Centers of Medical Excellence Transplant Operations Manual

A supplemental document to the Highmark Blue Cross Blue Shield Provider Manual

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Centers of Medical Excellence Transplant Operations Manual

Highmark Blue Cross Blue Shield (Highmark BCBS) partners with Wellpoint companies to administer certain services to Medicaid Managed Care (MMC), Health and Recovery Plan (HARP) and Child Health Plus (CHPlus). Please note, this information is specific to the MMC, HARP, and CHPlus programs only.

Highmark BCBS retains the right to add to, delete from and otherwise modify this Provider Manual. Contracted providers must acknowledge this Provider Manual and any other written materials provided by Highmark BCBS as proprietary and confidential.

Please note: Material in this provider manual is subject to change. Please go to www.bcbswny.com/stateplans for the most up-to-date information.

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Wellpoint Partnership Plan, LLC provides management services for Highmark Blue Cross Blue Shield's managed Medicaid.
Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross Blue Shield Association.
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INTRODUCTION

Welcome to the Highmark Blue Cross Blue Shield (Highmark BCBS) network provider family. We're pleased you have joined the Highmark BCBS network, which represents some of the finest health care practitioners in the state of New York.

We bring the best expertise available nationally to operate local, community-based health care plans with experienced local staff to complement our operations. We are committed to assisting you in providing quality health care.

We believe hospitals, physicians and other providers play a pivotal role in managed care. We can only succeed by working collaboratively with you and other caregivers. Earning your loyalty and respect is essential to maintaining a stable, high-quality provider network.

If you are interested in participating in any of our quality improvement committees or learning more about specific policies, please contact us. Most committee meetings are prescheduled at times and locations intended to be convenient for you. Please call Provider Services at **866-231-0847** with any suggestions, comments or questions that you may have. Together, we can arrange for and provide an integrated system of coordinated, efficient and quality care for our members and your patients.

Please note this provider manual will be amended as our operational policies change. We will notify you by mail, phone or email.

If you believe you do not have our most current edition of our manual, please call us at **866-231-0847** to receive a new one.

OVERVIEW

Who is Highmark BCBS?

Highmark BCBC is a division of HealthNow New York Inc., an independent licensee of the BlueCross and BlueShield Association. Since 1936, Highmark BCBS has helped millions of people lead healthier lives. Highmark BCBS offers a full range of insured, self-insured and government programs.

Child Health Plus (CHPlus) and Medicaid Managed Care (MMC), the government-sponsored health insurance programs, provide services to eligible members in Allegany, Cattaraugus, Chautauqua, Erie, Orleans and Wyoming counties. Services cover families and individuals. Highmark BCBS also offers dental and vision plans. As a community-based, not-for-profit health plan, Highmark BCBS contributes significantly to organizations that strengthen and enrich the health of our community.

We're dedicated to improving the quality of life of each member by providing the best and most reliable health care to the communities we serve.

Mission
Our mission is to operate a community-focused managed care company with an emphasis on the public sector health care market. We will coordinate members' physical and behavioral health care, offering a continuum of education, access, care and outcome programs that we believe results in lower costs, improved quality and better health statuses for these members.

Strategy
Our strategy is to:

- Improve access to preventive primary care services by ensuring the selection of a primary care provider (PCP) who will serve as provider, care manager and coordinator for all basic medical services
- Educate members about their benefits and responsibilities and the appropriate use of health care services
- Encourage stable, long-term relationships between providers and members
- Discourage medically inappropriate use of specialists and emergency rooms
- Commit to community-based enterprises and community outreach
- Facilitate the integration of physical and behavioral health care
- Foster quality improvement mechanisms that actively involve providers in re-engineering health care delivery
- Encourage a customer service orientation with regular measurement of member and provider satisfaction

Summary
Escalating health care costs are driven in part by a pattern of fragmented, episodic care and, quite often, unmanaged health problems of members. We strive to educate members, to encourage the appropriate use of the managed care system and to be involved in all aspects of their health care.

QUICK REFERENCE INFORMATION

Please call Provider Services at the National Customer Care department for precertification/notification, health plan network information, member eligibility, claims information, inquiries and recommendations you may have about improving our processes and managed care program.

