge (while he or 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 <i>Important Message From Medicare</i> .                                                                                                                                           |
| 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 <b>Detailed Notice of Discharge</b> .                                                                                                                                                                                               |
| 3    | The facility will deliver the <b>Detailed Notice of Discharge</b> 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 (1) 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*, if applicable, click on the **Tip Sheet** icon. The timeline outlines the responsibilities of each individual who has a role in the process. This tip sheet is also available in the **Tip Sheet Index**, which is accessible in **ADDITIONAL RESOURCES** at the bottom of the manual home page.

**TIP SHEET**

*Continued on next page*

## 5.3 ADVISING MEMBERS OF THEIR INPATIENT RIGHTS AT DISCHARGE, Continued

### 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.

[What Is My Service Area?](#)

### Locating forms



Current copies of the *Important Message From Medicare* and the *Detailed Notice of Discharge* are available on the CMS website at:

<https://www.cms.gov/medicare/medicare-general-information/bni/hospitaldischargeappealnotices.html>

In addition, a Highmark branded Detailed Notice of Discharge is available. This form can also be found on the Resource Center – select **FORMS**, and then **Miscellaneous Forms**. Scroll to the **DETAILED NOTICE OF DISCHARGE** heading.

### FOR MORE INFORMATION



Beneficiary and Family Centered Care QIOs (BFCC-QIOs) handle case reviews. The BFCC-QIO for the region that includes Pennsylvania is [Livanta](#). West Virginia is serviced by [Kepro](#).

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 at [qualityinsights.org](http://qualityinsights.org).

In addition, you may call Highmark's Provider Service Center at:

- **Pennsylvania:**
  - o Freedom Blue PPO: **1-866-588-6967**
  - o Community Blue Medicare HMO : **1-888-234-5374**
  - o Community Blue Medicare PPO and Plus PPO: **1-866-588-6967**
  - o Security Blue HMO (Western Region only): **1-866-517-8585**
- **West Virginia:** Freedom Blue PPO: **1-888-459-4020**

### 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. Please see the next section of this unit.

## 5.3 NOTICE OF MEDICARE NON-COVERAGE (NOMNC)

### Introduction



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.

### Time frame



The NOMNC form should be issued **no later than two (2) days before** the proposed end of services.

[What Is My Service Area?](#)

### 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 in order to sign for receipt of it. The member or appointed or authorized representative must be able to understand that he or 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
- 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.

*Continued on next page*



## 5.3 NOTICE OF MEDICARE NON-COVERAGE (NOMNC), Continued

### 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.

[What Is My Service Area?](#)

### 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
- 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.

*Continued on next page*



## 5.3 NOTICE OF MEDICARE NON-COVERAGE (NOMNC), Continued

### Retain Copy



Facilities should retain a copy of the completed and signed NOMNC form in their records.

[What Is My Service Area?](#)

### SNFs managed by naviHealth



For skilled nursing facilities managed by naviHealth, a copy of the completed and signed NOMNC form should **also** be faxed to naviHealth at **1-844-496-7209**.

### Locating form



The **Notice of Medicare Non-Coverage** forms applicable to Highmark Medicare Advantage plans are located on the Provider Resource Centers for your service area. Select **FORMS**, and then Miscellaneous Forms. Scroll to the **NOTICE OF MEDICARE NON-COVERAGE** heading to access the form.

## 5.3 MEDICARE OUTPATIENT OBSERVATION NOTICE (MOON)

### Overview



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 twenty-four (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.

[What Is My Service Area?](#)

### 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. Effective 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 thirty-six (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 at:

<https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html?redirect=/bni>

## 5.3 PRESERVICE ORGANIZATION DETERMINATIONS

### Overview



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 or her appeal rights.

**Please Note:** The *Advance Beneficiary Notice of Noncoverage* (ABN) used for the Original Medicare program is not applicable to Medicare Advantage plans.

[What Is My Service Area?](#)

### Notification of non-coverage determinations



The Centers for Medicare & Medicaid Services (CMS) issued clarification on May 5, 2014, that the practice of providers giving a preservice denial notice to members in advance of performing a service is not compliant with CMS regulations for Medicare Advantage plans.

**The *Preservice Denial Notice* that providers were previously directed to issue to Highmark members is no longer valid and must not be used.** 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.**

Per CMS, exceptions to this policy are services or items that are never covered by Medicare or the member's Medicare Advantage plan. The exceptions for Highmark Medicare Advantage members are listed on the next page.

*Continued on next page*

## 5.3 PRESERVICE ORGANIZATION DETERMINATIONS, Continued

### 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. Acupuncture\*
11. Naturopath services (uses natural or alternative therapies)
12. Services provided to veterans in Veterans Affairs (VA) facilities
13. Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines
14. 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
15. Medical determination of refractive state (Medical Refraction)

The services listed above are not eligible for payment and can be billed to the member.

\*Acupuncture is **not excluded** for the Community Blue Medicare HMO product in Pennsylvania.

[What Is My Service Area?](#)

### 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.**

*Continued on next page*

## 5.3 PRESERVICE ORGANIZATION DETERMINATIONS, Continued

### 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:

- **Pennsylvania:**
  - o Freedom Blue PPO: **1-866-588-6967**
  - o Community Blue Medicare HMO : **1-888-234-5374**
  - o Community Blue Medicare PPO and Plus PPO: **1-866-588-6967**
  - o Security Blue HMO (Western Region only): **1-866-517-8585**
- **West Virginia:** Freedom Blue PPO: **1-888-459-4020**

**Please Note:** This process is not applicable to services or items that require prior authorization. Requests for prior authorization are to be submitted via NaviNet®.

[What Is My Service Area?](#)

### Time frame for reviews



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 fourteen (14) calendar days** after receiving the request. Highmark will extend the time frame up to fourteen (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 non-contracting provider may change Highmark's decision to deny.

In cases involving the need for **urgent care**, Highmark will provide notification of the decision **within seventy-two (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 seventy-two (72) hours or the non-urgent case turnaround time of fourteen (14) calendar days up to an additional fourteen (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.

*Continued on next page*

## 5.3 PRESERVICE ORGANIZATION DETERMINATIONS, Continued

### Time frame for reviews (continued)



For non-participating providers, Highmark may also extend the urgent seventy-two (72) hour or non-urgent fourteen (14) calendar day time frames up to an additional fourteen (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.

[What Is My Service Area?](#)

### 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 or 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-EMERGENT AMBULANCE TRANSPORT

### Prior authorization requirements



Effective January 1, 2017, prior authorization from Highmark is required for non-emergent ambulance transports for Highmark Medicare Advantage plan members in 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.**

[What Is My Service Area?](#)

### 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/stretchers 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), non-emergency transport, Level 1
- **A0428** – Ambulance service Basic Life Support (BLS), non-emergency transport

*Continued on next page*

## 5.3 NON-EMERGENT AMBULANCE TRANSPORT, Continued

### 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
- 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.

This form is also available on the Provider Resource Center – select **FORMS**, and then **Miscellaneous Forms**.

[What Is My Service Area?](#)

### 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:

- NaviNet® Auth Submission
- Fax: **1-888-236-6321**
- Telephone: **1-800-547-3627**

The request form is required when submitting requests by fax. It is recommended that you complete this form prior to submitting requests via NaviNet or calling Highmark. The completed form will provide the information needed during the NaviNet submission process or when requesting authorization by phone.

### Tips for submitting requests via NaviNet



If submitting a prior authorization request via NaviNet, select **Authorization Submission** from the NaviNet Plan Central menu, and then **Auth Submission** from the fly-out menu.

- Select **Outpatient** (Category) and **Planned Medical** (Service) on the NaviNet Selection Form.
- Enter all of the required details that are outlined on the Non-Emergent Ambulance Prior Authorization for Medicare Advantage Members form in the Comments section of the NaviNet Request Form.

The submission/request will pend for review; Highmark may contact you if additional information is needed.

*Continued on next page*



## 5.3 NON-EMERGENT AMBULANCE TRANSPORT, Continued

### Decision notification



Highmark will make a determination **within forty-eight (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/NaviNet). 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.

[What Is My Service Area?](#)

### 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

[What Is My Service Area?](#)

### Overview



For Highmark's Medicare Advantage members in Pennsylvania and West Virginia, registration and authorization requirements under the Physical Medicine Management Program apply for physical therapy, occupational therapy, and manipulation services. WholeHealth Networks, Inc. (WHN), a subsidiary of Tivity Health Support, LLC., provides medical management for these services.

Highmark's Clinical Services staff continues to perform medical management for speech therapy provided to our Medicare Advantage members. Speech therapy requires authorization from the initial treatment visit. A complete treatment plan is required for authorization.

NaviNet® is the preferred method for submission for all authorization requests to Highmark and to WHN.

### Physical therapy, occupational therapy, and manipulation services



Medicare Advantage members must be registered with WHN with their first visit **each calendar year** for physical therapy, occupational therapy, and/or manipulation services. Registration provides an "auto-approval" for eight (8) visits for manipulation services or for eight (8) visits for physical therapy and occupational therapy combined. If additional visits are needed in the calendar year, a request for authorization must be submitted to WHN. Registrations and authorization requests are submitted to WHN via NaviNet.

For complete details, including instructions for submitting requests, please see the applicable administrative guide for your service area:

- **Pennsylvania:** [Physical Medicine Management Program Administrative Guide](#)
- **West Virginia:** [Physical Medicine Management Program Administrative Guide](#)

The guide is also available on the Provider Resource Center. Select **Clinical Reference Materials** from the main menu, and then click on **Physical Medicine Management Program**. Additional reference materials, including training modules for submitting requests, are available on this site.

### 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 NaviNet.

**Note:** Clinical Services reserves the right to request a full plan of treatment as deemed necessary.

*Continued on next page*

## 5.3 AUTHORIZATION REQUESTS FOR OUTPATIENT THERAPY SERVICES, Continued

[What Is My Service Area?](#)

### Submitting speech therapy requests via NaviNet



To submit authorization requests for speech therapy through NaviNet:

| STEP | ACTION                                                                                                                                                                           |
|------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1    | The authorization request to begin treatment must be initiated by the member's physician who is requesting the therapy services.                                                 |
| 2    | Select <b>Authorization Submission</b> on Plan Central.                                                                                                                          |
| 3    | Select <b>Auth Submission</b> from the fly-out menu.                                                                                                                             |
| 4    | On the <b>Selection Form</b> , select <b>Outpatient</b> from the "Category" options, and then <b>Speech Therapy</b> from the dropdown options for "Service."                     |
| 5    | If the plan of treatment has already been developed by the speech therapist, that information can be entered into the <b>Request Form</b> comment block titled "Treatment Plan." |
| 6    | Submit the request.                                                                                                                                                              |

### Telephone requests



If you are not yet NaviNet-enabled, authorization requests for speech therapy for Medicare Advantage members can be submitted to Highmark by contacting Clinical Services at:

Pennsylvania:

- Freedom Blue PPO: **1-866-588-6967**
- Community Blue Medicare HMO: **1-888-234-5374**
- Community Blue Medicare PPO and Plus PPO: **1-866-588-6967**
- Security Blue HMO (Western Region only): **1-866-517-8585**

West Virginia Freedom Blue PPO: **1-800-269-6389**

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

### Overview



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.

[What Is My Service Area?](#)

### Documentation requirements



For each encounter, Medicare Advantage medical records must include, but not be limited to, all of 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 name (on each page) and date of birth.

### CMS signature and credentials requirements



The Centers for Medicare & Medicaid Services (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.

*Continued on next page*

## 5.3 MEDICAL RECORD DOCUMENTATION REQUIREMENTS, Continued

[What Is My Service Area?](#)

### Acceptable provider signatures



Valid provider signatures include: (i) electronic signatures which include credentials; (ii) handwritten signatures including credentials; (iii) printed name including credentials accompanied by provider initials; and (iv) facsimiles of original written or electronic signatures that include credentials.

| TYPE                                                                                                                      | ACCEPTABLE                                                                                                                                                                                                                                 |
|---------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Hand-written signature including credentials</li> </ul>                            | <ul style="list-style-type: none"> <li>Mary C. Smith, MD; or MCS, MD</li> </ul> <p>Examples:</p> <ul style="list-style-type: none"> <li><i>Mary C. Smith, MD</i></li> <li><b>Mary C. Smith MD</b> <i>MCS, MD</i></li> </ul>                |
| <ul style="list-style-type: none"> <li>Electronic signature, including credentials</li> </ul>                             | <ul style="list-style-type: none"> <li>Requires authentication by the responsible provider</li> </ul> <p>Examples include but are not limited to:<br/>           “Approved by,” “Signed by,”<br/>           “Electronically signed by”</p> |
|                                                                                                                           | <ul style="list-style-type: none"> <li>Must be password protected and used exclusively by the individual provider</li> </ul>                                                                                                               |
| <ul style="list-style-type: none"> <li>Printed name including credentials, accompanied by handwritten initials</li> </ul> | <p>Example:</p> <ul style="list-style-type: none"> <li><b>Mary C. Smith MD</b> <i>MCS</i></li> </ul>                                                                                                                                       |
| <ul style="list-style-type: none"> <li>Facsimile</li> </ul>                                                               | <ul style="list-style-type: none"> <li>Other than an original signature, such as included on medical record copy</li> </ul>                                                                                                                |

Continued on next page

## 5.3 MEDICAL RECORD DOCUMENTATION REQUIREMENTS, Continued

### Invalid provider signatures



The following table provides information on invalid provider signatures:

| TYPE                                                                                                                                                                  | UNACCEPTABLE unless...                                                                                                                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Typed name with credentials</li> </ul> <p>Example:<br/><b>Mary C. Smith MD</b></p>                                             | <ul style="list-style-type: none"> <li>The provider includes a written signature or initials plus credentials</li> </ul>                           |
| <ul style="list-style-type: none"> <li>Non-physician or non-physician extender signature (e.g., medical student)</li> </ul> <p>Example:<br/><i>John Jones, PA</i></p> | <ul style="list-style-type: none"> <li>Co-signed by supervising physician</li> </ul> <p>(Refer to acceptable examples in the preceding table.)</p> |
| <ul style="list-style-type: none"> <li>Provider of services signature without credentials</li> </ul> <p>Example:<br/><i>Mary C. Smith</i></p>                         | <ul style="list-style-type: none"> <li>Name is linked to provider credentials or name with credentials on practitioner stationery</li> </ul>       |
| <ul style="list-style-type: none"> <li>Signature stamp, including credentials</li> </ul> <p>Example:<br/><i>maryesmith MD</i></p>                                     | <ul style="list-style-type: none"> <li>Prior to 2008</li> </ul> <p>(Stamped signatures are not permitted on medical records after 2008.)</p>       |

[What Is My Service Area?](#)

## 5.3 RECORD RETENTION POLICY

### Overview



Highmark complies with, and requires its contracted providers to comply with, the Centers for Medicare & Medicaid Services (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.

[What Is My Service Area?](#)

### Policy



CMS revised its regulations with respect to records retention and access to records, increasing the period from six (6) to ten (10) 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 (10) 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

### Overview



Effective January 1, 2015, the Centers for Medicare & Medicaid Services (CMS) may reimburse providers for certain chronic care management services. According to a CMS memorandum dated April 10, 2015, however, reimbursement for such chronic care management services is dependent on the agreement in place between the provider and the Medicare Advantage plan.

### Provider agreements



Highmark's Medicare Advantage Provider Agreements require providers to deliver care coordination services to members with complex or serious medical conditions, including those members with multiple chronic conditions. In pertinent part, providers are contractually obligated to perform the following:

- Assist in the development and implementation of member treatment plans
- Conduct a health assessment of all new members within ninety (90) days of the effective date of their enrollment, when applicable
- Inform members of follow-up care, when applicable
- Provide members with training in self-care, when applicable

### Provider agreement reimbursement provisions



As detailed above, the responsibilities of providers to deliver care coordination services, including chronic care management services, are already part of providers' responsibilities to perform health services pursuant to the terms of the Medicare Advantage Provider Agreements, and for which payment is made under Highmark's professional provider fee schedule. This existing contractual obligation is not changed as a result of the decision by CMS to allow for separate payment for chronic care management services. Therefore, Highmark will not make a separate payment for providing chronic care management services.

[What Is My Service Area?](#)



## 5.3 ADVANCE DIRECTIVES

### Overview



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.

[What Is My Service Area?](#)

### Definitions



An **advance directive** is written instructions, such as living wills and medical (or durable) powers 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.

*Continued on next page*

## 5.3 ADVANCE DIRECTIVES, Continued

### 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;
- 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.

[What Is My Service Area?](#)

### 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.

*Continued on next page*

## 5.3 ADVANCE DIRECTIVES, Continued

[What Is My Service Area?](#)

### Procedure



| STEP | ACTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1    | <p>Ask the member whether he or she has executed an advance directive. Document the response in the member's chart.</p> <ul style="list-style-type: none"> <li>If the member <i>has completed</i> an advance directive, go to Step 2.</li> <li>If the member <i>has not completed</i> 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.</li> </ul> |
| 2    | <p>Review the advance directive.</p> <ul style="list-style-type: none"> <li>If you <b>are willing</b> 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.</li> <li>If you <b>are not willing</b> 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.</li> </ul>                             |
| 3    | <p>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.</p>                                                                                                                                                                                                                                                                  |

### Highmark West Virginia responsibilities



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 **1-304-558-0050**.

Highmark West Virginia may monitor compliance with this section by review of a provider's medical records during a site visit.

*Continued on next page*

## 5.3 ADVANCE DIRECTIVES, Continued

[What Is My Service Area?](#)

### WV forms and additional information



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 **1-304-558-3317**; or
- West Virginia Center for End-of-Life Care at **1-877-209-8086**.

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 **1-888-258-2428** for general (not state-specific) educational information on advance directives.

## 5.3 THE AIS HOME VISIT PROGRAM

### Introduction



The AIS Home Visit Program is offered as part of all Highmark Medicare Advantage plans. The program was developed to ensure that members with life-limiting illness have access to uniquely trained professionals who provide palliative care.

The program is intended to bring a more comprehensive approach to our members and provide home-based palliative care and support services that enhance the member's quality of life.

[What Is My Service Area?](#)

### What is the AIS Home Visit Program?



The AIS Home Visit Program is a specialized component of the overall care management program available to Highmark Medicare Advantage members. The program is focused on caring for the medical and non-medical needs of our Medicare Advantage members who are facing a serious or chronic life-limiting illness. This includes members diagnosed with cancer, heart disease, end-stage renal kidney disease, stroke, or other neurological disorders including, but not limited to, advanced frailty. The program seeks to enhance palliative care services to control pain and symptoms, provide emotional support, facilitate decision making related to care, and coordinate services.

Highmark has partnered with Aspire Health to provide home-based care and support services for Highmark Medicare Advantage members, including those enrolled in Freedom Blue PPO, Community Blue Medicare HMO, Community Blue Medicare PPO and Plus PPO, and Security Blue HMO (available in the PA Western Regional only). While in the program, members are able to receive curative care treatment and all other eligible services available through their Medicare Advantage plan.

Highmark wants to ensure our members have continuous and coordinated care that intervenes early in the patient's diagnosis. The AIS Home Visit Program takes a comprehensive approach to helping our members and families through expert symptom management, discussions about "goals of care," coordination of care, and education. Care is provided by a team of physicians, nurse practitioners, social workers, and chaplains who work together with a member's existing physicians to develop a plan of care that best fits the needs of each member and their families. The program can provide unlimited visits based on clinical need.

Referrals to the AIS Home Visit Program may be made by a member's PCP or specialty provider, family members, self, community case managers, internal Highmark staff, or others.

*Continued on next page*

## 5.3 THE AIS HOME VISIT PROGRAM, Continued

[What Is My Service Area?](#)

### Participation guidelines



The AIS Home Visit Program is available to Highmark Medicare Advantage members for whom their provider would “not be surprised” of death within one year (as stated in CPT II code 1150F). Attestation demonstrates medical necessity.

Participation in the program is voluntary and no authorization is required. The member may be referred to the AIS Home Visit Program by their PCP or a specialty provider, family members, self, a community case manager, a Highmark Health Coach, or others.

Members are not required to be homebound or meet a skilled level of care to be considered eligible for program services. They may receive services within their home or while in a personal care or assisted-living facility.

### How does AIS differ from hospice?



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 the AIS Home Visit Program.

| HOSPICE...                                                                                                                                                                                                                                                                                                                                                                    | ADVANCED ILLNESS SERVICES...                                                                                                                                                                                                                                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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 <b>six months or less</b> .                                                                                                                                                                                                                                                                                                              | Is available when the provider attests to “no surprise” of member death <b>within one year</b> .                                                                                                                                                                                                                                        |
| <p><b>Is a Medicare benefit.</b> 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.</p> <p><b>While in an active hospice election period, the member is not eligible for the AIS Home Visit Program.</b></p> | <p><b>Is a Highmark program.</b> Services are covered under the member’s Medicare Advantage plan. Members are not eligible for the AIS Home Visit Program if they are in an active hospice election period.</p> <p><b>If a member revokes a hospice election, the member would then be eligible for the AIS Home Visit Program.</b></p> |

**Note:** While a member is in an active hospice election period covered under traditional Medicare, the member’s Medicare Advantage plan will continue to cover supplemental or extra benefits, such as vision and dental, which are not covered by Medicare.

*Continued on next page*

## 5.3 THE AIS HOME VISIT PROGRAM, Continued

[What Is My Service Area?](#)

### Hospice services



All Medicare certified hospice providers will be able to continue providing hospice care to Highmark Medicare Advantage members. The AIS Home Visit 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



Additional information on the AIS Home Visit Program is available on the Provider Resource Center – select **CARE MANAGEMENT PROGRAMS** from the main menu.

Providers can refer members for AIS Home Visit Program services by faxing the [AIS Home Visit Referral Form](#) to **1-888-878-3824**. This form is also located on the AIS Home Visit Program page on the Provider Resource Center.

Members may contact Member Services at the number on the back of their ID cards for information on AIS Home Visit Program participation.

## 5.3 UNCONFIRMED DIAGNOSIS CODE (UDC) PROGRAM

### Introduction



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.

[What Is My Service Area?](#)

### Program overview



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



Complete program information is available on the NaviNet® Provider Resource Center – select **EDUCATION/MANUALS** from the main menu, and then **Risk Adjustment Programs**.



## 5.3 IDENTIFYING MEMBERS WITH END STAGE RENAL DISEASE

### Definition



**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.

[What Is My Service Area?](#)

### 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 in order 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.                                                                                                                                                                                                      |

## CHAPTER 5: CARE AND QUALITY MANAGEMENT

### UNIT 4: BEHAVIORAL HEALTH

#### IN THIS UNIT



| TOPIC                                                      | SEE PAGE |
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[What Is My Service Area?](#)

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The **PA ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The **DE ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

## 5.4 GENERAL INFORMATION

### Objectives

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 if authorization is required, always verify the member's benefits prior to providing services. Eligibility and benefits can be verified via NaviNet® 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.**

### NaviNet® Eligibility and Benefits Inquiry

To verify behavioral health benefits via NaviNet, select the **Eligibility and Benefits Inquiry** transaction from the main menu on Highmark Plan Central. Click on the **Additional Benefit Provisions** link on the Eligibility and Benefits Detail page. From the pop-up box, select **Behavioral Health/Substance Abuse** for detailed behavioral health benefits.

### 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.

*Continued on next page*

## 5.4 GENERAL INFORMATION, Continued

### Contact information

When NaviNet® is not available and/or for medical management questions/issues that cannot be handled through NaviNet, Highmark Behavioral Health Services can be reached by calling the telephone number for your service area:

- PA Western & Northeastern Regions: **1-800-258-9808**
- PA Central Region: **1-800-628-0816**
- Delaware: **1-800-421-4577**
- West Virginia: **1-800-344-5245**

### Hours of availability:

- Monday through Friday – 8:30 a.m. to 7 p.m.
- Saturday and Sunday – 8:30 a.m. to 4:30 p.m. (limited staffing for urgent requests)

[What Is My Service Area?](#)

### 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 in order 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 4.2: 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, 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 in any provider contract shall mean health care services (or such similar term as contained in the applicable benefit agreement or plan document to include, but not be limited to, “health services and supplies,” “services and supplies,” and/or “medications and 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:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury, or disease; and
- Not primarily for the convenience of the patient, physician, or other health care 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.

### Medical necessity criteria for substance abuse treatment

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 at <http://www.asam.org/>, or by contacting ASAM at 1-301-656-3920.

*Continued on next page*

## 5.4 MEDICAL NECESSITY CRITERIA, Continued

|                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Medical necessity criteria for all other behavioral health services</b> | <p>Highmark's Behavioral Health Services department applies InterQual Criteria for Behavioral Health when reviewing the medical necessity of behavioral health services.</p> <p>NaviNet-enabled facilities are able to view the InterQual Criteria via the Automated Care Management (ACM) application. If for any reason NaviNet is not available, facilities can call Highmark Behavioral Health Services for medical necessity criteria applicable to a particular case.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Criteria reviewed annually</b>                                          | <p>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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prudent layperson laws for emergency services</b>                       | <p>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.</p> <p>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.</p> |

## 5.4 SERVICES REQUIRING AUTHORIZATION

### Behavioral health authorization

Authorization (or “pre-authorization”) 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)

Although authorization is not required for emergency services, an authorization is required if an emergency service results in an inpatient admission.

### Outpatient services

Traditional outpatient behavioral health treatment does not require authorizations. However, partial hospitalization, intensive outpatient programs, and home health care services for psychiatric care **do require authorization**.

For partial hospitalization and intensive outpatient psychiatric services, the following procedure codes are included on Highmark’s List of Procedures/DME Requiring Authorization:

- S0201 – partial hospitalization services, less than 24 hours, per diem
- S9480 – intensive outpatient psychiatric services, per diem

To quickly access Highmark’s List of Procedures/DME Requiring, select **REQUIRING AUTHORIZATION** from the **Quicklinks** bar at the top of the Provider Resource Center home page.

### IMPORTANT! Exceptions



For important changes in Delaware legislation affecting authorization requirements for drug and alcohol dependency treatment in Delaware effective January 1, 2018, please see the next section of this unit.

[What Is My Service Area?](#)

### 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

### Policy



Effective January 1, 2018, as 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



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.

[What Is My Service Area?](#)

### Concurrent utilization review



Concurrent utilization review is prohibited during the first fourteen (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; thirty (30) days of Intensive Outpatient Program treatment; or five (5) days of inpatient withdrawal management, provided that the facility notifies Highmark Delaware of both the admission and the initial treatment plan within forty-eight (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



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.

*Continued on next page*



## 5.4 DELAWARE DRUG AND ALCOHOL DEPENDENCY TREATMENT MANDATE, Continued

### Applicability



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



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.

[What Is My Service Area?](#)

### FOR MORE INFORMATION

For additional information on this mandate, please see [Chapter 4.2: 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 NaviNet® 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

### NaviNet® authorization request submission required

Authorization requests must be submitted through Highmark's NaviNet® provider portal for the following behavioral health services:

- Inpatient Admissions
- Inpatient Transfers
- Partial Hospitalization (PHP)
- Intensive Outpatient Services (IOP)

Requests for authorization of inpatient behavioral health services are submitted via NaviNet® by the facility providing services.

### Instructional manual for NaviNet® submissions

For assistance with submitting authorization requests through NaviNet, please see the [Behavioral Health Automated Care Management \(ACM\) Authorization Submission Manual](#).

This manual is also available under **EDUCATION/MANUALS** on the Provider Resource Center.

*Continued on next page*

## 5.4 AUTHORIZATION REQUESTS, Continued

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**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 (2) business days** from the receipt of the request.

---

**Continued stay  
requests for  
PHP and IOP**

If an authorization expires and continued treatment is necessary, **a new authorization request must be submitted** through NaviNet for outpatient behavioral health services (partial hospitalization and intensive outpatient services). A continued stay request should be submitted on the last covered day of the previous authorization.

---

## 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 the provider is NaviNet®-enabled, they can retrieve the authorization notice through the NaviNet **Referral/Authorization Inquiry** transaction. (Select the authorization in question in order to view it.)
- If the provider is not NaviNet-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 non-authorization 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.

*[Why blue italics?](#)*

### 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* toll-free phone number: **1-866-634-6468**. *Hours of operation are from 8:30 a.m. to 4:30 p.m. (EST), Monday through Friday. A live agent will take the necessary information and forward the request to a Highmark clinical peer reviewer.*

*Continued on next page*

## 5.4 POTENTIAL OUTCOMES OF AUTHORIZATION REVIEW, Continued

### Peer-to-peer conversation (continued)

*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 (1) 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.

[Why blue italics?](#)

### 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 5.5: Denials, Grievances, and Appeals](#) for more information on appeal rights.

## 5.4 CONCURRENT REVIEW

|                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Definition:<br/>Concurrent review</b>       | <b>Concurrent review</b> , also known as continued stay review, is an assessment that determines medical necessity and appropriateness for an extension of previously authorized services.                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Plan-specific requirements</b>              | 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, <b>always verify plan-specific requirements</b> via NaviNet®, or by contacting Highmark Behavioral Health Services.                                                                                                                                                                                                                                                                                    |
| <b>When is review completed?</b>               | Concurrent reviews for behavioral health services must be completed on or before the "Last Covered Day" (LCD) of the previous authorization.                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Time frames</b>                             | <p>Concurrent review decisions for behavioral health services are communicated to the provider <b>within one (1) business day</b>, or no later than twenty-four (24) hours, from receipt of the request.</p> <p>In view of the short turnaround time imposed by regulating bodies, providers are reminded to <b>forward all relevant clinical information as quickly as possible</b> to avoid denials based on lack of clinical data.</p>                                                                                                                                                            |
| <b>Who initiates?</b>                          | The provider is ultimately responsible for initiating the concurrent review process; however, it can be initiated by the behavioral health care manager as well.                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Initiating the review</b>                   | <p>Concurrent review requests for inpatient care are normally submitted via NaviNet®. (NaviNet can be used even if the original case was initiated by telephone contact with Highmark Behavioral Health Services.) However, if NaviNet is unavailable or the facility is not NaviNet-enabled, concurrent reviews can be initiated by calling Highmark Behavioral Health Services.</p> <p>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.</p> |
| <b>Continued stay requests for PHP and IOP</b> | If an authorization expires and continued treatment is necessary, <b>a new authorization request must be submitted</b> through NaviNet for outpatient behavioral health services (partial hospitalization and intensive outpatient services). A continued stay request should be submitted on the last covered day of the previous authorization.                                                                                                                                                                                                                                                    |

*Continued on next page*

## 5.4 CONCURRENT REVIEW, Continued

### Types of information to be provided

The information below should be provided to the behavioral health care manager for a concurrent review whether through a telephone dialogue or a “Note” on the NaviNet screen:

- 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).

*Continued on next page*

## 5.4 CONCURRENT REVIEW, Continued

### 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 (2) 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 5.3: Medicare Advantage Procedures](#).

[What Is My Service Area?](#)

### Late notice cases

Normally, authorization is in place before behavioral health services are rendered. However, if for some reason services were initiated without authorization and the member remains in treatment, the behavioral health care manager initiates an **immediate review of the services going forward** from the point at which Highmark Behavioral Health Services was notified. Although there was no initial authorization process, **this is considered a concurrent review**.

In addition to performing a concurrent review of the services provided from the point of notification on, Highmark Behavioral Health Services will also initiate a **retrospective review** of the services rendered prior to notification in late notice cases.



## 5.4 RETROSPECTIVE REVIEW

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**Definition** 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.

---

**Late notice initiates review for medical necessity** When a facility provides late notice that a member has been admitted as an inpatient for behavioral health services, Highmark Behavioral Health Services will initiate both a concurrent review for services going forward as well as a retrospective medical necessity review of the services rendered to the point of notification.

---

**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.

[What Is My Service Area?](#)

**Compliance** 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 address below:

Highmark Behavioral Health Services  
120 Fifth Avenue, Suite P4205  
Pittsburgh, PA 15222-3099  
Attention: Benefit Analyst

---

**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.
- 

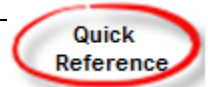
*Continued on next page*

## 5.4 RETROSPECTIVE REVIEW, Continued

### Review results in approval

If an authorization is issued, the rendering provider can obtain the authorization number from the **Referral/Authorization Inquiry** transaction via NaviNet®.

To have a previously denied claim adjusted, the provider can then open a NaviNet Investigation, reporting the newly obtained authorization number. Providers who are not NaviNet-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.

*Why blue italics?*

### 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: 1-866-634-6468. Hours of operation are from 8:30 a.m. to 4:30 p.m. (EST), Monday through Friday. 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 (1) 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.*

*Continued on next page*

## 5.4 PROVIDER APPEAL PROCESS, Continued

### Initiating an appeal

Either the attending provider or the facility may initiate an appeal either 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

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.

### Time frame: Expedited appeals

For an expedited appeal, a decision is rendered **within one (1) business day** of receipt of complete information, not to exceed seventy-two (72) hours of receipt of the request.

**Note:** For Pennsylvania Act 68 expedited appeals, the decision time frame is not to exceed forty-eight (48) hours. Please refer to the [Chapter 5.5: Denials, Grievances, and Appeals](#), section titled "Expedited Grievance: Filing On Behalf of a Member (PA Act 68)," for additional information.

[What Is My Service Area?](#)

### 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. |

*Continued on next page*

## 5.4 PROVIDER APPEAL PROCESS, Continued

### 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 thirty (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 [Chapter 5.5: Denials, Grievances, and Appeals](#).

## 5.4 DISCHARGE PLANNING AND POST-DISCHARGE FOLLOW-UP CARE

|                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|----------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Discharge planning</b>              | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Encourage follow-up appointment</b> | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Contact following discharge</b>     | <p>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.</p> <p>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.</p> |
| <b>Continuing care coordination</b>    | <p>Highmark Behavioral Health Services is committed to working with providers to support members in maintaining the gains achieved during inpatient treatment.</p> <p>It is very important that the member leaves the facility having scheduled a follow-up appointment with a psychiatrist or other behavioral health provider <b>within seven (7) days</b> 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.</p>                                                                                                                                                   |
| <b>When medication is prescribed</b>   | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

*Continued on next page*

## 5.4 DISCHARGE PLANNING AND POST-DISCHARGE FOLLOW-UP CARE, Continued

### 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.

This form is also available on the Provider Resource Center – select **FORMS**, and then **Behavioral Health Forms**.

[What Is My Service Area?](#)

### 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 are 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 5.3: Medicare Advantage Procedures](#).

## CHAPTER 5: CARE AND QUALITY MANAGEMENT

### UNIT 5: DENIALS, GRIEVANCES, AND APPEALS

#### IN THIS UNIT



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#### What Is My Service Area?

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The **PA ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The **DE ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.



## 5.5 MEDICAL NECESSITY DENIALS

### Introduction

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.

### 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 medically 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 NaviNet® 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 (1) 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. NaviNet®-enabled providers also receive denial notifications through the **Referral/Authorization Inquiry** transaction.

*Continued on next page*

## 5.5 MEDICAL NECESSITY DENIALS, Continued

### 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

### 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. The NaviNet **Eligibility and Benefits Inquiry** transaction provides the information needed to make this determination.

If NaviNet 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.

Quick  
Reference

### Notification of denial

When authorization requests are submitted by telephone contact with Clinical Services, the care manager can assist the facility 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 facility 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

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**Purpose** 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.

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**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. **The peer-to-peer conversation option is not available for Medicare Advantage members.**

**Note:** If the provider chooses to proceed with an appeal, the peer-to-peer option is forfeited and no longer available to the provider.

---

**Process** The provider has **two (2) business days** after notification of an authorization denial to initiate a peer-to-peer review for commercial members. The provider may initiate the peer-to-peer conversation by calling Clinical Services. Clinical Services will make the peer-to-peer conversation available **within one (1) business day** after receiving a request.

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.

[\*Why blue italics?\*](#)

**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: **1-866-634-6468**. *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. Requests will then be forwarded to the Highmark clinical peer reviewer who made the determination (or an appropriate designee).*

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*Continued on next page*

## 5.5 PEER-TO-PEER CONVERSATION, Continued

### Initiating a peer-to-peer conversation (continued)

*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 (1) business day from the time of the request.

[Why blue italics?](#)

### 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.

### naviHealth peer-to-peer conversations



Peer-to-peer conversations should be requested directly from naviHealth 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 naviHealth via their toll-free telephone number **1-844-838-0929**.

[What Is My Service Area?](#)

## 5.5 PROVIDER APPEALS

[What Is My Service Area?](#)

### Overview

Highmark follows an established appeals/grievance process as a mechanism for providers and members to appeal an adverse benefit determination. This section will describe the specific processes as they apply to providers appealing on their own behalf.

A provider may appeal a medical necessity denial decision, including decisions to deny experimental/investigational or cosmetic procedures. 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, the Federal Employee Program (FEP), 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 the Reconsideration and Appeal process for FEP, please contact FEP Customer Service:
  - o Pennsylvania: **1-866-763-3608**
  - o Delaware: **1-800-721-8005**
  - o West Virginia: **1-800-535-5266**
- For information regarding appeals in Pennsylvania, Delaware, 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.

In Pennsylvania and West Virginia, a provider has **one-hundred eighty (180) days** from the date of the initial denial of coverage in which to file an appeal. In Delaware, a provider must file an appeal within **ninety (90) days** of the denial.

### 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.

*Continued on next page*

## 5.5 PROVIDER APPEALS, Continued

[What Is My Service Area?](#)

### Types of provider appeals (continued)

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.

### Standard appeal

A **standard appeal** is used under all other circumstances, 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.

In Pennsylvania, the standard appeal is the final level of internal appeal for facility providers. For Pennsylvania practitioners, the Medical Review Committee will consider any unresolved provider matters. You will be notified of the decision in writing. The decision is considered your final level of internal appeal and not subject to further appeal to Highmark. Please see the [Medical Review Committee](#) section at the end of this unit for additional information about this committee.

*Continued on next page*

## 5.5 PROVIDER APPEALS, Continued

[What Is My Service Area?](#)

### 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 within time frames established by the applicable regulations and standards.
- Verbal (as applicable) and written communication of the decision within time frames established by the applicable regulations and standards.

### Delaware provider arbitration rights



If a provider is not satisfied with a Highmark Blue Cross Blue Shield Delaware final appeal decision regarding reimbursement, the provider may have the right to arbitration.

If a member is covered under a health benefits plan that is regulated by Delaware insurance law, and you are a provider as defined by 18 Del. C. §333(a)(1), you have the right to seek review of our decision regarding the final disposition of a claim(s). The Delaware Insurance Department provides claim arbitration services which are in addition to, but do not replace, any other legal or equitable right you may have to review this decision or any right of review based on your contract with Highmark Delaware.

You can contact the Delaware Insurance Department for information about arbitration by calling the Arbitration Secretary at **1-302-674-7322**. You 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 sixty (60) days** from the date you receive the adverse determination from Highmark Delaware; otherwise, the Highmark Delaware decision will be final.

### 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.



## 5.5 EXPEDITED PROVIDER APPEAL PROCESS

[What Is My Service Area?](#)

### Expedited appeals 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.

| EXPEDITED PROVIDER APPEAL PROCESS |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|-----------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>How to Initiate</b>            | <p><b>Contact Clinical Services to initiate an expedited appeal.</b> Clinical Services may request additional information to be faxed if needed.</p> <ul style="list-style-type: none"> <li>• Pennsylvania: <ul style="list-style-type: none"> <li>• Western Region Facilities: <b>1-800-242-0514</b></li> <li>• Western Region Professional Providers: <b>1-800-547-3627</b></li> <li>• Central Region Facilities: <b>1-866-803-3708</b></li> <li>• Central Region Professional Providers: <b>1-866-731-8080</b></li> <li>• Northeastern Region: <b>1-800-452-8507</b></li> </ul> </li> <li>• Delaware: <ul style="list-style-type: none"> <li>• For IP/OP medical requests: <b>1-800-572-2872</b></li> <li>• For IP/OP behavioral health requests: <b>1-800-421-4577</b></li> </ul> </li> <li>• West Virginia: <b>1-800-344-5245</b></li> </ul> |
| <b>When to Initiate</b>           | <p>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:</p> <ul style="list-style-type: none"> <li>• Pennsylvania and West Virginia: Within <b>one hundred eighty (180) days</b> from receipt of the denial notification</li> <li>• Delaware: Within <b>ninety (90) days</b> from receipt of the denial notification</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Decision Time Frame</b>        | <p>As expeditiously as the member's health requires, but <b>not to exceed seventy-two (72) hours</b> from receipt of the appeal request, a decision is rendered to uphold or reverse the original denial.</p> <p><b>Note:</b> For Act 68 expedited appeals in Pennsylvania, the decision time frame is <b>not to exceed forty-eight (48) hours</b>. Please refer to the section later in this unit titled "Expedited Grievance: Filing On Behalf of a Member (PA Act 68)" for additional information.</p>                                                                                                                                                                                                                                                                                                                                         |

*Continued on next page*

## 5.5 EXPEDITED PROVIDER APPEAL PROCESS, Continued

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**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
-

## 5.5 STANDARD PROVIDER APPEAL PROCESS

[What Is My Service Area?](#)

|                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|---------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Introduction</b>             | <p>This process applies to preservice denials in non-urgent situations <b>and</b> also to appeals of a post-service denial decision, including denials resulting from retrospective reviews of services rendered without the required authorization.</p> <p>Requests for standard appeals may be submitted either by telephone or in writing.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>When to initiate</b>         | <p>A provider must file an appeal within the applicable time frame from the initial denial of coverage:</p> <ul style="list-style-type: none"> <li>• Pennsylvania and West Virginia: Within <b>one hundred eighty (180) days</b> from receipt of the denial notification</li> <li>• Delaware: Within <b>ninety (90) days</b> from receipt of the denial notification</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Appeal process</b>           | <p>The following process is followed for standard provider appeals:</p> <ol style="list-style-type: none"> <li>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).</li> <li>2. 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.</li> <li>3. A clinical peer reviewer who was not involved in the original denial decision reviews the case.</li> <li>4. The provider is notified of the decision by telephone <b>within thirty (30) calendar days</b> of receipt of the request and all pertinent information. Written notification is sent to the provider and the member.</li> </ol> |
| <b>To initiate by telephone</b> | <p>To initiate a standard provider appeal by phone, contact Clinical Services by calling the applicable telephone number for your service area:</p> <p><b>PENNSYLVANIA:</b></p> <ul style="list-style-type: none"> <li>• Western Region Facilities: <b>1-800-242-0514</b></li> <li>• Western Region Professional Providers: <b>1-800-547-3627</b></li> <li>• Central &amp; Northeastern Region Facilities: <b>1-866-803-3708</b></li> <li>• Central &amp; Northeastern Region Professional Providers: <b>1-866-731-8080</b></li> </ul> <p><b>DELAWARE:</b></p> <ul style="list-style-type: none"> <li>• For IP/OP medical requests: <b>1-800-572-2872</b></li> <li>• For IP/OP behavioral health requests: <b>1-800-421-4577</b></li> </ul> <p><b>WEST VIRGINIA: 1-800-344-5245</b></p>                                                                              |

*Continued on next page*

## 5.5 STANDARD PROVIDER APPEAL PROCESS, Continued

[What Is My Service Area?](#)

### Mailing addresses

Submit all pertinent information to the applicable address below:

|                                                                   | PRESERVICE APPEALS                                                                                                                                                                                        | POST-SERVICE APPEALS                                                                                                                                                                                            |
|-------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Pennsylvania: Western Region</b>                               | Professional Providers & Facilities:<br>Highmark<br>120 Fifth Avenue<br>Suite P4301<br>Pittsburgh, PA 15222                                                                                               | Professional Providers & Facilities:<br>Highmark<br>Medical Review<br>P.O. Box 890392<br>Camp Hill, PA 17089-0392                                                                                               |
| <b>Pennsylvania: Central, Eastern, &amp; Northeastern Regions</b> | Professional Providers:<br>Highmark Blue Shield<br>Attn: Appeals<br>P.O. Box 890035<br>Camp Hill, PA 17089-0035<br><br>Facilities:<br>Highmark<br>120 Fifth Avenue<br>Suite P4301<br>Pittsburgh, PA 15222 | Professional Providers:<br>Highmark Blue Shield<br>Attn: Appeals<br>P.O. Box 890035<br>Camp Hill, PA 17089-0035<br><br>Facilities:<br>Highmark<br>Medical Review<br>P.O. Box 890392<br>Camp Hill, PA 17089-0392 |
| <b>Delaware</b><br>(all providers)                                | Highmark BCBSDE, Inc.<br>Medical Management Appeals<br>P.O. Box 1991<br>Del Code 1-8-40<br>Wilmington, DE 19899-1991                                                                                      | Highmark BCBSDE, Inc.<br>Medical Management Appeals<br>P.O. Box 1991<br>Del Code 1-8-40<br>Wilmington, DE 19899-1991                                                                                            |
| <b>West Virginia</b><br>(all providers)                           | Highmark West Virginia<br>Attention: Appeals Committee<br>P.O. Box 535095<br>Pittsburgh, PA 15253-5095                                                                                                    | Highmark West Virginia<br>Attention: Medical Review<br>P.O. Box 1948<br>Parkersburg, WV 26102                                                                                                                   |
| <b>Behavioral Health Services</b><br>(all service areas)          | Please submit the information to:<br>Highmark Clinical Services<br>Attn: Behavioral Health<br>120 Fifth Avenue, Suite P4205<br>Pittsburgh, PA 15222                                                       |                                                                                                                                                                                                                 |

### Final level of internal appeals

In West Virginia and Delaware, provider appeal rights are exhausted after the standard appeal. In Pennsylvania, the standard appeal is the final level of internal appeal for facility providers. For Pennsylvania practitioners, the Medical Review Committee will consider any unresolved provider matters; the decision is considered your final level of internal appeal and not subject to further appeal to Highmark. Please see the [Medical Review Committee](#) section at the end of this unit for additional information about this committee.

## 5.5 FILING AN APPEAL ON BEHALF OF THE MEMBER

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### Overview

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.

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).

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 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, which include contract exclusions, non-covered benefits, and 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

The appeal may be submitted verbally or in writing and should include supporting documentation. Unless requesting an expedited appeal, the following forms must be completed to submit an appeal request in writing:

- Pennsylvania and West Virginia: [Designation of an Authorized Representative](#)
- Delaware: [Designation of Personal Representative for Appeal Processes](#)

These forms can be found on the Provider Resource Center in your service area. Select **FORMS** from the main menu, and then **Miscellaneous 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 Designation (must be in writing) at any time during the process.

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## 5.5 FILING AN APPEAL ON BEHALF OF THE MEMBER, Continued

**Filing time frame** The appeal must be filed no later than **one-hundred eighty (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 can be mailed to:

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### 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

### DELAWARE:

Highmark Blue Cross Blue Shield Delaware  
Attn: Customer Service Appeals Team  
P.O. Box 8832  
Wilmington, DE 19899-8832

### WEST VIRGINIA:

Highmark West Virginia  
P. O. Box 1988  
Parkersburg, WV 26101

**FEP members** For member appeals and reconsiderations for the Federal Employee Program (FEP), please contact **FEP Customer Service** for your service area:

- Pennsylvania: **1-866-763-3608**
- Delaware: **1-800-721-8005**
- West Virginia: **1-800-535-5266**

*Continued on next page*

## 5.5 FILING AN APPEAL ON BEHALF OF THE MEMBER, Continued

|                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|-------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Letter acknowledging receipt</b> | <p>An acknowledgement letter will be sent to the member or to the provider filing on behalf of the member <b>within five (5) business days</b> from receipt of the request. The letter will include:</p> <ul style="list-style-type: none"> <li>• A description of the appeal process.</li> <li>• A statement affording the opportunity for the member to submit written comments, documents, or other information relating to the appeal.</li> <li>• 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.</li> </ul> |
| <b>Medical necessity appeals</b>    | <p>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 that was involved in the adverse benefit determination.</p>                                                                                                                                                                                              |
| <b>Benefit related appeals</b>      | <p>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.</p> <div data-bbox="1052 1098 1380 1155" style="border: 1px solid blue; border-radius: 10px; padding: 2px; text-align: center;"> <a href="#">What Is My Service Area?</a> </div>                                                                                                                                                                                                                                                                                                                    |
| <b>Decision time frame</b>          | <p>In Pennsylvania and West Virginia, the member and the provider filing on behalf of the member will be notified of the decision in writing <b>within thirty (30) calendar days</b> from receipt of the request.</p> <p>In Delaware, the member and the provider filing on behalf of the member will be notified of the decision in writing <b>within thirty (30) calendar days</b> from receipt of the request for preservice appeals, and <b>thirty to sixty (30-60) calendar days</b> for post-service appeals.</p> <p>Decision letters will provide information on any additional appeal rights that are available.</p>                                                                |

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## 5.5 FILING AN APPEAL ON BEHALF OF THE MEMBER, Continued

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### 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;
- 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 seventy-two (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.

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## 5.5 GRIEVANCE: FILING ON BEHALF OF A MEMBER (PA ACT 68)

### Overview



The Pennsylvania Quality Health Care Accountability Protection Act (Act 68) is legislation enacted to protect the rights of those enrolled in managed care health plans. This act contains provisions that require health plans to establish procedures for member dissatisfactions, complaints, and grievances according to the legislative guidelines.

Any Highmark managed care member has the right to file a grievance for a medical necessity issue or a complaint for a benefit issue, as applicable, if they are not satisfied with decisions made by Highmark. Act 68 gives the provider the option of filing a grievance, but not a complaint, on behalf of the member as long as the provider obtains the member's written consent. An Act 68 grievance 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.

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### Definitions



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 managed care 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 a **grievance** when the member, or the member's authorized representative, files a written or verbal request for review of a denial of payment of a health care service **on the basis of medical necessity and appropriateness**.

### Applicable products



The Act 68 grievance process described here applies to these Highmark managed care products in Pennsylvania:

- Commercial HMO products in the Western and Northeastern Regions.
- Children's Health Insurance Program (CHIP) HMO plans in the Western and Northeastern Regions; and CHIP PPO Plus plans in the Central Region.

Although the Act 68 Grievance process applies to HMO commercial plans, even those not governed by the Employee Retirement Income Security Act of 1974 (ERISA), **self-insured employer groups are not obliged to comply with this process.**

*Continued on next page*

## 5.5 GRIEVANCE: FILING ON BEHALF OF A MEMBER (PA ACT 68),

Continued

### Definition of a member grievance/appeal



A **member grievance/appeal** is a process by which a member or member's authorized representative (or provider on behalf of a member), with the written consent of the member, may file a written or verbal grievance regarding the denial of payment of a health care service on the basis of medical necessity and appropriateness. A grievance may be filed regarding a decision that:

1. Disapproves full or partial payment for a requested health care service; or
2. Approves the provision of a requested health care service for a lesser scope or duration than expected; or
3. Disapproves payment for the provision of a requested health care service but approves payment for the provision of an alternative health care service.

[What Is My Service Area?](#)

### Member's written consent required



A valid written consent, signed by the member, is required before a provider may proceed with the Act 68 grievance process. The [Designation of an Authorized Representative](#) form must be completed in its entirety. This form is available on the Provider Resource Center -- select **FORMS**, and then **Miscellaneous Forms**.

The member may not submit a separate grievance on the same issue without rescinding the consent in writing. The member may rescind consent at any time during the grievance process.

### Filing time frame and address



The appeal must be filed no later than **one-hundred eighty (180) days** after receipt of the original denial notification.

The grievance may be submitted verbally or in writing with supporting documentation and the completed three-page *Designation of an Authorized Representative* form. Verbal grievances 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

### Billing restrictions



Once a health care provider assumes responsibility for filing a grievance, the provider may not bill the member or the member's legal representative for services that are the subject of the grievance until the grievance process has been completed or the member rescinds consent.

*Continued on next page*

## 5.5 GRIEVANCE: FILING ON BEHALF OF A MEMBER (PA ACT 68),

Continued

### Letter to acknowledge receipt



An acknowledgement letter will be sent to the member and the provider filing on behalf of the member **within five (5) business days** from receipt of the grievance request.

The acknowledgement letter will include the following information:

- The right to submit additional information to support the appeal.
- Thirty (30) days for resolution.
- Confirmation that Highmark considers the matter to be a grievance rather than a complaint, and that the member, member's representative, or provider may question the classification of complaints and grievances by contacting the Pennsylvania Department of Health.
- Description of the grievance process.
- Member may appoint a representative to act on his or her behalf at any time during the internal grievance process.
- The member, the member's representative, or the provider filing on behalf of the member may review information related to the grievance upon request and also 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 grievance.

[What Is My Service Area?](#)

### Grievance review process – First Level



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 grievance 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 thirty (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.

*Continued on next page*

## 5.5 GRIEVANCE: FILING ON BEHALF OF A MEMBER (PA ACT 68),

Continued

### Requesting a second level grievance review



It is not necessary for written member consent for each level of the grievance process. A second level grievance request **must be submitted in writing within forty-five (45) days** from receipt of the first level grievance decision.

A hearing notification letter will be sent to the member and to the provider filing on behalf of the member **at least fifteen (15) days** prior to the hearing date. The notification advises the member and the provider filing on the member's behalf that they have the right to attend and appear before the Second Level Review Committee or participate via phone.

[What Is My Service Area?](#)

### Grievance review process – Second Level



The Second Level Review Committee will be made up of three (3) or more individuals who did not previously participate in the decision to deny coverage or payment for the services. The members of the Review Committee shall have the duty to be impartial in their review and decision. A provider in the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment will be assigned. It will be an individual who was not involved in any previous adverse decisions regarding the grievance and will not be a subordinate of any individual previously involved.

The member and the provider filing on behalf of the member will be notified of the decision **within thirty (30) days** from receipt of the grievance request. The decision letter will include specifics of the grievance issue and reasons for the decision, as well as the procedure and time frames for filing a request for an external review. This letter will also advise whether the member/provider has third level external review rights (grandfathered groups), or independent external review rights (non-grandfathered groups).

### Grievance review process – Third Level



**The Third Level grievance review process applies to grandfathered groups only.** Third level review requests must be submitted to Highmark **within fifteen (15) days** from receipt of the second level grievance decision. Within five (5) business days of receiving the request, Highmark will notify the Pennsylvania Department of Health (DOH) and request an assignment of an Independent Review Organization (IRO).

The DOH will randomly select an IRO to review the case and will notify the member and the provider filing on behalf of the member of the assigned IRO. Highmark will forward the case file to the IRO **within fifteen (15) days** of the request. Highmark will send the member and provider notification when the external grievance is filed, which will include a listing of all documents forwarded to the IRO. Any additional information must be submitted within fifteen (15) days of receipt of the notice that the external grievance was filed.

*Continued on next page*

## 5.5 GRIEVANCE: FILING ON BEHALF OF A MEMBER (PA ACT 68),

Continued

### Grievance review process – Third Level (continued)



The IRO will assign a practitioner in the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment involved in the grievance and who was not involved in any previous decisions related to the grievance. The assigned IRO will review and issue a written decision **within sixty (60) days** of the filing of the request for an external grievance review. The written notification of the decision will be sent to the member, the provider filing on behalf of the member, Highmark, and the DOH. Highmark will implement the IRO's decision within the time frame specified by the IRO.

If the external grievance is requested by a provider, the Plan and the provider must each establish an escrow account in the amount of half the anticipated cost of the review. If the IRO's decision in an external grievance review filed by a provider is against the provider in full, the provider shall pay the fees and costs associated with the external grievance. If the IRO's decision is against the Plan in full or in part, the Plan will pay the fees and costs associated with the external grievance review.

[What Is My Service Area?](#)

### Independent external review



**Independent external review applies to non-grandfathered groups.** Independent external review requests must be submitted to Highmark **within four (4) months** from receipt of the second level decision letter. **Within five (5) business days** from Highmark's receipt of the external review request, 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 member/member's representative has provided all the information and forms required to process an external review.

**Within one (1) business day** after completion of the preliminary review, Highmark will issue a written notification to the member and the provider filing on behalf of the member. If the request is not complete, the notification will describe the necessary information needed to proceed.

Highmark will assign an Independent Review Organization (IRO) who will review all information and make a decision **within forty-five (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, and Highmark.

## 5.5 EXPEDITED GRIEVANCE: FILING ON BEHALF OF A MEMBER (PA ACT 68)

### Overview



A managed care member may request an expedited review at any stage of the Act 68 grievance review 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 grievance process, the member has **one-hundred eighty (180) days** from the notification of an adverse benefit determination to file an expedited grievance. Act 68 also gives the provider the option of filing an expedited grievance on behalf of the member.

**Note:** When an expedited grievance is requested, an additional level of internal appeal is not available.

[What Is My Service Area?](#)

### Expedited grievance defined



An **expedited grievance** is a request for an expedited review of an initial denial for a medical, pharmaceutical, or behavioral health service based on medical necessity and appropriateness when:

- A delay in decision-making might jeopardize the member's life, health, or ability to regain maximum function based on a prudent layperson's judgment and confirmed by the treating practitioner; *or*
- In the opinion of a practitioner with knowledge of the member's medical condition, a delay 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*
- It is 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*
- it is concerning a concurrent review.

### Expedited grievance process



Requests from providers may be either verbal or in a written format and will be accepted as expedited requests. If a member submits the same type of request, Highmark requires the provider to submit a *Physician Certification for Expedited Review Form* for verification that the service requires an expedited review. The form is sent directly to the provider and should be returned to Highmark immediately.

Expedited grievances will follow the Second Level review process (see previous section on the standard grievance process), with verbal and written notification of the decision to the member and provider **within forty-eight (48) hours** from receipt of the request.

*Continued on next page*

## 5.5 EXPEDITED GRIEVANCE: FILING ON BEHALF OF A MEMBER (PA ACT 68), Continued

### Expedited grievance process (continued)



It is the responsibility of the member, or the provider filing on behalf of the member, to provide information to Highmark in an expedited manner to allow Highmark to conform to the requirements of the expedited process. The hearing may be held by telephone if the member and/or provider on behalf of the member cannot be present in the short time frame. All information presented at the hearing is read into the record.

If Highmark cannot provide a copy of the report of the same or similar specialist to the member/provider prior to the expedited hearing, Highmark may read the report into the record at the hearing and provide the member and the provider filing on behalf of the member with a copy of the report at that time.

The written decisions to the member and 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.

[What Is My Service Area?](#)

### Expedited external review



For grandfathered groups, the member or provider on behalf of the member has **two (2) business days** from the receipt of the expedited grievance decision to contact Highmark to request an expedited external review.

Highmark will submit a request for an expedited external review to the Pennsylvania Department of Health (DOH) **within twenty-four (24) hours** of receipt of the request. The DOH will assign an Independent Review Organization (IRO) **within one (1) business day** of receiving the request for an expedited review. Highmark will then transfer a copy of the case file to the IRO **within one (1) business day** after being assigned to an IRO. The IRO will have **two (2) business days** following the receipt of the case file to make a decision.

For non-grandfathered groups, the written notification of the expedited review decision will state the basis of the decision, including any clinical rationale and the procedure for obtaining an expedited independent external review. The member or provider on behalf of the member has **four (4) months** from the receipt of the expedited grievance decision to request an expedited external review.



## 5.5 EXPEDITED REVIEW PROCESS UNDER THE AUTISM MANDATE (PA ACT 62)

### 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 twenty-one (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 fifty-one (51) or more employees. The mandate also applies to any contract executed on or after July 1, 2009, by the Children's Health Insurance Program (CHIP).

[What Is My Service Area?](#)

### Expedited internal review process



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). The Second Level Review Committee is made up of three (3) 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 forty-eight (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 (2) business days from receipt of the expedited grievance decision to request an expedited external review.

*Continued on next page*



## 5.5 EXPEDITED REVIEW PROCESS UNDER THE AUTISM MANDATE (PA ACT 62), Continued

[What Is My Service Area?](#)

### Expedited external review



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



To determine if a member is covered under the autism mandate, you can verify the member's coverage using the **Eligibility and Benefits Inquiry** function in NaviNet® or by calling the Provider Service Center.

[Quick  
Reference](#)

## 5.5 MEDICARE ADVANTAGE: PROVIDER APPEALING ON OWN BEHALF

### Overview



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.

[What Is My Service Area?](#)

### When the provider can appeal on its own behalf



A provider can make use of this provider appeal process when all of the following are true:

- The provider is contracted with Highmark
- The member has coverage under a Medicare Advantage product
- The services in question have a medical necessity denial determination, including denials for services considered experimental/investigational or cosmetic in nature
- The member is held financially harmless
- The provider seeks a resolution in order to obtain payment for the services

### Types of appeals



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



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.

*Continued on next page*

## 5.5 MEDICARE ADVANTAGE: PROVIDER APPEALING ON OWN BEHALF, Continued

### Member expedited review rights (continued)



Although these processes are largely member-driven, the provider may represent the member and initiate the expedited review. Highmark must automatically provide an expedited determination to any expedited review request made or supported by a provider.

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 in order to make the request.

[What Is My Service Area?](#)

### Requests for medical records



Providers may be contacted by a Highmark Medical Clinical Services care manager 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 naviHealth denials



A denial of post-acute care services will be issued by naviHealth, similar to the approval of services. naviHealth generates the notification of denial of coverage to both the provider and to the patient. If requested, naviHealth also offers a peer-to-peer clinical conversation with the naviHealth Medical Director.

**Any appeal of the denial of services rendered by naviHealth 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 **1-800-485-9610**.

**naviHealth** will handle appeals after the member has been discharged from the post-acute care facility and a denial has been received. naviHealth can be contacted for **post service** provider appeals as follows:

- Phone **1-844-838-0929**; Fax **1-855-893-5963**
- Address for appeals: naviHealth  
Attention: Provider Appeals  
10 Cadillac Drive, Suite 400  
Brentwood, TN 3702

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## 5.5 MEDICARE ADVANTAGE: PROVIDER APPEALING ON OWN BEHALF, Continued

[What Is My Service Area?](#)

### Expedited appeal process



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. All concurrent service appeals are considered urgent.

The table below explains the process for expedited reviews of initial determinations or appeals for Medicare Advantage members:

| EXPEDITED APPEALS                          |                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|--------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>How to Initiate</b>                     | Requests for expedited review can be initiated either verbally or in writing.<br><br>Call the Medicare Advantage Expedited Review Department at <b>1-800-485-9610</b> ;<br><br><b>or</b><br><br>Fax the information to <b>1-800-894-7947</b> ;<br><br><b>or</b><br><br>Submit all pertinent medical and other information to:<br>Medicare Advantage<br>Expedited Review Department<br>P.O. Box 535073<br>Pittsburgh, PA 15253-5073 |
| <b>When to Initiate</b>                    | Prior to rendering services, continuing services, or prior to the member's discharge from the facility; but <b>within one hundred eighty (180) days</b> from receipt of the denial notification.                                                                                                                                                                                                                                   |
| <b>Decision Time Frame</b>                 | As expeditiously as the member's health requires, but <b>not to exceed seventy-two (72) hours</b> from receipt of the appeal request. The 72-hour time frame may be extended by up to fourteen (14) calendar days if the member requests or if additional information is needed.                                                                                                                                                   |
| <b>If a denial determination is upheld</b> | If the initial denial determination is upheld, Highmark is required to forward the case to the CMS appeals contractor <b>within twenty-four (24) hours</b> of the decision. The appeals contractor may request additional information. If you are contacted, please respond to the request immediately.                                                                                                                            |

*Continued on next page*

## 5.5 MEDICARE ADVANTAGE: PROVIDER APPEALING ON OWN BEHALF, Continued

### Standard appeal process



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                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                             |                              |          |          |                      |                |                 |                 |                           |                          |
|------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|------------------------------|----------|----------|----------------------|----------------|-----------------|-----------------|---------------------------|--------------------------|
| <a href="#">What Is My Service Area?</a> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                             |                              |          |          |                      |                |                 |                 |                           |                          |
| <b>How to Initiate</b>                   | <p>Call the applicable Provider Service Center number:</p> <p><b>PENNSYLVANIA</b></p> <ul style="list-style-type: none"> <li>Freedom Blue PPO: <b>1-866-588-6967</b></li> <li>Community Blue HMO: <b>1-888-234-5374</b></li> <li>Community Blue Medicare PPO: <b>1-866-588-6967</b></li> <li>Community Blue Medicare PPO Plus: <b>1-866-588-6967</b></li> <li>Security Blue HMO (Western Region Only): <b>1-866-517-8585</b></li> </ul> <p><b>WEST VIRGINIA:</b> Freedom Blue PPO: <b>1-888-459-4020</b></p> <p><i>or</i></p> <p>Submit all pertinent medical and other information to the appropriate address below:</p> <table border="0"> <tr> <td><b>Pre-Service Appeals:</b></td><td><b>Post-Service Appeals:</b></td></tr> <tr> <td>Highmark</td><td>Highmark</td></tr> <tr> <td>Grievance Department</td><td>Medical Review</td></tr> <tr> <td>P.O. Box 535047</td><td>P.O. Box 890392</td></tr> <tr> <td>Pittsburgh, PA 15253-5073</td><td>Camp Hill, PA 17089-0392</td></tr> </table> | <b>Pre-Service Appeals:</b> | <b>Post-Service Appeals:</b> | Highmark | Highmark | Grievance Department | Medical Review | P.O. Box 535047 | P.O. Box 890392 | Pittsburgh, PA 15253-5073 | Camp Hill, PA 17089-0392 |
| <b>Pre-Service Appeals:</b>              | <b>Post-Service Appeals:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                             |                              |          |          |                      |                |                 |                 |                           |                          |
| Highmark                                 | Highmark                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                             |                              |          |          |                      |                |                 |                 |                           |                          |
| Grievance Department                     | Medical Review                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                             |                              |          |          |                      |                |                 |                 |                           |                          |
| P.O. Box 535047                          | P.O. Box 890392                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                             |                              |          |          |                      |                |                 |                 |                           |                          |
| Pittsburgh, PA 15253-5073                | Camp Hill, PA 17089-0392                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                             |                              |          |          |                      |                |                 |                 |                           |                          |
| <b>When to Initiate</b>                  | Within <b>sixty (60) days</b> from receipt of the denial notification.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             |                              |          |          |                      |                |                 |                 |                           |                          |
| <b>Decision Time Frame</b>               | Within <b>thirty (30) calendar days</b> from the receipt of the appeal request.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                             |                              |          |          |                      |                |                 |                 |                           |                          |

## 5.5 MEDICARE ADVANTAGE: APPEALS ON BEHALF OF A MEMBER

### Overview



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 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. The member's written consent would be required.

[What Is My Service Area?](#)

### Representative statement



In order to file an appeal on behalf of the member, the provider must have written authorization to do so from the member or from the individual holding the member's power of attorney. The written statement must be forwarded to Highmark along with the appeal materials. Without the statement appointing the facility to act as a representative, the facility cannot initiate an appeal on the member's behalf.

The Centers for Medicare & Medicaid Services (CMS) form entitled *Appointment of Representative* can be used for this purpose and is available on the CMS website at: [www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf](http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf).

Although the member is not required to use the CMS form and they may write their own representative statement appointing a provider 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 provider** (either contracting or non-contracting) can act as the member's representative *without* a signed representative statement.

*Continued on next page*

## 5.5 MEDICARE ADVANTAGE: APPEALS ON BEHALF OF A MEMBER,

Continued

### Types of appeals



Two types of appeals are available to the member or to the facility acting as the member's appointed representative:

- Expedited appeal
- Standard appeal

[What Is My Service Area?](#)

### Expedited appeals



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 **seventy-two (72) hours** from receipt of the request.

### Standard appeals



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 **thirty (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 5.3: Medicare Advantage](#).

### Non-participating providers



A non-participating provider can file a standard appeal on behalf of a Medicare Advantage member for post-service denials only if it 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 that do not participate with Highmark's Medicare Advantage products should follow the standard appeals process as outlined below when appealing a post-service denial.

*Continued on next page*



## 5.5 MEDICARE ADVANTAGE: APPEALS ON BEHALF OF A MEMBER,

Continued

[What Is My Service Area?](#)

### Appeal processes



The table below explains the expedited and standard appeal processes for Medicare Advantage.

|                            | EXPEDITED APPEALS                                                                                                                                                                                                                                                                                                                        | STANDARD APPEALS                                                                                                                                                                                                                                 |
|----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>How to Initiate</b>     | <p>Call the Medicare Advantage Expedited Review Department at <b>1-800-485-9610</b>.</p> <p><b>or</b></p> <p><b>Fax</b> the request to <b>1-800-894-7947</b>.</p> <p><b>or</b></p> <p>Submit all pertinent information to:<br/>Medicare Advantage<br/>Expedited Appeals Department<br/>P.O. Box 535073<br/>Pittsburgh, PA 15253-5073</p> | <p>Submit all pertinent information to:<br/>Highmark Appeals and Grievance Department<br/>P.O. Box 534047<br/>Pittsburgh, PA 15253-5047</p> <p><b>or</b></p> <p><b>Fax</b> the information to the Appeals department at <b>717-635-4209</b>.</p> |
| <b>When to Initiate</b>    | <ul style="list-style-type: none"> <li>• <b>Prior authorization denials:</b><br/>Before rendering the service.</li> <li>• <b>Concurrent review denials:</b><br/>Before discharge or continuation of treatment.</li> </ul>                                                                                                                | <b>Within sixty (60) days</b> from receipt of the denial notification (if good cause is shown, written requests can be accepted after 60 days).                                                                                                  |
| <b>Decision Time Frame</b> | Within one (1) business day of receipt of complete information, <b>not to exceed seventy-two (72) hours</b> from receipt of the request.                                                                                                                                                                                                 | As expeditiously as the member's health requires, but <b>no later than thirty (30) calendar days</b> from the receipt of the appeal request.                                                                                                     |

### Fourteen (14) day extension



The health plan or the facility filing on behalf of the member may request extensions of up to **fourteen (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



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.

The appeals contractor may request additional information. In such cases, a Medicare Advantage appeals administrator 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

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Overview</b>                      | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Expedited appeals</b>             | <p>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.</p> <p>To request an expedited appeal, please contact Highmark's Prescription Drug Department <b>by fax</b> at <b>1-866-240-8123</b>; or <b>by calling 1-800-600-2227</b>.</p> <p>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 (2) business days of receipt of your appeal request.</p>                 |
| <b>Standard appeals</b>              | <p>If you are not eligible for an expedited appeal, or if your expedited appeal resulted in an adverse determination, you may initiate a standard appeal.</p> <p>To request a standard appeal, please contact the Highmark Prescription Drug Department <b>by fax</b> at <b>1-866-240-8123</b>; or <b>by calling 1-800-600-2227</b>.</p> <p>You will be permitted to provide additional information over the telephone, by fax, or by other appropriate means. A decision will be rendered within thirty (30) days of receipt of your appeal request.</p> <p>Appeal requests can also be mailed to:</p> <p style="padding-left: 40px;">Highmark<br/>P.O. Box 279<br/>Pittsburgh, PA 15230-2717<br/>Attn: Provider Appeal Review Committee</p> |
| <b>Appeals on behalf of a member</b> | Providers can initiate appeals on behalf of the member with the member's written consent. 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 one hundred eighty days (180) of member receipt of denial.                                                                                                                                                                                                                                                                                                                                                                                     |

*Continued on next page*

## 5.5 PROVIDER APPEAL RIGHTS FOR PRESCRIPTION DRUG BENEFITS, Continued

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### Appeals on behalf of a member (continued)

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.

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### Questions?

If you have questions about your right to appeal, or about how to file an appeal, please call the Highmark Prescription Drug Department at **1-800-600-2227** between 8:30 a.m. and 4:30 p.m., Monday through Friday.

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## 5.5 MEDICAL REVIEW COMMITTEE – PA ONLY

### What is the MRC?



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.

[What Is My Service Area?](#)

### Breakdown of committee members



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



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



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



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



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, their decision is considered your final level of internal appeal. You will be notified of the MRC decision in writing.

*Continued on next page*

## 5.5 MEDICAL REVIEW COMMITTEE – PA ONLY, Continued

### MRC Process (continued)



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.

[What Is My Service Area?](#)

### 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:

Medical Review Committee (MRC) Coordinator  
Financial Investigations and Provider Review – SP 1W  
Highmark Blue Shield  
P.O. Box 890089  
Camp Hill, PA 17989-0089

### 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.

## CHAPTER 5: CARE AND QUALITY MANAGEMENT

### UNIT 6: QUALITY MANAGEMENT

#### IN THIS UNIT



| TOPIC                                                                              | SEE PAGE |
|------------------------------------------------------------------------------------|----------|
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| Highmark Quality Program Committees                                                | 6        |
| Functional Areas and Their Responsibilities                                        | 8        |
| Case Review Process for Quality Concerns                                           | 13       |
| Corrective Action and Sanctioning                                                  | 15       |
| Clinical Quality                                                                   | 16       |
| Practitioner Office/Facility Site Quality and Medical/Treatment Record Evaluations | 21       |
| Service Quality                                                                    | 34       |
| Highmark Quality Initiatives                                                       | 47       |
| Peer Review Protections                                                            | 50       |

[What Is My Service Area?](#)

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The **PA ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The **DE ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

## 5.6 QUALITY MANAGEMENT PROGRAM OVERVIEW

|                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Introduction</b>                | <p>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.</p> <p>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.</p>                                                                                                                                                            |
| <b>Purpose</b>                     | <p>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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Definitions</b>                 | <p><b>Quality improvement processes</b> 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.</p> <p><b>Quality management</b> is the integrative process that links knowledge, structure, and processes together throughout the organization to assess and improve quality.</p>                                                                                                                                                                                                                                                                                                                                       |
| <b>Highmark Quality Management</b> | <p>Highmark's Quality Management, part of the Clinical Services 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.</p> <p>Quality Management is also accountable for compliance with all applicable external accrediting and regulatory entities such as the:</p> <ul style="list-style-type: none"> <li>• Centers for Medicare &amp; Medicaid (CMS)</li> <li>• National Committee for Quality Assurance (NCQA)</li> <li>• Pennsylvania Department of Health</li> <li>• Pennsylvania Insurance Department</li> </ul> |

*Continued on next page*

## 5.6 QUALITY MANAGEMENT PROGRAM OVERVIEW, Continued

### Organizational structure

The organizational structure of Highmark's Quality Management divides staff responsibilities into these distinct functional areas:

- Accreditation & Compliance
- Clinical Performance Measurement
- Clinical and Service Quality

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 goals of the Quality Program

The goals of the Quality Program are as follows:

1. 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 and 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, customer intimacy, and support 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; and
8. Identify members with complex health needs (e.g., physical or developmental disabilities, multiple chronic conditions, severe mental illness) to effectively manage their special health care needs.

*Continued on next page*

## 5.6 QUALITY MANAGEMENT PROGRAM OVERVIEW, Continued

### 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. Focus group results
14. 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.

*Continued on next page*



## 5.6 QUALITY MANAGEMENT PROGRAM OVERVIEW, Continued

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### **Behavioral health activities**

Behavioral health activities that 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.
  - Adoption and dissemination of clinical practice guidelines for the treatment of depression, substance abuse, and attention deficit hyperactivity disorder (ADHD).
  - New and ongoing preventive behavioral health clinical initiatives.
  - Depression Condition Management Program.
-

## 5.6 HIGHMARK QUALITY PROGRAM COMMITTEES

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Overview</b>                                              | <p>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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Highmark Quality, Safety, and Value Committee (HQSVC)</b> | <p>The Highmark Quality, Safety, and Value Committee (HQSVC) 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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Care Management and Quality Committee (CMQC)</b>          | <p>The Care Management and Quality Committee (CMQC) is a multi-disciplinary committee representing western, central, and northeastern Pennsylvania, Delaware, 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, and physicians in administrative positions with involvement in care management in hospitals are active members.</p> <p>The CMQC has responsibility for the review and approval of the Care Management and Quality 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.</p> <p>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 member satisfaction, health care equity, accessibility of services, practitioner and provider availability, continuity of care, credentialing and recredentialing, delegation and business arrangement oversight, and ongoing regulatory and accrediting body compliance.</p> |

*Continued on next page*

## 5.6 HIGHMARK QUALITY PROGRAM COMMITTEES, Continued

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### **Clinical Advisory Committee (CAC)**

The physician-based Clinical Advisory Committee (CAC) serves to provide input and direction into the clinical quality activities and initiatives of the plan. The CAC reports to the CMQC and was given authority to oversee the clinical activities of the internal Clinical Work Group. The CAC is comprised of practicing Highmark network physicians and other clinical representatives from primary care and appropriate specialties.

The committee is chaired by the designated Senior Medical Director of the Quality Program and is responsible for providing input and direction to the internal Clinical Work Group for the selection and adoption of preventive/chronic care initiatives; identifying outcome measures; quantitative and qualitative data analyses, implementation of intervention strategies, and re-evaluation; and reviewing and approving clinical practice and preventive health guidelines. The CAC meets at least quarterly.

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### **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, 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, and Neurosciences -- 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.

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## 5.6 FUNCTIONAL AREAS AND THEIR RESPONSIBILITIES

### Introduction

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

#### Clinical Performance Measures

1. Annual Healthcare Effectiveness Data and Information Sets (HEDIS®) reporting to meet National Committee for Quality Assurance (NCQA), Centers for Medicare & Medicaid Services (CMS), 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: record of administration, data management, and processes which serve to collect information about how the plan's information management practices comply with HEDIS® reporting requirements and associated on-site audit activities. One Roadmap and audit process will be completed for the Commercial, Medicare Advantage, and Marketplace products in Pennsylvania, West Virginia, and Delaware. Another Roadmap and audit process is required separately by the State of PA for the Children's Health Insurance Plan (CHIP) HMO and CHIP GPPO products. This audit includes a review of the health information system that is maintained to support data collection and analysis efforts for quality improvement activities.
3. Annual patient-level data submission used to calculate the summary-level data for all reported products by the required due date(s).
4. Complete Health Organization Questionnaires (HOQ) on the NCQA website by the CMS-designated due date for all products.
5. Clinical quality of care case reviews of referred member dissatisfactions or adverse events related to deviations from standards of care to include serious reportable events and/or hospital-acquired conditions to ensure a continued network of quality focused providers and to correct all problems identified through internal surveillance, complaints, or other mechanisms.
6. Network facilitation of Blue Distinction® Specialty Care (BDSC) applications for designation in one or more of the BDSCs in the Blue Cross Blue Shield Association (BCBSA)-sponsored BDSC Program, demonstrating expertise in delivering quality and cost effective health care in that specialty area.
7. Patient safety-related activities that demonstrate the measurement of/improvement in the quality and safety of care provided to members.
8. Quality responses for Sales-related requests for information (RFIs).

*Continued on next page*

## 5.6 FUNCTIONAL AREAS AND THEIR RESPONSIBILITIES, Continued

### Clinical Services Quality (continued)

#### Clinical and Service Quality (Medical and Behavioral Health)

1. Appointment accessibility monitoring to ensure that members have appropriate access to primary care, behavioral health care, and specialty care services.
2. Telephone accessibility monitoring to ensure that members have appropriate access to organization services.
3. Member experience/satisfaction monitoring (e.g., dissatisfactions, complaints, appeals, member satisfaction surveys) and determination of service quality improvement opportunities to correct all problems identified through internal surveillance, complaints, or other mechanisms.
4. Vendor selection/management for administration and analysis of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®), behavioral health experience, and enrollee experience surveys.
5. 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.
6. Network adequacy plan maintenance and monitoring specific to the Marketplace products.
7. Clinical outcome monitoring, analysis, and planning/design of initiatives focused on improving the care provided to members, with targeted focus on measures selected for Medicare Advantage Star ratings, Federal Employee Program (FEP) Performance Improvements projects, CHIP Performance Improvement Projects, and Marketplace Quality Reporting System (QRS).
8. Quality Improvement Strategy (QIS) for Marketplace members and Quality Improvement Projects (QIPS) for all Medicare Advantage products.
9. Clinical Practice Guideline (medical and behavioral health) adoption from nationally-recognized evidence-based sources, with practitioner input, and distribution to practitioners to help them make decisions about appropriate health care for specific clinical circumstances and relevant compliance monitoring. Guideline compliance monitoring is done via annual HEDIS® measurements, on-site reviews, and Pay for Value Program outcomes.
10. Continuity and coordination of care monitoring of transitions within medical care and between medical and behavioral health care, identifying opportunities for improvement, and taking action as appropriate.
11. 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. Outreach to improve compliance with Preventive Health Guidelines is also conducted by this team, with expansion of these activities anticipated in 2018.

*Continued on next page*

## 5.6 FUNCTIONAL AREAS AND THEIR RESPONSIBILITIES, Continued

### Clinical Services Quality (continued)

12. Patient safety activity monitoring and development of a formal Patient Safety Program.
13. 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.
14. Behavioral Health Preventive Program management, such as those components focused on alcohol use screening and depression screening post-cardiac event.
15. Collaboration with Clinical Operations on the development and reporting of Chronic Care Improvement Project(s) (CCIPs).
16. Practitioner/provider interventions designed to encourage participation in CMS and Health and Human Services (HHS) Quality Improvement initiatives as applicable.
17. Member and provider interventions to reduce health care disparities.

### Accreditation and Regulatory Compliance

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 Pennsylvania, West Virginia, and Delaware.
  - b. CMS quality-related activities related to Quality Improvement Program components: Quality Improvement Project (QIP) selection, monitoring, and reporting; Chronic Care Improvement Program (CCIP) selection, monitoring, and reporting in collaboration with Clinical Operations.
  - c. Pennsylvania Department of Health (PA DOH) and Pennsylvania Insurance Department (PID) annual reporting/technical advisory monitoring for assigned requirements.
  - d. West Virginia Insurance Commission/Bureau of Medical Services (BMS) compliance (credentialing, delegation oversight, and NCQA accreditation only).
  - 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.

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## 5.6 FUNCTIONAL AREAS AND THEIR RESPONSIBILITIES, Continued

### Clinical Services Quality

(continued)

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 West Virginia and 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.).
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. Member focus group coordination and proposal(s) to improve outcomes.
9. Communications to members and providers regarding Quality Program goals/objectives, progress towards achieving goals, ability to provide input, etc.
10. Health services contracting monitoring to ensure compliance with NCQA requirements.
11. Compliance audits of member notification of practitioner termination and continued access to care to ensure continuity and coordination of care membership.
12. 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.
13. Process improvement lead for Quality area and support for other project teams within Clinical Services (as needed).

### Credentialing Compliance

For Credentialing Compliance functions, please see the Highmark Provider Manual's [Chapter 3.2: Professional Provider Credentialing](#).

*Continued on next page*

## 5.6 FUNCTIONAL AREAS AND THEIR RESPONSIBILITIES, Continued

### Risk Revenue Management

#### Risk Revenue Management Functions

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. 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, etc. This includes, but is not limited to, 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:
  - a. Specified member complaints (Pennsylvania, West Virginia [including West Virginia Family Health (WVFH) as applicable], and Delaware [including Health Options as applicable]).
  - b. Offices with less than 20 office hours availability (PA and DE)
  - c. Annual randomly chosen sample (PA and WV)
  - d. Medical Director requests (PA, WV, and DE)
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 (PA, WVFH as applicable, and DE).
3. Chart abstraction for ICD-10 coding and accurate documentation for the Risk Adjustment, Risk Mitigation Data Validation, and/or Unconfirmed Diagnosis Codes Projects to ensure compliance with CMS data reporting requirements (PA and WV).
4. Chart abstraction for the annual Healthcare Effectiveness Data and Information Set (HEDIS®) hybrid (medical record) reporting requirement (PA, WV, and DE).
5. Inform and educate practice sites regarding data completeness.
6. Educate provider offices relating to Office Site/Medical Record evaluations, HEDIS® medical record review, and/or relating to Revenue Program Management projects.



## 5.6 CASE REVIEW PROCESS FOR QUALITY CONCERNS

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### Overview

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 number of sources, including providers, members, and internal Highmark departments.

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### The initial review

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.
- 

### Analysis of medical records

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.

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### Medical Director review outcomes

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.

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## 5.6 CASE REVIEW PROCESS FOR QUALITY CONCERNS, Continued

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**Provider  
responsibilities**

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 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 involves
- The length 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

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### Clinical Practice and Preventive Guidelines

Preventive services are available for the entire plan membership, which include:

- Adults age 65 and over
- Adults ages 19-64
- Pediatric ages 0-18
- Prenatal/Perinatal

The Outcomes and Guidelines Quality team, in conjunction with participating network providers, review and update the Clinical Practice and Preventive Health Guidelines on an annual basis. The Guidelines are placed on the applicable websites via the Provider Resource Center. A notice regarding the Preventive Health Schedule is also published in the member newsletter and made available via a microsite.

These guidelines are available to the provider community as a reference tool to encourage and assist providers in planning their patients' care.

The **Clinical Practice and Preventative Health Guidelines**, and many other valuable clinical resources are available online via the Resource Center. To access these materials, go to the Resource Center and select **EDUCATION/MANUALS**.

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### 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).

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## 5.6 CLINICAL QUALITY, Continued

### Condition Management Program (continued)

Members are eligible to receive health coaching for these chronic conditions:

- Asthma
- Chronic kidney disease
- COPD
- Depression
- Diabetes
- Heart disease
- Heart failure
- High-risk pregnancy
- HIV/AIDS
- Hyperlipidemia
- Hypertension
- Inflammatory Bowel Disease
- Metabolic Syndrome
- Migraine
- Musculoskeletal
- Osteoporosis
- Upper GI

Providers, members, and family members can learn about the program and refer to the program by calling the 24/7 health information line at **1-888-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 also 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.

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## 5.6 CLINICAL QUALITY, Continued

### 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:

- Collaboration with other departmental areas to catalog the plan's various patient safety activities.
- Development of patient safety-focused written educational offerings for member and provider communications.

### Quality of care case reviews

Clinical Services – Quality 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 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.

| STEP | WHO DOES IT?                                      | WHAT IS DONE?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|------|---------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1    | Registered Nurse from Clinical Services – Quality | <p>Performs a preliminary review to determine whether there is potential for a quality issue.</p> <p>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.</p> <ul style="list-style-type: none"> <li>• IF medical record review indicates no potential for an adverse outcome, closes the case but maintains a record of it to track the provider for similar issues.</li> <li>• IF potential for an adverse outcome is identified or the provider may have contributed to an adverse outcome, passes the case to a Medical Director for review.</li> </ul> |
| 2    | A Highmark Medical Director                       | <p>Reviews the case.</p> <ul style="list-style-type: none"> <li>• IF this review indicates there is no quality issue, the case is closed and tracked by provider for similar issues.</li> <li>• 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 helpful to the review.</li> </ul>                                                                                                                                                                                                                                                              |

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## 5.6 CLINICAL QUALITY, Continued

### Quality of care case reviews (continued)

| STEP | WHO DOES IT?                      | WHAT IS DONE?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|------|-----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 3    | A Highmark Medical Director       | <p>Reviews the case with any additional information provided by the involved provider.</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• The involved provider is notified in writing of the decision, corrective action required, and their appeal rights.</li> </ul> |
| 4    | Provider/ Practitioner            | May choose to appeal these actions before a subcommittee of the Highmark Network Quality and Credentials Committee.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 5    | Clinical Services – Quality Staff | <ul style="list-style-type: none"> <li>• Documents the outcome of the case via the Member Dissatisfaction Tracking Database.</li> <li>• Tracks the incident(s) and providers for similar trending patterns.</li> <li>• Generates confidential reports from this database on a quarterly basis for the Clinical Services – Quality Medical Director to take further action if needed.</li> </ul>                                                                                                                                                                                                                                                                   |

### 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) requirements, and/or those of the Pennsylvania and/or Delaware Department of Health (PA DOH, DE DOH).

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## 5.6 CLINICAL QUALITY, Continued

### HEDIS® (continued)

Understanding the categories in which plans are rated can help you make a choice based on what is important to you. 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) 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.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).



## 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 (Registered Nurses) 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:** When a member dissatisfaction is received about 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:** Annually, using a statistically valid sampling methodology, practice sites will be selected for the Practice Office/Facility Site Quality and Medical/Treatment Record Evaluations.
3. **Annual Less Than 20 Hours Per Week Sites:** 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 twenty (20) hours a week at each practice site (Keystone Health Plan West [KHPW] and Premier Blue Shield networks in Pennsylvania). In addition, any Delaware or West Virginia primary site providing less than twenty (20) primary care hours to members will also have Practice Office/Facility Site Quality and Medical/Treatment Record Evaluations performed. On an annual basis, sites identified as providing less than twenty (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.

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## 5.6 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT RECORD EVALUATIONS, Continued

### Facility quality review process

Quality Management will coordinate the oversight and documentation of an onsite quality assessment visit based upon the type, size, and complexity of the health delivery organization for any facility provider not accredited by a recognized accreditation agency such as CMS or the applicable state agency. A Clinical Quality Management Analyst, who is also a registered nurse, will schedule and complete both the Facility Medical/Treatment Record and the Facility Site Quality evaluations.

Follow-up reviews will be conducted within six (6) months of the previous evaluations for all facility sites that score below Highmark's threshold of eighty (80) percent on both the Facility Medical/Treatment Record and the Facility Site Quality Evaluations. To view these forms, please click on the links below:

- [Facility Medical/Treatment Record Evaluation](#)
- [Facility Site Quality Evaluation](#)

**Note:** Facilities identified with continuous opportunities for improvement for three (3) consecutive visits within a six (6) month interval will be presented to the Credentials Committee as an exception for further recommendations. Providers with deficiencies on repeated re-evaluations may be terminated from the network.

### 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 eighty (80) percent 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.

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## 5.6 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT RECORD EVALUATIONS, Continued

### Review measures

The following tables include the measures assessed in each component of the evaluation.

| PROFESSIONAL OFFICE/FACILITY SITE QUALITY EVALUATION                                                                                                                                                                                                            |     |             |        |                   |                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|-------------|--------|-------------------|--------------------------|
|                                                                                                                                                                                                                                                                 | PCP | Specialists | OB/GYN | Behavioral Health | Applies to Facility Site |
| 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                        |

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## 5.6 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT RECORD EVALUATIONS, Continued

| PROFESSIONAL OFFICE/FACILITY SITE QUALITY EVALUATION (continued)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                       |             |        |                   |                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-------------|--------|-------------------|--------------------------|
| MEASURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Applies to professional office sites: |             |        |                   | Applies to Facility Site |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | PCP                                   | Specialists | OB/GYN | Behavioral Health |                          |
| 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: a) identifies how the laboratory, diagnostic procedures, and/or consultation appointments are tracked; b) identifies staff responsible to ensure results are returned to the office; c) identifies when and how staff match test results with patient's chart; d) identifies how the reviewer (practitioner) notifies how the results should be handled. | X                                     |             |        |                   |                          |

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## 5.6 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT RECORD EVALUATIONS, Continued

| PROFESSIONAL OFFICE/FACILITY SITE QUALITY EVALUATION (continued)                                                                                                                                                                                                                                                                                                                                |                                       |             |        |                   |                          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-------------|--------|-------------------|--------------------------|
| MEASURE                                                                                                                                                                                                                                                                                                                                                                                         | Applies to professional office sites: |             |        |                   | Applies to Facility Site |
|                                                                                                                                                                                                                                                                                                                                                                                                 | PCP                                   | Specialists | OB/GYN | Behavioral Health |                          |
| There is a process in place to ensure patients are notified of abnormal results.                                                                                                                                                                                                                                                                                                                | ×                                     | ×           | ×      | ×                 | ×                        |
| 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: a) OB - high fever, persistent vomiting/diarrhea, bladder infection, increased swelling; b) GYN – unusual vaginal discharge or vaginal bleeding post-menopause/hysterectomy, or detection of breast mass/breast lump. |                                       |             | ×      |                   |                          |
| Regular and routine care appointments that are non-urgent but in need of attention are available within 2-7 days: a) OB – small amount of swelling in ankles or hands, sciatica pain (including hip/leg pain), respiratory infection, UTI symptoms; b) GYN – increased menstrual cramps.                                                                                                        |                                       |             | ×      |                   |                          |
| Regular and routine care appointments for routine wellness appointments are available within 30 days (e.g., regular routine obstetrical and gynecological appointments).                                                                                                                                                                                                                        |                                       |             | ×      |                   |                          |
| Immediate intervention for a life-threatening emergency is required to prevent death or serious harm to patient or others.                                                                                                                                                                                                                                                                      |                                       |             |        | ×                 |                          |
| 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.                                                                                                                                                                                                                    |                                       |             |        | ×                 |                          |
| Timely evaluation (within 48 hours) is needed for urgent care 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.                                                                                                                                                                                                                                                                          |                                       |             |        | ×                 |                          |
| There is a fire extinguisher that is visible, easily accessible, and the expiration date is current.                                                                                                                                                                                                                                                                                            |                                       |             |        |                   | ×                        |
| The exits are clearly marked.                                                                                                                                                                                                                                                                                                                                                                   |                                       |             |        |                   | ×                        |
| A written emergency disaster and evacuation plan is posted in patient areas.                                                                                                                                                                                                                                                                                                                    |                                       |             |        |                   | ×                        |
| Used syringes, scalpels, etc. are disposed of in rigid, unpierceable, leak proof containers and the containers are accessible in the area of use.                                                                                                                                                                                                                                               |                                       |             |        |                   | ×                        |

*Continued on next page*

## 5.6 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT RECORD EVALUATIONS, Continued

| PROFESSIONAL OFFICE/FACILITY SITE QUALITY EVALUATION (continued)                                                                                                                                                                                                     |                                       |             |        |                   |                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-------------|--------|-------------------|--------------------------|
| MEASURE                                                                                                                                                                                                                                                              | Applies to professional office sites: |             |        |                   | Applies to Facility Site |
|                                                                                                                                                                                                                                                                      | PCP                                   | Specialists | OB/GYN | Behavioral Health |                          |
| Biohazard wastes are disposed in red, labeled biohazardous waste bags and contained within a labeled, rigid closeable container.                                                                                                                                     |                                       |             |        |                   | ×                        |
| 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 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.                                                                                                                                           |                                       |             |        |                   | ×                        |
| A thermometer is present in the medication refrigerator/freezer and the temperature is recorded daily.<br>Refrigerator: 35-46 degrees F (2-8 C).<br>Freezer: 5 degrees F (-5C).                                                                                      |                                       |             |        |                   | ×                        |
| Medical equipment and instruments are properly disinfected or sterilized. a) Heat temperature strips and spore testing; b) Cold disinfection (20-45 minutes); c) Cold sterilization (10 hours).                                                                      |                                       |             |        |                   | ×                        |
| All medications and prescription pads are adequately protected from patient access.                                                                                                                                                                                  |                                       |             |        |                   | ×                        |
| All medications, including samples, are checked for expiration dates on a regular basis.                                                                                                                                                                             |                                       |             |        |                   | ×                        |
| A CPR-certified staff member is present during all hours of operation. (Current CPR cards should be on file and available for review.)                                                                                                                               |                                       |             |        |                   | ×                        |
| A system for the supply of oxygen is available in the event of a medical emergency. (Not applicable for Retail Clinic sites.)                                                                                                                                        |                                       |             |        |                   | ×                        |
| 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.) |                                       |             |        |                   | ×                        |
| There is a reliable emergency electrical power source available.                                                                                                                                                                                                     |                                       |             |        |                   | ×                        |
| Consent forms are utilized for invasive procedures performed in the facility.                                                                                                                                                                                        |                                       |             |        |                   | ×                        |
| There is an infection control plan in place.                                                                                                                                                                                                                         |                                       |             |        |                   | ×                        |

Continued on next page

## 5.6 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT RECORD EVALUATIONS, Continued

| PROFESSIONAL OFFICE/FACILITY SITE QUALITY EVALUATION (continued)                                                                                               |                                       |             |        |                   |                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-------------|--------|-------------------|--------------------------|
| MEASURE                                                                                                                                                        | Applies to professional office sites: |             |        |                   | Applies to Facility Site |
|                                                                                                                                                                | PCP                                   | Specialists | OB/GYN | Behavioral Health |                          |
| There is a process in place to ensure patients are notified of abnormal test results.                                                                          |                                       |             |        |                   | ×                        |
| The facility has a written policy in effect specifying how communication to the PCP or referring provider is handled in the facility.                          |                                       |             |        |                   | ×                        |
| There is evidence of formal job descriptions which include education/certification requirements for each specified position.                                   |                                       |             |        |                   | ×                        |
| There is documentation of current professional licenses/certificates on file.                                                                                  |                                       |             |        |                   | ×                        |
| There is evidence of outcome measurements for quality improvement which targets high volume services, consumer services, billing practices, or adverse events. |                                       |             |        |                   | ×                        |
| Patient satisfaction surveys are completed and reviewed.                                                                                                       |                                       |             |        |                   | ×                        |

| PROFESSIONAL/FACILITY MEDICAL RECORD EVALUATION                                                                                                                                                                  |                          |             |        |                   |                     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------|--------|-------------------|---------------------|
| MEASURE                                                                                                                                                                                                          | Applies to professional: |             |        |                   | Applies to Facility |
|                                                                                                                                                                                                                  | PCP                      | Specialists | OB/GYN | Behavioral Health |                     |
| An individual clinical record is established, organized, easily located and data is easily retrievable for each patient.                                                                                         | ×                        | ×           | ×      | ×                 | ×                   |
| Each page in the medical record contains the patient's name. Another form of patient identification (e.g., birth date, social security number, identification number, etc.) is documented on the medical record. | ×                        | ×           | ×      | ×                 | ×                   |
| Significant illnesses and medical and behavioral health conditions are indicated on the current problem list and are updated after each office visit and hospitalization.                                        | ×                        | ×           | ×      | ×                 |                     |
| 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.              | ×                        | ×           | ×      | ×                 | ×                   |
| The medical record includes notes from each visit.                                                                                                                                                               |                          |             |        |                   | ×                   |
| Vital signs for each visit are documented.                                                                                                                                                                       |                          |             |        |                   | ×                   |

Continued on next page

## 5.6 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT RECORD EVALUATIONS, Continued

| PROFESSIONAL/FACILITY MEDICAL RECORD EVALUATION                                                                                                                                                                                                                                                                                                                                                                     |                          |   |   |   |                     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|---|---|---|---------------------|
| MEASURE                                                                                                                                                                                                                                                                                                                                                                                                             | Applies to professional: |   |   |   | Applies to Facility |
| Medication and other allergies, adverse reactions, and relevant medical conditions are clearly documented and dated prominently in the record. It is noted if the patient has no known allergies, no history of adverse reactions, or relevant medical conditions.                                                                                                                                                  | X                        | X | X | X | X                   |
| 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 | X                   |
| All entries in the record are dated and are legible to someone other than the writer.                                                                                                                                                                                                                                                                                                                               | X                        | 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 | 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 drugs or other substance abuse. (Assessed at least annually.)                                                                                                                                                                          | X                        | X | X | X | X                   |
| 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 | X                   |
| There is documentation in the medical record that patients are notified of abnormal test results.                                                                                                                                                                                                                                                                                                                   | X                        | X | X | X | X                   |

*Continued on next page*



## 5.6 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT RECORD EVALUATIONS, Continued

| PROFESSIONAL/FACILITY MEDICAL RECORD EVALUATION (continued)                                                                                                                                                                                                                  |                          |             |        |                   |                     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------|--------|-------------------|---------------------|
| MEASURE                                                                                                                                                                                                                                                                      | Applies to professional: |             |        |                   | Applies to Facility |
|                                                                                                                                                                                                                                                                              | PCP                      | Specialists | OB/GYN | Behavioral Health |                     |
| 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                 | 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      |                   | 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      |                   | X                   |
| The assessments or diagnostic impressions (working diagnoses) are consistent with the findings.                                                                                                                                                                              | X                        | X           | X      |                   | X                   |
| The treatment or therapy plans are consistent with the diagnoses.                                                                                                                                                                                                            | X                        | X           | X      |                   | X                   |
| The records contain documentation that the patient/caregiver received and understood instructions regarding the plan of care.                                                                                                                                                |                          |             |        |                   | X                   |
| There is evidence of 6 well care visits in the first 15 months of life to include the following: a) a health and developmental history (physical and mental); b) a physical exam; c) 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: a) developmental assessment; b) anticipatory guidance; c) BMI and BMI percentile; d) counseling for diet/nutrition; e) counseling for physical activity.                                         | X                        |             |        |                   |                     |
| 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                        |             |        |                   |                     |

Continued on next page

## 5.6 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT RECORD EVALUATIONS, Continued

| PROFESSIONAL/FACILITY MEDICAL RECORD EVALUATION (continued)                                                                                                                                                                                                                 |                          |             |        |                   |                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------|--------|-------------------|---------------------|
| MEASURE                                                                                                                                                                                                                                                                     | Applies to professional: |             |        |                   | Applies to Facility |
|                                                                                                                                                                                                                                                                             | PCP                      | Specialists | OB/GYN | Behavioral Health |                     |
| A complete adolescent immunization record with dates of service include: a) meningococcal vaccine (prior to age 13); b) Tdap/Td (between 10-13 years of age). Parental refusal of immunization is documented, if applicable.                                                | ×                        |             |        |                   |                     |
| Adults have routine health screenings that include: a) up-to-date recommended immunizations/vaccinations; b) BMI documented at least every 2 years; c) a physical exam every 1-2 years for patients 19-49 years; d) 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.                                                                                                                    | ×                        |             |        |                   |                     |
| Adults 65 years of age and older are assessed annually for comprehensive pain screening (i.e., Multidimensional Pain Inventory, Faces Pain Scale, etc.)                                                                                                                     | ×                        |             |        |                   |                     |
| 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.                                                                                                                       | ×                        |             |        |                   |                     |
| 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.                                                                                            | ×                        |             |        |                   |                     |
| Adults 65 years of age and older are assessed annually for discussion of bladder control issues.                                                                                                                                                                            | ×                        |             |        |                   |                     |
| The medical record notes colorectal cancer screening for patients 50-75 years of age by any of the following: a) fecal occult blood test – yearly; b) flexible sigmoidoscopy every 5 years; c) double contrast barium enema every 5 years; d) colonoscopy every 10 years.   | ×                        | ×           |        |                   |                     |
| 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.                                                        | ×                        | ×           |        |                   |                     |
| Adults diagnosed with a cardiovascular condition receive an LDL-C screening annually. (Target LDL-C is less than 100.)                                                                                                                                                      | ×                        | ×           |        |                   |                     |

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## 5.6 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT RECORD EVALUATIONS, Continued

| PROFESSIONAL/FACILITY MEDICAL RECORD EVALUATION (continued)                                                                                                                                                                                                                     |                          |             |        |                   |                     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------|--------|-------------------|---------------------|
| MEASURE                                                                                                                                                                                                                                                                         | Applies to professional: |             |        |                   | Applies to Facility |
|                                                                                                                                                                                                                                                                                 | PCP                      | Specialists | OB/GYN | Behavioral Health |                     |
| Patients diagnosed with diabetes mellitus have yearly:<br>a) BP monitoring (<140/90); b) HBA1C and lipid profile;<br>c) nephropathy screening or ACE/ARB prescription; d) dilated retinal eye exam; e) 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.                                                                                                                                   | ×                        | ×           |        |                   |                     |
| Patients diagnosed with rheumatoid arthritis were prescribed a disease modifying anti-rheumatic drug.                                                                                                                                                                           | ×                        | ×           |        |                   |                     |
| 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.                     | ×                        | ×           |        |                   |                     |
| The medical record has evidence of a Chlamydia screening for sexually active women ages 16-24 years of age.                                                                                                                                                                     | ×                        |             | ×      |                   |                     |
| The medical record has evidence of a Pap test every 3 years for women 21-64 years of age.                                                                                                                                                                                       | ×                        |             | ×      |                   |                     |
| The medical record has evidence of mammogram screening every 2 years for women 40-69 years of age.                                                                                                                                                                              | ×                        |             | ×      |                   |                     |
| There is documentation in the medical record that the patient 65 years of age and older was counseled regarding an Advance Directive. (Assess annually.)                                                                                                                        | ×                        |             |        |                   |                     |
| 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.)                                    | ×                        |             |        |                   |                     |
| 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 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. |                          |             | ×      |                   | ×                   |

Continued on next page

## 5.6 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT RECORD EVALUATIONS, Continued

| PROFESSIONAL/FACILITY MEDICAL RECORD EVALUATION (continued)                                                                                                                                                                                                                                                                                                                                                                             |                          |             |        |                   |                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------|--------|-------------------|---------------------|
| MEASURE                                                                                                                                                                                                                                                                                                                                                                                                                                 | Applies to professional: |             |        |                   | Applies to Facility |
|                                                                                                                                                                                                                                                                                                                                                                                                                                         | PCP                      | Specialists | OB/GYN | Behavioral Health |                     |
| 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 are documented in the clinical record.                                                                                                                                                                                                                     |                          |             |        | X                 |                     |
| The mental status exam documents: a) affect/mood; b) speech; c) appearance; d) thought content; e) judgment; f) insight; g) attention; h) memory; i) 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 estimated time frame for goal attainment or problem resolution, and include a preliminary discharge plan, if applicable.                                                                                                                                                                                                               |                          |             |        | X                 |                     |
| 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                 |                     |

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## 5.6 PRACTITIONER OFFICE/FACILITY SITE QUALITY AND MEDICAL/TREATMENT RECORD EVALUATIONS, Continued

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### Partners in Quality Tool Kit

Highmark is committed to promoting quality education and care to members and practitioners. A *Partners in Quality Tool Kit* was developed as a resource for network participating office sites to assist in promoting quality health care to their patients and members.

The tool kit includes 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 Partners in Quality Tool Kit 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 *Partners in Quality Tool Kit* is available on Highmark's online Provider Resource Centers via the Highmark website and NaviNet.® From the main menu, select **EDUCATION/MANUALS**, and then **Quality Management Partners in Quality Tool Kit**.

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## 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 Management Council. Member satisfaction is also monitored through review of member dissatisfactions, complaints, and appeals.

### **2017 CAHPS® and QHP EES survey results**

Highmark contracted 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 find out about the overall experiences of our members and to identify areas of improvement. The results of the 2017 surveys revealed that members continue to rate the health plan highly when compared to other commercial health plans nationally.

The 2017 results are listed in the grids below.

*CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).*

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## 5.6 SERVICE QUALITY, Continued

[What Is My Service Area?](#)


### CAHPS® 2017 Pennsylvania Commercial Survey Comparison

| Survey Question                                                            | HMO                 |                                           |                                                            | PPO                     |                          |                                                 |                                             |                                                            |                                                       |                                                        |
|----------------------------------------------------------------------------|---------------------|-------------------------------------------|------------------------------------------------------------|-------------------------|--------------------------|-------------------------------------------------|---------------------------------------------|------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------|
|                                                                            | 2017 Commercial HMO | 2017 Commercial HMO First Priority Health | 2017 Quality Compass (Non-PPO) 90 <sup>th</sup> Percentile | 2017 Commercial EPO/PPO | 2017 Commercial PPO HHIC | 2017 Commercial PPO Highmark Coverage Advantage | 2017 Commercial PPO Highmark Benefits Group | 2017 Commercial PPO Highmark Select Resources <sup>1</sup> | 2017 Commercial PPO First Priority Life Insurance Co. | 2017 Quality Compass (PPO) 90 <sup>th</sup> Percentile |
| Personal Doctor                                                            | 87.7%↑              | 84.4%↑                                    | 89.4%                                                      | 85.7%↑                  | 84.5%↑                   | 84.0%↓                                          | 84.1%↓                                      | 80.8%                                                      | 88.3%↑                                                | 88.5%                                                  |
| Specialist                                                                 | 88.5%↓              | 86.2%↑                                    | 89.1%                                                      | 87.4%↑                  | 86.8%↑                   | 90.1%↑                                          | 86.4%↑                                      | 73.0%                                                      | 85.5%↑                                                | 88.8%                                                  |
| All Health Care                                                            | 85.4%↑              | 75.7%↑                                    | 84.7%                                                      | 82.8%↑                  | 80.2%↑                   | 75.8%↓                                          | 80.4%↑                                      | 76.5%                                                      | 77.2%↑                                                | 82.5%                                                  |
| Health Plan                                                                | 84.2%↑              | 66.0%↑                                    | 77.8%                                                      | 70.6%↑                  | 69.8%↑                   | 57.5%↓                                          | 57.8%↑                                      | 23.0%                                                      | 59.6%↓                                                | 71.5%                                                  |
| <b>Getting Needed Care</b>                                                 | 89.5%↑              | 86.9%↓                                    | 91.5%                                                      | 90.2%↑                  | 86.4%↓                   | 87.0%↓                                          | 88.8%↑                                      | 88.7%                                                      | 86.8%↓                                                | 91.0%                                                  |
| Ease of getting care, tests, treatment needed                              | 92.9%↑              | 91.6%↓                                    | 93.8%                                                      | 92.3%↑                  | 89.9%↓                   | 88.0%↓                                          | 93.0%↑                                      | 88.2%                                                      | 90.8%↑                                                | 93.9%                                                  |
| Obtained appointment with specialist as soon as needed                     | 86.1%↑              | 82.2%↓                                    | 89.9%                                                      | 88.1%↑                  | 82.9%↓                   | 86.0%↓                                          | 84.5%↓                                      | 89.2%                                                      | 82.7%↓                                                | 88.9%                                                  |
| <b>Getting Care Quickly</b>                                                | 84.8%↓              | 86.1%↓                                    | 90.0%                                                      | 90.7%↑                  | 87.2%↔                   | 85.3%↓                                          | 89.2%↑                                      | 84.4%                                                      | 86.4%↓                                                | 89.4%                                                  |
| Obtained needed care right away                                            | 85.2%↓              | 89.0%↓                                    | 93.2%                                                      | 92.2%↓                  | 89.0%↓                   | 87.0%↓                                          | 94.0%↑                                      | 80.0%                                                      | 87.9%↓                                                | 93.2%                                                  |
| Obtained appointment for care as soon as needed                            | 84.4%↓              | 83.3%↓                                    | 88.3%                                                      | 89.1%↑                  | 85.3%↑                   | 83.7%↓                                          | 84.4%↑                                      | 88.9%                                                      | 85.0%↓                                                | 87.7%                                                  |
| <b>How Well Doctors Communicate</b>                                        | 96.9%↔              | 96.8%↑                                    | 97.2%                                                      | 96.0%↑                  | 96.6%↓                   | 97.5%↓                                          | 96.8%↑                                      | 95.9%                                                      | 96.3%↓                                                | 97.4%                                                  |
| Doctors explained things in an understandable way                          | 96.9%↓              | 98.4%↑                                    | 98.3%                                                      | 96.3%↑                  | 97.8%↓                   | 97.8%↓                                          | 98.4%↑                                      | 97.7%                                                      | 97.3%↓                                                | 98.5%                                                  |
| Doctors listened carefully to you                                          | 96.5%↑              | 97.2%↑                                    | 97.3%                                                      | 96.3%↑                  | 97.8%↑                   | 97.8%↑                                          | 96.1%↑                                      | 95.2%                                                      | 95.9%↓                                                | 97.4%                                                  |
| Doctors showed respect for what you had to say                             | 97.7%↑              | 97.6%↑                                    | 98.2%                                                      | 97.5%↑                  | 96.4%↓                   | 96.4%↓                                          | 95.6%↓                                      | 95.3%                                                      | 97.7%↑                                                | 98.1%                                                  |
| Doctors spent enough time with you                                         | 96.5%↑              | 94.0%↔                                    | 96.5%                                                      | 93.8%↑                  | 94.2%↓                   | 97.8%↓                                          | 97.3%↑                                      | 95.3%                                                      | 94.1%↓                                                | 96.2%                                                  |
| <b>Customer Service</b>                                                    | 91.3%↑              | 88.5%↓                                    | 94.2%                                                      | 80.7%↓                  | 81.4%↑                   | 88.1%↓                                          | 84.7%↑                                      | 88.1%                                                      | 78.3%↓                                                | 93.3%                                                  |
| Getting information/help from customer service                             | 86.7%↑              | 84.2%↓                                    | 90.0%                                                      | 72.9%↓                  | 75.0%↑                   | 85.7%↑                                          | 74.2%↓                                      | 85.7%                                                      | 69.6%↓                                                | 89.8%                                                  |
| Treated with courtesy and respect by customer service staff                | 96.0%↓              | 92.7%↓                                    | 98.2%                                                      | 88.6%↓                  | 87.8%↓                   | 90.5%↓                                          | 95.2%↑                                      | 90.5%                                                      | 87.0%↓                                                | 98.2%                                                  |
| <b>Claims Processing</b>                                                   | 95.6%↑              | 79.4%↓                                    | 93.9%                                                      | 92.5%↓                  | 94.4%↑                   | 83.1%↓                                          | 91.1%↑                                      | 95.0%                                                      | 90.8%↑                                                | 93.4%                                                  |
| Claims handled quickly                                                     | 95.5%↑              | 80.5%↓                                    | 93.1%                                                      | 91.8%↓                  | 96.3%↑                   | 84.7%↓                                          | 89.9%↑                                      | 93.8%                                                      | 90.4%↑                                                | 92.7%                                                  |
| Claims handled correctly                                                   | 95.8%↑              | 78.3%↓                                    | 95.5%                                                      | 93.2%↑                  | 92.6%↑                   | 81.4%↓                                          | 92.3%↑                                      | 96.3%                                                      | 91.2%↑                                                | 94.7%                                                  |
| <b>Plan Information on Costs</b>                                           | 66.6%↓              | 61.9%↑                                    | 70.1%                                                      | 61.4%↓                  | 60.7%↓                   | 68.7%↑                                          | 57.8%↑                                      | 60.0%                                                      | 61.6%↑                                                | 67.3%                                                  |
| Able to find out from health plan cost of health care service or equipment | 65.4%↓              | 62.0%↑                                    | 71.3%                                                      | 58.1%↓                  | 69.2%↑                   | 70.7%↑                                          | 48.5%↓                                      | 53.3%                                                      | 64.4%↑                                                | 66.9%                                                  |
| Able to find out from health plan cost of prescription medicines           | 67.8%↑              | 61.9%↑                                    | 70.8%                                                      | 64.8%↓                  | 52.1%↓                   | 66.7%↑                                          | 67.0%↑                                      | 66.7%                                                      | 58.8%↑                                                | 70.1%                                                  |

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## 5.6 SERVICE QUALITY, Continued

[What Is My Service Area?](#)


### CAHPS® 2017 Pennsylvania Commercial Survey Comparison (continued)

| Survey Question                                                                                                            | HMO                 |                                           |                                                            | PPO                     |                          |                                                 |                                             |                                                |                                                       |                                                        |
|----------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------|------------------------------------------------------------|-------------------------|--------------------------|-------------------------------------------------|---------------------------------------------|------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------|
|                                                                                                                            | 2017 Commercial HMO | 2017 Commercial HMO First Priority Health | 2017 Quality Compass (Non-PPO) 90 <sup>th</sup> Percentile | 2017 Commercial EPO/PPO | 2017 Commercial PPO HHIC | 2017 Commercial PPO Highmark Coverage Advantage | 2017 Commercial PPO Highmark Benefits Group | 2017 Commercial PPO Highmark Select Resources* | 2017 Commercial PPO First Priority Life Insurance Co. | 2017 Quality Compass (PPO) 90 <sup>th</sup> Percentile |
| <b>Shared Decision Making</b>                                                                                              | 79.0%↓              | 85.5%↑                                    | 85.6%                                                      | 81.0%↑                  | 84.4%↑                   | 85.3%↑                                          | 86.4%↑                                      | 85.9%                                          | 83.8%↓                                                | 85.5%                                                  |
| Doctor/health provider talked about reasons you might want to take a medicine                                              | 92.7%↓              | 95.9%↑                                    | 96.6%                                                      | 93.8%↑                  | 97.3%↑                   | 97.3%↑                                          | 93.7%↑                                      | 92.3%                                          | 89.4%↓                                                | 97.2%                                                  |
| Doctor/health provider talked about reasons you might not want to take a medicine                                          | 68.5%↓              | 79.7%↑                                    | 79.7%                                                      | 74.1%↑                  | 73.6%↓                   | 70.7%↓                                          | 81.1%↑                                      | 80.8%                                          | 76.5%↑                                                | 80.5%                                                  |
| Doctor/health provider asked you what you thought was best when talking about starting or stopping a prescription medicine | 75.8%↓              | 81.0%↑                                    | 84.4%                                                      | 75.0%↓                  | 82.2%↑                   | 88.0%↑                                          | 84.4%↑                                      | 84.6%                                          | 85.6%↑                                                | 83.6%                                                  |
| <b>Health Promotion and Education</b>                                                                                      |                     |                                           |                                                            |                         |                          |                                                 |                                             |                                                |                                                       |                                                        |
| Doctor or other health provider talked about specific things to prevent illness                                            | 77.0%↓              | 75.4%↑                                    | 81.0%                                                      | 75.9%↓                  | 69.5%↑                   | 72.9%↓                                          | 74.2%↑                                      | 76.0%                                          | 79.6%↑                                                | 80.2%                                                  |
| <b>Coordination of Care</b>                                                                                                |                     |                                           |                                                            |                         |                          |                                                 |                                             |                                                |                                                       |                                                        |
| Personal doctor seems informed and up-to-date about the care received from doctors or other health providers               | 83.3%↑              | 88.8%↑                                    | 88.1%                                                      | 88.0%↑                  | 77.8%↓                   | 90.9%↑                                          | 87.4%↑                                      | 75.0%                                          | 86.3%↑                                                | 87.7%                                                  |
| <b>Providing Needed Information</b>                                                                                        |                     |                                           |                                                            |                         |                          |                                                 |                                             |                                                |                                                       |                                                        |
| Written materials or the Internet provided the information needed about how the health plan works                          | 75.0%↑              | 55.4%↓                                    | 74.2%                                                      | 63.0%↓                  | 63.2%↑                   | 64.4%↓                                          | 63.2%↑                                      | 54.8%                                          | 63.5%↑                                                | 73.7%                                                  |
| <b>Ease of Filling Out Forms</b>                                                                                           |                     |                                           |                                                            |                         |                          |                                                 |                                             |                                                |                                                       |                                                        |
| Forms were easy to fill out                                                                                                | 96.8%↑              | 96.6%↑                                    | 97.5%                                                      | 97.1%↓                  | 96.0%↑                   | 96.5%↑                                          | 95.4%↓                                      | 95.0%                                          | 95.1%↓                                                | 97.3%                                                  |

YELLOW shading indicates AT or BELOW the 2017 Quality Compass 90<sup>th</sup> Percentile.

<sup>1</sup> No trending available. First year survey was fielded.

↑ ↓ ↔ indicates above, below, or equal to previous year results.

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## 5.6 SERVICE QUALITY, Continued

[What Is My Service Area?](#)


### CAHPS® 2017 Pennsylvania Children's Health Insurance Program (CHIP) Survey Comparison

| Survey Question                                                                                                            | 2017 CHIP<br>HMO Results | 2017 CHIP<br>GPO Results | 2017 CHIP<br>HMO First<br>Priority Health<br>Results | 2017 SPH<br>Analytics Book<br>of Business <sup>1</sup><br>90 <sup>th</sup> Percentile |
|----------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|------------------------------------------------------|---------------------------------------------------------------------------------------|
| Personal Doctor                                                                                                            | 89.7%↓                   | 91.5%↑                   | 90.6%↓                                               | 92.0%                                                                                 |
| Specialist                                                                                                                 | 87.3%↓                   | 92.6%↑                   | 85.7%↑                                               | 91.6%                                                                                 |
| All Health Care                                                                                                            | 90.0%↓                   | 91.9%↑                   | 86.7%↓                                               | 90.0%                                                                                 |
| Health Plan                                                                                                                | 90.0%↓                   | 92.0%↓                   | 86.5%↓                                               | 91.3%                                                                                 |
| <b>Getting Needed Care</b>                                                                                                 | 89.0%↓                   | 89.2%↓                   | 83.7%↓                                               | 89.7%                                                                                 |
| Ease of getting care, tests, treatment needed                                                                              | 94.7%↓                   | 95.1%↓                   | 92.1%↓                                               | 94.5%                                                                                 |
| Obtained appointment with specialist as soon as needed                                                                     | 83.3%↓                   | 83.3%↓                   | 75.4%↓                                               | 85.9%                                                                                 |
| <b>Getting Care Quickly</b>                                                                                                | 95.7%↓                   | 95.0%↓                   | 92.6%↓                                               | 95.0%                                                                                 |
| Obtained needed care right away                                                                                            | 96.5%↓                   | 95.5%↓                   | 95.6%↑                                               | 97.1%                                                                                 |
| Obtained appointment for care as soon as needed                                                                            | 94.9%↓                   | 94.5%↑                   | 89.6%↓                                               | 93.8%                                                                                 |
| <b>How Well Doctors Communicate</b>                                                                                        | 96.6%↓                   | 97.9%↑                   | 97.1%↓                                               | 96.7%                                                                                 |
| Doctors explained things in an understandable way                                                                          | 97.1%↓                   | 98.4%↓                   | 96.6%↑                                               | 97.4%                                                                                 |
| Doctors listened carefully to you                                                                                          | 96.3%↓                   | 98.7%↑                   | 97.2%↑                                               | 97.2%                                                                                 |
| Doctors showed respect for what you had to say                                                                             | 96.8%↓                   | 98.4%↓                   | 97.9%↓                                               | 98.2%                                                                                 |
| Doctors spent enough time with you                                                                                         | 96.3%↓                   | 96.0%↑                   | 96.6%↓                                               | 94.7%                                                                                 |
| <b>Customer Service</b>                                                                                                    | 92.6%↓                   | 94.0%↑                   | 87.3%↓                                               | 92.8%                                                                                 |
| Getting information/help from customer service                                                                             | 89.4%↓                   | 91.4%↑                   | 82.4%↓                                               | 89.1%                                                                                 |
| Treated with courtesy and respect from customer service staff                                                              | 95.8%↓                   | 96.7%↑                   | 92.3%↓                                               | 97.5%                                                                                 |
| <b>Shared Decision Making</b>                                                                                              | 75.2%↓                   | 75.9%↓                   | 75.7%↓                                               | 82.3%                                                                                 |
| Doctor/health provider talked about reasons you might want to take a medicine                                              | 96.6%↑                   | 94.4%↓                   | 94.9%↑                                               | 97.5%                                                                                 |
| Doctor/health provider talked about reasons you might not want to take a medicine                                          | 56.9%↓                   | 60.2%↓                   | 56.0%↓                                               | 69.8%                                                                                 |
| Doctor/health provider asked you what you thought was best when talking about starting or stopping a prescription medicine | 72.0%↓                   | 73.1%↓                   | 76.2%↑                                               | 83.6%                                                                                 |
| <b>Health Promotion and Education</b>                                                                                      |                          |                          |                                                      |                                                                                       |
| Doctor or other health provider talked about specific things to prevent illness                                            | 64.3%↓                   | 64.9%↑                   | 61.7%↓                                               | 73.5%                                                                                 |
| <b>Coordination of Care</b>                                                                                                |                          |                          |                                                      |                                                                                       |
| Personal doctor seems informed and up-to-date about the care from doctors or other health providers                        | 83.2%↓                   | 85.5%↔                   | 82.9%↓                                               | 88.4%                                                                                 |
| <b>Ease of filling out Forms</b>                                                                                           |                          |                          |                                                      |                                                                                       |
| Forms were easy to fill out                                                                                                | 94.1%↓                   | 92.4%↓                   | 91.9%↓                                               | 97.2%                                                                                 |

YELLOW shading indicates AT or BELOW the 2017 SPH Analytics Book of Business (BoB) 90<sup>th</sup> percentile.

<sup>1</sup> The 2017 SPH Analytics Book of Business consists of 69 Medicaid Child (Non-CCC and CCC) samples that conducted surveys with SPH in 2017 and submitted data to NCQA.

↑ ↓ ↔ indicates above, below, or equal to previous year results.

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## 5.6 SERVICE QUALITY, Continued

[What Is My Service Area?](#)


### CAHPS® 2017 Medicare Advantage Survey Comparison -- Pennsylvania and West Virginia

| MEDICARE ADVANTAGE<br>Survey Question                            | 2017 Medicare<br>Advantage HMO<br>PA | 2017 Medicare<br>Advantage PPO<br>PA | 2017 Medicare<br>Advantage PPO<br>WV | 2017 CMS<br>National Average |
|------------------------------------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|------------------------------|
| Personal Doctor                                                  | 95%↓                                 | 96%↑                                 | 94%↔                                 | 94%                          |
| Specialist                                                       | 95%↑                                 | 94%↑                                 | 94%↑                                 | 93%                          |
| All Health Care                                                  | 90%↔                                 | 90%↓                                 | 92%↑                                 | 89%                          |
| Health Plan                                                      | 89%↓                                 | 88%↓                                 | 88%↑                                 | 90%                          |
| Prescription Drug Plan                                           | 84%↓                                 | 87%↔                                 | 83%↔                                 | 88%                          |
| <b>Getting Needed Care</b>                                       | 93%↔                                 | 93%↑                                 | 94%↑                                 | 90%                          |
| Ease of getting care, tests, treatment needed                    | 92%↑                                 | 93%↑                                 | 95%↑                                 | 90%                          |
| Obtained appointment with specialist as soon as needed           | 93%↓                                 | 93%↔                                 | 94%↑                                 | 90%                          |
| <b>Getting Care Quickly</b>                                      | 85%↑                                 | 85%↑                                 | 84%↑                                 | 83%                          |
| Obtained needed care right away                                  | 92%↓                                 | 94%↑                                 | n/a                                  | 91%                          |
| Obtained appointment for care as soon as needed                  | 91%↑                                 | 92%↑                                 | 93%↑                                 | 90%                          |
| Saw the person came to see within 15 minutes of appointment time | 72%↑                                 | 70%↑                                 | 65%↑                                 | 68%                          |
| <b>How Well Doctors Communicate</b>                              | 97%↔                                 | 97%↔                                 | 96%↔                                 | 95%                          |
| Doctors explained things in an understandable way                | 96%↔                                 | 96%↓                                 | 97%↑                                 | 95%                          |
| Doctors listened carefully to you                                | 96%↔                                 | 97%↔                                 | 97%↑                                 | 96%                          |
| Doctors showed respect for what you had to say                   | 98%↔                                 | 98%↑                                 | 98%↑                                 | 96%                          |
| Doctors spent enough time with you                               | 96%↔                                 | 96%↑                                 | 97%↑                                 | 94%                          |
| <b>Customer Service</b>                                          | 94%↔                                 | 95%↑                                 | 97%↑                                 | 93%                          |
| Getting information/help from customer service                   | 88%↑                                 | 90%↑                                 | 92%↑                                 | 87%                          |
| Treated with courtesy and respect by customer service staff      | 96%↓                                 | 97%↔                                 | 99%↑                                 | 96%                          |
| Forms were easy to fill out                                      | 97%↔                                 | 97%↑                                 | 97%↔                                 | 97%                          |
| <b>Coordination of Care</b>                                      | 92%↑                                 | 92%↔                                 | 93%↑                                 | 91%                          |
| Doctor had medical records or other information about your care  | 98%↔                                 | 98%↓                                 | 100%↑                                | 97%                          |
| Personal doctor's office followed up to give you test results    | 89%↑                                 | 89%↓                                 | 93%↑                                 | 88%                          |
| Got test results as soon as you needed                           | 90%↔                                 | 92%↔                                 | 93%↑                                 | 89%                          |
| Doctor talked about prescription medicines                       | 88%↔                                 | 86%↔                                 | 87%↑                                 | 86%                          |
| Got help managing care                                           | 97%↑                                 | 98%↔                                 | n/a                                  | 96%                          |
| Doctor informed and up-to-date about specialty care              | 88%↑                                 | 87%↓                                 | 88%↑                                 | 87%                          |

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## 5.6 SERVICE QUALITY, Continued<sup>95</sup>

[What Is My Service Area?](#)


### CAHPS® 2017 Medicare Advantage Survey Comparison – Pennsylvania and West Virginia (continued)

| MEDICARE ADVANTAGE<br>Survey Question                                                                           | 2017 Medicare<br>Advantage HMO<br>PA | 2017 Medicare<br>Advantage PPO<br>PA | 2017 Medicare<br>Advantage PPO<br>WV | 2017 CMS<br>National Average |
|-----------------------------------------------------------------------------------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|------------------------------|
| <b>Getting Needed Prescription Drugs</b>                                                                        | 96%↓                                 | 96%↔                                 | 97%↔                                 | 95%                          |
| Ease of using health plan to get prescribed medicines                                                           | 96%↔                                 | 95%↓                                 | 95%↔                                 | 94%                          |
| Ease of using health plan to fill prescriptions at local pharmacy                                               | 97%↓                                 | 96%↔                                 | 98%↔                                 | 96%                          |
| Ease of using health plan to fill prescriptions by mail                                                         | 93%↓                                 | 95%↔                                 | 93%↑                                 | 93%                          |
| <b>Staying Healthy</b>                                                                                          |                                      |                                      |                                      |                              |
| Annual Flu Vaccine (Respondents answering "Yes")                                                                | 76%↓                                 | 75%↓                                 | 76%↑                                 | 73%                          |
| <b>Single Items</b>                                                                                             |                                      |                                      |                                      |                              |
| Delaying or Not Filling a Prescription (Respondents answering "No")                                             | 89%↓                                 | 90%↔                                 | 88%↑                                 | 87%                          |
| Pneumonia Vaccine (Respondents answering "Yes")                                                                 | 80%↓                                 | 80%↓                                 | 77%↔                                 | 73%                          |
| Contact: Filled or Refilled a Prescription (Respondents answering "Yes")                                        | 45%↑                                 | 47%↑                                 | 38%↑                                 | 48%                          |
| Contact: Taking Medications as Directed (Respondents answering "Yes")                                           | 24%↑                                 | 21%↑                                 | 24%↑                                 | 31%                          |
| <b>New Questions</b>                                                                                            |                                      |                                      |                                      |                              |
| Health plan offered to lower copay due to health condition (Respondents answering "Yes")                        | 4%                                   | 1%                                   | 3%                                   | 5%                           |
| Health plan offered extra benefits due to health condition (Respondents answering "Yes")                        | 6%                                   | 3%                                   | 4%                                   | 8%                           |
| Spent one or more nights in a hospital (Respondents answering "No")                                             | 86%                                  | 86%                                  | n/a                                  | 88%                          |
| Difficulty walking or climbing stairs (Respondents answering "No")                                              | 72%                                  | 76%                                  | 63%                                  | 69%                          |
| Difficulty dressing or bathing (Respondents answering "No")                                                     | 92%                                  | 94%                                  | 90%                                  | 90%                          |
| Difficulty doing errands alone because of physical, mental, or emotional condition (Respondents answering "No") | 84%                                  | 89%                                  | 77%                                  | 84%                          |
| Use the Internet at home (Respondents answering "Yes")                                                          | 49%                                  | 65%                                  | 54%                                  | 61%                          |

YELLOW shading indicates AT or BELOW the 2017 CMS National Average.

↑ ↓ ↔ indicates above, below, or equal to previous year results. If no arrow is shown, the score in 2016 was an "n/a" or question not included on 2016 survey.

n/a = either too few beneficiaries answered the question to permit reporting or the score had very low reliability.

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## 5.6 SERVICE QUALITY, Continued

[What Is My Service Area?](#)


### CAHPS® 2017 Medicare Advantage Blue Rx Survey Comparison

| MEDICARE ADVANTAGE BLUE RX               |                                                                                    | 2017 Medicare Advantage Blue Rx | 2017 CMS National Average |
|------------------------------------------|------------------------------------------------------------------------------------|---------------------------------|---------------------------|
| Survey Question                          |                                                                                    |                                 |                           |
| Q9                                       | Rating of Prescription Drug Plan                                                   | 82%↑                            | 84%                       |
| <b>Getting Needed Prescription Drugs</b> |                                                                                    | 94%↓                            | 94%                       |
| Q4                                       | Ease of using health plan to get prescribed medicines                              | 92%↓                            | 93%                       |
| Q6                                       | Ease of using health plan to fill prescriptions at local pharmacy                  | 94%↓                            | 95%                       |
| Q8                                       | Ease of using health plan to fill prescriptions by mail                            | 95%↑                            | 90%                       |
| <b>Single Items</b>                      |                                                                                    |                                 |                           |
| Q12                                      | Spent one or more nights in a hospital                                             | n/a                             | 86%                       |
| Q13                                      | Delaying or Not Filling a Prescription                                             | 86%↓                            | 87%                       |
| Q3A                                      | Contact: Filled or Refilled a Prescription                                         | 47%↑                            | 48%                       |
| Q3B                                      | Contact: Taking Medications as Directed                                            | 29%↑                            | 25%                       |
| Q14                                      | Received Mail Order Medicines Not Requested (Respondents answering "No")           | 98%                             | ●                         |
| <b>New Questions</b>                     |                                                                                    |                                 |                           |
| Q16                                      | Difficulty walking or climbing stairs                                              | 67%                             | 69%                       |
| Q17                                      | Difficulty dressing or bathing                                                     | 89%                             | 88%                       |
| Q18                                      | Difficulty doing errands alone because of physical, mental, or emotional condition | 80%                             | 81%                       |
| Q23                                      | Use the internet at home                                                           | 54%                             | 63%                       |

YELLOW shading indicates AT or BELOW the 2017 CMS National Average.

↑ ↓ indicates above or below previous year results. If no arrow is shown, the score in 2016 was an "n/a" or question not included on 2016 survey.

n/a = either too few beneficiaries answered the question to permit reporting or the score had very low reliability.

● indicates no benchmark data available.

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## 5.6 SERVICE QUALITY, Continued

[What Is My Service Area?](#)


### CAHPS® 2017 Delaware Survey Comparison

| Survey Question                                                                                                            | 2017 Commercial<br>HMO/POS/EPO/PPO<br>Results | 2017 Quality<br>Compass (PPO)<br>90 <sup>th</sup> Percentile |
|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|--------------------------------------------------------------|
| Personal Doctor                                                                                                            | 85.7%↑                                        | 88.5%                                                        |
| Specialist                                                                                                                 | 83.1%↓                                        | 88.8%                                                        |
| All Health Care                                                                                                            | 74.9%↓                                        | 82.5%                                                        |
| Health Plan                                                                                                                | 63.6%↑                                        | 71.5%                                                        |
| <b>Getting Needed Care</b>                                                                                                 | 87.9%↓                                        | 91.0%                                                        |
| Ease of getting care, tests, treatment needed                                                                              | 91.5%↑                                        | 93.9%                                                        |
| Obtained appointment with specialist as soon as needed                                                                     | 84.2%↓                                        | 88.9%                                                        |
| <b>Getting Care Quickly</b>                                                                                                | 87.3%↓                                        | 89.4%                                                        |
| Obtained needed care right away                                                                                            | 88.8%↓                                        | 93.2%                                                        |
| Obtained appointment for care as soon as needed                                                                            | 85.9%↑                                        | 87.7%                                                        |
| <b>How Well Doctors Communicate</b>                                                                                        | 96.3%↑                                        | 97.4%                                                        |
| Doctors explained things in an understandable way                                                                          | 96.0%↑                                        | 98.5%                                                        |
| Doctors listened carefully to you                                                                                          | 96.4%↑                                        | 97.4%                                                        |
| Doctors showed respect for what you had to say                                                                             | 96.4%↑                                        | 98.1%                                                        |
| Doctors spent enough time with you                                                                                         | 96.4%↑                                        | 96.2%                                                        |
| <b>Customer Service</b>                                                                                                    | 89.4%↑                                        | 93.3%                                                        |
| Getting information/help from customer service                                                                             | 83.5%↑                                        | 89.8%                                                        |
| Treated with courtesy and respect by customer service staff                                                                | 95.3%↑                                        | 98.2%                                                        |
| <b>Claims Processing</b>                                                                                                   | 90.2%↑                                        | 93.4%                                                        |
| Claims handled quickly                                                                                                     | 88.4%↑                                        | 92.7%                                                        |
| Claims handled correctly                                                                                                   | 92.1%↑                                        | 94.7%                                                        |
| <b>Plan Information on Costs</b>                                                                                           | 59.6%↓                                        | 67.3%                                                        |
| Able to find out from health plan cost of health care service or equipment                                                 | 56.8%↓                                        | 66.9%                                                        |
| Able to find out from health plan cost of prescription medicines                                                           | 62.4%↓                                        | 70.1%                                                        |
| <b>Shared Decision Making</b>                                                                                              | 80.8%↓                                        | 85.5%                                                        |
| Doctor/health provider talked about reasons you might want to take a medicine                                              | 95.1%↓                                        | 97.2%                                                        |
| Doctor/health provider talked about reasons you might not want to take a medicine                                          | 79.7%↑                                        | 80.5%                                                        |
| Doctor/health provider asked you what you thought was best when talking about starting or stopping a prescription medicine | 67.5%↓                                        | 83.6%                                                        |

Continued on next page

## 5.6 SERVICE QUALITY, Continued

[What Is My Service Area?](#)


### CAHPS® 2017 Delaware Survey Comparison (continued)

| Survey Question                                                                                              | 2017 Commercial<br>HMO/POS/EPO/PPO<br>Results | 2017 Quality<br>Compass (PPO)<br>90 <sup>th</sup> Percentile |
|--------------------------------------------------------------------------------------------------------------|-----------------------------------------------|--------------------------------------------------------------|
| <b>Health Promotion and Education</b>                                                                        |                                               |                                                              |
| Doctor or other health provider talked about specific things to prevent illness                              | 75.5%↑                                        | 80.2%                                                        |
| <b>Coordination of Care</b>                                                                                  |                                               |                                                              |
| Personal doctor seems informed and up-to-date about the care received from doctors or other health providers | 81.9%↓                                        | 87.7%                                                        |
| <b>Providing Needed Information</b>                                                                          |                                               |                                                              |
| Written materials or the Internet provided the information needed about how health plan works                | 58.3%↑                                        | 73.7%                                                        |
| <b>Ease of Filling Out Forms</b>                                                                             |                                               |                                                              |
| Forms were easy to fill out                                                                                  | 95.5%↓                                        | 97.3%                                                        |

YELLOW shading indicates AT or BELOW the 2017 Quality Compass 90<sup>th</sup> percentile

↑ ↓ indicates above or below previous year results

*Continued on next page*

## 5.6 SERVICE QUALITY, Continued

[What Is My Service Area?](#)


### CAHPS® 2017 West Virginia Commercial Survey Comparison

| Survey Question                                                                                                            | 2017 Commercial PPO Results | 2017 Quality Compass (PPO) 90 <sup>th</sup> Percentile |
|----------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------------------------------------|
| Personal Doctor                                                                                                            | 85.4%↓                      | 88.5%                                                  |
| Specialist                                                                                                                 | 88.8%↑                      | 88.8%                                                  |
| All Health Care                                                                                                            | 80.3%↑                      | 82.5%                                                  |
| Health Plan                                                                                                                | 68.8%↑                      | 71.5%                                                  |
| <b>Getting Needed Care</b>                                                                                                 | 89.2%↓                      | 91.0%                                                  |
| Ease of getting care, tests, treatment needed                                                                              | 91.3%↓                      | 93.9%                                                  |
| Obtained appointment with specialist as soon as needed                                                                     | 87.1%↓                      | 88.9%                                                  |
| <b>Getting Care Quickly</b>                                                                                                | 86.8%↑                      | 89.4%                                                  |
| Obtained needed care right away                                                                                            | 89.0%↑                      | 93.2%                                                  |
| Obtained appointment for care as soon as needed                                                                            | 84.6%↓                      | 87.7%                                                  |
| <b>How Well Doctors Communicate</b>                                                                                        | 96.1%↑                      | 97.4%                                                  |
| Doctors explained things in an understandable way                                                                          | 97.1%↓                      | 98.5%                                                  |
| Doctors listened carefully to you                                                                                          | 94.9%↓                      | 97.4%                                                  |
| Doctors showed respect for what you had to say                                                                             | 96.0%↓                      | 98.1%                                                  |
| Doctors spent enough time with you                                                                                         | 96.3%↑                      | 96.2%                                                  |
| <b>Customer Service</b>                                                                                                    | 91.2%↑                      | 93.3%                                                  |
| Getting information/help from customer service                                                                             | 88.2%↑                      | 89.8%                                                  |
| Treated with courtesy and respect by customer service staff                                                                | 94.1%↓                      | 98.2%                                                  |
| <b>Claims Processing</b>                                                                                                   | 90.4%↑                      | 93.4%                                                  |
| Claims handled quickly                                                                                                     | 89.6%↑                      | 92.7%                                                  |
| Claims handled correctly                                                                                                   | 91.2%↑                      | 94.7%                                                  |
| <b>Plan Information on Costs</b>                                                                                           | 65.6%↑                      | 67.3%                                                  |
| Able to find out from health plan cost of health care service or equipment                                                 | 61.1%↑                      | 66.9%                                                  |
| Able to find out from health plan cost of prescription medicines                                                           | 70.1%↑                      | 70.1%                                                  |
| <b>Shared Decision Making</b>                                                                                              | 84.0%↑                      | 85.5%                                                  |
| Doctor/health provider talked about reasons you might want to take a medicine                                              | 97.0%↔                      | 97.2%                                                  |
| Doctor/health provider talked about reasons you might not want to take a medicine                                          | 75.2%↑                      | 80.5%                                                  |
| Doctor/health provider asked you what you thought was best when talking about starting or stopping a prescription medicine | 79.8%↑                      | 83.6%                                                  |

Continued on next page

## 5.6 SERVICE QUALITY, Continued

[What Is My Service Area?](#)


### CAHPS® 2017 West Virginia Commercial Survey Comparison (continued)

| Survey Question                                                                                              | 2017 Commercial PPO Results | 2017 Quality Compass (PPO) 90 <sup>th</sup> Percentile |
|--------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------------------------------------|
| <b>Health Promotion and Education</b>                                                                        |                             |                                                        |
| Doctor or other health provider talked about specific things to prevent illness                              | 76.8%↑                      | 80.2%                                                  |
| <b>Coordination of Care</b>                                                                                  |                             |                                                        |
| Personal doctor seems informed and up-to-date about the care received from doctors or other health providers | 84.8%↑                      | 87.7%                                                  |
| <b>Providing Needed Information</b>                                                                          |                             |                                                        |
| Written materials or the Internet provided the information needed about how health plan works                | 62.7%↓                      | 73.7%                                                  |
| <b>Ease of Filling out Forms</b>                                                                             |                             |                                                        |
| Forms were easy to fill out                                                                                  | 96.4%↑                      | 97.3%                                                  |

YELLOW shading indicates AT or BELOW the 2017 Quality Compass 90<sup>th</sup> Percentile.

↑ ↓ ↔ indicates above, below, or equal to previous year results.

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## 5.6 SERVICE QUALITY, Continued

[What Is My Service Area?](#)

### 2017 Marketplace Qualified Health Plan Enrollee Experience Survey (EES)

| Survey Question                                                            | 2017 Highmark Inc. EPO | 2017 Highmark West Virginia PPO | 2017 HHIC PPO | 2017 Highmark Delaware EPO | 2017 CMS National Average |
|----------------------------------------------------------------------------|------------------------|---------------------------------|---------------|----------------------------|---------------------------|
| Personal Doctor                                                            | 88%↓                   | 92%↓                            | 96%↑          | 95%↑                       | 93%                       |
| Specialist                                                                 | 91%↓                   | 93%↓                            | 91%↓          | 94%↔                       | 90%                       |
| All Health Care                                                            | 84%↓                   | 80%↓                            | 87%↓          | 89%↑                       | 86%                       |
| Health Plan                                                                | 57%↓                   | 47%↓                            | 63%↓          | 65%↑                       | 67%                       |
| <b>Getting Needed Care</b>                                                 | 87%↑                   | 84%↓                            | 87%↓          | 84%↓                       | 84%                       |
| Ease of getting care, tests, treatment needed                              | 90%↑                   | 83%↓                            | 88%↓          | 87%↓                       | 86%                       |
| Obtained appointment with specialist as soon as needed                     | 84%↑                   | 84%↓                            | 87%↓          | 79%↓                       | 83%                       |
| <b>Single Item – Access to Care</b>                                        |                        |                                 |               |                            |                           |
| Obtained needed care after hours                                           | 59%                    | 52%↓                            | 54%           | 77%↑                       | 63%                       |
| <b>Getting Care Quickly</b>                                                | 83%↑                   | 77%↓                            | 85%↓          | 81%↑                       | 82%                       |
| Obtained needed care right away                                            | 81%↔                   | 79%↓                            | 90%↔          | 81%↓                       | 84%                       |
| Obtained appointment for care as soon as needed                            | 85%↑                   | 76%↓                            | 79%↓          | 81%↑                       | 78%                       |
| <b>How Well Doctors Communicate</b>                                        | 94%↓                   | 94%↓                            | 96%↑          | 95%↔                       | 95%                       |
| Doctors explained things in an understandable way                          | 97%↔                   | 94%↓                            | 99%↑          | 96%↓                       | 95%                       |
| Doctors listened carefully to you                                          | 94%↓                   | 93%↓                            | 96%↑          | 95%↑                       | 95%                       |
| Doctors showed respect for what you had to say                             | 92%↓                   | 95%↔                            | 97%↑          | 95%↓                       | 96%                       |
| Doctors spent enough time with you                                         | 93%↓                   | 92%↓                            | 96%↑          | 92%↓                       | 93%                       |
| <b>Customer Service</b>                                                    | 78%↓                   | 80%↓                            | 75%↓          | 87%↑                       | 83%                       |
| Getting information/help from customer service                             | 65%↓                   | 71%↓                            | 64%↓          | 77%↑                       | 74%                       |
| Treated with courtesy and respect by customer service staff                | 91%↓                   | 90%↓                            | 86%↓          | 97%↑                       | 92%                       |
| <b>Single Items</b>                                                        |                        |                                 |               |                            |                           |
| Longer than expected wait time to speak to customer service staff          | 59%↓                   | 66%↓                            | 58%↔          | 55%↓                       | 69%                       |
| Forms were easy to fill out                                                | 56%↓                   | 61%↑                            | 61%↓          | 41%↓                       | 72%                       |
| Explanation of forms                                                       | 68%↓                   | 70%↔                            | 85%↑          | 70%↔                       | 75%                       |
| <b>Access to Information</b>                                               | 54%↑                   | 52%↓                            | 63%↑          | 60%↑                       | 57%                       |
| Providing needed information                                               | 50%↑                   | 55%↓                            | 62%↑          | 66%↑                       | 62%                       |
| Able to find out from health plan cost of health care service or equipment | 61%↑                   | 45%↓                            | 69%↑          | 55%↑                       | 52%                       |
| Able to find out from health plan cost of prescription medicines           | 52%↓                   | 54%↓                            | 56%↓          | 58%↑                       | 58%                       |

Continued on next page

## 5.6 SERVICE QUALITY, Continued

[What Is My Service Area?](#)

### 2017 Marketplace Qualified Health Plan Enrollee Experience Survey (EES) (continued)

| Survey Question                                                           | 2017 Highmark Inc. EPO | 2017 Highmark West Virginia PPO | 2017 HHIC PPO | 2017 Highmark Delaware EPO | 2017 CMS National Average |
|---------------------------------------------------------------------------|------------------------|---------------------------------|---------------|----------------------------|---------------------------|
| <b>Care Coordination</b>                                                  | 89%↑                   | 86%↓                            | 94%↑          | 90%↑                       | 88%                       |
| Doctor had medical records or other information about your care           | 97%↔                   | 97%↓                            | 98%↓          | 98%↑                       | 96%                       |
| Personal doctor's office followed up to give you test results             | 89%↓                   | 86%↓                            | 88%↔          | 77%↓                       | 86%                       |
| Got test results as soon as you needed                                    | 88%↓                   | 90%↓                            | 95%↓          | 93%↑                       | 90%                       |
| Doctor talked about prescription medicines                                | 86%↑                   | 87%↓                            | 92%↑          | 93%↑                       | 87%                       |
| Got help managing care                                                    | 93%                    | 80%↓                            | 94%↑          | 89%↑                       | 85%                       |
| Doctor informed and up-to-date about specialty care                       | 79%↑                   | 76%↓                            | 92%↑          | 84%↑                       | 82%                       |
| <b>Getting Information In a Needed Language or Format</b>                 | 92%↓                   | 60%↓                            | 97%↑          | 73%↑                       | 69%                       |
| Obtained interpreter when needed                                          | n/a                    | n/a                             | n/a           | n/a                        | 73%                       |
| Forms available in preferred language                                     | 86%↓                   | 93%↑                            | 93%↓          | 84%↑                       | 90%                       |
| Forms available in needed format                                          | n/a                    | n/a                             | n/a           | n/a                        | 58%                       |
| <b>Cost</b>                                                               | 82%↓                   | 76%↓                            | 81%↓          | 82%↓                       | 83%                       |
| Health plan did not pay for needed care                                   | 87%↑                   | 78%↓                            | 82%↓          | 80%↓                       | 83%                       |
| Paid out of own pocket for care you thought would be covered              | 77%↓                   | 76%↓                            | 81%↓          | 80%↓                       | 82%                       |
| Delayed or did not visit doctor because you were worried about cost       | 79%↑                   | 67%↓                            | 73%↓          | 79%↓                       | 78%                       |
| Delayed or did not fill prescriptions because you were worried about cost | 89%↓                   | 83%↓                            | 88%↓          | 90%↔                       | 90%                       |
| <b>Likelihood to Recommend</b>                                            |                        |                                 |               |                            |                           |
| Likelihood to recommend                                                   | 51%↓                   | 44%↓                            | 56%↓          | 59%↓                       | 63%                       |
| <b>Flu</b>                                                                |                        |                                 |               |                            |                           |
| Annual Flu Vaccine                                                        | 44%↑                   | 39%↓                            | 47%↑          | 45%↑                       | n/a                       |
| <b>SMOKING USE CESSATION</b>                                              |                        |                                 |               |                            |                           |
| <b>Medical Assistance With Smoking and Tobacco Use Cessation</b>          |                        |                                 |               |                            |                           |
| Advising smokers and tobacco users to quit                                | n/a                    | n/a                             | n/a           | n/a                        | n/a                       |
| Discussing cessation medications                                          | n/a                    | n/a                             | n/a           | n/a                        | n/a                       |
| Discussing cessation strategies                                           | n/a                    | n/a                             | n/a           | n/a                        | n/a                       |
| <b>ASPIRIN USE</b>                                                        |                        |                                 |               |                            |                           |
| <b>Aspirin Use and Discussion</b>                                         |                        |                                 |               |                            |                           |
| Aspirin use                                                               | 23%↑                   | 31%↓                            | 30%↑          | 26%↓                       | n/a                       |
| Discussing aspirin risk and benefits                                      | 37%↑                   | 46%↔                            | 40%↑          | 41%↑                       | n/a                       |

YELLOW shading indicates score EQUAL TO or BELOW the 2017 CMS National Average.

↑ ↓ ↔ indicates above, below, or equal to previous year results. No arrow indicates no trending from previous year.

n/a = either too few beneficiaries answered the question to permit reporting or the score had very low reliability; or question not asked on survey.

## 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.

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### Medicare Advantage Quality Improvement Project (QIP)



Medicare Advantage Organizations (MAOs) are required to initiate one self-selected Quality Improvement Project (QIP) per year. Reports on these projects are to be submitted in advance of the MAO's routine audit by the Centers for Medicare & Medicaid Services (CMS).

Quality Management selects and implements an annual QIPs as determined by CMS. Examples of such projects include: "Improving the percentage of diabetic members who are receiving an annual diabetic retinal eye exam" and "Improving the Rate of Congestive Heart Failure (CHF) Readmissions." Representatives from key areas of the plan meet throughout the year to analyze the quantitative and qualitative data collected. 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 fifty (50) beds implement an evidence-based initiative that improves healthcare 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 fifty (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 in order to show compliance.

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## 5.6 HIGHMARK QUALITY INITIATIVES, Continued

### Safety initiatives (continued)

- Obtaining/maintaining accreditation by 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 (3) 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 that is 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 Equity and Quality Services

Highmark has made reducing health care disparities a priority. The Health Equity & Quality Services area leads Highmark's efforts to reduce disparities and improve the delivery of culturally and linguistically appropriate services. These actions impact Highmark members, providers, employees, and the surrounding communities.

#### Training to Meet the Needs of Diverse Patients

Highmark offers cultural competency training to network physicians, nurses and office staff through partnerships with medical societies, network hospitals and our provider website. These training opportunities are meant to increase cultural awareness through computer-based, self-learning courses, and "live" presentations to clinicians.

#### Member Outreach

Highmark continuously seeks information about our members, even after they enroll. We collect voluntary, self-identified information on race, ethnicity, language preference, and education level. These outreach efforts have led to the enhancement of existing quality improvement programs, as well as the development of focused initiatives and interventions, which helps to close the health care gap for our diverse members.

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## 5.6 HIGHMARK QUALITY INITIATIVES, Continued

### Health Equity and Quality Services (continued)

#### Leading the Way

In 2011, Highmark became the nation's first Blue Cross and Blue Shield Plan to receive a Distinction in Multicultural Health Care (MHC) for the Pennsylvania Commercial and Medicare Advantage HMO products offered through the managed care network in western Pennsylvania, awarded by the National Committee for Quality Assurance (NCQA). The award recognizes health plans, wellness, disease management, and managed behavioral health organizations for their ability to address the health care needs of minorities through a set of evidence-based requirements. Specifically, Highmark was noted for designating the reduction of health care disparities as a strategic goal; successfully collecting and analyzing race, ethnicity and language data; and implementing interventions that address heart disease and diabetes among African-American members. Highmark was again awarded NCQA's Distinction in MHC in 2013 for the Pennsylvania Commercial and Medicare Advantage HMO and PPO products offered through Highmark, and the managed care network in western Pennsylvania, further highlighting our leadership in working to improve health care.

## 5.6 PEER REVIEW PROTECTIONS

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### Protected activities

Activities of the Highmark Quality Program, including activities of the staff, medical directors, and the Network Quality and Credentials Committee, are 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 know that the confidentiality of such information will be maintained and protected.

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### West Virginia Code



Under West Virginia law (W.Va. Code §30-3C-1 et seq.), 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.

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## CHAPTER 5: CARE AND QUALITY MANAGEMENT

### UNIT 7: VALUE-BASED REIMBURSEMENT PROGRAMS

#### IN THIS UNIT



| TOPIC                                       | SEE PAGE |
|---------------------------------------------|----------|
| Payment Innovation                          | 2        |
| True Performance Program                    | 5        |
| Quality Blue Hospital Pay for Value Program | 8        |

[What Is My Service Area?](#)

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The **PA ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The **DE ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

## 5.7 PAYMENT INNOVATION

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### Introduction

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 cost and quality 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

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.

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## 5.7 PAYMENT INNOVATION, Continued

### Specialist solutions

Highmark will be transitioning specialist reimbursement toward risk through the Bundled Payment and Specialist Efficiency programs beginning in 2018.

Highmark will be piloting bundled payment solutions using retrospective gain shares in 2018, and will progress from retrospective gain shares to prospective payments beginning in 2019. They will be 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).

We have already begun exploring the use of bundled payments in an integrated way through the close collaboration with Allegheny Health Network (AHN), our own integrated delivery and financing health system. Working closely with AHN orthopaedic surgeons and oncologists, we have co-developed clinical pathways that maximize quality while reducing overall costs and improving patient experiences.

To assist in impactful referrals, PCPs will receive information on the highest-value specialists through Specialist Efficiency, which monitors cost and detects variability in care delivery within select specialties.

### Facility value-based solution

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 (COPD, Simple Pneumonia, and Major Joint Replacement of the Lower Extremities) 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.

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## 5.7 PAYMENT INNOVATION, Continued

### Post-acute solutions

HM Home & Community Services is a Highmark fully-owned subsidiary that manages post-acute services. HM Home & Community Services is creating and operating a number of ongoing initiatives aimed at managing avoidable costs while increasing quality.

Through the Skilled Nursing Facility (SNF) Pay-For-Value Program, skilled nursing facilities are financially incentivized to provide high-value care and have readmission rates that are less than or equal to industry benchmarks. The program will be incorporating more advanced reimbursement methodologies that will echo across our Home Health and Long-Term Acute Care (LTAC) Pay-For-Value Programs in 2018, including episodic and bundled payments, as well as foster collaboration between acute and post-acute providers.

### Clinically Integrated Networks (CINs)

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 2018 and beyond.

### Pharmaceutical solutions

Value-based payment methodologies for pharmaceuticals and incentives for following the evidence-based Care Pathways program have been implemented at our own integrated delivery and financing health system, Allegheny Health Network (AHN). They were rolled out in 2017, have been highly utilized, and will be further developed and enhanced in 2018.

In addition, Highmark has value-based purchasing agreements in place with select pharmaceutical manufacturers and are expanding them for 2018.

## 5.7 TRUE PERFORMANCE PROGRAM

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### Overview

The True Performance Program is a leap forward in value-based reimbursement methodology and 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](#).

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### Participants

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 percent (30%) of their revenue risk based on performance cost and quality metrics.

Physician value-based contracts are expected to steadily increase through the next few years as participation in value-based programs expands across all of Highmark's service areas.

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### Reimbursement opportunities

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 percent (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 percent (75%) of total program reimbursement.

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## 5.7 TRUE PERFORMANCE PROGRAM, Continued

### Reimbursement opportunities (continued)

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

Risk-adjusted care coordination fees are advanced monthly for each attributed member as long as a minimum quality performance on thirty (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. Appropriate Treatment for Children with URI
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. Immunizations for Adolescents
7. Development Screening in the First Three Years of Life
8. Medication Management for People With Asthma
9. Cervical Cancer Screening
10. Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis
11. Chlamydia Screening in Women
12. Comprehensive Diabetes Care: Medical Attention for Nephropathy
13. Comprehensive Diabetes Care: Eye Exam (Retinal) Performed
14. Breast Cancer Screening
15. Colorectal Cancer Screening
16. Adult BMI Assessment
17. Comprehensive Diabetes Care: HbA1c Control ( $\leq 9\%$ )
18. Medication Adherence for Diabetes Medication
19. Medication Adherence for Hypertension: Renin Angiotensin System Antagonists (RASA)
20. Medication Adherence for Cholesterol (Statins)
21. Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
22. All-Cause Readmissions
23. Annual Monitoring for Patients on Persistent Medications
24. Statin Therapy for Patients With Cardiovascular Disease
25. MTM Program Completion Rate for CMR

*Continued on next page*

## 5.7 TRUE PERFORMANCE PROGRAM, Continued

### Quality

### Metrics

(continued)

26. Osteoporosis Management in Women Who Had a Fracture
27. Annual Wellness and Initial Preventative Physical Exam Rate
28. Statin Therapy for Patients With Diabetes
29. Medication Reconciliation Post Discharge
30. Use of High-Risk Medications in the Elderly

### Opportunities for advanced arrangements

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

|                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Introduction</b>          | <p>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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Purpose</b>               | <p>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.</p> <p>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.</p>                                                                                                                                                                                                                                                                                                            |
| <b>Definition</b>            | <p>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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Program participation</b> | <p>Eligibility in Highmark's Quality Blue Hospital Program requires Participants to have a current contract with Highmark for the period of July 1, 2018 through June 30, 2019 (hereafter fiscal year; "FY 2019").</p> <p>In order to have a current contract for FY 2019, a hospital must meet the following criteria:</p> <ul style="list-style-type: none"> <li>• The hospital has signed one or more Highmark network participating contracts that under the terms of such contracts will be in effect during FY 2019.</li> <li>• The hospital is not in default under the terms and conditions of the aforesaid network contracts at any time during FY 2019.</li> <li>• 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, 2019 (for avoidance of doubt, this criteria is satisfied by the notice providing for a termination date prior to June 30, 2019, whether the contract is actually terminated on June 30, 2019).</li> </ul> |

*Continued on next page*

## 5.7 QUALITY BLUE HOSPITAL PAY FOR VALUE PROGRAM, Continued

### Program participation (continued)

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
- Average Episode of Care Costs for Chronic Obstructive Pulmonary Disease ("COPD"), Simple Pneumonia, and Major Joints of the Lower Extremities

For calendar year 2018 ("CY 2018"), Palliative Care for Complex Patients 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

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 2018, 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
- 2) Cost and Utilization:
  - a. Average Episode of Care Costs
    - i. Chronic Obstructive Pulmonary Disease ("COPD")
    - ii. Simple Pneumonia
    - iii. Major Joints of the Lower Extremities

### Program evaluation and scoring

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 2018 Program begins January 1, 2018, and concludes December 31, 2018. 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.

*Continued on next page*

## 5.7 QUALITY BLUE HOSPITAL PAY FOR VALUE PROGRAM, Continued

### **Program evaluation and scoring** (continued)

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**

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 additional information regarding the Quality Blue Hospital Program, contact your Highmark Clinical Transformation Consultant or Provider Account Liaison.



## CHAPTER 6: BILLING AND PAYMENT

### UNIT 1: GENERAL CLAIM SUBMISSION GUIDELINES

#### IN THIS UNIT



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[What Is My Service Area?](#)

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The **PA ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The **DE ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

## 6.1 INTRODUCTION TO CLAIM SUBMISSION

### Overview

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... |                                                                                   |
|-----------------------|---------------------------|-----------------------------------------------------------------------------------|
| <b>Electronically</b> | Professional              | ASC X12N 837 Health Care Claim: Professional Transaction Version 005010 ("837P")  |
|                       | Facility                  | ASC X12N 837 Health Care Claim: Institutional Transaction Version 005010 ("837I") |
| <b>On paper</b>       | 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.

[Why blue italics?](#)

### 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](http://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](http://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.

[What Is My Service Area?](#)

### 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 120 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.

### 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

[What Is My Service Area?](#)

### Pennsylvania



The Prompt Payment Provision of Pennsylvania's Act 68 of 1998 stipulates that health insurers pay "clean claims" within forty-five (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 forty-five (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 two dollars (\$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 forty-five (45) day parameter, which were required for the processing of the claim.

The formula for calculating Act 68 interest penalty payments is as follows:

$[(\text{annual interest \%} / \text{payment days in a year}) \times \text{Amount paid on the claim}] \times \text{Penalty Days}$

**OR**

$[(.10/365) \times \text{Amount paid on the claim}] \times \text{Penalty Days}$

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.

*Continued on next page*

## 6.1 PROMPT PAYMENT REQUIREMENTS, Continued

### 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 thirty (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.

[What Is My Service Area?](#)

### 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 forty (40) days of receipt if submitted manually, or thirty (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 percent (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

[What Is My Service Area?](#)

### 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 forty (40) days of receipt if submitted manually, or thirty (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.”

*Continued on next page*

## 6.1 WEST VIRGINIA PROMPT PAY ACT, Continued

### 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 (3) business days after it was submitted, based upon the written or electronic record of the date of submittal by the person submitting the claim.

[What Is My Service Area?](#)

### 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 thirty (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 fifteen (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 thirty (30) days.

We cannot refuse to pay a claim for covered benefits if we fail to request needed information within thirty (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 forty (40) days, Highmark West Virginia will pay interest, at the rate of ten percent (10%) per year, on clean claims, accruing after the fortieth (40<sup>th</sup>) day. We will provide an explanation of the interest assessed at the time the claim is paid.

*Continued on next page*



## 6.1 WEST VIRGINIA PROMPT PAY ACT, Continued

[What Is My Service Area?](#)

### 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.

*Continued on next page*

## 6.1 WEST VIRGINIA PROMPT PAY ACT, Continued

### 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 (1) 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).

[What Is My Service Area?](#)

### Provider recovery process



Under the Act, upon receipt of a retroactive denial, the provider has forty (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 thirty (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 thirty (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 thirty (30) days or the amount will be offset against future payments.

## 6.1 WEST VIRGINIA SELF-FUNDED ACCOUNTS

### Policy



Highmark West Virginia acts **only** as a third-party administrator for a self-funded benefit plan (i.e., the benefits are not insured by Highmark West Virginia 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 West Virginia for the amount of the claim and the administrative cost to process and pay the claim. Highmark West Virginia 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 West Virginia to fund claims (whether such claims have been paid already by Highmark West Virginia or not), then a provider shall not hold Highmark West Virginia liable, but must look to the self-funded plan or the patient for payment. Highmark West Virginia 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 West Virginia.

### 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.

[What Is My Service Area?](#)

### Special circumstances for terminated accounts



Upon termination of a self-funded group, Highmark West Virginia 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 twelve (12) months, and claims received after this period will be denied.

## 6.1 NEW PATIENT VS. ESTABLISHED PATIENT

### Overview

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.

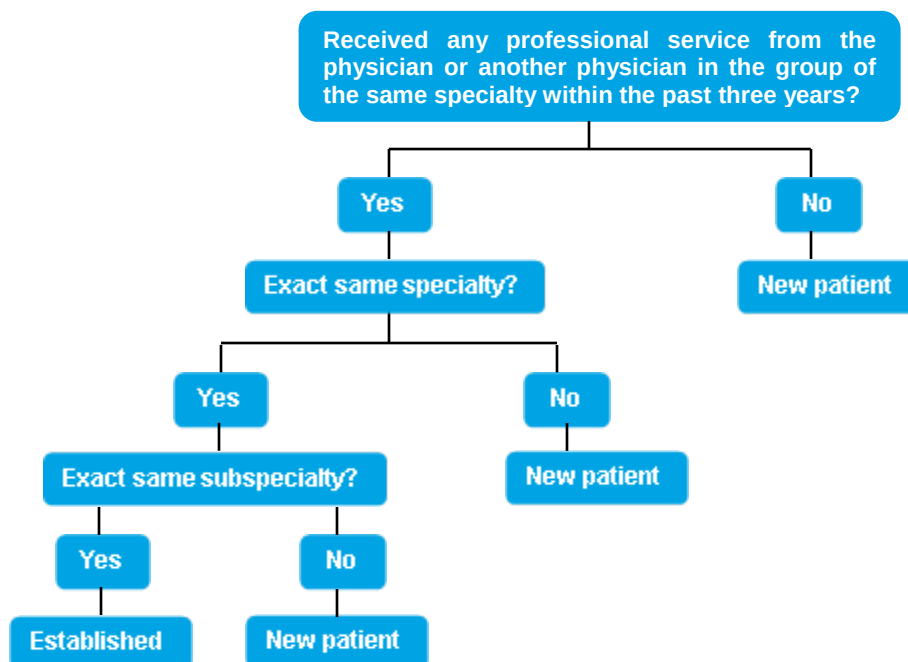
### CPT guidelines for new vs. established patients

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

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### Overview

Highmark requires professional and facility providers in all places of service, including an office setting, to complete the “Service Facility Location” field when submitting 837P, 837I, and 1500 Health Insurance Claim Form claims. **The Service Facility Location is the physical location where the services were performed.**

It is important to complete the Service Facility Location field when it is different than the billing provider address 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.

---

### Field location

The Service Facility Location is completed on facility and professional claims as follows:

- **837I:** Loop 2310E
- **837P:** 2310C
- **1500 Health Insurance Claim Form:** Item# 32 a, b, c

**Note:** A physical street address must be reported for the Service Facility Location -- a P.O. Box or lock box will not be accepted.

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## 6.1 DIAGNOSIS CODE REPORTING

### International Classification of Diseases (ICD)

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, 10<sup>th</sup> 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.

### Be as accurate as possible

Highmark will reject your claims for payment if you submit them without complete or accurate diagnosis codes.

### NaviNet® Diagnosis Code Inquiry

NaviNet® includes a diagnosis code inquiry that lets you look up diagnosis codes by code or description, and also provides effective dates and end dates for the codes.

## 6.1 REPORTING NATIONAL DRUG CODES

### 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           | <u>0</u> 9999-9999-99   | 0002-7597-01<br>Zyprexa® 10mg Vial | <u>0</u> 0002759701            |
| 5-3-2                                       | 99999-999-99            | 5-4-2           | 99999- <u>0</u> 999-99  | 50242-040-62<br>Xolair® 150mg vial | 50242 <u>0</u> 04062           |
| 5-4-1                                       | 99999-9999-9            | 5-4-2           | 99999-9999- <u>0</u> 9  | 60575-4112-1<br>Synagis® 50mg vial | 605754112 <u>0</u> 1           |

## 6.1 DOCUMENTATION REQUIREMENTS

### Overview

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.*

[What Is My Service Area?](#)

### 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;

*Continued on next page*



## 6.1 DOCUMENTATION REQUIREMENTS, Continued

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**Criteria for  
documentation  
submission**  
(continued)

- 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

### Introduction

Providers can check the status of a claim by using NaviNet® Claim Status Inquiry 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.

**Quick  
Reference**

### NaviNet® Claim Status Inquiry

Claim Status Inquiry 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, or you can look up claims dating back seven years.

To check claim status, select **Claim Status Inquiry** under **Workflows for this Plan** to access the **Search** screen and enter the patient and claim details.

### 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.

*Continued on next page*

## 6.1 CLAIM STATUS INQUIRIES, Continued

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### 276/277 -- Health Care Claim Status Request and Response Transaction (continued)

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, PAYMENT & REIMBURSEMENT**, and then **Electronic Data Interchange (EDI) Services**; or click on the applicable link below to access the applicable site directly:

- Pennsylvania: [www.highmark.com/edi](http://www.highmark.com/edi)
- Delaware: [highmark.com/bcbsde](http://highmark.com/bcbsde)
- West Virginia: [www.highmark.com/edi-wv](http://www.highmark.com/edi-wv)

Providers in all regions can contact Highmark EDI Services by telephone at **1-800-992-0246**.

[What Is My Service Area?](#)

## 6.1 CLAIM INVESTIGATION

### Introduction

A claim investigation is the ordinary means providers use to communicate their questions regarding pending, paid, or denied claims.

### When claim investigation is appropriate

An investigation 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 investigation. A claim investigation is appropriate if any of the atypical situations listed below occurs:

- A claim has been pending for more than forty-five (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 investigations can be launched from NaviNet® Claim Status Inquiry or through the 276/277 Health Care Claim Status Request and Response transactions.

### NaviNet® Claim Investigation

**Claim Investigation** is available for NaviNet's professional and facility users in two areas within **Claim Status Inquiry**: 1) **Search Results** and 2) **Claim Status Details**.

Claim Status: Search Results

| Claim ID   | Patient                    | Service Date(s)          | Billed Amount | Payment Number | Payment Date | Paid Amount | Status    |                     |
|------------|----------------------------|--------------------------|---------------|----------------|--------------|-------------|-----------|---------------------|
| XXXXXXXXXX | JANE A DOE<br>(XXXXXXXXXX) | 09/27/2017 to 09/27/2017 | \$138.00      | --             | 09/28/2017   | \$0.00      | Finalized | Claim Investigation |
| XXXXXXXXXX | JANE A DOE<br>(XXXXXXXXXX) | 09/27/2017 to 09/27/2017 | \$138.00      | --             | 10/24/2017   | \$0.00      | Finalized | Claim Investigation |

or

Claim Status Details | JANE A DOE  
Born on 04/19/1985

View/print Claim Investigation

Finalized (Claim Status as of 11/01/2017) Claim ID: XXXXXXXXXX Service Dates: 09/27/2017 to 09/27/2017

The claim/encounter has completed the adjudication cycle and no more action will be taken.

|                                                                                          |                                                                                             |
|------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| <b>INSURANCE DETAILS</b><br>Highmark<br>Member ID: XXXXXXXXXX                            | <b>Total Billed:</b><br><b>\$205.00</b>                                                     |
| <b>BILLING ENTITY</b><br>ABC FAMILY HEALTH<br>NPI: XXXXXXXXXX<br>Provider ID: XXXXXXXXXX | <b>Total Paid:</b><br><b>\$135.00</b><br>Payment Number: XXXXXXXXXX<br>(Paid on 11/01/2017) |

When you click on the **Claim Investigation** link, a new window will open (see next page).

*Continued on next page*



## 6.1 CLAIM INVESTIGATION, Continued

### NaviNet® Claim Investigation (continued)

The claim number and patient name will be displayed on the claim investigation screen. Select the **Investigation Type** from the choices in the dropdown, and then enter pertinent information in the **Comments** box. Highmark needs enough information to readily address your request about the claim in question. Complete the **Contact** fields, and then click **Submit**. An informational page confirms that the investigation was submitted.

**IMPORTANT!** Please include contact information for Highmark to reach the appropriate person if additional information is needed.

### NaviNet® Claim Investigation Inquiry

You can check the status of an investigation by using NaviNet's **Claim Investigation Inquiry** under **Workflows for this Plan** on Highmark Plan Central.

*Continued on next page*

## 6.1 CLAIM INVESTIGATION, Continued

### NaviNet® User Guides

NaviNet User Guides are available for help when submitting claim investigations. To access **User Guides** for both professional and facility providers, select **Help** from the toolbar, and then select the applicable Highmark option for your service area.

These guides provide more detailed instructions for claim investigation submission, including an **Investigation Type Reference Table** that provides the minimum amount of information you must include in the Comments box for each investigation type.

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### 276/277 Health Care Claim Status Request and Response transactions

Claim investigations 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, PAYMENT & REIMBURSEMENT**, and then **Electronic Data Interchange (EDI) Services**; or click on the applicable link below to access the applicable site directly:

- Pennsylvania: [www.highmark.com/edi](http://www.highmark.com/edi)
- Delaware: [highmark.com/bcbsde](http://highmark.com/bcbsde)
- West Virginia: [www.highmark.com/edi-wv](http://www.highmark.com/edi-wv)

Providers in all regions can contact Highmark EDI Services by telephone at **1-800-992-0246**.

## 6.1 HIGHMARK'S INTERNAL BILLING DISPUTE PROCESS

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### Disputes overview

Any provider that 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.**

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### 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 a NaviNet® Claim Investigation Inquiry
- 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.

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*Continued on next page*

## 6.1 HIGHMARK'S INTERNAL BILLING DISPUTE PROCESS, Continued

### 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



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.

[What Is My Service Area?](#)

## 6.1 THE TOP TEN BILLING ERRORS – AND HOW TO AVOID THEM

**Common claims reporting errors** Claims processing experts identified the top ten common 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. |
| Performing provider name and number                                                                                                                                                                   | The performing practitioner name and practitioner 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 SNF), 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.                                                                                                                                                                                                                                                         |
| Zero charges or adjustments are being reported                                                                                                                                                        | Unless the claim is an encounter, zero dollars or blank charges are not acceptable.                                                                                                                                                                                                                                                |
| Claims are range dated but the number of services do not clearly correspond with the date range (e.g., indication that services were performed 01-01-16 through 01-10-16 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-on-one basis, you should itemize the services.                                             |
| Submit HCPCS codes that are not valid for the time the service was rendered (e.g., billing for a service performed in 2015 with a code that was not in place until 2016 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.                                                                                                                                                                                                                               |

## CHAPTER 6: BILLING AND PAYMENT

### UNIT 2: ELECTRONIC CLAIM SUBMISSION

#### IN THIS UNIT



| TOPIC                                        | SEE PAGE |
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| Highmark EDI Services Support                | 4        |
| Required Electronic Claim Submission Formats | 5        |
| Real-Time Estimation and Adjudication        | 6        |
| Claims Record Management                     | 9        |
| Attachments for Electronic Claims            | 11       |
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The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The **PA ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The **DE ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

## 6.2 BENEFITS OF ELECTRONIC CLAIM SUBMISSION

### Introduction

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 (7) to fourteen (14) calendar days, whereas paper claims will process in twenty-one (21) to twenty-seven (27) calendar days.

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### 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.

*Continued on next page*

## 6.2 BENEFITS OF ELECTRONIC CLAIM SUBMISSION, Continued

### 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.

### NaviNet® claim submission

HIPAA-compliant 1500 (837P) and UB (837I) claim submission transactions are also available to participating professional providers and facilities in NaviNet.

[What Is My Service Area?](#)

### FOR MORE INFORMATION

For information on signing up for EDI and also NaviNet, please see the manual's [Chapter 1.3: Electronic Solutions – EDI & NaviNet](#).

To learn more about electronic claims submission, visit the **Electronic Data Interchange (EDI) Services** website. You can access the site by selecting **CLAIMS, PAYMENT & REIMBURSEMENT** 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](http://highmark.com/edi)
- Delaware: [highmark.com/bcbsde](http://highmark.com/bcbsde)
- West Virginia: [highmark.com/edi-wv](http://highmark.com/edi-wv)



## 6.2 HIGHMARK EDI SERVICES SUPPORT

### Overview

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

To contact a support analyst by phone, call **1-800-992-0246**.

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### 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](http://highmark.com/edi)
- Delaware: [highmark.com/bcbsde](http://highmark.com/bcbsde)
- West Virginia: [highmark.com/edi-wv](http://highmark.com/edi-wv)

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

### 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.

### 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

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
- NaviNet® UB Claim Submission

Professional providers have the following options:

- Submission via any electronic data interchange vendor or billing service
- NaviNet® 1500 Claim Submission

**Note:** The NaviNet claim submission transactions are compliant with the HIPAA 837P and 837I formats.

## 6.2 REAL-TIME ESTIMATION AND ADJUDICATION

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### Introduction

Highmark's Real-Time tools are available to all NaviNet®-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 Real-Time Claims Adjudication.

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.

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### Real-Time Provider Estimation

The Real-Time Provider Estimation 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 function in NaviNet also allows the provider to print and give the member a *Highmark Real-Time Member Liability Statement-Estimate* for his/her records.

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 the real-time claims adjudication tool (see below).

In NaviNet, we also make it is easy to turn a real-time estimation into a real-time 1500 Claim Submission with just a click of a button. For instructions on 1500 Claim and Estimate Submission, tutorials are available in the *NaviNet User Guides*. Select **Help** from the NaviNet toolbar to access them in **NaviNet Support**.

**Note:** Real-Time Estimation can be used for all Highmark products; however, estimate submission is not available for the Federal Employee Program (FEP).

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## 6.2 REAL-TIME ESTIMATION AND ADJUDICATION, Continued

### Real-Time Claims Adjudication

The Real-Time Claims Adjudication tool 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.

This function in NaviNet also allows the provider to print a *Highmark Real-Time Member Liability Statement* to give to the member for his/her records.

### 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 (3) 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 thirty (30) calendar days**.

### NaviNet User Guides

User Guides are available in NaviNet for real-time estimate submission and claim submission. To access NaviNet User Guides for both professional and facility providers, select **Help** from the toolbar, click on the **Health Plan** tab, and then select the applicable Highmark option for your service area.

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## 6.2 REAL-TIME ESTIMATION AND ADJUDICATION, Continued

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### 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, PAYMENT & REIMBURSEMENT** from the main menu, or click on the applicable link below to access the applicable site directly:

- Pennsylvania: [highmark.com/edi](http://highmark.com/edi)
- Delaware: [highmark.com/bcbsde](http://highmark.com/bcbsde)
- West Virginia: [highmark.com/edi-wv](http://highmark.com/edi-wv)

[What Is My Service Area?](#)

## 6.2 CLAIMS RECORD MANAGEMENT

|                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Overview</b>                                                      | Highmark provides electronic acknowledgments to enhance your ability to track and monitor your claim transactions.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Acknowledgment transactions</b>                                   | <p>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:</p> <ul style="list-style-type: none"> <li>• 999 – Implementation Acknowledgment for Health Care Insurance</li> <li>• 277CA– Claim Acknowledgement</li> <li>• 835– Electronic Remittance Advice ERA</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>999 – Implementation Acknowledgment for Health Care Insurance</b> | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>277CA – Health Care Claim Acknowledgment</b>                      | <p>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.</p> <p>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 -- <b>this rejected claim data must be corrected and the claim resubmitted electronically.</b></p> <p>Trading partners submitting 837 claim transactions in Version 5010 must be able to accept the 005010X214 277 Health Care Claim Acknowledgment (277CA) Transaction.</p> |

*Continued on next page*

## 6.2 CLAIMS RECORD MANAGEMENT, Continued

### 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 (7) 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, PAYMENT & REIMBURSEMENT** from the main menu), or by clicking the applicable link below to access the site directly:

- Pennsylvania: [highmark.com/edi](http://highmark.com/edi)
- Delaware: [highmark.com/bcbsde](http://highmark.com/bcbsde)
- West Virginia: [highmark.com/edi-wv](http://highmark.com/edi-wv)

[What Is My Service Area?](#)

## 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:

| PENNSYLVANIA                                                                                                                             | DELAWARE                                                                                                                                                  | WEST VIRGINIA                                                         |
|------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|
| <b>Attention:</b> Document Preparation/Image                                                                                             | <b>Attention:</b> Document Preparation/Image                                                                                                              | <b>Attention:</b> CDC Area                                            |
| <b>Fax to:</b> 1-888-910-8797                                                                                                            | <b>Fax to:</b> 1-888-910-9601                                                                                                                             | <b>Fax to:</b> 1-844-235-7266                                         |
| <b>Mail to:</b><br>Highmark Blue Shield<br>PWK (Paperwork)<br>Additional<br>Documentation<br>P.O. Box 890176<br>Camp Hill, PA 17089-0176 | <b>Mail to:</b><br>Highmark Blue Cross<br>Blue Shield Delaware<br>PWK (Paperwork)<br>Additional<br>Documentation<br>P.O. Box 8832<br>Wilmington, DE 19899 | <b>Mail to:</b><br>Highmark WV<br>P.O. Box 7026<br>Wheeling, WV 26003 |

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### 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](#)

These cover sheets are also available on the Provider Resource Center. Select **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, PAYMENT & REIMBURSEMENT** from the main menu to access the **Electronic Data Interchange (EDI) Services** website.

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

### Overview

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.

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### Highmark Delaware



| DELAWARE     |                          |                                                                                                         |
|--------------|--------------------------|---------------------------------------------------------------------------------------------------------|
| NAIC CODE    | PROVIDER TYPE            | PRODUCTS                                                                                                |
| <b>00070</b> | Facility provider types  | All Highmark Delaware products; BlueCard claims; and Medicare Advantage claims for any other Blue Plan. |
| <b>00570</b> | All other provider types | All Highmark Delaware products; BlueCard claims; and Medicare Advantage claims for any other Blue Plan. |

### Highmark West Virginia



| WEST VIRGINIA |                    |                                                                                                                                |
|---------------|--------------------|--------------------------------------------------------------------------------------------------------------------------------|
| NAIC CODE     | PROVIDER TYPE      | PRODUCTS                                                                                                                       |
| <b>54828</b>  | All provider types | All Highmark West Virginia products; BlueCard claims; and Medicare Advantage claims for any other Blue Plan.                   |
| <b>15459</b>  | All provider types | Highmark Senior Solutions Company Medicare Advantage Freedom Blue PPO (West Virginia plan only with alpha prefix <b>HSR</b> ). |

*Continued on next page*

## 6.2 NAIC CODES, Continued

### Pennsylvania


[What Is My Service Area?](#)

| PENNSYLVANIA  |                                                                          |                                                                                                                                                                                                                                                                                                                                                  |
|---------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| NAIC CODE     | PROVIDER TYPE                                                            | PRODUCTS                                                                                                                                                                                                                                                                                                                                         |
| <b>54771W</b> | Western and Northeastern Regions -- facility type providers (UB-04/837I) | <ul style="list-style-type: none"> <li>• All Highmark commercial products;</li> <li>• Medicare Advantage Security Blue HMO and Medicare Advantage Community Blue HMO administered by Highmark Choice Company; and</li> <li>• All BlueCard products and Medicare Advantage claims for any other Blue Plan.</li> </ul>                             |
| <b>54771C</b> | Central Region facility type providers (UB-04/837I)                      | <ul style="list-style-type: none"> <li>• All Highmark commercial products;</li> <li>• Medicare Advantage Community Blue HMO administered by Highmark Choice Company; and</li> <li>• All BlueCard products and Medicare Advantage claims for any other Blue Plan.</li> </ul>                                                                      |
| <b>54771</b>  | All other provider types (1500/837P)                                     | <ul style="list-style-type: none"> <li>• All Highmark commercial products;</li> <li>• Medicare Advantage Security Blue HMO (Western Region only) and Medicare Advantage Community Blue HMO, both administered by Highmark Choice Company; and</li> <li>• All BlueCard products and Medicare Advantage claims for any other Blue Plan.</li> </ul> |
| <b>15460</b>  | All provider types                                                       | <ul style="list-style-type: none"> <li>• Medicare Advantage Freedom Blue PPO administered by Highmark Senior Health Company (Pennsylvania plans only with alpha prefixes <b>HRT, TDM, USK, HRF</b>).</li> <li>• Medicare Advantage Community Blue Medicare PPO and Community Blue Medicare Plus PPO.</li> </ul>                                  |

## 6.2 CLAIM STATUS INQUIRIES

### Introduction

Highmark offers providers electronic means of checking the status of a claim through NaviNet® Claim Status Inquiry or the HIPAA 276/277 Health Care Claim Status Request and Response transactions.

### NaviNet® Claim Status Inquiry

NaviNet Claim Status Inquiry 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, or you can look up claims dating back seven years.

If you have a question about how a claim was processed, you can launch a claims investigation and have the claim researched without going back to Plan Central or making a call to Highmark.

For more information, including instructions on how to access NaviNet's Claim Status Inquiry and claim investigation transactions, please see [Chapter 6.1: General Claim Submission Guidelines](#).

### 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 **Electronic Data Interchange (EDI) Services** from the main menu; or click on the applicable link below to access the applicable site directly:

- Pennsylvania: [www.highmark.com/edi](http://www.highmark.com/edi)
- Delaware: [highmark.com/bcbsde](http://highmark.com/bcbsde)
- West Virginia: [www.highmark.com/edi-wv](http://www.highmark.com/edi-wv)

Providers in all regions can contact Highmark EDI Operations by phone at **1-800-992-0246**.

[What Is My Service Area?](#)

## 6.2 NAVINET 1500 AND UB CLAIM SUBMISSION

### Introduction

NaviNet® claim submission transactions let you submit HIPAA-compliant 837P Professional claims and 837I Institutional claims fast and easy in real-time.

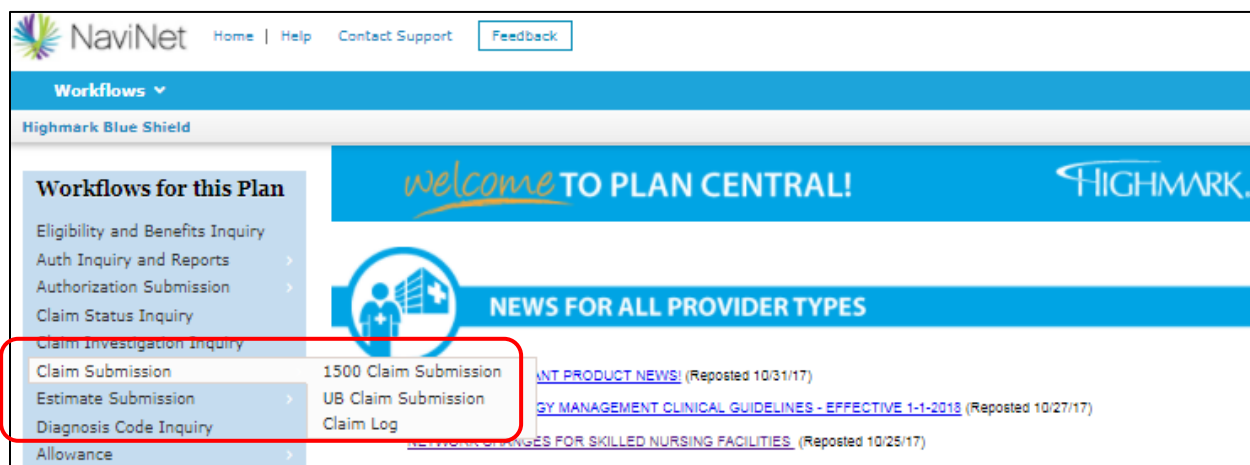
NaviNet's real-time single claim submission lets you know the status of a claim at the time of entry and claim errors are corrected online. When submitted on the date the services were rendered, these capabilities allow providers to accurately identify and collect member responsibility before the patient leaves the office.

### Accessing claim submission transactions

To access the claim submission transaction in NaviNet, first select Claim Submission under **Workflows For This Plan**. And then on the fly-out menu, select as follows:

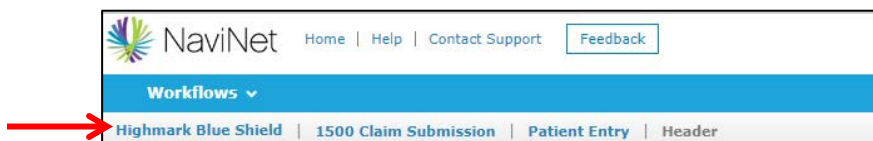
- Professional Services: Select **1500 Claim Submission**
- Facilities: Select **UB Claim Submission**

After selecting the transaction type, the **Patient Entry screen appears for both 1500 and UB submissions.**



### Wayfinder

NaviNet's "Wayfinder" allows you to navigate between screens through the claim submission process by clicking on the screen name in the bar.



*Continued on next page*

## 6.2 NAVINET 1500 AND UB CLAIM SUBMISSION, Continued

### Claim submission screens

The claim submission process navigates through the following screens for both 1500 and UB submissions – required fields are notated with a red asterisk:

- **Patient Entry:** For an easier and faster way to confirm your patient information, enter the patient's Member/Subscriber ID and the Statement Period From and Thru fields, and then click on **ID Search**. The patient information will automatically populate and you can click on **Continue** to advance to the next screen.
- **Header:** General information is entered on the Header screen, such as Billing Provider, Rendering/Servicing Provider, Patient Account Number
- **Payer:** Highmark can be entered as primary, secondary, or tertiary payer. If Highmark is secondary or tertiary, you will be required to enter all applicable information from the previous payer(s).
- **Detail:** Enter the information identifying the services – such as date of service, HCPCS/HIPPS codes, modifiers, and revenue codes -- and the charges for the services.
- **Verification:** Key patient, code, and payer information will be displayed here. Confirm that the data on screen is correct and click **Submit**. If you need to make a change, you can use the Wayfinder (or "breadcrumb bar") to go back to the screen that needs revision.

### Claim Log

To review your claims submitted via NaviNet, select **Claim Submission** under Workflows For This Plan, and then click **Claim Log**.

### 1500 Claim Submission tips

- Professional claims are limited to 50 lines.
- Clicking **Exit** on any screen takes you out of the claims submission process.
- If you want to leave a screen without submitting information, use the Wayfinder.
- Only claims originally submitted through NaviNet can be corrected and resubmitted through the Claim Log.
- Do not enter a decimal point when entering ICD-10 diagnosis codes.
- If you receive the error "Entity not approved as an electronic submitter. (code=496, source=Claim)," please contact NantHealth Support for assistance.
- On the Patient Entry screen, if you select anything in the Relationship to Subscriber field other than "18-Self/Subscriber", you must manually enter the subscriber information in the fields provided.
- To submit a Claim Attachment (PWK), on the header page, choose the Attachment Method (Fax, Mail, or Available on Request), type the Attachment Control Number, which is assigned by the provider, select the Attachment Type from the dropdown list, and continue to submit the claim. A cover sheet must accompany your attachment; you can obtain one from the Resource Center under the EDI link.

*Continued on next page*

## 6.2 NAVINET 1500 AND UB CLAIM SUBMISSION, Continued

### UB Claim Submission tips

- Clicking **Exit** on any screen takes you out of the claims submission process.
- Do not enter a decimal point when entering ICD-10 diagnosis codes.
- To add more service lines to the Claim Submission Detail screen, select the number of lines from the dropdown menu and click **Add Lines**. A maximum of 999 service lines are available for each claim.
- Only claims originally submitted through NaviNet can be corrected and resubmitted through the Claim Log.
- When reporting an adjustment bill type on the Claim Submission Header screen, the original claim number is required.
- The first name and last name are required when reporting Attending, Operating, or Other providers.

### FOR MORE INFORMATION

For detailed instructions and additional tips, **User Guides** are available in NaviNet for 1500 and UB claim submission.

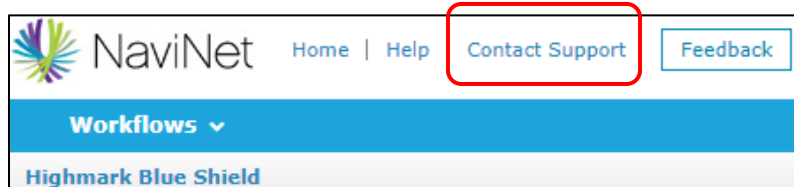
To access NaviNet User Guides for both professional and facility providers, select **Help** from the toolbar, and then select the applicable Highmark option for your service area.

### NaviNet support

If you have a critical issue, NaviNet Support is available by calling **1-888-482-8057**. Phone support is available Monday through Friday from 8 a.m. to 11 p.m. and on Saturday from 8 a.m. to 3 p.m.

You can also open a case online any time to get assistance from the NaviNet Customer Support team, or “chat” with a NaviNet Customer Service representative in real time. Live chat is also available Monday through Friday from 8 a.m. to 11 p.m. and on Saturday from 8 a.m. to 3 p.m.

Click on **Contact Support** on the top left of the NaviNet screen to open a case or to access live chat:



## CHAPTER 6: BILLING AND PAYMENT

### UNIT 3: FACILITY (UB-04/837I) BILLING

#### IN THIS UNIT



| TOPIC                                                                       | SEE PAGE |
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#### What Is My Service Area?

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The PA ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The DE ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The WV ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

## 6.3 FACILITY BILLING OVERVIEW

### Introduction

Highmark requires facility providers to bill electronically via 837 Institutional (837I) electronic transactions. HIPAA-compliant UB Claim Submission is also available in NaviNet®. In some cases, claim submission may be necessary on UB-04 paper claim forms.

### Facility Bulletins

In the past, Highmark published Facility Bulletins to communicate policies and procedures to facilities. Although the publication of newly created Facility Bulletins was discontinued in 2015, Highmark has reviewed previously published bulletins in Pennsylvania to evaluate their content. As the bulletins were evaluated, Highmark determined if the information was still current and valid, or if the information was outdated and/or superseded in a more recent bulletin (or communication). Those bulletins deemed to be outdated, or superseded in a more recent communication, were marked as obsolete and added to the Facility Bulletin Archive.

Facility Bulletins continue to be available online to providers as resources and for historical reference in all service areas. The *Highmark Provider Manual*, provider newsletters, Special Bulletins, and other communications (e.g., Plan Central Messages) should be referenced for the most up-to-date information.

Facility Bulletins can be accessed from the Provider Resource Center by selecting **NEWLETTERS/NOTICES** from the main menu.

[What Is My Service Area?](#)

### Billing Highlights



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 NaviNet® Provider Resource Centers in Pennsylvania -- select **CLAIMS, PAYMENT & REIMBURSEMENT** from the main menu.

### 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 is for **all inpatient acute care hospitals, including critical access hospitals**, for all claims.

### Potential reduction in payment for Hospital Acquired Conditions (HAC)

Medicare Grouper for all DRG-reimbursed inpatient acute care hospitals, including critical access hospitals for commercial business, features logic that prevents the assignment of a higher 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
- Pressure ulcer stages III and IV
- Falls and trauma
- Catheter-associated urinary tract infection
- Vascular catheter-associated infection
- Manifestations of poor glycemic control
- Surgical site infection, mediastinitis, following coronary artery bypass graft
- Surgical site infection following certain orthopedic procedures
- Surgical site infections following bariatric surgery for obesity
- Surgical site infection following cardiac implantable electronic device (CIED) procedures
- Deep vein thrombosis and pulmonary embolism following certain orthopedic 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 procedure** was performed
- Surgery was performed on the **wrong body part**
- Surgery was performed on the **wrong patient**

*Continued on next page*

## 6.3 PRESENT ON ADMISSION/ADVERSE EVENTS, Continued

### Facility Bulletins available



For additional information, Facility Bulletins are available in Pennsylvania and West Virginia. To access these Facility Bulletins, select **NEWSLETTERS/NOTICES** from the Provider Resource Center main menu, and then **Facility Bulletins**.

Click on the **Facility Bulletin Search** to search for all related bulletins by the following Bulletin Numbers (ordered from most recent to oldest):

- **Pennsylvania:**
  - o Western Region:
    - HOSP-2012-023-W; MPC-2012-018-W
    - PROV-2012-002-W
    - PROV-2011-004-W
    - HOSP-2009-010-W
    - HOSP-2009-001-W
    - HOSP-2008-008-W; MPC-2008-003-W
    - HOSP-2008-001-W; MPC-2008-001-W
  - o Central & Northeastern Regions:
    - HOSP-2012-023-C; MAHOSP-2012-009-C
    - PROV-2012-002-C
    - PROV-2011-004-C
    - HOSP-2009-003-C
    - HOSP-2009-002-C
    - HOSP-2008-007-C; MAHOSP-2008-005-C
    - HOSP-2008-003-C
    - HOSP-2008-002-C; MAHOSP-2008-001-C
- **West Virginia:**
  - o HWV-HOSP-2012-018; HHIC-HOSP-2012-005
  - o HWC-PROV-2012-001; HHIC-PROV-2012-001
  - o MS-HOSP-2009-003; HHIC-HOSP-2009-003
  - o MS-HOSP-2009-002; HHIC-HOSP-2009-002

[What Is My Service Area?](#)

## 6.3 NATIONAL CORRECT CODING INITIATIVE (NCCI) EDITS

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### Introduction

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 of 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's implementation and after appropriate evaluation.

---

## 6.3 CLAIM ADJUSTMENTS

### Overview

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                                                                                                                                                |
|------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>XX5 Late</b><br>Charges Only          | This code is to be used for submitting additional new charges or lines which were identified by the facility after the original claim was submitted (use XX7 for BlueCard®).                                                                                                                                                          | Adjust the original claim to include the additional charges.                                                                                                   |
| <b>XX7</b><br>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. |
| <b>XX8</b><br>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 claims 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.

*Continued on next page*

## 6.3 CLAIM ADJUSTMENTS, Continued

### Original claim number required

The original claim number is required when submitting adjustment bill types XX5, XX7, and XX8 on claims via NaviNet® UB Claim Submission and HIPAA 837I batch and real-time submissions.

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 GUIDELINES FOR HIPPS REPORTING

### Background

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 | GUIDELINES                                                                                                                                                                                                                                                                                                          |
|---------------------------------|--------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Home Health</b>              | <b>0023</b>  | This revenue code (and the corresponding HIPPS codes) should be reported <b>in addition to</b> the revenue lines representing the home health service billed by the facility.                                                                                                                                       |
| <b>Skilled Nursing Facility</b> | <b>0022</b>  | This revenue code (and the corresponding HIPPS codes) should be reported <b>in addition to</b> 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). |

*Continued on next page*

## 6.3 GUIDELINES FOR HIPPS REPORTING, Continued

### 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 naviHealth assigns the RUG level



naviHealth assigns the appropriate 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 naviHealth assigns the RUG Code level:

- **HIPPS code:** naviHealth 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 naviHealth has assigned the RUG level.

For information on Highmark's partnership with naviHealth for post-acute care management for Highmark Medicare Advantage members, please visit the Provider Resource Center (in Pennsylvania and West Virginia). Select **Care Management Programs** from the main menu on the left, and then click on **Post-Acute Care Management for Medicare Advantage Members**.

### Service date

For revenue code 0023, the date of service should equal the date of the first billable service on the claim.

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### 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.

*Continued on next page*

## 6.3 GUIDELINES FOR HIPPS REPORTING, Continued

### 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<br>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<br>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. NaviNet-submitted claims in this situation would appear in the Claims Log. |
| 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. NaviNet-submitted claims in this situation would appear in the Claims Log. |
| 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. NaviNet-submitted claims in this situation would appear in the Claims Log. |
| No revenue code 0022 or 0023         | A HIPPS code.                                                                         | This is not an acceptable combination in NaviNet, and the provider will be prompted to correct the code.                                                             |

### REMINDER: Check your Claims Log

Providers who submit claims electronically via NaviNet® are reminded to check their NaviNet Claims Log regularly to ensure that any claims rejected for these reasons are addressed in a timely fashion.



## 6.3 OUTPATIENT SERVICES PRIOR TO AN INPATIENT STAY

### Introduction

This section outlines Highmark's longstanding billing guidelines for outpatient services -- Emergency Department (ED), observation, pre-admission testing, etc. -- rendered prior to an inpatient admission.

The guidelines shown below are applicable whether or not the member remains at the facility throughout the forty-eight (48) hour period or leaves the facility and returns to be admitted within the forty-eight (48) hour time frame. Information is included for both Commercial and Medicare Advantage members.

### Commercial members

Please refer to the table below for guidelines on when outpatient services should be billed on the inpatient claim for commercial members (see next page for excluded services):

| SCENARIO                                                     | If...                                                                                                                                                                       | Then...                                                       |
|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| Member Seeking Emergency Department (ED) Services            | A member receives ED services within a 48-hour period prior to an inpatient admission to the <b>same</b> facility for a related diagnosis...                                | <b>all</b> services need to be billed on the inpatient claim. |
| Member Receiving Observation Services                        | A member receives observation services within a 48-hour period prior to an inpatient admission to the <b>same</b> facility for a related diagnosis...                       | <b>all</b> services need to be billed on the inpatient claim. |
| Member Receiving Pre-Admission and Other Outpatient Services | A member receives pre-admission or other outpatient services within a 48-hour period prior to an inpatient admission to the <b>same</b> facility for a related diagnosis... | <b>all</b> services need to be billed on the inpatient claim. |

*Continued on next page*

## 6.3 OUTPATIENT SERVICES PRIOR TO AN INPATIENT STAY, Continued

### Medicare Advantage members



Please refer to the table below for guidelines on when outpatient services should be billed on the inpatient claim for Medicare Advantage members:

| SCENARIO                                                     | If ...                                                                                                                                                                      | Then ...                                                      |
|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| Member Seeking Emergency Department (ED) Services            | a member receives ED services within a 24-hour period prior to an inpatient admission to the <b>same</b> facility for a related diagnosis...                                | <b>all</b> services need to be billed on the inpatient claim. |
| Member Receiving Observation Services                        | a member receives observation services within a 48-hour period prior to an inpatient admission to the <b>same</b> facility for a related diagnosis...                       | <b>all</b> services need to be billed on the inpatient claim. |
| Member Receiving Pre-Admission and Other Outpatient Services | a member receives pre-admission or other outpatient services within a 72-hour period prior to an inpatient admission to the <b>same</b> facility for a related diagnosis... | <b>all</b> services need to be billed on the inpatient claim. |

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### 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.

### Excluded services

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. They are as follows:

- **Chemotherapy and/or Outpatient Surgery:** These services should not be included on the inpatient claim as long as they are **not performed on the same day** of the inpatient admission. If they are performed on the same day as the inpatient admission, then they are to be included on the inpatient claim.
- **Maternity Services:** Outpatient diagnostic and/or Emergency Department services **provided in conjunction with a maternity-related diagnosis prior to the inpatient admission** should not be included on the inpatient claim.

## 6.3 MODIFIER REQUIRED FOR OFF-CAMPUS OUTPATIENT SERVICES

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**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.

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**Main campus & 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.

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**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](#).

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## 6.3 HOME HEALTH AGENCY BILLING HOME INFUSION SERVICES FOR MEDICARE ADVANTAGE

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### 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 services



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

|                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                        |
|-------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Overview</b>                                             | 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.                                                                                                                                                                                                    |
| <b>Requirement for claim submission</b>                     | <p>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:</p> <ul style="list-style-type: none"> <li>• 40 – Expired at home</li> <li>• 41 – Expired in a medical facility</li> <li>• 42 – Expired (place unknown)</li> </ul> |
| <b>Extending the authorization to include date of death</b> | 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.                                                                                                                                                      |

**Quick  
Reference**

## 6.3 DIAGNOSTIC VS. ROUTINE PAP SMEARS

|                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Introduction</b>                                | These guidelines clarify billing for both outpatient diagnostic pap smears and routine pap smears.                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Billing for routine pap smears</b>              | If billing for a <b>routine pap smear</b> , only report a <b>routine</b> diagnosis on the claim to ensure that the claim will process correctly.                                                                                                                                                                                                                                                                                                                                                  |
| <b>Billing for diagnostic pap smears</b>           | <p>If billing for a <b>diagnostic pap smear</b> as a follow-up to a routine pap smear, and <b>no other services are being reported</b> on the claim, the diagnosis code reported should only be <b>diagnostic</b> and related to the symptom or chief complaint of the patient.</p> <p><b>Note:</b> 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.</p> |
| <b>Diagnostic pap smears with routine services</b> | <p>If billing for a diagnostic pap smear <b>and</b> a routine service:</p> <ul style="list-style-type: none"> <li>• Report the diagnosis related to the symptom or chief complaint of the patient for the diagnostic pap smear, and</li> <li>• Also report the routine diagnosis for the routine service provided.</li> </ul>                                                                                                                                                                     |

## 6.3 REVISED AND DISCONTINUED BILL TYPES FOR HOME HEALTH

### Overview

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      | Outpatient (plan of treatment under Part A, including DME under Part A) | Discontinued                                                   |
| 034X      | Other (for medical and surgical services not under a plan of treatment) | Home Health Services <b>not</b> 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 (see next page for sample).
- 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.

### 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

Pennsylvania Western Region facilities are required to submit Major Medical claims via a red UB-04 paper claim (available at [nubc.org](http://nubc.org)), rather than electronically.



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### 6.3 SAMPLE UB-04 CLAIM FORM

## TIP SHEET

**Sample UB-04** Click on the Tip Sheet icon for a full-size version of the sample UB-04 claim form.

|                      |  |  |  |  |  |  |  |  |  |                      |  |  |  |  |  |  |  |  |  |                                                                                               |  |  |  |  |  |  |  |  |  |
|----------------------|--|--|--|--|--|--|--|--|--|----------------------|--|--|--|--|--|--|--|--|--|-----------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|
|                      |  |  |  |  |  |  |  |  |  |                      |  |  |  |  |  |  |  |  |  | 1. DATE OF BILL<br>2. DATE OF BILL<br>3. PERIOD NO.<br>4. PERIOD COVER PERIOD FROM TO THROUGH |  |  |  |  |  |  |  |  |  |
| 5. PRESENT NAME      |  |  |  |  |  |  |  |  |  | 6. PRESENT ADDRESS   |  |  |  |  |  |  |  |  |  |                                                                                               |  |  |  |  |  |  |  |  |  |
| 7. BIRTH DATE        |  |  |  |  |  |  |  |  |  | 8. DATE              |  |  |  |  |  |  |  |  |  | 9. CONDITION CODE                                                                             |  |  |  |  |  |  |  |  |  |
| 10. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 11. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 12. OCCURRENCE CODE                                                                           |  |  |  |  |  |  |  |  |  |
| 13. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 14. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 15. OCCURRENCE CODE                                                                           |  |  |  |  |  |  |  |  |  |
| 16. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 17. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 18. OCCURRENCE CODE                                                                           |  |  |  |  |  |  |  |  |  |
| 19. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 20. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 21. OCCURRENCE CODE                                                                           |  |  |  |  |  |  |  |  |  |
| 22. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 23. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 24. OCCURRENCE CODE                                                                           |  |  |  |  |  |  |  |  |  |
| 25. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 26. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 27. OCCURRENCE CODE                                                                           |  |  |  |  |  |  |  |  |  |
| 28. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 29. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 30. OCCURRENCE CODE                                                                           |  |  |  |  |  |  |  |  |  |
| 31. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 32. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 33. OCCURRENCE CODE                                                                           |  |  |  |  |  |  |  |  |  |
| 34. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 35. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 36. OCCURRENCE CODE                                                                           |  |  |  |  |  |  |  |  |  |
| 37. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 38. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 39. OCCURRENCE CODE                                                                           |  |  |  |  |  |  |  |  |  |
| 40. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 41. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 42. OCCURRENCE CODE                                                                           |  |  |  |  |  |  |  |  |  |
| 43. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 44. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 45. OCCURRENCE CODE                                                                           |  |  |  |  |  |  |  |  |  |
| 46. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 47. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 48. OCCURRENCE CODE                                                                           |  |  |  |  |  |  |  |  |  |
| 49. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 50. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 51. OCCURRENCE CODE                                                                           |  |  |  |  |  |  |  |  |  |
| 52. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 53. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 54. OCCURRENCE CODE                                                                           |  |  |  |  |  |  |  |  |  |
| 55. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 56. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 57. OCCURRENCE CODE                                                                           |  |  |  |  |  |  |  |  |  |
| 58. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 59. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 60. OCCURRENCE CODE                                                                           |  |  |  |  |  |  |  |  |  |
| 61. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 62. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 63. OCCURRENCE CODE                                                                           |  |  |  |  |  |  |  |  |  |
| 64. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 65. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 66. OCCURRENCE CODE                                                                           |  |  |  |  |  |  |  |  |  |
| 67. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 68. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 69. OCCURRENCE CODE                                                                           |  |  |  |  |  |  |  |  |  |
| 70. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 71. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 72. OCCURRENCE CODE                                                                           |  |  |  |  |  |  |  |  |  |
| 73. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 74. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 75. OCCURRENCE CODE                                                                           |  |  |  |  |  |  |  |  |  |
| 76. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 77. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 78. OCCURRENCE CODE                                                                           |  |  |  |  |  |  |  |  |  |
| 79. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 80. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 81. OCCURRENCE CODE                                                                           |  |  |  |  |  |  |  |  |  |
| 82. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 83. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 84. OCCURRENCE CODE                                                                           |  |  |  |  |  |  |  |  |  |
| 85. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 86. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 87. OCCURRENCE CODE                                                                           |  |  |  |  |  |  |  |  |  |
| 88. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 89. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 90. OCCURRENCE CODE                                                                           |  |  |  |  |  |  |  |  |  |
| 91. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 92. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 93. OCCURRENCE CODE                                                                           |  |  |  |  |  |  |  |  |  |
| 94. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 95. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 96. OCCURRENCE CODE                                                                           |  |  |  |  |  |  |  |  |  |
| 97. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 98. OCCURRENCE CODE  |  |  |  |  |  |  |  |  |  | 99. OCCURRENCE CODE                                                                           |  |  |  |  |  |  |  |  |  |
| 100. OCCURRENCE CODE |  |  |  |  |  |  |  |  |  | 101. OCCURRENCE CODE |  |  |  |  |  |  |  |  |  | 102. OCCURRENCE CODE                                                                          |  |  |  |  |  |  |  |  |  |
| 103. OCCURRENCE CODE |  |  |  |  |  |  |  |  |  | 104. OCCURRENCE CODE |  |  |  |  |  |  |  |  |  | 105. OCCURRENCE CODE                                                                          |  |  |  |  |  |  |  |  |  |
| 106. OCCURRENCE CODE |  |  |  |  |  |  |  |  |  | 107. OCCURRENCE CODE |  |  |  |  |  |  |  |  |  | 108. OCCURRENCE CODE                                                                          |  |  |  |  |  |  |  |  |  |
| 109. OCCURRENCE CODE |  |  |  |  |  |  |  |  |  | 110. OCCURRENCE CODE |  |  |  |  |  |  |  |  |  | 111. OCCURRENCE CODE                                                                          |  |  |  |  |  |  |  |  |  |
| 112. OCCURRENCE CODE |  |  |  |  |  |  |  |  |  | 113. OCCURRENCE CODE |  |  |  |  |  |  |  |  |  | 114. OCCURRENCE CODE                                                                          |  |  |  |  |  |  |  |  |  |
| 115. OCCURRENCE CODE |  |  |  |  |  |  |  |  |  | 116. OCCURRENCE CODE |  |  |  |  |  |  |  |  |  | 117. OCCURRENCE CODE                                                                          |  |  |  |  |  |  |  |  |  |
| 118. OCCURRENCE CODE |  |  |  |  |  |  |  |  |  | 119. OCCURRENCE CODE |  |  |  |  |  |  |  |  |  | 120. OCCURRENCE CODE                                                                          |  |  |  |  |  |  |  |  |  |
| 121. OCCURRENCE CODE |  |  |  |  |  |  |  |  |  | 122. OCCURRENCE CODE |  |  |  |  |  |  |  |  |  | 123. OCCURRENCE CODE                                                                          |  |  |  |  |  |  |  |  |  |
| 124. OCCURRENCE CODE |  |  |  |  |  |  |  |  |  | 125. OCCURRENCE CODE |  |  |  |  |  |  |  |  |  | 126. OCCURRENCE CODE                                                                          |  |  |  |  |  |  |  |  |  |
| 127. OCCURRENCE CODE |  |  |  |  |  |  |  |  |  | 128. OCCURRENCE CODE |  |  |  |  |  |  |  |  |  | 129. OCCURRENCE CODE                                                                          |  |  |  |  |  |  |  |  |  |
| 130. OCCURRENCE CODE |  |  |  |  |  |  |  |  |  | 131. OCCURRENCE CODE |  |  |  |  |  |  |  |  |  | 132. OCCURRENCE CODE                                                                          |  |  |  |  |  |  |  |  |  |
| 133. OCCURRENCE CODE |  |  |  |  |  |  |  |  |  | 134. OCCURRENCE CODE |  |  |  |  |  |  |  |  |  | 135. OCCURRENCE CODE                                                                          |  |  |  |  |  |  |  |  |  |
| 136. OCCURRENCE CODE |  |  |  |  |  |  |  |  |  | 137. OCCURRENCE CODE |  |  |  |  |  |  |  |  |  |                                                                                               |  |  |  |  |  |  |  |  |  |

## CHAPTER 6: BILLING AND PAYMENT

### UNIT 4: PROFESSIONAL (1500/837P) REPORTING TIPS

#### IN THIS UNIT



| TOPIC                                                                     | SEE PAGE |
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#### What Is My Service Area?

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The **PA ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The **DE ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

## 6.4 INTRODUCTION

### Overview

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 & NaviNet](#) 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<br><br><b>Note:</b> 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 services

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.

*Continued on next page*

## 6.4 INTRODUCTION, Continued

### 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 on 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 **1-866-425-8275**. You can also e-mail [1099inquiry@highmark.com](mailto:1099inquiry@highmark.com).

*Continued on next page*

## 6.4 INTRODUCTION, Continued

### Avoid Form 1099-Misc errors (continued)

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 BILLING FIRST PRIORITY HEALTH NETWORK PCP SERVICES (PA ONLY)

[What Is My Service Area?](#)

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



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 Highmark Blue Shield Provider Resource Centers on the Highmark Blue Shield website and also via NaviNet® – select **Administrative Reference Materials**, and then click on **First Priority Health Network Resources**.

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

### Overview

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.

*Continued on next page*

## 6.4 MODIFIERS, Continued

### 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 **Forms** from the main menu, and then click on **Miscellaneous 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 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| <b>Attention:</b> Document Preparation/Image                                                                                       | <b>Attention:</b> Document Preparation/Image                                                                                                     | <b>Attention:</b> CDC Area                                                                        |
| <b>Fax to:</b> 1-888-910-8797                                                                                                      | <b>Fax to:</b> 1-888-910-9601                                                                                                                    | <b>Fax to:</b> 1-844-235-7266                                                                     |
| <b>Mail to:</b><br>Highmark Blue Shield<br>PWK (Paperwork) Additional Documentation<br>P.O. Box 890176<br>Camp Hill, PA 17089-0176 | <b>Mail to:</b><br>Highmark Blue Cross Blue Shield Delaware<br>PWK (Paperwork) Additional Documentation<br>P.O. Box 8832<br>Wilmington, DE 19899 | <b>Mail to:</b><br>Highmark West Virginia<br>P.O. Box 7026<br>Wheeling, WV 26003-0766             |
|                                                                                                                                    |                                                                                                                                                  | <a href="#">What Is My Service Area?</a>                                                          |

### 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.

*Continued on next page*



## 6.4 MODIFIERS, Continued

### Claim review and adjudication (continued)

- 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 investigation through NaviNet.® Specific instructions as to where to submit supporting documentation will be included in the response to your claim investigation. If you are not NaviNet-enabled, contact Provider Service for instructions on how to submit your supporting documentation.

[What Is My Service Area?](#)

### Assistant and co-surgery -- Modifiers 62, 80, 81, 82, & AS



#### Assistant Surgeon

In Pennsylvania and West Virginia, Highmark will reimburse eligible surgical procedures billed with modifiers 80, 81, 82, and AS at 16% of the allowable amount. For criteria for payment of assistant surgery, please see Highmark Medical Policy S-16.

- 80 -- Assistant surgeon
- 81 -- Minimum assistant surgeon
- 82 -- Assistant surgeon (when qualified resident surgeon not available)
- AS -- Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist services for assistant at surgery

#### Co-Surgeon

In Pennsylvania and West Virginia, Highmark will reimburse eligible surgical procedures billed with modifier 62 (two surgeons) at 62.5% of the contract allowance. For criteria for payment of co-surgery, please see Highmark Medical Policy S-112.

**Note:** Highmark Medical Policy for your service area can be accessed via your regional Provider Resource Center – select **CLAIMS, PAYMENT & REIMBURSEMENT** from the main menu, and then click on **Medical Policy**.

*Continued on next page*

## 6.4 MODIFIERS, Continued

[What Is My Service Area?](#)

### Assistant and co-surgery -- Modifiers 62, 80, 81, 82, & AS



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. This regulation applies to Delaware health insurance policies that follow Delaware mandates.

Highmark Delaware will reimburse eligible surgical procedures billed with modifiers 62, 80, 81, and 82 at 16% of the allowable amount.

- 62 -- Two surgeons
- 80 -- Assistant surgeon
- 81 -- Minimum assistant surgeon
- 82 -- Assistant surgeon (when qualified resident surgeon not available)

Modifier AS will be reimbursed at 13.6% of the allowable amount.

AS -- Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist services for assistant at surgery

For criteria for payment of assistant surgery, please see Highmark Delaware Medical Policy S-16. Criteria for payment of co-surgery can be found in Highmark Delaware Medical Policy S-112.

**Note:** Highmark Delaware Medical Policy can be accessed via the Highmark Delaware Provider Resource Center – select **CLAIMS, PAYMENT & REIMBURSEMENT** from the main menu, and then **Medical Policy**.

### FOR MORE INFORMATION

Please see **Highmark Reimbursement Policies** for Assistant at Surgery and Co-Surgery. Reimbursement Policies are available on the Provider Resource Center under **CLAIMS, PAYMENT & REIMBURSEMENT**.

## 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.

#### “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 |    |    |    |    |    | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES<br>(Explain Unusual Circumstances) |    |  |  |  |      | E. DIAGNOSIS POINTER | F. \$ CHARGES |   | G. DAYS OR UNITS | H. PRIOR AUTH. |
|---------------------------|----|----|----|----|----|---------------------|--------|-------------------------------------------------------------------------|----|--|--|--|------|----------------------|---------------|---|------------------|----------------|
| MM                        | DD | YY | MM | DD | YY |                     |        | CPT/HCPCS I MODIFIER                                                    |    |  |  |  |      |                      |               |   |                  |                |
| 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 |    |    |    |    |    | B. PLACE OF SERVICE |    | C. EMG |    | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) |    |          |    | E. DIAGNOSIS POINTER |    | F. \$ CHARGES |    | G. DAYS OR UNITS |    | H. PRIOR AUTH. |    |    |    |
|---------------------------|----|----|----|----|----|---------------------|----|--------|----|----------------------------------------------------------------------|----|----------|----|----------------------|----|---------------|----|------------------|----|----------------|----|----|----|
| From                      |    | To |    |    |    | FROM                |    | TO     |    | CPT/HCPCS                                                            |    | MODIFIER |    |                      |    |               |    |                  |    |                |    |    |    |
| MM                        | DD | YY | MM | DD | YY | MM                  | DD | YY     | MM | DD                                                                   | YY | MM       | DD | YY                   | MM | DD            | YY | MM               | DD | YY             | MM | DD | YY |
| 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 |    |    |    |    |    | B. PLACE OF SERVICE |  | C. EMG |  | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) |       |          |  | E. DIAGNOSIS POINTER |  | F. \$ CHARGES |   | G. DAYS OR UNITS |  | H. PRIOR AUTH. |  |
|---------------------------|----|----|----|----|----|---------------------|--|--------|--|----------------------------------------------------------------------|-------|----------|--|----------------------|--|---------------|---|------------------|--|----------------|--|
| From                      |    |    | To |    |    | SPRCL               |  |        |  | CPT/NCPS                                                             |       | MODIFIER |  |                      |  |               |   |                  |  |                |  |
| MM                        | DD | YY | MM | DD | YY |                     |  |        |  |                                                                      |       |          |  |                      |  |               |   |                  |  |                |  |
| 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 |    |    |    |    |    | B. PLACE OF SERVICE |    | C. EMG |    | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) |       |    |    | E. DIAGNOSIS POINTER |    | F. \$ CHARGES |      | G. DAYS OR UNITS |    | H. PRIOR AUTH. |    |    |
|---------------------------|----|----|----|----|----|---------------------|----|--------|----|----------------------------------------------------------------------|-------|----|----|----------------------|----|---------------|------|------------------|----|----------------|----|----|
| From                      |    | To |    |    |    |                     |    |        |    | CPT/HCPCS                                                            |       |    |    | MODIFIER             |    |               |      |                  |    |                |    |    |
| MM                        | DD | YY | MM | DD | YY | FROM                | TO | MM     | DD | YY                                                                   | MM    | DD | YY | MM                   | DD | YY            | MM   | DD               | YY | MM             | DD | YY |
| 04                        | 15 | 14 |    |    |    |                     |    | 22     |    |                                                                      | 20610 | RT |    |                      |    |               | ABCD |                  | 70 | 00             | 2  |    |

or

| 24. A. DATE(S) OF SERVICE |    |    |    |    |    | B. PLACE OF SERVICE |  | C. EMG |  | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) |  |       |    |    |  | E. DIAGNOSIS POINTER |      | F. \$ CHARGES |    | G. DAYS OR UNITS |   | H. PRIOR AUTH. |  |
|---------------------------|----|----|----|----|----|---------------------|--|--------|--|----------------------------------------------------------------------|--|-------|----|----|--|----------------------|------|---------------|----|------------------|---|----------------|--|
| From                      |    |    | To |    |    |                     |  |        |  | CPT/HCPCS I MODIFIER                                                 |  |       |    |    |  |                      |      |               |    |                  |   |                |  |
| MM                        | DD | YY | MM | DD | YY |                     |  |        |  |                                                                      |  |       |    |    |  |                      |      |               |    |                  |   |                |  |
| 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 TIMED THERAPY CODES

### Overview

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 fifteen (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 (8) 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 (8) minutes through and including twenty-two (22) minutes. If the duration of a single modality or procedure in a day is greater than or equal to twenty-three (23) minutes, through and including thirty-seven (37) minutes, then two (2) units should be billed. The pattern remains the same for treatment times in excess of the chart below.

Timed intervals for one (1) through eight (8) 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 (1) 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.

*Continued on next page*

## 6.4 TIMED THERAPY CODES, Continued

### 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 (3) units.** Bill the procedures you spent the most time providing. You would have one (1) 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.

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### FOR MORE INFORMATION

The Centers for Medicare & Medicaid Services (CMS) claims processing Publication 100-04 can be referenced for additional details.

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## 6.4 FREQUENCY TYPE CODES AND ADJUSTMENTS

### Introduction

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 the NaviNet® claim entry screen by selecting the appropriate frequency type code and providing the original claim number.

### 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.

**IMPORTANT!**  
Adjustment claim changes effective January 1, 2018

Effective January 1, 2018, providers must submit corrected (replacement) claims electronically; Highmark will not accept requests for claim corrections via telephone or NaviNet® Claim Investigation.

**Please Note:** If the original claim was submitted on paper, the replacement claim must also be submitted on paper. Please see [Chapter 6.5: 1500 Claim Form Guidelines](#).

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## 6.4 FREQUENCY TYPE CODES AND ADJUSTMENTS, Continued

### 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

*Continued on next page*

## 6.4 FREQUENCY TYPE CODES AND ADJUSTMENTS, Continued

### **Frequency Type 8 – Void/ cancellation of a prior claim (continued)**

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

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### Introduction

**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, PAYMENT & REIMBURSEMENT** from the main menu.

**Coverage for services may vary for individual members, based on the terms of the benefit contract. Please check Highmark members' benefits via NaviNet® or, if not-NaviNet-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 **CLAIMS, PAYMENT & REIMBURSEMENT** from the main menu, and then click on **Medical Policy**.

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### 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.

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## 6.4 ANESTHESIA REPORTING TIPS, Continued

### 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 |    |    |    |    |    | B. PLACE OF SERVICE | C. CPT/HCPCS | D. PROCEDURES, SERVICES, OR SUPPLIES |          | E. DIAGNOSIS | F. CHARGES |         | G. DATE OF SERVICE | H. TIME | I. QUAL | J. PROVIDER ID # |
|---------------------------|----|----|----|----|----|---------------------|--------------|--------------------------------------|----------|--------------|------------|---------|--------------------|---------|---------|------------------|
| MM                        | DD | YY | MM | DD | YY |                     |              | EXPLAIN UNUSUAL CIRCUMSTANCES        | MODIFIER |              | \$         | CHARGES | OR                 | UNITS   |         |                  |
| 04                        | 15 | 14 | 04 | 15 | 14 | 20                  |              | 00830                                | AA       | A            | 2750       | 00      | 243                |         | NPI     |                  |
|                           |    |    |    |    |    |                     |              |                                      |          |              |            |         |                    |         | NPI     |                  |
|                           |    |    |    |    |    |                     |              |                                      |          |              |            |         |                    |         | NPI     |                  |
|                           |    |    |    |    |    |                     |              |                                      |          |              |            |         |                    |         | NPI     |                  |

When the surgical procedure code is a **NOS/NOC surgical service**, please report as follows:

| 24. A. DATE(S) OF SERVICE |    |    |    |    |    | B. PLACE OF SERVICE | C. CPT/HCPCS | D. PROCEDURES, SERVICES, OR SUPPLIES |          | E. DIAGNOSIS | F. CHARGES |         | G. DATE OF SERVICE | H. TIME | I. QUAL | J. PROVIDER ID # |
|---------------------------|----|----|----|----|----|---------------------|--------------|--------------------------------------|----------|--------------|------------|---------|--------------------|---------|---------|------------------|
| MM                        | DD | YY | MM | DD | YY |                     |              | EXPLAIN UNUSUAL CIRCUMSTANCES        | MODIFIER |              | \$         | CHARGES | OR                 | UNITS   |         |                  |
| 04                        | 15 | 14 | 04 | 15 | 14 | 20                  |              | 00320                                | QY       | A            | 2750       | 00      | 243                |         | NPI     |                  |
| 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:
  - o Spinal (low spinal, saddle block)
  - o Epidural (caudal)
  - o Nerve block (retrobulbar, brachial plexus block, etc.)
  - o 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**.

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## 6.4 ANESTHESIA REPORTING TIPS, Continued

### 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 fifteen (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.

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## 6.4 ANESTHESIA REPORTING TIPS, Continued

### Medical direction (supervision) of anesthesia overview (continued)

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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|----------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| AA       | 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 "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.)<br><br><b>Note:</b> Do not report the AA modifier when the anesthesiologist is medically directing one or more anesthesiologists, regardless of the employment status of the anesthesiologists. |
| 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.)<br><ul style="list-style-type: none"> <li>• Report modifier 47 in conjunction with the basic service, for example, the surgery code.</li> <li>• Do not use modifier 47 as a modifier for anesthesia codes 00100-01999.</li> <li>• Do not report modifier 47 for moderate sedation (see information about moderate sedation further in this unit.)</li> </ul>                                                                                                                          |

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## 6.4 ANESTHESIA REPORTING TIPS, Continued

[What Is My Service Area?](#)

**Medical direction (supervision) of anesthesia reporting/ payment (PA & DE)**



### **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/50percent 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.

*Continued on next page*

## 6.4 ANESTHESIA REPORTING TIPS, Continued

[What Is My Service Area?](#)

**Medical direction (supervision) of anesthesia reporting/payment (WV)**



### **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 –60 percent/40 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 – 95 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 95 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 –**

**95 percent/5percent 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 95 percent of the fee that is allowed for the anesthesiologist's personal performance of the anesthesia services is made to the anesthesiologist. The remaining five (5) 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.

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## 6.4 ANESTHESIA REPORTING TIPS, Continued

### Modifying units

Modifying units represent those circumstances that necessitate skills of a physician beyond those usually required. Report modifying units (representative of age, total body hypothermia, controlled hypertension, and emergency) with the following HCPCS procedure codes. These procedure codes are not associated with number of units; therefore, please do not report additional units.

Highmark will pay these HCPCS codes at a flat fee. You must report procedure codes 99100, 99116, 99135 or 99140 on the same claim as the anesthesia service (00100-01999).

| CODE  | DESCRIPTION                                           |
|-------|-------------------------------------------------------|
| 99100 | Extreme age, under 1 year or 71 years of age or older |
| 99116 | Total body hypothermia                                |
| 99135 | Controlled hypertension                               |
| 99140 | Emergency conditions                                  |

**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       | Physical status 1 | 0               |
| P2       | Physical status 2 | 0               |
| P3       | Physical status 3 | 1               |
| P4       | Physical status 4 | 2               |
| P5       | Physical status 5 | 3               |

### 1500 Claim Form (02/12) claim example

1500 claim example for anesthesia services personally performed by physician:

| 24. A. DATE(S) OF SERVICE |    |    |    |    |    | B. PLACE OF SERVICE |    | C. EMO |    | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS |    |    |   | E. DIAGNOSIS |   | F. CHARGES |    | G. CODE OR UNITS |   | H. PAYMENT |   |
|---------------------------|----|----|----|----|----|---------------------|----|--------|----|--------------------------------------------------------------------------------|----|----|---|--------------|---|------------|----|------------------|---|------------|---|
| MM                        | DD | YY | MM | DD | YY | FROM                | TO | FROM   | TO | 1                                                                              | 2  | 3  | 4 | 1            | 2 | 1          | 2  | 1                | 2 | 1          | 2 |
| 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.

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## 6.4 ANESTHESIA REPORTING TIPS, Continued

### Administration of anesthesia for surgical/nonsurgical procedures, same provider (continued)

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.

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## 6.4 ANESTHESIA REPORTING TIPS, Continued

### 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

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:

- 01960 – anesthesia for vaginal delivery only
- 01961 – anesthesia for cesarean delivery only
- 01962 – anesthesia for urgent hysterectomy following delivery
- 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

*Continued on next page*

## 6.4 ANESTHESIA REPORTING TIPS, Continued

### Anesthesia related to obstetrical care

(continued)

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 Highmark West Virginia, payment for continuous epidurals will be reimbursed up to a maximum of fifteen (15) time units for 01967, 01960, and 01961 and for the combined time billed with 01967 and 01968.

A maximum of eight (8) 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 (1) unit. The number of services reported for a week of five fractions would be one (1). **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 ten (10) hyperfractions or five (5) days. The number of services billed for that week should be one (1).
- 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

### 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 Certified Registered Nurse Practitioners (CRNPs), Physician Assistants (PAs), and Nurse Midwives.

### Reimbursement for services performed by mid-level providers

The reimbursement for all services not considered "incident to" is reduced when they are performed by a mid-level provider.

Services performed by PAs and assistant-at-surgery services performed by CRNPs are reimbursed at either eighty-five (85) percent of the physician fee schedule allowance or eighty (80) percent of charge, whichever is lower. Other services performed by CRNPs are reimbursed at either eighty-five (85) percent of the physician fee schedule or one hundred (100) percent of charge, whichever is lower. When a service is provided by a nurse midwife, payment is made at the lower of one hundred (100) percent of the fee schedule amount or eighty (80) percent of charge.

### Applicable Medicare Advantage products



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 (PA Western Region only)
- Community Blue Medicare HMO (PA only)

[What Is My Service Area?](#)

### 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.

## 6.4 REPORTING PLACE OF SERVICE FOR DIAGNOSTIC SERVICES PROVIDED IN A HOSPITAL

**Overview** 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.

Please visit NaviNet® and choose the *Network Facility Inquiry* to find NPI numbers for all licensed facilities.

### FOR MORE INFORMATION

Please refer to [Chapter 4.5: Outpatient Radiology and Laboratory](#) for additional information on the Highmark Radiology Management Program’s 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:                                                              |
|-----------------------------------------------------------|----------------------------------------------------------------------|-----------------------------------------------------------------------------|
| FEP Claims<br>P.O. Box 890062<br>Camp Hill, PA 17089-0062 | Federal Employee<br>Program<br>P.O. Box 1991<br>Wilmington, DE 19899 | FEP Claims<br>Highmark West Virginia<br>P.O. Box 7026<br>Wheeling, WV 26003 |

- 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.

[What Is My Service Area?](#)

## 6.4 CONCURRENT MAJOR MEDICAL PROCESSING (PA ONLY)

### Overview



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.

[What Is My Service Area?](#)

### Sample EOB

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 | PAYMENT 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: xxxxxxxxxxxxxx                                                                                                                      |             |                         |              |                 |                         |               |                       |              |                         | PATIENT: NAME MEMBER: NAME CLAIM NUMBER: 0000000000 |              |                             |               |  |  |  |  |  |  |
| 09/12/06                                                                                                                                                       | 1           | 98942                   | 001          | 55.00           |                         | 54.50         | .50                   | 25           | 10.90                   | C1                                                  |              | 43.60                       | J0080         |  |  |  |  |  |  |
| 09/12/06                                                                                                                                                       | 1           | 97140                   | 001          | 25.00           |                         | 25.00         |                       |              | 5.00                    | C1                                                  |              | 20.00                       | J0080         |  |  |  |  |  |  |
| 09/12/06                                                                                                                                                       | 1           | 97032                   | 001          | 30.00           |                         | 20.00         | 10.00                 | 25           | 4.00                    | C1                                                  |              | 16.00                       | J0080         |  |  |  |  |  |  |
| CLAIM TOTALS                                                                                                                                                   |             |                         |              |                 |                         |               | 10.50                 |              | 19.90                   |                                                     |              | 79.60                       |               |  |  |  |  |  |  |
| PATIENT ACCT #: MEMBER ID: xxxxxxxxx                                                                                                                           |             |                         |              |                 |                         |               |                       |              |                         | PATIENT: NAME MEMBER: NAME CLAIM NUMBER: 0000000000 |              |                             |               |  |  |  |  |  |  |
| 09/15/06                                                                                                                                                       | 1           | 98942                   | 025          | 55.00           |                         | 52.00         | 3.00                  | 25           | 10.00                   | D1                                                  |              | 42.00                       | J0080         |  |  |  |  |  |  |
| 09/15/06                                                                                                                                                       | 1           | 97530                   |              | 30.00           |                         |               |                       |              | 30.00                   | H1                                                  |              | E5252, J0080                |               |  |  |  |  |  |  |
| 09/15/06                                                                                                                                                       | 1           | 97140                   | 025          | 25.00           |                         | 25.50         | 1.50                  | 25           |                         |                                                     |              | 23.50                       | J0080         |  |  |  |  |  |  |
| CLAIM TOTALS                                                                                                                                                   |             |                         |              |                 |                         |               | 4.50                  |              | 40.00                   |                                                     |              | 65.50                       |               |  |  |  |  |  |  |
| PATIENT ACCT #: MEMBER ID: CONCURRENT MAJOR MEDICAL                                                                                                            |             |                         |              |                 |                         |               |                       |              |                         | PATIENT: NAME MEMBER: NAME CLAIM NUMBER: 0000000000 |              |                             |               |  |  |  |  |  |  |
| 09/01/06                                                                                                                                                       | 1           | 99213                   | 012          | 70.00           |                         | 70.00         |                       |              | 70.00                   | C1                                                  |              | 56.00                       | B5000A, J9040 |  |  |  |  |  |  |
| CLAIM TOTALS                                                                                                                                                   |             |                         |              |                 |                         |               |                       |              | 14.00                   |                                                     |              | 56.00                       |               |  |  |  |  |  |  |
| CLAIM SPECIFIC MESSAGE(S):<br>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: 0000000000 |              |                             |               |  |  |  |  |  |  |
| 09/18/06                                                                                                                                                       | 1           | 99213                   | 001          | 60.00           |                         | 60.00         |                       |              | 12.00                   | C1                                                  |              | 48.00                       | J0080         |  |  |  |  |  |  |



PF00000000  
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## 6.4 MEDICARE PART B SUPPLEMENTAL CLAIMS

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### Overview

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.

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### Medicare claims cross over to Blue Plans

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 thirty (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 NaviNet® before resubmitting.

To 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.

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### If a claim does not cross over

If you have not received payment from Highmark within thirty (30) days and, after checking claim status in NaviNet, 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.

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*Continued on next page*



## 6.4 MEDICARE PART B SUPPLEMENTAL CLAIMS, Continued

### If a claim does not cross over (continued)

When submitting the EOMB, please use the PWK 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 Claims Attachment Cover Sheet](#)

The cover sheet is also available on the Provider Resource Center. Select **FORMS**, and then click on **Miscellaneous 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 their complete name and address.*

|  PENNSYLVANIA                                     |  DELAWARE                                                       |  WEST VIRGINIA |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| <b>Attention:</b> Document Preparation/Image                                                                                       | <b>Attention:</b> Document Preparation/Image                                                                                                     | <b>Attention:</b> CDC Area                                                                        |
| <b>Fax to:</b> 1-888-910-8797                                                                                                      | <b>Fax to:</b> 1-888-910-9601                                                                                                                    | <b>Fax to:</b> 1-844-235-7266                                                                     |
| <b>Mail to:</b><br>Highmark Blue Shield<br>PWK (Paperwork) Additional Documentation<br>P.O. Box 890176<br>Camp Hill, PA 17089-0176 | <b>Mail to:</b><br>Highmark Blue Cross Blue Shield Delaware<br>PWK (Paperwork) Additional Documentation<br>P.O. Box 8832<br>Wilmington, DE 19899 | <b>Mail to:</b><br>Highmark West Virginia<br>P.O. Box 7026<br>Wheeling, WV 26003-0766             |
|                                                                                                                                    |                                                                                                                                                  | <a href="#">What Is My Service Area?</a>                                                          |

### Paper claim submission

If you must submit a paper claim, mail the EOMB with a completed 1500 Claim Form (Version 02/12) to:

|  PENNSYLVANIA |  DELAWARE      |  WEST VIRGINIA |
|--------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
| <b>Medigap:</b><br>Highmark Blue Shield Medigap<br>P.O. Box 898845<br>Camp Hill, PA 17089-8845   | <b>All other products:</b><br>Highmark Blue Shield<br>P.O. Box 890052<br>Camp Hill, PA 17089-0052 | Highmark Blue Cross Blue Shield Delaware<br>P.O. Box 8830<br>Wilmington, DE 19899-8830              |
|                                                                                                  |                                                                                                   | Highmark Blue Cross Blue Shield West Virginia<br>P.O. Box 7026<br>Wheeling, WV 26003                |

## 6.4 PERSONAL CHOICE CLAIMS (PA ONLY)

### Background



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.

[What Is My Service Area?](#)

### Electronic claims submissions



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



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.

*Continued on next page*

## 6.4 PERSONAL CHOICE CLAIMS (PA ONLY), Continued

### IBC prefixes



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/pdfs/providers/claims\\_and\\_billing/edi/ibc\\_professional\\_payer\\_id.pdf](https://www.ibx.com/pdfs/providers/claims_and_billing/edi/ibc_professional_payer_id.pdf)

### Questions?



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](mailto:claims.edi-admin@ibx.com)

[What Is My Service Area?](#)

## CHAPTER 6: BILLING AND PAYMENT

### UNIT 5: 1500 CLAIM FORM GUIDELINES

#### IN THIS UNIT



| TOPIC                                                   | SEE PAGE |
|---------------------------------------------------------|----------|
| The 1500 Health Insurance Claim Form                    | 2        |
| OCR Scanning of Paper Claims                            | 4        |
| Guidelines for Submitting Paper Claims                  | 5        |
| Diagnosis Code Reporting                                | 7        |
| Additional Tips for Submitting Paper Claims             | 8        |
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[What Is My Service Area?](#)

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The **PA ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The **DE ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

## 6.5 THE 1500 HEALTH INSURANCE CLAIM FORM

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### Background

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](http://nucc.org).

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### 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.**

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### 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 & NaviNet](#) for information on how to take advantage of the electronic solutions available to you.

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*Continued on next page*

## 6.5 THE 1500 HEALTH INSURANCE CLAIM FORM, Continued

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### **Electronic claims submission** (continued)

You may also want to consider NaviNet® for submitting claims to Highmark. NaviNet 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! NaviNet even provides access to Highmark's tools for real-time claim estimation and adjudication. Additional information about NaviNet is also available in [Chapter 1.3: Electronic Solutions – EDI & NaviNet](#).

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## 6.5 OCR SCANNING OF PAPER CLAIMS

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### 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](mailto:1500form@tfpdata.com) , or telephone **1-800-482-9367, ext. 58029**; or
  - The Government Printing Office:  
<http://bookstore.gpo.gov/catalog/government-forms-phone-directories>, or telephone **1-866-512-1800**.
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## 6.5 GUIDELINES FOR SUBMITTING PAPER CLAIMS

### Introduction

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:
  - o Use **10-pitch PICA** type.
  - o Submit all claims on 20 pound paper.
  - o **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.

*Continued on next page*



## 6.5 GUIDELINES FOR SUBMITTING PAPER CLAIMS, Continued

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**If multiple forms are necessary**  
(continued)

**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.

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**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](#).

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## 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 (7) characters.
6. You may report a maximum of twelve (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.

|                                                                                     |    |    |            |       |    |            |  |           |           |                     |   |    |  |                                                                      |  |                      |  |
|-------------------------------------------------------------------------------------|----|----|------------|-------|----|------------|--|-----------|-----------|---------------------|---|----|--|----------------------------------------------------------------------|--|----------------------|--|
| 21. DIAGNOSES OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) |    |    |            |       |    |            |  |           |           | ICD Ind.            | 0 |    |  |                                                                      |  |                      |  |
| A. S13101A                                                                          |    |    | B. S139XXA |       |    | C. S23101A |  |           | D. M62838 |                     |   |    |  |                                                                      |  |                      |  |
| E. S33101A                                                                          |    |    | F. M5127   |       |    | G.         |  |           | H.        |                     |   |    |  |                                                                      |  |                      |  |
| I.                                                                                  |    |    | J.         |       |    | K.         |  |           | L.        |                     |   |    |  |                                                                      |  |                      |  |
| 24. A. DATE(S) OF SERVICE                                                           |    |    |            |       |    |            |  |           |           | B. PLACE OF SERVICE |   | C. |  | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) |  | E. DIAGNOSIS POINTER |  |
| From                                                                                |    | To |            | SPICE |    | EMG        |  | CPT/HCPCS |           | MODIFIER            |   |    |  |                                                                      |  |                      |  |
| MM                                                                                  | DD | YY | MM         | DD    | YY |            |  |           |           |                     |   |    |  |                                                                      |  |                      |  |
| 04                                                                                  | 15 | 14 | 04         | 15    | 14 | 10         |  |           | 99212     |                     |   |    |  | ABCDE                                                                |  |                      |  |

## 6.5 ADDITIONAL TIPS FOR SUBMITTING PAPER CLAIMS

### Overview

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 Services.

### Before you begin...

Always verify the patient's information via NaviNet® or the HIPAA 270/271 Health Care Eligibility Benefit Inquiry and Response transaction before completing the claim form. NaviNet's Eligibility and Benefits 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.

*Continued on next page*

## 6.5 ADDITIONAL TIPS FOR SUBMITTING PAPER CLAIMS, Continued

### 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:
  - o An “individual consideration” (IC) or “unlisted procedure” code is reported.
  - o The service performed is a new procedure.
  - o The service performed is potentially cosmetic.
  - o Multiple primary surgeons participated in a surgical procedure.
  - o The terminology for the reported code indicates, “by report” (BR).
  - o A pre-authorization letter advised you to submit specific reports.
  - o 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.

*Continued on next page*

## 6.5 ADDITIONAL TIPS FOR SUBMITTING PAPER CLAIMS, Continued

### 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                                        |                                     |
|------------------------------------------------------------|-------------------------------------|
| <b>Correct:</b> YYZ123456789001                            |                                     |
| <b>Incorrect:</b> YYZ-123-456-789001; ID # YYZ123456789001 |                                     |
| CHARGES                                                    |                                     |
| <b>Correct:</b> 20.00                                      |                                     |
| <b>Incorrect:</b> \$20.00                                  |                                     |
| DATE OF BIRTH: 8-digit format                              | ALL OTHER DATES: 6-digit format     |
| <b>Correct:</b> 12271949                                   | <b>Correct:</b> 122713; 021414      |
| <b>Incorrect:</b> 12/27/49; 12-27-1949                     | <b>Incorrect:</b> 12/27/13; 2-14-14 |
| INSURED'S POLICY GROUP NUMBER                              |                                     |
| <b>Correct:</b> 123456; NAS123                             |                                     |
| <b>Incorrect:</b> GRP # 123456; GRP # NAS123               |                                     |

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## 6.5 ADDITIONAL TIPS FOR SUBMITTING PAPER CLAIMS, Continued

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### 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](https://highmark.com/edi)
- Delaware: [highmark.com/bcbsde](https://highmark.com/bcbsde)
- West Virginia: [highmark.com/edi-wv](https://highmark.com/edi-wv)

Or, you may call EDI Operations at **1-800-992-0246**.

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## 6.5 1500 CLAIM FORM COMPLETION INSTRUCTIONS

### Introduction

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. Photocopies, discontinued, or outdated versions of the 1500 Claim Form will not be accepted and will be returned to providers.

### 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.

| 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).<br><br><b>Please do not staple over the Quick Response (QR) code symbol.</b> 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.<br><br>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. |

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## 6.5 1500 CLAIM FORM COMPLETION INSTRUCTIONS, Continued

| ITEM # | FIELD TITLE /DESCRIPTION        | INSTRUCTIONS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|--------|---------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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                  | <p>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. <b>Do not use terms such as "Self" or "Same" if the patient is also the Insured.</b></p> <p>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 <b>not</b> be included with the name.</p>            |
| 5      | PATIENT'S ADDRESS               | <p>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.</p> <p>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 <b>without</b> the hyphen.</p>                                                            |
| 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               | <p>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.</p> <p>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 <b>without</b> the hyphen.</p> |
| 8      | RESERVED FOR NUCC USE           | <b>Highmark does not need this information to adjudicate the claim.</b> Leave blank.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

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## 6.5 1500 CLAIM FORM COMPLETION INSTRUCTIONS, Continued

| ITEM #         | FIELD TITLE /DESCRIPTION               | INSTRUCTIONS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|----------------|----------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>9</b>       | OTHER INSURED'S NAME                   | <p>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. <b>Do not use periods within the name.</b></p> <p>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 <b>not</b> be included with the name.</p> |
| <b>9a</b>      | OTHER INSURED'S POLICY OR GROUP NUMBER | Enter the policy or group number of the other insured.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>9b</b>      | RESERVED FOR NUCC USE                  | <b>Highmark does not need this information to adjudicate the claim.</b> Leave blank.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>9c</b>      | RESERVED FOR NUCC USE                  | <b>Highmark does not need this information to adjudicate the claim.</b> Leave blank.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>9d</b>      | INSURANCE PLAN NAME OR PROGRAM NAME    | Enter the other insured's insurance plan or program name.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>10a,b,c</b> | 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.                                                                                                                                                                       |
| <b>10d</b>     | 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 <a href="http://www.nucc.org">http://www.nucc.org</a> under Code Sets.                                                                                                                                                                                                                                                                                                                                                            |

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## 6.5 1500 CLAIM FORM COMPLETION INSTRUCTIONS, Continued

| ITEM #     | FIELD TITLE /DESCRIPTION                   | INSTRUCTIONS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|------------|--------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>11</b>  | 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. <b>Do not use a hyphen or space as a separator within the policy or group number.</b> If Item #4 is completed, then this box should also be completed.                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>11a</b> | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>11b</b> | OTHER CLAIM ID (Designated by NUCC)        | <b>Highmark does not need this information to adjudicate the claim.</b> Leave blank.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>11c</b> | INSURANCE PLAN NAME OR PROGRAM NAME        | Enter the insurance plan or program name of the insured.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>11d</b> | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>12</b>  | PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE | <b>Highmark does not need this information to adjudicate the claim.</b><br>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." |
| <b>13</b>  | INSURED'S OR AUTHORIZED PERSON'S SIGNATURE | <b>Highmark does not need this information to adjudicate the claim.</b><br>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."                                                              |

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## 6.5 1500 CLAIM FORM COMPLETION INSTRUCTIONS, Continued

[What Is My Service Area?](#)

| ITEM # | FIELD TITLE /DESCRIPTION                            | INSTRUCTIONS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|--------|-----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 14     | DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) | <p>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.</p> <p>Enter the applicable qualifier to identify which date is being reported:</p> <ul style="list-style-type: none"> <li>• 431 - Onset of Current Symptoms or Illness</li> <li>• 484 - Last Menstrual Period</li> </ul> <p><b>Be sure to enter the date and qualifier in the correct fields.</b><br/>The qualifier is entered to the right of the vertical, dotted line.</p> <p> <b>For physical, occupational, and speech therapy services:</b> This box <b>must</b> be completed if the Highmark Delaware member has a per condition benefit.</p>                                                                                                                                                            |
| 15     | OTHER DATE                                          | <p>Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit format (MM DD YY). <i>(Previous pregnancies are not a similar illness.)</i> Leave blank if unknown.</p> <p>Enter the applicable qualifier to identify which date is being reported.</p> <ul style="list-style-type: none"> <li>• 454 - Initial Treatment</li> <li>• 304 - Latest Visit or Consultation</li> <li>• 453 - Acute Manifestation of a Chronic Condition</li> <li>• 439 - Accident</li> <li>• 455 - Last X-ray</li> <li>• 471 - Prescription</li> <li>• 090 - Report Start (Assumed Care Date)</li> <li>• 091 - Report End (Relinquished Care Date)</li> <li>• 444 - First Visit or Consultation</li> </ul> <p><b>Be sure to enter the date and qualifier in the correct fields.</b><br/>The qualifier is entered between the left-hand set of vertical, dotted lines.</p> <p> <b>For physical, occupational, and speech therapy services:</b> Please provide date if applicable.</p> |
| 16     | DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION  | <p>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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |

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## 6.5 1500 CLAIM FORM COMPLETION INSTRUCTIONS, Continued

| ITEM #     | FIELD TITLE /DESCRIPTION                          | INSTRUCTIONS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|------------|---------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>17</b>  | NAME OF REFERRING PROVIDER OR OTHER SOURCE        | <p>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.</p> <p>If multiple providers are involved, <b>enter <u>one</u> provider only</b> using the following priority order:</p> <ol style="list-style-type: none"> <li>1. Referring Provider</li> <li>2. Ordering Provider</li> <li>3. Supervising Provider</li> </ol> <p>Enter the applicable qualifier to identify which provider is being reported.</p> <ul style="list-style-type: none"> <li>• DN - Referring Provider</li> <li>• DK - Ordering Provider</li> <li>• DQ - Supervising Provider</li> </ul> <p><b>Enter the qualifier to the left of the vertical, dotted line.</b></p> |
| <b>17a</b> | OTHER ID#                                         | <p><b>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.</b> The <b>PXC</b> 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.</p>                                                                                                                                                                                                                                                              |
| <b>17b</b> | NPI#                                              | Enter the NPI number of the referring provider, ordering provider, or other source in Item #17b.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>18</b>  | 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).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>19</b>  | ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | <b>Highmark does not need this information to adjudicate the claim.</b> Leave blank.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>20</b>  | OUTSIDE LAB? \$CHARGES                            | <b>Highmark does not need this information to adjudicate the claim.</b> Leave blank.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

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## 6.5 1500 CLAIM FORM COMPLETION INSTRUCTIONS, Continued

| ITEM # | FIELD TITLE /DESCRIPTION                       | INSTRUCTIONS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|--------|------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 21     | DIAGNOSIS OR<br>NATURE OF ILLNESS<br>OR INJURY | <p>The “<b>ICD Indicator</b>” identifies the version of the ICD code set being reported. Enter <b>0</b> (zero) for ICD-10-CM.</p> <p><b>Enter the indicator between the vertical, dotted lines in the upper right-hand area of the field.</b></p> <p>*****</p> <p>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 <b>left-justified</b> on each line. Do <b>not</b> include the decimal point within the diagnosis code. Relate lines A - L to the lines of service in 24E by the <u>letter</u> of the line.</p> <p><b>** Do not provide narrative description in this field. **</b></p> <p><b>Highmark will accept <u>only</u> ICD-10-CM diagnosis codes.</b></p> <p>*****</p> <p>Please see instructions regarding Federal Employee Program (FEP) claims and anesthesia reporting in <a href="#">Chapter 6.4: Professional (1500/837P) Reporting Tips</a>.</p> |
| 22     | RESUBMISSION                                   | <p>When resubmitting a claim, enter the appropriate bill frequency code left justified in the left-hand side of the field.</p> <ul style="list-style-type: none"> <li>• 7 - Replacement of prior claim</li> <li>• 8 - Void/cancel of prior claim</li> </ul> <p>List the original reference number for resubmitted claims.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 23     | PRIOR<br>AUTHORIZATION<br>NUMBER               | <p>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 (<i>Physician’s Medical Necessity Certification</i>) form to the claim.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

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## 6.5 1500 CLAIM FORM COMPLETION INSTRUCTIONS, Continued

| ITEM #                                              | FIELD TITLE /DESCRIPTION                                                                                                                                                                                                                                                                                 | INSTRUCTIONS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |           |                     |                                 |                                                                                                                                                                                                                                                                                                          |                                                     |                                            |                                     |                                                                                                                 |
|-----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|---------------------|---------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|--------------------------------------------|-------------------------------------|-----------------------------------------------------------------------------------------------------------------|
| 24                                                  |                                                                                                                                                                                                                                                                                                          | <p>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. <b>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.</b></p> <p>The following are types of supplemental information, and their qualifier, that can be entered <b>in the shaded lines of Boxes 24A through 24H:</b></p> <table><tr><th>QUALIFIER</th><th>TYPE OF INFORMATION</th></tr><tr><td><b>7</b> Anesthesia information</td><td>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.</td></tr><tr><td><b>ZZ</b> Narrative description of unspecified code</td><td>Narrative description of unspecified code.</td></tr><tr><td><b>N4</b> National Drug Codes (NDC)</td><td>National Drug Codes (NDC) for drugs: Report the qualifier, N4, prior to the 11-digit* NDC, e.g., N499999999999.</td></tr></table> <p>To enter supplemental information <b>in the shaded area</b>, 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.</p> <p><i>* 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 <b>Reporting National Drug Codes</b> in <b>Chapter 6.2: General Claim Submission Guidelines</b>.</i></p> | QUALIFIER | TYPE OF INFORMATION | <b>7</b> 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. | <b>ZZ</b> Narrative description of unspecified code | Narrative description of unspecified code. | <b>N4</b> National Drug Codes (NDC) | National Drug Codes (NDC) for drugs: Report the qualifier, N4, prior to the 11-digit* NDC, e.g., N499999999999. |
| QUALIFIER                                           | TYPE OF INFORMATION                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |           |                     |                                 |                                                                                                                                                                                                                                                                                                          |                                                     |                                            |                                     |                                                                                                                 |
| <b>7</b> 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. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |           |                     |                                 |                                                                                                                                                                                                                                                                                                          |                                                     |                                            |                                     |                                                                                                                 |
| <b>ZZ</b> Narrative description of unspecified code | Narrative description of unspecified code.                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |           |                     |                                 |                                                                                                                                                                                                                                                                                                          |                                                     |                                            |                                     |                                                                                                                 |
| <b>N4</b> National Drug Codes (NDC)                 | National Drug Codes (NDC) for drugs: Report the qualifier, N4, prior to the 11-digit* NDC, e.g., N499999999999.                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |           |                     |                                 |                                                                                                                                                                                                                                                                                                          |                                                     |                                            |                                     |                                                                                                                 |

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## 6.5 1500 CLAIM FORM COMPLETION INSTRUCTIONS, Continued

| ITEM #     | FIELD TITLE /DESCRIPTION          | INSTRUCTIONS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|------------|-----------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>24A</b> | 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. <b>An exception to this is prolonged detention care. Do not range date these services even when performed on consecutive days.</b>                                                                                                                                          |
| <b>24B</b> | 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:<br><a href="https://www.cms.gov/place-of-service-codes">https://www.cms.gov/place-of-service-codes</a>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>24C</b> | EMG                               | <b>Highmark does not need this information to adjudicate the claim.</b> Leave blank.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>24D</b> | 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.                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>24E</b> | 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.<br><br><b>Enter letters left justified in the field.</b> 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.<br><br><b>Diagnosis codes must be entered in Item Number 21 only.</b> Do not enter them in 24E. |
| <b>24F</b> | \$ 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.                                                                                                                                                                                                                                                                                                                                                                                                                               |

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## 6.5 1500 CLAIM FORM COMPLETION INSTRUCTIONS, Continued

| ITEM #                       | FIELD TITLE /DESCRIPTION | INSTRUCTIONS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                              |                      |                |                |
|------------------------------|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|----------------------|----------------|----------------|
| 24G                          | DAYS OR UNITS            | <p>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.</p> <p>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.</p> <p>The following qualifiers are to be used when reporting an NDC quantity. Report the qualifier prior to the quantity, e.g., UN2.</p> <table><tr><td><b>F2</b> International Unit</td><td><b>ML</b> Milliliter</td></tr><tr><td><b>GR</b> Gram</td><td><b>UN</b> Unit</td></tr></table>                                                                                                                                                                                                                                                                 | <b>F2</b> International Unit | <b>ML</b> Milliliter | <b>GR</b> Gram | <b>UN</b> Unit |
| <b>F2</b> International Unit | <b>ML</b> Milliliter     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                              |                      |                |                |
| <b>GR</b> Gram               | <b>UN</b> Unit           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                              |                      |                |                |
| 24H                          | EPSDT/FAMILY PLAN        | <b>Highmark does not need this information to adjudicate the claim.</b> Leave blank.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                              |                      |                |                |
| 24I                          | ID QUALIFIER             | <p>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.)</p> <p><b>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.</b> When required to report the Rendering Provider's Taxonomy Code, enter the <b>PXC</b> Provider Taxonomy qualifier in the shaded area of Item #24I.</p> <p><b>Note:</b> 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.</p> |                              |                      |                |                |

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## 6.5 1500 CLAIM FORM COMPLETION INSTRUCTIONS, Continued

[Why blue italics?](#)

| ITEM #     | FIELD TITLE /DESCRIPTION | INSTRUCTIONS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|------------|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>24J</b> | RENDERING PROVIDER ID#   | <p>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.</p> <p>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.</p> <p><i><b>Note:</b> 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.</i></p> <p><b>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.</b> In the shaded area of Item #24J, enter the Rendering Provider's Taxonomy Code when required.</p> |
| <b>25</b>  | FEDERAL TAX ID NUMBER    | <p>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. <b>This must be the tax ID which correlates to the billing provider reported in Item #33.</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>26</b>  | PATIENT'S ACCOUNT NO.    | <p>Optional. Highmark does not require this number for processing; however, we can reference this number when contacting your office for additional information.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>27</b>  | ACCEPT ASSIGNMENT?       | <p>Enter an X in the correct box. Only one box can be marked.</p> <p><b>Note:</b> This box is required for government claims only.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>28</b>  | TOTAL CHARGE             | <p>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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

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## 6.5 1500 CLAIM FORM COMPLETION INSTRUCTIONS, Continued

| ITEM # | FIELD TITLE /DESCRIPTION                                            | INSTRUCTIONS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|--------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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                                               | <b>Highmark does not need this information to adjudicate the claim.</b> 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                               | <p>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 <u>must</u> be reported. Enter the 9-digit ZIP code <b>without</b> the hyphen. The use of zeros (0000) or spaces for the last four digits of the ZIP+4 code is not valid.</p> <p>Enter the name and address information in the following format:</p> <p style="padding-left: 40px;">1st Line – Name<br/>2nd Line – Address<br/>3rd Line - City, State and ZIP+4 Code</p> <p><b>Note:</b> A physical street address <u>must</u> be reported for the Service Facility Location -- a P.O. Box or lock box will not be accepted.</p> <p><b>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.</b> Highmark always requires the Service Facility Location when the Place of Service reported in Item #24B is one of the following:</p> <p style="padding-left: 40px;">21 - Inpatient Hospital<br/>22 - Outpatient Hospital<br/>23 - Emergency Room – Hospital<br/>31 - Skilled Nursing Facility<br/>32 - Nursing Facility<br/>51 - Inpatient Psychiatric Facility<br/>61 - Comprehensive Inpatient Rehabilitation Facility</p> |

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## 6.5 1500 CLAIM FORM COMPLETION INSTRUCTIONS, Continued

| ITEM #     | FIELD TITLE /DESCRIPTION     | INSTRUCTIONS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|------------|------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>32a</b> | SERVICE FACILITY - NPI#      | Enter the NPI number of the service facility location.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>32b</b> | SERVICE FACILITY - Other ID# | <p><b>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.</b></p> <p>Enter the <b>PXC</b> Provider Taxonomy qualifier followed by the Provider's Taxonomy Code when required.</p>                                                                                                                                                                                                                                                                                                                                                         |
| <b>33</b>  | BILLING PROVIDER INFO & PH # | <p>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 <u>must</u> be reported. Enter the 9-digit ZIP code <b>without</b> the hyphen. The use of zeros (0000) or spaces for the last four digits of the ZIP+4 code is not valid.</p> <p>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:<br/> 1st Line - Name<br/> 2nd Line – Address<br/> 3rd Line - City, State and ZIP+4 Code</p> <p><b>Note:</b> A physical street address <u>must</u> be reported for the Billing Provider -- a P.O. Box or lock box will not be accepted.</p> |
| <b>33a</b> | BILLING PROVIDER - NPI#      | Enter the NPI number of the billing provider reported in Item #33.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>33b</b> | BILLING PROVIDER - Other ID# | <p><b>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.</b> Enter the <b>PXC</b> qualifier followed by the Provider's Taxonomy Code when required.</p>                                                                                                                                                                                                                                                                                                                                                               |

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## 6.5 1500 CLAIM FORM COMPLETION INSTRUCTIONS, Continued

### 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

# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Highmark Blue Shield  
P.O. Box 890173

Comp HBI PA 17089-0173

| PATIENT AND INSURED INFORMATION                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|
| 1. MEDICARE (Medicare) <input type="checkbox"/> MEDICAID (Medicaid) <input type="checkbox"/> TRICARE (TRICARE) <input type="checkbox"/> CHAMPVA (Member ID) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA (FECA) <input type="checkbox"/> OTHER (ID#) <input checked="" type="checkbox"/>            |  |  |  |  |  |  |  |  |  |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)<br>Doe Jr, John J                                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  |
| 3. PATIENT'S BIRTH DATE (MM/DD/YY)<br>01/01/1907 M <input checked="" type="checkbox"/> F <input type="checkbox"/>                                                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  |
| 4. INSURED'S NAME (Last Name, First Name, Middle Initial)<br>Doe, John J                                                                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  |
| 5. PATIENT'S ADDRESS (No., Street)<br>123 N Main Street                                                                                                                                                                                                                                                                               |  |  |  |  |  |  |  |  |  |
| 6. PATIENT RELATIONSHIP TO INSURED<br>Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input checked="" type="checkbox"/> Other <input type="checkbox"/>                                                                                                                                                          |  |  |  |  |  |  |  |  |  |
| 7. INSURED'S ADDRESS (No., Street)<br>123 N Main Street                                                                                                                                                                                                                                                                               |  |  |  |  |  |  |  |  |  |
| 8. RESERVED FOR NUCC USE                                                                                                                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)<br>Doe, Mary A                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  |
| 10. IS PATIENT'S CONDITION RELATED TO:<br>a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |  |  |  |  |  |  |  |  |
| 11. INSURED'S POLICY GROUP OR FECA NUMBER<br>1234567                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  |
| 12. INSURED'S DATE OF BIRTH (MM/DD/YY)<br>01/01/1958 M <input checked="" type="checkbox"/> F <input type="checkbox"/>                                                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  |
| 13. OTHER CLAIM ID (Designated by NUCC)                                                                                                                                                                                                                                                                                               |  |  |  |  |  |  |  |  |  |
| 14. INSURANCE PLAN NAME OR PROGRAM NAME<br>Highmark Blue Shield                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  |
| 15. IS THERE ANOTHER HEALTH BENEFIT PLAN?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 5, 6, and 9.                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  |
| 16. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)<br>SIGNED: _____ DATE: _____                                                                                                                                          |  |  |  |  |  |  |  |  |  |
| 17. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM/DD/YY)<br>09/30/19 QUAL: 401                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |  |
| 18. NAME OF REFERRING PROVIDER OR OTHER SOURCE<br>DR. Jane A. Smith MD                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  |
| 20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate ICD-9-CM to service list below (242))<br>A. 99358 B. 7806 C. V180 D. E8789<br>E. _____ F. _____ G. _____ H. _____<br>I. _____ J. _____ K. _____ L. _____                                                                                                                         |  |  |  |  |  |  |  |  |  |
| 21. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)<br>09/30/19 To 10/11/19                                                                                                                                                                                                                                                            |  |  |  |  |  |  |  |  |  |
| 22. OTHER DATE (QUAL, 454)<br>09/25/05                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  |
| 23. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)<br>CPT/HCPCS: _____ MODIFIER: _____                                                                                                                                                                                                                             |  |  |  |  |  |  |  |  |  |
| 24. DIAGNOSIS POINTERS<br>F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____                                                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  |
| 25. PRIOR AUTHORIZATION NUMBER<br>T 06123456789                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  |
| 26. FEDERAL TAX ID, NUMBER<br>123456789                                                                                                                                                                                                                                                                                               |  |  |  |  |  |  |  |  |  |
| 27. PATIENT'S ACCOUNT NO.<br>123456789                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  |
| 28. ACCEPT ASSIGNMENT? (For group, indicate yes back)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  |
| 29. TOTAL CHARGE<br>\$ 9999.00                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  |
| 30. AMOUNT PAID<br>\$ 00.00                                                                                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)<br>Joseph Jones MD 89390                                                                                                                                        |  |  |  |  |  |  |  |  |  |
| 32. SERVICE FACILITY LOCATION INFORMATION<br>ABC Hospital<br>123 Facility Lane<br>Anytown, PA 12345-1234                                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  |
| 33. BILLING PROVIDER INFO & PH # (612) 345.6789                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  |
| 34. SIGNATURE OF PHYSICIAN OR SUPPLIER<br>SIGNED: _____ DATE: _____                                                                                                                                                                                                                                                                   |  |  |  |  |  |  |  |  |  |
| 35. SIGNATURE OF PHYSICIAN OR SUPPLIER<br>SIGNED: _____ DATE: _____                                                                                                                                                                                                                                                                   |  |  |  |  |  |  |  |  |  |

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

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## CHAPTER 6: BILLING AND PAYMENT

### UNIT 6: COORDINATION OF BENEFITS

#### IN THIS UNIT



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[What Is My Service Area?](#)

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The PA ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The DE ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The WV ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.



## 6.6 COORDINATION OF BENEFITS OVERVIEW

|                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|-----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Introduction</b>                     | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Coordination of benefits defined</b> | <p><b>Coordination of benefits (COB)</b> 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.</p> <p>COB allows patients to receive up to one hundred (100) percent 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.</p> <p>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.</p> |
| <b>Workers compensation insurance</b>   | <p>Workers compensation insurance covers medical treatment for work-related injuries or illnesses.</p> <ul style="list-style-type: none"> <li>Federal and state laws require employers to provide this coverage to their employees.</li> <li>Employees are entitled to full coverage for all employment-related health care expenses through their workers compensation insurance.</li> <li>Highmark is not liable to pay claims under these circumstances, unless workers' compensation benefits have been exhausted.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Automobile insurance</b>             | <p>The following apply to coverage for medical treatment related to automobile accidents:</p> <ul style="list-style-type: none"> <li>Highmark may pay for covered services after the automobile insurance benefits are exhausted.</li> <li>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.</li> </ul>                                                                                                                                                                                                        |

*Continued on next page*

## 6.6 COORDINATION OF BENEFITS OVERVIEW, Continued

### Automobile insurance (continued)

- 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.

*Continued on next page*



## 6.6 COORDINATION OF BENEFITS OVERVIEW, Continued

---

### **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 DETERMINING ORDER OF COVERAGE

### Introduction

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."

*Continued on next page*

## 6.6 DETERMINING ORDER OF COVERAGE, Continued

### Dependent child (continued)

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 NaviNet® Eligibility and Benefits. Providers must call the Provider Service Center to check for this information.*

Quick  
Reference

## 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.

[What Is My Service Area?](#)

### Pennsylvania NAIC Model



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.

*Continued on next page*

## 6.6 COB PAYMENT METHODOLOGIES, Continued

### Pennsylvania NAIC Model (continued)



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.

[What Is My Service Area?](#)

### Delaware and West Virginia NAIC Model



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.

*Continued on next page*

## 6.6 COB PAYMENT METHODOLOGIES, Continued

### Hard Non - Duplication COB Model (continued)

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, 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 percent reimbursement, not to exceed the primary Other Insurance member liability. If the lesser of the two amounts is

*Continued on next page*

## 6.6 COB PAYMENT METHODOLOGIES, Continued

### Soft Non - Duplication II COB Model (continued)

greater than the Other Insurance member liability, Highmark will pay the Other Insurance member liability at 100 percent 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

[TIP SHEET](#)

In order to understand the different COB models outlined in this unit, click on the Tips Sheet icon to the left for a document that provides 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

### Overview

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 Services. Provider Services will investigate and advise if a refund is required.

Quick  
Reference

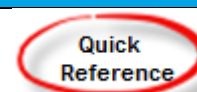


## 6.6 DUPLICATE PAYMENTS

### 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<br>Attn: Cashier<br>P.O. Box 898820<br>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<br>Attention: Treasury<br>P.O. Box 1991<br>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<br>Attention: Third Party Recoveries Department<br>P.O. Box 1948 Parkersburg, WV 26102<br><b>Fax to: 304-424-0320</b> |



### 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

### Introduction

When a member has Medicare and other insurance, there are certain rules that decide whether Medicare or the other insurance pays first.

### Retiree coverage

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

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 Services to determine whether TEFRA applies.**

**Quick Reference**

### Active, retiree/laid-off, & Medicare coverage

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.

*Continued on next page*

## 6.6 MEDICARE BENEFICIARIES, Continued

### Medicare and persons with disabilities

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)

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; <b>or</b> , 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.**

*Continued on next page*

## 6.6 MEDICARE BENEFICIARIES, Continued

### End-stage renal disease (ESRD) (continued)

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?

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 <b>20 or more employees</b> ...                 | 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 <b>less than 20 employees</b> ...               | 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 <b>100 or more employees</b> ...   | 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 <b>less than 100 employees</b> ... | 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 form a 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.

*Continued on next page*

## 6.6 MEDICARE BENEFICIARIES, Continued

---

**Group  
coverage  
doesn't exist**

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

### Overview

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

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

Please allow at least thirty (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.

## CHAPTER 6: BILLING AND PAYMENT

### UNIT 7: PAYMENT/EOBS/REMITTANCES

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| Non-Network Payment Guidelines                                          | 26       |

[What Is My Service Area?](#)

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The PA ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The DE ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The WV ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

## 6.7 OVERVIEW

### Introduction

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, PAYMENT & REIMBURSEMENT** from the main menu, and then **Reimbursement Policy**.

*[Why blue italics?](#)*

### 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. If you have questions about MHPAEA, you can email your questions to:*  
**[HPMeditor@highmark.com](mailto:HPMeditor@highmark.com)**.

### 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 cost and quality 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 **[Chapter 5.7: Value-Based Reimbursement Programs](#)**.

### FOR MORE INFORMATION

Additional information, such as **Medical Policy** and **HCPCS Information**, is available under the **CLAIMS, PAYMENT & REIMBURSEMENT** category on the Provider Resource Center to assist you in billing services for reimbursement from Highmark.



## 6.7 PAYMENT METHODOLOGY FOR PROFESSIONAL SERVICES

|                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|---------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Overview</b>                             | <p>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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>How to obtain a usual charge profile</b> | <p>A usual charge profile for allowances for specific codes or for frequently reported procedures can be found on NaviNet® (select <b>Allowance</b> from the menu under <b>Workflows for this Plan</b>), or by writing to:</p> <p style="padding-left: 40px;">Highmark Blue Shield<br/>         Fee Based Pricing and Analysis<br/>         P.O. Box 890089<br/>         Camp Hill, PA 17089-0089</p> <p>Please include your provider name, address, and NPI (National Provider Number) on your request.</p> <p>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. The procedure codes listed represent those most frequently performed by health care professionals in this specialty. Allowances are current as of the date of the report created by this request.</p> |
| <b>Plan Allowance</b>                       | <p>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. In the event that 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.</p> <p>Plan Allowance amounts are updated periodically to respond to changing economic and market conditions. In Pennsylvania, the timing of updates and methodology employed are subject to approval by the Pennsylvania Insurance Department.</p>                                                                                                                                                                                                                                                                                                       |
| <b>Fee-for-service method</b>               | <p>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.</p> <p>Fee-for-service payments may be subject to member program copayments, coinsurance, and deductibles, and according to the terms of the provider's contract. 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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                    |

*Continued on next page*

## 6.7 PAYMENT METHODOLOGY FOR PROFESSIONAL SERVICES,

Continued

[What Is My Service Area?](#)

### Premier Blue Shield fee structure



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 under **CLAIMS, PAYMENT & REIMBURSEMENT** on the NaviNet® Provider Resource Centers in both the Western and Central Regions in Pennsylvania.

### First Priority Health PCP payment methodologies



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 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, and copayments. For more details, please see [Chapter 4.1: PCPs and Specialists](#).

### IMPORTANT: Access to fee schedules

Fee schedules are only available via your secure NaviNet login. After logging into NaviNet, select **Resource Center** from the **Workflows for this Plan** menu on Highmark Plan Central. Select **CLAIMS, PAYMENT & REIMBURSEMENT** from the Provider Resource Center main menu, and then **Fee Schedule Information**.

### Medicare Advantage claims are paid differently



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.

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

|                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|----------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Overview</b>                  | <p>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.)</p> <p>Regardless of your practice location, all Highmark EOBs are available electronically on NaviNet® by choosing <b>AR Management</b>, and then clicking on the <b>EOB and Remittance</b> option in the fly-out menu.</p>                                                                                                          |
| <b>Electronic EOBs</b>           | <p>All new assignment accounts and practitioners who are newly participating with Highmark are automatically enrolled in NaviNet, the free, easy online solution linking physician offices with Highmark and other health plans. They are also automatically enrolled to receive electronic funds transfers and paperless EOB statements.</p> <p>All network participating providers are required to enroll in NaviNet, Electronic Funds Transfers (EFT), and paperless EOB statements. After becoming NaviNet-enabled, you can enroll in EFT and paperless EOBs through NaviNet's <b>EFT Attestation and Registration</b> transaction. For more information, please see the manual's <a href="#">Chapter 3.1: Network Participation Overview</a> (see the section titled "Electronic Transaction Requirements.")</p> |
| <b>Non-network providers</b>     | <p>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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Key information on an EOB</b> | <p>Both the network provider and member EOB contain the following key information:</p> <ul style="list-style-type: none"> <li>• Patient name</li> <li>• Member identification number</li> <li>• Member name</li> <li>• Claim number</li> <li>• Date of service</li> <li>• Procedure code</li> <li>• Provider charge</li> <li>• Highmark Blue Shield/Medicare allowance</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                     |

*Continued on next page*

# 6.7 EXPLANATION OF BENEFITS FOR MEDICAL-SURGICAL CONTRACTS, Continued

**Key  
information  
on an EOB**  
(continued)

- Non-chargeable amount
- Member liability amount
- Other amount
- Amount applied to deductible
- Amount applied to co-insurance
- Amount deducted for coordination of benefits

## 6.7 EXAMPLE OF MEDICAL-SURGICAL EOB

### First page of the EOB

The first page of the Explanation of Benefits (EOB) provides a summary of the provider's information and payment summary.

|                                                                                                            |            |                    |           |
|------------------------------------------------------------------------------------------------------------|------------|--------------------|-----------|
|                           |            | Page 1 of 4        |           |
| <b>EXPLANATION OF BENEFITS<br/>DEPOSIT NOTICE ONLY</b>                                                     |            | SEPTEMBER 15, 2017 |           |
| <b>PROVIDER SUMMARY</b>                                                                                    |            |                    |           |
| Provider: ABC FAMILY PRACTICE<br>Provider Number: 0987654321                                               |            |                    |           |
| <b>DIRECT DEPOSIT SUMMARY</b>                                                                              |            |                    |           |
| FUNDS AVAILABLE DATE                                                                                       | 09/25/2017 | EFT PAYMENT NUMBER | 99XXXXXXX |
| ACCOUNT TYPE                                                                                               | CHECKING   |                    |           |
| TOTAL EFT PROVIDER DEPOSIT .....                                                                           |            | \$847.57           |           |
| TOTAL INTEREST CALCULATED .....                                                                            |            | \$0.00             |           |
| TOTAL MEMBER PAYMENTS .....                                                                                |            | \$0.00             |           |
| <br>Camp Hill, PA 17089 |            |                    |           |
| ABC FAMILY PRACTICE<br>321 MAIN STREET<br>ANY TOWN, USA 12345-6789                                         |            |                    |           |
|                                                                                                            |            |                    | PFXXXXXX  |
| "VISIT US AT OUR WEBSITE: <a href="http://www.highmark.com">www.highmark.com</a> "                         |            |                    |           |

*Continued on next page*

## 6.7 EXAMPLE OF MEDICAL-SURGICAL EOB, Continued

### Claim detail pages

The pages that follow the summary page provide details of the claims associated with the payment.

Page 2 of 4  
SEPTEMBER 10, 2017

Provider Number: 0987654321  
Provider Name: ABC FAMILY HEALTH

| DATE(S)<br>OF<br>SVC                                                                                                                                      | NUM<br>OF<br>SVCS | REVENUE/<br>PROCEDURE<br>CODE | PAY-<br>MENT<br>CODE | PROVIDER<br>CHARGE         | OUR<br>ALLOWANCE | NON-<br>CHARGEABLE<br>AMOUNT | NON-<br>CHG<br>CODE | MEMBER<br>LIABILITY<br>AMOUNT | MEM<br>LIAB<br>CODE | OTHER<br>AMOUNT | AMOUNT(S)<br>PAID<br>(* = MEMBER) | MESSAGE<br>CODES |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-------------------------------|----------------------|----------------------------|------------------|------------------------------|---------------------|-------------------------------|---------------------|-----------------|-----------------------------------|------------------|
| PATIENT ACCT #: 123456                                                                                                                                    |                   | PATIENT: JACK PUBLIC          |                      | CLAIM NUMBER: 20XXXXXXXXXX |                  |                              |                     |                               |                     |                 |                                   |                  |
| MEMBER ID: XXXXXXXXXXXX                                                                                                                                   |                   | MEMBER: JACK PUBLIC           |                      |                            |                  |                              |                     |                               |                     |                 |                                   |                  |
| 09/07/2017                                                                                                                                                | 1                 | 99392-00                      | 026                  | 150.00                     | 77.52            | 72.48                        | 25                  |                               |                     |                 | 77.52                             | J0080            |
| 09/07/2017                                                                                                                                                | 1                 | 90633-00                      | 026                  | 50.00                      | 40.93            | 9.07                         | 25                  |                               |                     |                 | 40.93                             | J0080            |
| 09/07/2017                                                                                                                                                | 1                 | 90657-00                      | 026                  | 32.00                      | 19.05            | 12.95                        | 25                  |                               |                     |                 | 19.05                             | J0080            |
| 09/07/2017                                                                                                                                                | 1                 | G0008-00                      | 026                  | 25.00                      | 20.77            | 4.23                         | 25                  |                               |                     |                 | 20.77                             | J0080            |
| CLAIM TOTALS                                                                                                                                              |                   |                               |                      |                            |                  | 98.73                        |                     |                               |                     |                 | 158.27                            |                  |
| PATIENT ACCT #: 123457                                                                                                                                    |                   | PATIENT: JANE PUBLIC          |                      | CLAIM NUMBER: 20XXXXXXXXXX |                  |                              |                     |                               |                     |                 |                                   |                  |
| MEMBER ID: XXXXXXXXXXXX                                                                                                                                   |                   | MEMBER: JACK PUBLIC           |                      |                            |                  |                              |                     |                               |                     |                 |                                   |                  |
| 09/07/2017                                                                                                                                                | 1                 | 99385-00                      | 023                  | 203.00                     | 98.83            | 104.17                       | 25                  |                               |                     |                 | 98.83                             | J9040            |
| 09/07/2017                                                                                                                                                | 1                 | 90658-00                      | 023                  | 32.00                      | 22.29            | 9.71                         | 25                  |                               |                     |                 | 22.29                             | J9040            |
| CLAIM TOTALS                                                                                                                                              |                   |                               |                      |                            |                  | 113.88                       |                     |                               |                     |                 | 121.12                            |                  |
| CLAIM SPECIFIC MESSAGE(S):<br>We provide administrative claims payment services only and do not assume any financial risk or obligation regarding claims. |                   |                               |                      |                            |                  |                              |                     |                               |                     |                 |                                   |                  |
| PATIENT ACCT #: 123458                                                                                                                                    |                   | PATIENT: JIM PUBLIC           |                      | CLAIM NUMBER: 20XXXXXXXXXX |                  |                              |                     |                               |                     |                 |                                   |                  |
| MEMBER ID: XXXXXXXXXXXX                                                                                                                                   |                   | MEMBER: JACK PUBLIC           |                      |                            |                  |                              |                     |                               |                     |                 |                                   |                  |
| 09/07/2017                                                                                                                                                | 1                 | 99204-00                      | 026                  | 241.00                     | 166.00           | 75.00                        | 25                  | 20.00                         | D1                  |                 | 146.00                            | J0080            |
| 09/07/2017                                                                                                                                                | 1                 | 81025-00                      | 026                  | 13.00                      | 6.00             | 7.00                         | 25                  | 6.00                          | A1                  |                 | 6.00                              | X5018, J0080     |
| CLAIM TOTALS                                                                                                                                              |                   |                               |                      |                            |                  | 82.00                        |                     | 26.00                         |                     |                 | 146.00                            |                  |
| PATIENT ACCT #: 123459                                                                                                                                    |                   | PATIENT: JOHN Q PUBLIC        |                      | CLAIM NUMBER: 20XXXXXXXXXX |                  |                              |                     |                               |                     |                 |                                   |                  |
| MEMBER ID: XXXXXXXXXXXX                                                                                                                                   |                   | MEMBER: JOHN Q PUBLIC         |                      |                            |                  |                              |                     |                               |                     |                 |                                   |                  |
| 09/07/2017                                                                                                                                                | 1                 | 99385-00                      | 033                  | 203.00                     | 98.83            | 104.17                       | 25                  |                               |                     |                 | 98.83                             | J9040            |
| 09/07/2017                                                                                                                                                | 1                 | 81025-00                      |                      | 13.00                      |                  | 13.00                        |                     | 13.00                         | H1                  |                 | 13.00                             | H5006, J9040     |
| CLAIM TOTALS                                                                                                                                              |                   |                               |                      |                            |                  | 104.17                       |                     | 13.00                         |                     |                 | 98.83                             |                  |
| CLAIM SPECIFIC MESSAGE(S):<br>We provide administrative claims payment services only and do not assume any financial risk or obligation regarding claims. |                   |                               |                      |                            |                  |                              |                     |                               |                     |                 |                                   |                  |

Continued on next page

## 6.7 EXAMPLE OF MEDICAL-SURGICAL EOB, Continued

**Message Code descriptions** Descriptions for the Message Codes used in the claim details are provided at the end of the EOB.

[illegible]

## 6.7 FACILITY PAYMENT METHODOLOGY

### Overview

Highmark develops and maintains reimbursement methodologies for facility-type providers (UB-04/837I billers) that allow claims to pay at industry standards as well as 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 of 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 in NaviNet.®

### FOR MORE INFORMATION

For more details, you can find the **Highmark OPPS Based Payment Method Provider Training Manual**, and also the **APC Pricing Component Calendar**, on the Provider Resource Center in NaviNet. Select **CLAIMS, PAYMENT & REIMBURSEMENT** from the main menu.

*Continued on next page*



## 6.7 FACILITY PAYMENT METHODOLOGY, Continued

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**SNF RUG-based  
payment  
methodology**

Highmark 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 of the features, values, and workings of the Medicare per diem payment methodology with only a few exceptions.

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## 6.7 FACILITY REMITTANCE ADVICE

### Introduction

The Provider Remittance Advice is provided by Highmark's claim processing system and accounts for all claims adjudicated in the payment cycle, whether paid or 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 NaviNet® and is in PDF format, which can be downloaded, printed, or saved. For all Friday evening payment cycles, the Remittance Advice document is viewable on Monday morning.

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 directly through Highmark's Electronic Data Interchange (EDI) or through contacting your electronic vendor or clearinghouse. 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.

[What Is My Service Area?](#)

### 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, PAYMENT & REIMBURSEMENT**, or by clicking on the applicable link below for your service area:

- Pennsylvania: [highmark.com/edi](https://highmark.com/edi)
- Delaware: [highmark.com/bcbsde](https://highmark.com/bcbsde)
- West Virginia: [highmark.com/edi-wv](https://highmark.com/edi-wv)

An EDI support analyst may also be contacted by phone at **1-800-992-0246**.

### Parts of the Remittance Advice

The facility Provider Remittance Advice contains the following sections, in this order:

1. Recipient Payment Summary
2. Provider Payment Check Totals
3. Explanation of Provider Detail Headings
4. Credit Balance Detail
5. Detail Report

The sections of the Remittance Advice, including images, are explained on the pages that follow.

*Continued on next page*

## 6.7 FACILITY REMITTANCE ADVICE, Continued

### Recipient Payment Summary

The first section of the Remittance Advice provides a summary of check and payment information for all four payment types that will be detailed on the Provider Payment Check Totals pages. The Recipient Payment Summary consists of two pages:

Page 1



**1** ID NUMBER: 1234567890

**2**

RECIPIENT PAYMENT SUMMARY

| REGULAR         |              |              | FEDERAL HMO  |              | FEP          |              |
|-----------------|--------------|--------------|--------------|--------------|--------------|--------------|
| PROVIDER NUMBER | CHECK NUMBER | CHECK AMOUNT | CHECK NUMBER | CHECK AMOUNT | CHECK NUMBER | CHECK AMOUNT |
| 1234567890      | 99xxxxxxx    | 4,234,910.98 |              |              | 99xxxxxxx    | 38,661.19    |

**3**

|        |              |           |
|--------|--------------|-----------|
| TOTALS | 4,234,910.98 | 38,661.19 |
|--------|--------------|-----------|

**4**

|              |   |              |              |
|--------------|---|--------------|--------------|
| TOTAL CHECKS | 2 | TOTAL AMOUNT | 4,273,572.17 |
|--------------|---|--------------|--------------|

**5**

ABC HOSPITAL  
 123 MAIN STREET  
 ANY TOWN, USA 12345-6789

RM001234

**1** The recipient ID Number identifies the provider by NPI.

**2** The check number(s) and check amount(s) for each of the following payment types – Regular, Federal HMO, and FEP – are provided here for the applicable provider number(s).

**3** Total payment amounts of check(s) for each payment type on this page (Regular, Federal HMO, and FEP).

**4** Total number of checks and the total payment amount associated with this remittance.

**5** Provider name and billing address.

*Continued on next page*

## Page 2

Page 2



**HIGHMARK<sup>®</sup>**  
**BLUE SHIELD**  
An Independent Licensee of the Blue Cross and Blue Shield Association

ID NUMBER: 1234567890

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- Note: The information in fields labeled 1, 4, & 5 is duplicated on both pages of the Recipient Payment Summary.

*Continued on next page*

## 6.7 FACILITY REMITTANCE ADVICE, Continued

### Provider Payment Check Totals

This page summarizes the claim amounts that were totaled to determine this payment. It also provides the facility's check, no-pay check, or Electronic Funds Transfer (EFT) Notice of Deposit information. There are four **PROVIDER PAYMENT CHECK TOTALS** pages, in the following order:

1. **REGULAR PAYMENT** – Payment information for claims for all Highmark members and for out-of-area BlueCard claims, including both Regular and Complementary utilization.
2. **FEP PAYMENT** – Payment information for claims for members of the Blue Cross Blue Shield Federal Employees Program (FEP), with the exception of those in an HMO program.
3. **FEDERAL HMO PAYMENT** – Payment information for claims for federal employees enrolled in an FEP HMO program.
4. **NATIONAL ALLIANCE** – Payment information for claims for members with coverage under self-funded National Alliance Accounts powered by Highmark Blue Shield.

| HIGHMARK BLUE SHIELD<br>An Independent Licensee of the Blue Cross and Blue Shield Association                                                                                                                                                                                                                                                |                                                                                          |                     |            |                           |            |                           |      |            |     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|---------------------|------------|---------------------------|------------|---------------------------|------|------------|-----|
| <b>PROVIDER<br/>REMITTANCE ADVICE</b>                                                                                                                                                                                                                                                                                                        |                                                                                          |                     |            |                           |            |                           |      |            |     |
| <div>1</div> <div>ABC Hospital<br/>123 Main Street<br/>Any Town, USA 12345-6789</div> <div>Provider No. 1234567890</div> <div>Date: 06/03/09</div> <div>Bank Name: XYZ BANK</div> <div>AMOUNT: 308,746.15</div> <div>REGULAR TRANSFER</div> <div>THIS AMOUNT HAS BEEN DEPOSITED<br/>INTO YOUR BANK ACCOUNT</div> <div>REGULAR TRANSFER</div> | <div>3</div> <div>EFT FND<br/>308,746.15<br/>DATE: 06/03/09<br/>PAGE NUMBER: 00001</div> |                     |            |                           |            |                           |      |            |     |
| <div>2</div> <div>PROVIDER: 1234567890 ABC Hospital</div>                                                                                                                                                                                                                                                                                    |                                                                                          |                     |            |                           |            |                           |      |            |     |
| <div>4</div> <div><b>REGULAR PAYMENT<br/>PROVIDER PAYMENT CHECK TOTALS</b></div>                                                                                                                                                                                                                                                             |                                                                                          |                     |            |                           |            |                           |      |            |     |
| <div>5</div> <table border="1"> <tr> <td>REGULAR UTILIZATION</td> <td>297,032.43</td> </tr> <tr> <td>COMPLEMENTARY UTILIZATION</td> <td>11,714.65</td> </tr> <tr> <td>TOTAL INTEREST CALCULATED</td> <td>.93-</td> </tr> <tr> <td>ADJUSTMENT</td> <td>.00</td> </tr> </table>                                                                |                                                                                          | REGULAR UTILIZATION | 297,032.43 | COMPLEMENTARY UTILIZATION | 11,714.65  | TOTAL INTEREST CALCULATED | .93- | ADJUSTMENT | .00 |
| REGULAR UTILIZATION                                                                                                                                                                                                                                                                                                                          | 297,032.43                                                                               |                     |            |                           |            |                           |      |            |     |
| COMPLEMENTARY UTILIZATION                                                                                                                                                                                                                                                                                                                    | 11,714.65                                                                                |                     |            |                           |            |                           |      |            |     |
| TOTAL INTEREST CALCULATED                                                                                                                                                                                                                                                                                                                    | .93-                                                                                     |                     |            |                           |            |                           |      |            |     |
| ADJUSTMENT                                                                                                                                                                                                                                                                                                                                   | .00                                                                                      |                     |            |                           |            |                           |      |            |     |
| <div>6</div> <table border="1"> <tr> <td>REGULAR PAYMENT</td> <td></td> </tr> <tr> <td>PROVIDER PAYMENT</td> <td>308,746.15</td> </tr> <tr> <td>WITHHOLD AMOUNT</td> <td>.00</td> </tr> </table>                                                                                                                                             |                                                                                          | REGULAR PAYMENT     |            | PROVIDER PAYMENT          | 308,746.15 | WITHHOLD AMOUNT           | .00  |            |     |
| REGULAR PAYMENT                                                                                                                                                                                                                                                                                                                              |                                                                                          |                     |            |                           |            |                           |      |            |     |
| PROVIDER PAYMENT                                                                                                                                                                                                                                                                                                                             | 308,746.15                                                                               |                     |            |                           |            |                           |      |            |     |
| WITHHOLD AMOUNT                                                                                                                                                                                                                                                                                                                              | .00                                                                                      |                     |            |                           |            |                           |      |            |     |
| (See reverse side for explanation of Provider Remittance Detail Headings)                                                                                                                                                                                                                                                                    |                                                                                          |                     |            |                           |            |                           |      |            |     |
| RM000220                                                                                                                                                                                                                                                                                                                                     |                                                                                          |                     |            |                           |            |                           |      |            |     |

- 1 Payment area will display either check or electronic funds payment information (depending on your facility's selection).
- 2 Provider number and name populated here.
- 3 Payment amount, date, and remittance page number are displayed here.
- 4 Payment type (Regular, FEP, Federal HMO, or National Alliance).
- 5 This area indicates the total dollar amounts for claims of this type included in this remit and any interest or adjustment, if applicable.
- 6 The dollar amount for this type of payment will be shown here and withhold amounts, if applicable.

*Continued on next page*

## 6.7 FACILITY REMITTANCE ADVICE, Continued

**Explanation of Provider Detail Headings** This key to the fields on the Detail Report will follow each of the Provider Payment Check Totals pages. It provides the complete name for each field but no descriptions. (The page with this key will not have a page number.)

For more detailed descriptions of each field, please see the [Remittance Advice Detail Heading Descriptions](#).

| EXPLANATION OF PROVIDER REMITTANCE DETAIL HEADINGS |                    |                        |          |    |      |       |        |            |               |         |              |              |                |
|----------------------------------------------------|--------------------|------------------------|----------|----|------|-------|--------|------------|---------------|---------|--------------|--------------|----------------|
| 1st LINE                                           | PAT CONTROL NUMBER | PATIENT LNAME FIRST    | SER FROM | PS | COVD | BDATE | WEIGHT | TOTAL CHGS | DEDUCTIBLE    | PENALTY | OUTLIER AMT  | CONTRACT ADJ |                |
| 2nd LINE                                           | AGR NUMBER         | GRP PRDC DRG           | SER THRU | RM | NCVD | 2TIER | W      | ASG1       | COVERED CHGS  | COINSUR | OTHER INS PD | TRANSFER AMT | SUBR LIABILITY |
| 3rd LINE                                           | CLAIM NUMBER       | ST HCPC1 CA1 HCPC2 CA2 | PREV DT  | CI | VERS | 4TIER | P      | ASG2       | NET ALLOWANCE | COPAY   | NONCOV CHG   | BASE PAYMENT | PAYMENT        |
| 4th LINE                                           | PHO PPMI           | AGC ARC TOB MSG        |          |    |      |       |        |            |               |         | WITHHOLD     |              |                |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>First Line</b><br>PAT CONTROLNUMBER = PATIENT CONTROL NUMBER<br>PATIENT LNAME = PATIENT LAST NAME<br>FIRST = PATIENT FIRST NAME<br>A = ACCOMMODATION CODE 1<br>SER FROM = SERVICE FROM DATE<br>PS = PATIENT STATUS CODE<br>COVD = COVERED DAYS<br>BDATE = PATIENT BIRTHDATE (MMYY)<br>WEIGHT = DRG OR PMC WEIGHT<br>TOTAL CHARGES = TOTAL CHARGES<br>DEDUCTIBLE = MEMBER DEDUCTIBLE AMOUNT<br>PENALTY = PENALTY AMOUNT<br>OUTLIER AMT = DAY OR COST OUTLIER AMOUNT<br>CONTRACT ADJ = CONTRACTUAL ADJUSTMENT AMOUNT | <b>Second Line</b><br>AGR NUMBER = AGREEMENT NUMBER<br>GRP = MEMBER GROUP NUMBER<br>PRDC = PRODUCT ID CODE<br>DRG = DRG CODE<br>C = ACCOMMODATION CODE 2<br>SERV THRU = SERVICE THRU DATE<br>RM = REIMBURSEMENT METHOD CODE<br>NCVD = NON COVERED DAYS<br>2TIER = TIER CODE 1 AND CODE 2<br>W = WEIGHT ADJUSTMENT CODE<br>ASG1 = PMC ASSIGNMENT 1 OR PIRC CODE<br>COVERED CHGS = COVERED CHARGES AMOUNT<br>COINSURANCE = MEMBER COINSURANCE AMOUNT<br>OTHER INS PAID = OTHER INSURANCE PAID AMOUNT<br>TRANSFER AMT = TRANSFER AMOUNT<br>SUBR LIABILITY = MEMBER LIABILITY AMOUNT |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Third Line</b><br>CLAIM NUMBER = CLAIM NUMBER<br>ST = PROVIDER SITE NUMBER<br>HCPC1 = HCPCS CODE 1<br>CA1 = CATEGORY CODE 1<br>HCPC2 = HCPCS CODE 2<br>CA2 = CATEGORY CODE 2<br>PREV DT = PREVIOUS DATE PAID<br>CI = CONTRACTUAL INDICATOR<br>VERS = SOFTWARE PAYMENT METHODOLOGY VERSION<br>4TIER = TIER CODE 3 AND TIER CODE 4<br>P = MEMBER PENALTY/PROVIDER LIABILITY INDICATOR<br>ASG2 = PMC ASSIGNMENT 2<br>NET ALLOWANCE = NET ALLOWANCE AMOUNT<br>COPAY = MEMBER COPAY AMOUNT<br>NONCOVERED CHG = NON-COVERED CHARGE AMOUNT<br>BASE PAYMENT = BASE PAYMENT AMOUNT<br>PAYMENT = PAYMENT AMOUNT | <b>Fourth Line</b><br>PHO = PHO NETWORK<br>PPMI = PHO PAYMENT METHOD INDICATOR<br>AGC = ANSI GROUP CODE<br>ARC = ANSI REASON CODE<br>TOB = TYPE OF BILL<br>MSG = MESSAGE SEE BULLETIN FOR DETAIL<br>5TIER = TIER CODE 5<br>WITHHOLD = WITHHOLD AMOUNT |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

*Continued on next page*

## 6.7 FACILITY REMITTANCE ADVICE, Continued

### Credit Balance Detail

This page displays a summary of all offsets applied against the facility check or EFT payment, as well as any offset amounts that remain outstanding (Remaining Credit Balance). The page will not appear in the Remittance Advice if there are no offsets applied.

This page will appear immediately after the applicable Provider Payment Check Totals page (e.g., if applied to the Regular Payment, which is Page 1, then the Regular Payment Credit Balance Detail would be Page 2).

[illegible]

- 1 Indicates type of payment for the credit balance detail being displayed.
- 2 Remit date and page number.
- 3 Credit balance detail area with one line of information for each offset.
- 4 Dollar amount totals for each column on the page.

Continued on next page

## 6.7 FACILITY REMITTANCE ADVICE, Continued

## Detail Report

This report displays extensive payment information for each claim paid on this remittance advice. The report is broken down by type of utilization based on product. Within each category, the reports are divided further into Inpatient and Outpatient claims. Categories include:

- Regular Utilization Indemnity
- Complementary Utilization Indemnity
- Special Care
- Workers Comp
- Self-Insured
- Regular Utilization Network
- Complementary Utilization Network
- Security Blue
- FEP
- Major Medical
- Freedom Blue
- Community Blue Medicare HMO
- National Alliance

# HIGHMARK BLUE SHIELD

An Independent Licensee of the Blue Cross and Blue Shield Association

## PROVIDER REMITTANCE ADVICE

**1** PROVIDER 1234567890 ABC Hospital

DATE: 10/20/10  
PAGE NUMBER: 00056

REGULAR UTILIZATION NETWORK

| PAT CONTROL NUMBER<br>MEMBER ID<br>CLAIM NUMBER<br>PHO PPMI | PATIENT<br>GRP<br>HCPCT<br>AGC<br>RMK1 | LNAM<br>PRDC<br>CAY<br>ARC<br>RMK2 | FIRST<br>DNG<br>CA2<br>MSG<br>RMK3 | A<br>C | SER FROM<br>SER THRU<br>PREV DT | PS<br>RM<br>CI | COVD<br>NCVD<br>VERS | BDATE<br>2TIER<br>4TIER<br>STER | WEIGHT<br>W ASG1<br>P ASG2 | TOTAL CHARGES<br>COVERED CHGS<br>NET ALLOWANCE | DEDUCTIBLE<br>COINSURANCE<br>COPAY<br>OTHER ADJMT | PENALTY<br>OTHER INS PAID<br>NONCOVERED CHG<br>WITHHOLD | OUTLIER AMT<br>TRANSFER AMT<br>BASE PAYMENT | CONTRACT ADJ<br>SUBR LIABILITY<br>PAYMENT<br>INTEREST CALC |
|-------------------------------------------------------------|----------------------------------------|------------------------------------|------------------------------------|--------|---------------------------------|----------------|----------------------|---------------------------------|----------------------------|------------------------------------------------|---------------------------------------------------|---------------------------------------------------------|---------------------------------------------|------------------------------------------------------------|
| OUTPATIENT                                                  |                                        |                                    |                                    |        |                                 |                |                      |                                 |                            |                                                |                                                   |                                                         |                                             |                                                            |
| 12345-JP1<br>YYZ10X0000000000<br>0999999999 1<br>000        | PUBLIC<br>012345001<br>72100<br>131    | JACK<br>300<br>78320<br>131        | 4                                  |        |                                 |                |                      | 03-96                           |                            | 2,269.86<br>2,269.86<br>2,269.86               | .00<br>.00<br>.00                                 | .00<br>.00<br>.00                                       | .00<br>.00<br>.00                           | 1,363.14<br>.00<br>906.72<br>.00                           |
| 12345-JP2<br>YYZ10X0000000000<br>0888888888 1<br>000        | PUBLIC<br>012345002<br>99283<br>131    | JANE<br>400<br>99283<br>131        | 4                                  |        |                                 |                |                      | 04-09                           |                            | 285.00<br>285.00<br>285.00                     | .00<br>.00<br>.00                                 | .00<br>.00<br>.00                                       | .00<br>.00<br>.00                           | 114.92<br>.00<br>170.08<br>.00                             |
| 12345-JP3<br>YYZ10X0000000000<br>0777777777 1<br>000        | PUBLIC<br>012345003<br>131             | JIM<br>300<br>131                  | 4                                  |        |                                 |                |                      | 09-02                           |                            | 582.73<br>582.73<br>556.80                     | .00<br>25.93<br>.00                               | .00<br>.00<br>.00                                       | .00<br>.00<br>.00                           | 227.89<br>25.93<br>328.91<br>.00                           |
| 12345-JP4<br>YYZ10X0000000000<br>0666666666 1<br>000        | PUBLIC<br>012345004<br>131             | JOE<br>300<br>131                  | 4                                  |        |                                 |                |                      | 03-94                           |                            | 1,221.51<br>1,221.51<br>1,221.51               | .00<br>.00<br>.00                                 | .00<br>.00<br>.00                                       | .00<br>.00<br>.00                           | 777.69<br>.00<br>443.82<br>.00                             |
| 12345-JP5<br>YYZ10X0000000000<br>0555555555 1<br>000        | PUBLIC<br>012345005<br>131             | JOHN<br>300<br>78465<br>131        | 4                                  |        |                                 |                |                      | 10-54                           |                            | 4,120.47<br>4,120.47<br>4,120.47               | .00<br>.00<br>.00                                 | .00<br>.00<br>.00                                       | .00<br>.00<br>.00                           | 2,552.39<br>.00<br>1,568.08<br>.00                         |
| PAGE TOTALS                                                 |                                        |                                    |                                    |        |                                 |                |                      |                                 |                            | 8,479.57<br>8,479.57<br>8,453.64               | .00<br>25.93<br>.00                               | .00<br>.00<br>.00                                       | .00<br>.00<br>.00                           | 5,036.03<br>25.93<br>3,417.61<br>.00                       |

**4**

RM000255

- 1 Type of utilization based on product.
- 2 Indicates whether claims are inpatient or outpatient.
- 3 Claim information detail area with up to five lines of information for each claim.
- 4 Column dollar amount totals for the page.



## 6.7 ANSI CLAIM ADJUSTMENT GROUP AND REASON CODES

### Overview

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 (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 amount rejected is not the responsibility of the patient <b>without a supporting contract between the provider and the payer.</b>                                                                                          |
| 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 adjustment 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.        |

*Continued on next page*

## 6.7 ANSI CLAIM ADJUSTMENT GROUP AND REASON CODES,

Continued

### ANSI Group Codes (AGC) (continued)

| GROUP CODE                   | DESCRIPTION                                                                                                                                                                                                                                                                          |
|------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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, please visit:

<http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/>

## 6.7 OVERPAYMENTS AND REFUNDS

### Introduction

Highmark offers streamlined, electronic processes that simplify how you notify Highmark of claim overpayment and how Highmark will notify you when we identify overpayments.

[What Is My Service Area?](#)

### Provider identifies overpayment

#### If a provider identifies an overpayment:

- All Highmark-hosted NaviNet-enabled providers must use **NaviNet's Claim Investigation Inquiry** to notify Highmark of an overpayment. If you are not NaviNet-enabled and an overpayment was made, call Highmark Provider Services 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, please do not use NaviNet's Claim Investigations Inquiry or call Highmark Provider Services. Rather, send a check and a copy of the EOB with the overpaid claim circled to:

| PENNSYLVANIA                                                             | DELAWARE                                                                                                      | WEST VIRGINIA                                                            |
|--------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| Highmark<br>Attn: Cashier<br>P.O. Box 898820<br>Camp Hill, PA 17089-0150 | Highmark Blue Cross Blue Shield Delaware<br>Attention: Treasury<br>P.O. Box 1991<br>Wilmington, DE 19899-1991 | Highmark<br>Attn: Cashier<br>P.O. Box 890150<br>Camp Hill, PA 17001-9774 |

*Continued on next page*

## 6.7 OVERPAYMENTS AND REFUNDS, Continued

[What Is My Service Area?](#)

### 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 no longer 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 sixty (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                                                            |
|--------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| Highmark<br>Attn: Cashier<br>P.O. Box 890150<br>Camp Hill, PA 17001-9774 | Highmark Blue Cross Blue Shield Delaware<br>Attention: Treasury<br>P.O. Box 1991<br>Wilmington, DE 19899-1991 | Highmark<br>Attn: Cashier<br>P.O. Box 890150<br>Camp Hill, PA 17001-9774 |

## 6.7 ELECTRONIC MANUAL PAYMENTS

### Policy

When a manual payment is requested for a provider and the provider is both EFT and NaviNet®-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 NaviNet’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 **AR Management** from the Highmark Plan Central menu, and then select **Cash Management** from the fly-out menu. Click on the applicable check number from the list on the Provider Payment and History Inquiry page. On the check’s Detail Information screen, you are able to view additional information about the payment in the **Comments** field:

Check/EFT Number: 7700000001

Detail Information

Detail Related Claims

Issue Date: 05/29/2013

Amount:

Billing Provider #:

Name:

Address:

Tax ID #:

Check Status:

Check Status Date:

Internal Status:

Internal Status Date:

Remail Address:

Comments: Patient John Doe Date of Service 11/01/13 Claim# 12345678900

### FOR MORE INFORMATION

Highmark provides NaviNet at no cost to network participating providers. NaviNet integrates all insurer-provider transactions into one online system. For additional information about Highmark’s requirements for enrollment in NaviNet, EFT, and paperless EOBs, please see the section titled “Electronic Transaction Requirements” in [Chapter 1.3: Electronic Solutions-- EDI & NaviNet](#).

## 6.7 PAYMENT FOR FEP MEMBERS OVER 65

### Federal Employee Program (FEP)

For certain Federal Employee Program (FEP) members age 65 or more 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...                                                                                                                                                                                                                                                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• age 65 or over; and</li> <li>• does not have Medicare Part A, Part B, or both; and</li> <li>• has the FEP Plan as an annuitant or as a former spouse, or as a family member of an annuitant or former spouse; and</li> <li>• is not employed in a position that gives FEHB coverage.</li> </ul> | <ul style="list-style-type: none"> <li>• the law requires payment based on an amount set by Medicare's rules for what Medicare would pay, not the actual charge;</li> <li>• the member is responsible for applicable cost-sharing amounts (i.e., coinsurance);</li> <li>• the member is not responsible for any charges greater than the Medicare approved amount;</li> <li>• the law prohibits a hospital from collecting more than the Medicare approved amount.</li> </ul> | <p>The law requires the payment and the member's applicable coinsurance or copayment be based on:</p> <ul style="list-style-type: none"> <li>• the Medicare approved amount, or</li> <li>• the actual charge if it is lower than the Medicare approved amount.</li> </ul> |

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 and is <b>not</b> in the Preferred network     | Standard Option:                          | Deductibles, coinsurance, and copayments, and any balance up to the Medicare approved amount         |
|                                                                                                          | Basic Option:                             | 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               |
| Does not participate with Medicare and is <b>not</b> in our Preferred network                            | Standard Option:                          | Deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount     |

## 6.7 PAYMENT FOR THE PENNSYLVANIA CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

### CHIP payment levels



The table below shows payment levels for Highmark's social mission program for uninsured children in Pennsylvania – the Children's Health Insurance Program of Pennsylvania (CHIP).

| PROGRAM                 | COVERED PREVENTIVE SERVICES | COVERED MEDICAL VISITS | OTHER COVERED MEDICAL-SURGICAL SERVICES |
|-------------------------|-----------------------------|------------------------|-----------------------------------------|
| PA Western Region: CHIP | HMO                         | HMO                    | HMO                                     |
| PA Central Region: CHIP | PPO                         | PPO                    | PPO                                     |

[What Is My Service Area?](#)

### Reimbursement



Participating providers accept Highmark's reimbursement for services as payment in full without balance billing the members. There is no additional discount applied to provider reimbursement rates due to income level (providers receive the full Highmark reimbursement rate).

The CHIP HMO in the Western Region does not provide benefits for non-participating HMO providers unless the care was pre-authorized by Highmark.

For CHIP *PPO Plus* in the Central Region, non-network providers may bill the member for the difference between the indemnity fee for a given procedure and the actual charge made for that procedure.

### FORM MORE INFORMATION

To learn more about Pennsylvania's CHIP program, please see the manual's [Chapter 2.3: Other Government Programs](#).

## 6.7 NON-NETWORK PAYMENT GUIDELINES

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**Overview**

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.

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**Payment policy**

Highmark payment for covered service performed by non-network providers goes directly to the member who is responsible for reimbursing the non-network provider. Non-network providers do not receive Explanation of Benefits (EOB) statements.

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## CHAPTER 6: BILLING AND PAYMENT

### UNIT 8: PAYMENT REVIEW

#### IN THIS UNIT



| TOPIC                                         | SEE PAGE |
|-----------------------------------------------|----------|
| Financial Investigations and Provider Review  | 2        |
| Payment Review Process                        | 3        |
| Defining the Issues: Fraud, Waste, & Abuse    | 5        |
| Techniques Used for Investigation             | 6        |
| When a Case Is Identified                     | 7        |
| Claim Audits                                  | 10       |
| Claim Audit Dispute Process                   | 12       |
| Certified Review Entity (WV Only)             | 13       |
| Highmark's Medical Review Committee (PA Only) | 15       |
| Delaware Department of Insurance (DE Only)    | 16       |

#### What Is My Service Area?

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The PA ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The DE ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The WV ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

## 6.8 FINANCIAL INVESTIGATIONS AND PROVIDER REVIEW

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### FIPR overview

Highmark's Financial Investigations and Provider Review (FIPR) department's mission is to support Highmark's vision of providing affordable, quality health care by ensuring that provider reimbursements are appropriate and to protect Highmark's assets by investigating and resolving suspected incidents of health care insurance fraud, waste, or abuse.

In addition to conducting post-payment practice pattern reviews, FIPR also investigates potential member and provider fraud and abuse. Health insurance fraud 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 intention of changing the amount of health care benefits paid. Highmark's FIPR unit takes a proactive approach to detecting and investigating potential health care fraud and abuse. When necessary, FIPR takes 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](https://www.highmark.com). (Click on **Fraud Prevention** in the blue area at the bottom of the page.)

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### Highmark's Fraud Hotline

Highmark established a fraud hotline so that members and providers can notify FIPR of potential fraud. The fraud hotline is answered live during working hours, Monday through Friday 8 a.m. to 4 p.m. During non-working hours, 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: **1-800-438-2478**
  - West Virginia: **1-800-788-5661**
-

## 6.8 PAYMENT REVIEW PROCESS

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Overview</b>                      | <p>Payment review 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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Which providers are reviewed?</b> | <p>Highmark is required to monitor all providers in our participating, preferred, and managed care networks throughout Pennsylvania, Delaware, 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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>History of payment review</b>     | <p>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.</p> <p>Audits are now conducted due to regulations established by Federal and State regulatory agencies, such as the Centers for Medicare &amp; Medicaid Services (CMS), Federal Employee Program, and the 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.</p>                                                                                                                                                                                                      |
| <b>Who is conducting audits?</b>     | <p>Highmark's Financial Investigations and Provider Review (FIPR) audit 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, and auditors.</p> <p>Due to the complexity of facility billing and payment methodologies, Highmark also uses external audit firms to assist in audit reviews of paid claims. These audits are conducted to ensure that providers are complying with industry standards on appropriate billing and that payments are monitored for accuracy.</p> <p>Professional consultants are also engaged to support and advise Highmark personnel in the identification of problematic billing and coding issues.</p> |

[What Is My Service Area?](#)

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## 6.8 PAYMENT REVIEW PROCESS, Continued

### Ultimate goals of payment review

The ultimate goals of payment review are to:

- Be a deterrent to fraud, waste, and abuse by performing advanced analytical and investigational audits.
- 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, 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.

### 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.

### When problems are identified

When a potential fraud, waste, or abuse (FWA) problem is identified, what actions are taken to correct the provider’s reporting?

1. FIPR performs an investigation of the potential FWA.
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 DEFINING THE ISSUES: FRAUD, WASTE, & ABUSE

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|              |                                                                                                                                                                                                                                                                                                             |
|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Fraud</b> | <p><b>Fraud</b> is defined by state and federal laws and can include actions such as intentional misrepresentation or deception for the purpose of receiving payments that an individual or entity is not eligible to receive.</p> <p><b>Example:</b> Billing for services not rendered.</p>                |
| <b>Waste</b> | <p><b>Waste</b> is defined as the overutilization of professional medical services or the misuse of resources by a health care provider.</p> <p><b>Example:</b> A provider's belief is that every patient should receive an X-ray every time they have an appointment.</p>                                  |
| <b>Abuse</b> | <p><b>Abuse</b> 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.</p> <p><b>Example:</b> Billing separate services that should be bundled under one service code.</p> |

## 6.8 TECHNIQUES USED FOR INVESTIGATION

|                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|-------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Overview</b>                                             | In the payment review process, Highmark employs various techniques to investigate potential issues of fraud, waste, and abuse.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Routine surveys of paid claims</b>                       | 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.                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Statistical review of cumulative claims payment data</b> | <p>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.</p> <p>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.</p> |
| <b>Pre-payment review</b>                                   | <p>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.</p> <p>Highmark continually updates the fraud, waste, and abuse detection tools based on improvements in technology and data analysis techniques.</p>                                                     |
| <b>Special research studies</b>                             | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Ongoing investigations</b>                               | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

## 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 audit 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 audits. They also review statistical information on payments made and compare claim coding to Highmark medical and payment policies.

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## 6.8 WHEN A CASE IS IDENTIFIED, Continued

### 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 audits: 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

At this time, 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.

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## 6.8 WHEN A CASE IS IDENTIFIED, Continued

### When a provider disagrees with the findings

If the provider disagrees with the audit findings, they have the opportunity to provide additional clinical documentation in support of their position and have this information considered. Or, since the initial review may have been based on a limited sampling, the provider may request an expanded, statistically-valid review involving a larger number of records. The provider may be asked to sign a Tolling Agreement under certain circumstances.

**Note:** Any additional clinical documentation submitted by a Delaware provider after the initial audit findings will be reviewed by a reviewer that was not involved in the initial audit findings.

Providers in Pennsylvania also have the right to appeal their case to the Medical Review Committee (MRC). Determinations made by the MRC are binding on both the provider and Highmark. For additional information, please refer to the [Highmark's Medical Review Committee – PA ONLY](#) section of this unit.

Providers in Delaware 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. For additional information, please refer to the [Delaware Department of Insurance – DE ONLY](#) section of this unit.

Providers in West Virginia have the right to appeal their case to a certified review entity. Determinations made by the certified review entity are binding on both the provider and Highmark West Virginia. For additional information, please refer to the [Certified Review Entity \(CRE\) – WV ONLY](#) section of this unit.

## 6.8 CLAIM AUDITS

### Introduction

This section summarizes how Financial Investigations and Provider Review (FIPR) staff conducts retroactive post-payment audits of claim submissions and processing for potential fraud, waste, and abuse.

### Post-payment audits

FIPR staff periodically performs retroactive post-payment audits of practices and/or specific providers who have been selected based on their utilization and billing patterns, relative to their peers. Practices, specific providers, and members may also be selected for audit 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 audited. Typically, a certified professional coder and/or registered nurse perform the audits. However, qualified external consultants may on occasion be contracted to perform such audits on behalf of Highmark.

Similarly, FIPR staff may on occasion pend and audit a practice, specific provider, or member's claim on a pre-payment basis.

### Criteria used in E/M audits

In the performance of E/M (evaluation and management) audits (whether pre- or post-payment), the auditor 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).
- Practice or business owner must state in writing (by letter or email) which E/M guidelines will be used to perform the audit.
- 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).

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## 6.8 CLAIM AUDITS, Continued

### Criteria used in E/M audits (continued)

- 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 auditors document determinations of both over coding and under coding. In the event a FIPR auditor determines that documentation supports a higher level code than billed, the auditor gives credit for the underpayment.

### Review of results

At the conclusion of an audit, the results are submitted in writing to the practice via certified mail, and facsimile if applicable. The practice is afforded the opportunity to rebut audit findings by providing clarification and/or supporting documentation **within thirty (30) calendar days**.

Copies of audit worksheets may be made available to the practice upon written request. Additionally, the practice may request a meeting with FIPR staff to:

- Ensure the practice understands the audit process and results.
- Answer questions regarding correct billing and documentation.
- Afford the practice an opportunity to furnish additional supporting documentation and/or clarification.
- Discuss repayment arrangements, if applicable.

## 6.8 CLAIM AUDIT DISPUTE PROCESS

### **Claim audit dispute resolution process**

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 claim audit dispute?**

A claim audit dispute is a dispute that arises as a result of one or more claims audits conducted by Highmark and/or its designated agents. Claim audit disputes include, but are not limited to, disagreements between Highmark and the practice as to the appropriate code(s) assigned to a particular service or services rendered or supplied and/or diagnosis made of a Highmark member that has not been resolved by the parties through informal means. Disputes regarding benefit coverage are not claim audit disputes.

The claim audit dispute resolution process is intended to address a multitude of disputes and provides a means whereby Highmark and the practice will resolve any disputes related to claims for services submitted to Highmark.

Whenever a practice disputes a coding audit decision made by Highmark or its designated agent, the practice and Highmark shall make a good faith effort to resolve the dispute by first discussing the matter with the appropriate representative(s).

### **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 audit dispute process outlined in this unit.

## 6.8 CERTIFIED REVIEW ENTITY (WV ONLY)

[What Is My Service Area?](#)

### Use of a certified review entity (CRE)



Whenever a claim audit dispute arises which cannot be resolved through discussions between the parties, the practice will receive a letter from Highmark West Virginia or its designee requesting the practice to state its intention to either accept or appeal Highmark West Virginia's or its designee's decision. The practice shall comply with all written requests for the practice's intention to accept or appeal a coding decision within a specified time period, which is **ten (10) business days**.

If the practice fails to respond to the written request to state its intention to accept or appeal a coding decision by Highmark West Virginia or its designee within the specified time period, then the parties agree that the practice shall be deemed to have accepted the decision made by Highmark West Virginia or its designee by default, and Highmark West Virginia will perform automatic offset against future payments to recoup the stated overpayment.

If the practice chooses to appeal Highmark's or its designee's audit decision, the practice shall indicate its choice to appeal and have the claim audit dispute thereafter submitted to a certified review entity ("CRE") to perform a review and conclusively resolve the dispute.

**Within ten (10) business days**, Highmark West Virginia shall provide the practice with a written list of two (2) CREs from which the practice may choose one CRE. The practice shall designate which of the CREs it has selected in writing (by letter or email) to Highmark West Virginia **within ten (10) business days** of its receipt of the list of potential CREs from Highmark West Virginia. If the practice fails to select a CRE **within ten (10) business days**, Highmark West Virginia shall have the sole discretion to choose the CRE by default.

The CRE shall be independent (other than with respect to any contract with Highmark West Virginia to provide CRE services). The parties agree that the resolution process set forth here is the sole means for resolving claim audit disputes.

### Provision of files and additional information



**Within ten (10) business days** of receiving the practice's formal written request for the use of a CRE to resolve a claim audit dispute and the practice's formal written choice of a CRE, Highmark West Virginia must forward to the selected CRE a sub-sample of five (5) disputed audit records (or a greater number of audit records if mutually agreed to by both parties) pertaining to the claim audit dispute and provide notice of such action to the practice.

**Within ten (10) business days** of the practice's receipt of the notice that the file has been forwarded to the CRE, the practice may supply additional information to

*Continued on next page*

## 6.8 CERTIFIED REVIEW ENTITY (WV ONLY), Continued

### Provision of files and additional information (continued)



the CRE for consideration and shall simultaneously provide copies of the information to Highmark West Virginia.

Highmark West Virginia shall have **ten (10) business days** after receipt of the practice's additional information to provide any further information or comments it deems relevant to the dispute to the CRE for consideration and shall simultaneously provide copies of the information to the practice.

**Note:** This is not intended to restrict the practice/business owner or Highmark West Virginia from providing the CRE with additional information for consideration with respect to information submitted by the other party. Copies of such additional information shall be provided simultaneously to the other party.

### CRE decision



The CRE shall review and issue its decision **within thirty (30) calendar days** of receipt of the last information submitted. The decision shall be in writing and shall include:

1. A list of the information considered in reaching the decision;
2. The basis and clinical rationale for the decision; and
3. A brief statement of the decision.

[What Is My Service Area?](#)

### Binding decision



The decision by the CRE shall be **final and binding on, and non-appealable by, Highmark West Virginia and the practice/business owner**. Each party waives its right to commence litigation as to the claim audit dispute in a court of law as well as appeal the determination by the CRE of a coding audit dispute to a court of law.

### CRE fees and costs



When the CRE's decision is **fully in favor of one party, the other party shall pay the entire fees and costs** associated with the CRE's review and decision. If the CRE's decision is **partly in favor of each party, the parties shall share equally the cost of the review**. If required by the CRE, Highmark West Virginia and the practice shall make escrow deposits to cover the costs of the review by the CRE.

### Limitation time period



All disputes not resolved by negotiation as described in this section of this unit must be submitted to a CRE 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'S MEDICAL REVIEW COMMITTEE (PA ONLY)

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### MRC process



In Pennsylvania, any provider audit conducted by Financial Investigations and Provider Review (FIPR) staff which remains unresolved can be referred to the Medical Review Committee (MRC) for consideration. The committee is made up of a variety of medical specialties and lay members.

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 hearing 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 operated by the Corporation under Pennsylvania's preferred provider legislation.

[What Is My Service Area?](#)

### FOR MORE INFORMATION

For additional information regarding the Medical Review Committee, please see the manual's [Chapter 5.5: Denials, Grievances, and Appeals](#).

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## 6.8 DELAWARE DEPARTMENT OF INSURANCE (DE ONLY)

### Appeals to Highmark Delaware



In Delaware, any provider audit conducted by Financial Investigations and Provider Review (FIPR) staff that remains unresolved can be referred to the Delaware Department of Insurance (DOI) for consideration.

[What Is My Service Area?](#)

### Arbitration



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 **1-302-674-7322**.

All requests for arbitration must be filed **within sixty (60) days** from the date the provider receives the adverse determination from Highmark Delaware; otherwise, the Highmark Delaware decision will be final.



# HIGHMARK INC.

## THIRD PARTY CODE OF BUSINESS CONDUCT



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# HIGHMARK INC.

## THIRD PARTY CODE OF BUSINESS CONDUCT

### OVERVIEW

In today's business and legal environments, acting ethically and with a high degree of integrity differentiates a company from its competition as an organization that can be trusted. Highmark Inc.'s Ethics and Compliance Program requires that compliance is everyone's responsibility from the top to the bottom of the organization as well as Third Parties. The Ethics and Compliance Program is guided by our core Values and Principles of Integrity and is designed to promote a culture that encourages ethical behavior and commitment to comply with applicable federal and state laws, rules, regulations and guidance.

The Highmark Inc. Third Party Code of Business Conduct ("Third Party Code") applies to those who conduct business with and/or on behalf of Highmark Inc. such as vendors, consultants, subcontractors, suppliers and producers herein referred to as "Third Parties."

Highmark Inc. recognizes that Third Parties are independent entities and their cultural environments may be different from Highmark Inc.'s; however, Third Parties have a critical role in Highmark Inc.'s success and Highmark Inc. strives to conduct business with those who share similar values in compliance and ethics. Therefore, Highmark Inc.'s Third Parties and their employees and agents are expected to comply with standards of conducts as described in the Highmark Inc. Third Party Code and share and subscribe to Highmark Inc.'s commitment to ethical business practices. The Highmark Inc. Third Party Code sets the ethical tone for

conducting business with Highmark Inc. The Integrity and Compliance Department within Highmark Inc. is available to offer guidance and support.

### HIGHMARK INC.'S OBLIGATIONS TO THIRD PARTIES

The Highmark Inc. Code of Business Conduct ("Code") is designed to provide clear guidance of the business conduct expected of all employees. It reflects our commitment to the highest standards of ethical business conduct.

The Code provides guidance to all Highmark Inc. employees in carrying out their daily activities within appropriate ethical and legal standards. These obligations also apply to relationships with other employees, customers and Third Parties.

#### Values

We are committed to serving the health care needs of our patients and the broader community. We also embrace our accountability to the communities, partners and employers whose support drives the realization of our mission. We fulfill our commitments through the compassionate and professional work of our caregivers and employees. Therefore, we commit to these values.

**People Matter** - Every person contributes to our success. We strive for an inclusive culture, regarding people as professionals and respecting individual differences while focusing on the collective whole.

**Stewardship** - Working to improve the health of the communities we serve and wisely managing the assets which have been entrusted to us.

**Trust** - Earning trust by delivering on our commitments and leading by example.

**Integrity** - Committing to the highest standards encompassing every aspect of our behavior including high moral character, respect, honesty and personal responsibility.

**Customer-focused Collaboration** - Because no one person has all the answers, we actively seek to collaborate with each other to achieve the right outcomes for our customers.

**Courage** - Empowering each other to act in a principled manner and to take appropriate risks to do what is right to fulfill our mission.

**Innovation** - Committing to continuous learning and exploring new, better, and creative ways to achieve our vision.

**Excellence** - Being accountable for consistently exceeding the expectations of those we serve.

## Mission

Highmark Health's dedicated and respected employees will be leaders in the health care industry, working to improve the **total health care experience** of our customers.

## Vision

Highmark Health's dedicated and respected employees will be leaders in the health care industry, working to improve the **total health care experience** of our customers.

## Ethical and Compliance Standards

- Highmark Inc. aspires to maintain a culture that not only embraces the principle of doing the right things, but also doing things the right way.
- All Highmark Inc. employees have the responsibility to epitomize Highmark Inc.'s values and to perform their job with integrity.
- Highmark Inc. commits to dealing fairly with customers, Third Parties and competitors and to not take unfair advantage of anyone through manipulation, concealment, abuse of privileged information, misrepresentation of material factors, or any other unfair-dealing practice.

## Legal and Regulatory Compliance

- All Highmark Inc. employees must observe the applicable laws, rules, and regulations governing the company's products and services.
- Highmark Inc. respects and honors the intellectual property rights of others and will not use any copyrighted or patented materials without a license or approval.

## Diversity

- Highmark Inc. is committed to diversity and endeavors to make everyone feel welcome.
- Employees respect the unique attributes of others and recognize and embrace the many diverse perspectives and ideas that each brings to the workplace.

## Safe, Healthy, and Harassment-Free Work Environment

To continue to keep a safe and healthy workplace, Highmark Inc.:

- Treats its employees and visitors with professional respect and courtesy.

- Will not tolerate any harassment, which may be of a sexual, physical, written, or verbal nature, from our employees, customers, Third Parties, outside business invitees, or visitors.
- Maintains a safe and healthy work environment, free of illegal drugs, alcohol, and workplace violence.
- Will not tolerate actions or threats by anyone who disrupts business or places employees, customers, Third Parties, or visitors at risk of harm.

## HIGHMARK INC.'S EXPECTATIONS FOR THIRD PARTIES

Highmark Inc. strives to provide an environment that promotes fairness and equal opportunity, where differences in backgrounds are to be respected, and discrimination not tolerated. Highmark Inc. in turn expects its business partners, including Third Parties, to respect and share this commitment.

Third Parties have the responsibility to comply with and are expected to respect the Highmark Inc. Third Party Code and to conduct business activities and interactions ethically and with integrity. As such, Third Parties must adhere to the following standards when conducting business on behalf of Highmark Inc.:

### Ethical and Compliance Standards

- Cooperate with Highmark Inc.'s commitment to a safe and harassment-free workplace.
- Treat those whom you encounter with professional respect and courtesy, regardless of their position, age, race, sex, religion, national origin, ancestry, creed, sexual orientation, mental or physical disability, veteran status, or any other differences of a personal nature while conducting business with or on behalf of Highmark Inc.

### Legal and Regulatory Compliance

- Conduct business activities in full compliance with all applicable federal and state laws, regulations and contractual obligations while conducting business with or on behalf of Highmark Inc.
- Comply with all anti-corruption laws, including the United States Foreign Corrupt Practices Act, and not make any direct or indirect payments (including promises to pay, or authorizations to pay) of money, gifts or anything of value to officials of foreign governments.
- Comply with antitrust and fair competition laws and regulations when conducting business with or on behalf of Highmark Inc.
- Retain and dispose of Highmark Inc.'s business records in full compliance with all applicable legal and regulatory requirements.
- Comply with all applicable laws and regulations.

### Government Contract Compliance

A substantial portion of Highmark Inc. and its subsidiaries' and affiliates' businesses relate to their roles as government contractors. As a result Highmark Inc. must abide by certain laws and regulations. Therefore, Third Parties are required to abide by additional requirements and obligations while dealing with Highmark Inc.'s government business.

The following government business requirements apply to Third Parties whose contracts with Highmark Inc. support Medicare Advantage and Medicare Prescription Drug programs. Set requirements provide that Third Parties:

- Are prohibited from doing business with any person or entity that is currently debarred, suspended,



excluded, or declared ineligible to perform work under any government contract or subcontract. This will necessitate monthly inquiries to various government databases to ensure continued compliance.

- Are prohibited from offering or accepting any kickbacks, gifts, entertainment, gratuities, or anything of value from suppliers, consultants, or government officials in exchange for an unfair competitive advantage.
- Must keep company records that are accurate, complete and appropriately reflect transactions and events and conform to applicable legal, regulatory and accounting requirements and meets its applicable control procedures. These records are necessary to ensure that Highmark Inc. meets its contractual obligations with the state and federal governments.
- Must cooperate with investigations by government agencies and are prohibited from knowingly making false or misleading statements to a government official.
- Must validate that general compliance and training specific to fraud, waste and abuse (FWA) has been completed for all employees who have involvement in the administration or delivery of Medicare Advantage and the Medicare Prescription Drug program. This training must be completed within ninety (90) days of initial hiring and annually thereafter. Highmark Inc. reserves the right to audit Third Parties' training program to ensure compliance with the Centers for Medicare and Medicaid Services requirements.
- Must report compliance concerns and suspected or actual violations related to the Medicare Advantage and the Medicare Prescription Drug program.
- Must comply with applicable federal and state laws, rules, regulations and contractual obligations.

## Conflict of Interest

Third Parties shall avoid actual, or the appearance of, conflicts of interest while doing business with Highmark Inc. For example, Third Parties:

- Must not deal directly with any Highmark Inc. employee who has a financial interest in the Third Party, or whose spouse or immediate family member holds a financial interest in the Third Party in the course of negotiation or performance of its contract with Highmark Inc.
- Must not deal directly with any Highmark Inc. employee who is the spouse or immediate family member of the Third Parties' representative.
- Must disclose any material transaction or relationship that reasonably could be expected to give rise to a potential conflict of interest.
- Must not influence a business decision, either directly or indirectly through the Third Parties' relationship with Highmark Inc., which allows for personal gain or may adversely affect Highmark Inc.

## Gifts, Gratuities and Kickbacks and Expenses

- Must comply with Highmark Inc.'s gifting policy and avoid offering gifts or anything of value to Highmark Inc. employees where a business decision could be, or could be perceived to be, compromised. Also, avoid offering or accepting gifts or anything of value while acting on behalf of Highmark Inc.
- Must report to Highmark Inc. any and all entertainment, gifts or other items that are received by Highmark Inc.'s employees. Exempt from reporting are food, beverages and moderately priced meals or tickets to local events that are supplied by and attended in the interest of building positive business relationships.

- Must comply with Anti-kickback laws and not request, solicit, receive, offer, give or make payments of any kind, whether directly or indirectly, that would encourage a person to refer a person to another person for the furnishing of any item or service covered by the federal government.
- Must comply with Highmark Inc.'s expense reimbursement policy applicable to Third Parties.

### Safe, Healthy, and Harassment-Free Work Environment

- Must treat everyone, including Highmark Inc. employees, with dignity and respect.
- Must not possess, use, and or distribute illegal drugs and or alcohol while on Highmark Inc. owned or leased property.
- Must comply with all applicable laws and regulations regarding working conditions and labor laws.

### Information Privacy and Security

A significant amount of Highmark Inc.'s business involves the processing and use of information that is private and sensitive and that is protected by numerous federal and state laws. Both Highmark Inc. and its Third Parties must abide by these laws to the extent applicable.

Third Parties:

- Must protect the security of computer systems.
- Must protect information used to access computers, networks or systems. Protecting information used to access computers ultimately protects Third Parties as well as Highmark Inc.
- Must safeguard the confidentiality of personal and protected health information as well as personally identifiable information. Third Parties may also be exposed to confidential and proprietary information.

Third Parties may have access to such information only if they need it to perform their job and they may use and disclose it only as permitted or required by law and their contract with Highmark Inc. Any breach of this obligation to maintain the confidentiality of proprietary information, protected health information and personally identifiable information will be viewed very seriously and may result in termination of the contract.

### Competitively Sensitive Information

Competitively Sensitive Information is non-public information held by the System, which includes: past, present and future reimbursement rates and rate schedules; contracts with providers; contracts with payers; any term or condition in a payer-provider agreement that could be used to gain an unfair commercial advantage over a competitor or supplier, including but not limited to discounts, reimbursement methodologies, and provisions relating to performance, pay for performance, pay for value, tiering of providers, cost data and methodologies including specific cost and member information and revenue, or discharge information specific to the payer or provider; contract negotiations or negotiating positions, including but not limited to offers, counter-offers, party positions, and thought processes; specific plans regarding future negotiations or dealings with payers or providers; and claims reimbursement data.

The Pennsylvania Insurance Department requires strict compliance with the policy protecting Competitively Sensitive Information. This policy prevents the sharing of Competitively Sensitive Information among the corporate affiliates of Highmark Inc. Third Parties must abide by this policy. The sharing of Competitively Sensitive Information could result in the reduction of competition, competitive innovation, or pricing.

### Customers and Supplier Relations

Third Parties shall maintain straightforward business relationships with Highmark Inc. and its customers and suppliers.

Relationships should be based on the cost and the quality of the products and/or services, rather than on personal relationships.

Third Parties shall not take unfair advantage of Highmark Inc. customers through manipulation, coercion, misrepresentation of information, or abuse of privileged or confidential information.

### Proper Use of Company Assets

- Third Parties should ensure that Highmark Inc. corporate assets are used only for valid business purposes. Highmark Inc. corporate assets include not only our equipment, funds and office supplies, but also concepts, business strategies and plans, financial data and other information about Highmark Inc.'s business. These assets may not be used to derive personal gain.

### Adherence to Fraud, Waste and Abuse Guidelines

- Generally, health care fraud is a misstatement of fact knowingly made for the purpose of obtaining health care benefits, services or other things of value.
- Third Parties must not make false or misleading claims, records or statements in order to secure payment of a fraudulent claim on behalf of Highmark Inc.
- Highmark Inc. has policies and procedures in place to detect and prevent fraud, waste and abuse, and expects Third Parties to support the efforts of federal and state authorities by identifying and reporting incidents of fraud, waste and abuse to the Highmark Inc. Integrity and Compliance Department.
- Third Parties who raise questions or report concerns regarding potential or actual fraud, waste and abuse matters in connection with any of Highmark Inc.'s government programs are protected from retaliation and retribution for False Claims Act complaints,

as well as any other applicable anti-retaliation protections.

## HIGHMARK INC.'S EXPECTATIONS FOR APPOINTED PRODUCERS

Appointed Producers have the responsibility to comply with and are expected to respect the Highmark Inc. Third Party Code and to conduct business activities and interactions ethically and with integrity. As such, Appointed Producers must adhere to the following standards when conducting business on behalf of Highmark Inc.:

- Seek to truthfully, carefully, and accurately present a true picture of covered benefits by learning and keeping abreast of all relevant products, benefit plans, and applicable legislation and regulation, to the best of your ability.
- Make a conscientious effort to ascertain and understand all relevant circumstances pertaining to the client in order to recommend appropriate benefit plans.
- Inventory current benefit plans with the client to avoid selling duplicative insurance benefits.
- Honestly assess the likelihood that a client will meet underwriting and financial requirements and discover any adverse factor(s), to reduce false expectations of acceptance and adequacy of benefit plan.
- Possess a comprehensive understanding of products in order to honestly, openly, and effectively portray benefit plans and determine a client's understanding of key benefits and limitations.
- Clarify and verify the client's grasp of information and review pertinent issues.
- Protect proprietary and competitive information.



- Protect protected health information, confidential and financial information in compliance with existing state and federal laws and regulations.
- Obey all laws, including antitrust, governing business and professional activities and represent products in an ethical manner without fraud, misrepresentation, exaggeration, coercion, scare tactics, or concealment of pertinent facts.
- At all times, fully disclose, commission and compensation arrangements to the client.
- Ensure appropriate relationships by not offering or accepting any inducements that might compromise a reasonable business decision. Avoid any conflict of interest or the appearance of any conflict of interest.
- Use only authorized promotional materials unless prior written approval has been obtained, and fairly focus your presentation on positive benefit comparisons rather than disparaging remarks about the competition.
- Treat a client or a potential client with courtesy, respect, and priority in accordance with thoughtful, ethical, and legal business practices.

## COMPLYING WITH THE HIGHMARK INC. THIRD PARTY CODE OF BUSINESS CONDUCT

As a condition of contracting with Highmark Inc., Third Parties and their employees and agents are required to be knowledgeable of and adhere to the Highmark Inc. Third Party Code and be responsible for monitoring compliance with the standards in this Third Party Code. Third Parties are expected to seek guidance from Highmark Inc. when questions arise involving unethical business conduct pertaining to company business and inappropriate behaviors. Highmark Inc. may in its sole discretion, amend this Third Party Code and Third Parties must comply with any such amended Third Party Code.

In addition to any other specific contractual requirement, whenever a third party provides services onsite at any Highmark Inc. campus location, Third Parties must conduct themselves in accordance with and comply with all Highmark Inc. policies and procedures, including, but not limited to, onsite tour guidelines and other policies addressing the confidentiality of all visible and audible Highmark Inc. proprietary data.

## CONTACTS AND REPORTING CONCERNS

If you wish to report a questionable behavior by Highmark Inc. employees, Third Party and/or its employees and agents or potential noncompliance situation, or if you suspect potential or actual fraud, waste and abuse, you should contact the Highmark Inc. Integrity and Compliance Department. In addition to being a resource for Highmark Inc. employees, the Integrity and Compliance Department is available for questions by Highmark Inc. business partners like you. When a report is made to the Integrity and Compliance Department, appropriate action is taken to review and/or investigate the report to reduce the potential for recurrence and ensure on going compliance. Third Parties are expected to cooperate with the investigation of a suspected violation of this Code of Business Conduct or violation of any governmental law or regulation. In addition, as required and/or appropriate, the Integrity and Compliance Department may disclose investigation matters to applicable law enforcement or regulatory entities.

Failure to promptly report a known violation may result in action up to and including termination of the business relationship and is the sole discretion of Highmark Inc.

The Highmark Inc. Integrity and Compliance Department offer various methods for reporting concerns:

- 24-Hours a day/seven days a week Helpline:  
1 (800) 985-1056
- U.S. Post Office Box:  
Highmark Inc.  
Integrity and Compliance Department  
P. O. Box 22492  
Pittsburgh, PA 15222
- Fax: (717) 302-3650 or (412) 544-2475
- E-Mail: [integrity@highmark.com](mailto:integrity@highmark.com)

All inquiries to the Integrity and Compliance Department are confidential, subject to limitations imposed by law. When using the Integrity Helpline, you may remain anonymous. If you choose to make an anonymous report, you should provide enough information about the situation to allow the Integrity and Compliance Department to properly investigate it. If you do not provide enough details, the ability to pursue the matter will be limited. Highmark Inc. maintains a reprisal-free environment and has a policy of non-retaliation and non-intimidation to encourage employees, Third Parties and their employees to raise ethical or legal concerns in good faith. Third Parties who raise questions or report concerns regarding potential or actual fraud, waste and abuse matters in connection with any of Highmark Inc.'s government programs, you are protected from retaliation and retribution for False Claims Act complaints, as well as any other applicable anti-retaliation protections. All inquiries are confidential, subject to limitations imposed by law.

The Highmark Inc. Third Party Code of Business Conduct sets forth general principles to which Third Parties must comply. More restrictive requirements may be set forth in the contracts between Third Parties and Highmark Inc.



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