Highmark BCBS Phone Numbers

Provider Services telephone:	**866-231-0847**
Provider Services fax:	**800-964-3627**
AT&T Relay Service:	**711**
Automated Provider Inquiry Line for Member Eligibility:	**866-231-0847**
Electronic Data Interchange (EDI) Hotline:	**800-470-9630**
24/7 NurseLine:	**866-231-0847**
Member Services:	**866-231-0847**
Pharmacy Services:	**866-231-0847**
Appeals Inquiry:	**866-696-4701**

Other Contact Information

Vision services

- Member Services: **866-231-0847**
- Provider Services: **866-231-0847**
- Website: **www.bcbswny.com/stateplans**

Healthplex (dental services):

- Members: **800-468-9868**
- Providers: **888-468-2183**
- Website: **www.healthplex.com**

AIM (Radiology services):

- Providers: **800-714-0040**. The call center will be open to take calls 8 a.m. – 8 p.m. ET.
- Web portal: **www.providerportal.com**

HearUSA (Hearing services):

- Phone: **800-333-3389** (**888-300-3277** for TDD relay services)
- Website: **www.HearUSA.com**

Express Scripts (pharmacy benefit manager):

- Mail order: **800-596-4931**

OrthoNet (precertification for physical, occupational and speech therapy):

- Medical Management: **855-596-7618**
- Fax: **855-596-7626**
- Provider Services: **855-596-7618**

Medical Answering Services, LLC (MAS) nonemergent transportation:

- Allegany County: **866-271-0564**
- Cattaraugus County: **866-371-4751**
- Chautauqua County: **855-733-9405**
- Erie County: **800-651-7040**
- Orleans County: **866-260-2305**
- Wyoming County: **855-733-9403**
- Website: **https://www.medanswering.com**

Our website contains a full complement of resources, including inquiry tools for real-time eligibility, claims status and referral authorization status. In addition, the website provides general information you'll find helpful, such as forms, the Preferred Drug List (PDL), drugs requiring prior authorization, provider manuals, the referral directory, provider newsletters, claim status, electronic remittance advice (ERA) and electronic funds transfer (EFT) information, updates, clinical guidelines and other information to help us collaborate with you. Visit **www.bcbswny.com/stateplans** to learn more.

Ongoing Provider Communications
To ensure you're up-to-date with the information required to work effectively with us and our members, we periodically post information on our website and send you broadcast faxes, provider manual updates and newsletters.

Here is some more information to help you in your day-to-day interaction with us.

Member Eligibility	Contact the Provider Inquiry line at **866-231-0847**.
Notification/Precertification	• May be telephoned, submitted online or faxed to Highmark BCBS: o Telephone: **866-231-0847** o Fax: **800-964-3627** o Online: **www.bcbswny.com/stateplans** • Data required for complete notification/precertification: o Member ID number o Legible name of referring provider o Legible name of individual referred to provider o Number of visits/services o Date(s) of service o Diagnosis o Valid CPT®/HCPCS code • In addition, clinical information is required for precertification. Precertification forms are located on our website.
Claims Information	• Submit paper claims to: Highmark Blue Cross Blue Shield P.O. Box 62509 Virginia Beach, VA 23466-2509 • Electronic claims payer IDs o Emdeon: 27514 o Caparo (formerly MedAvant): 28804 o Availity: 26375 • Timely filing is within 90 days from the date of service, or per the terms of the provider agreement. • Highmark BCBS provides an online resource designed to significantly reduce the time your office spends verifying eligibility, claims status and authorization status. Log in to our website and browse through the *Claims* section for more details. • If you are unable to access the internet, you may receive claims status, eligibility verification and authorization status over the telephone at any time by calling our toll-free, automated Provider Inquiry Line at **866-231-0847**.
Medical Appeal Information	• Medical appeals must be filed within 90 calendar days of the date of the notice of action.

	• File a standard medical appeal at: Highmark Blue Cross Blue Shield Medical Appeals P.O. Box 62429 Virginia Beach, VA 23466-2429 • Fax an expedited appeal to **844-759-5954**.
Payment Disputes	• You have 45 calendar days from receipt of *Explanation of Payment (EOP)* to request an informal claim dispute resolution review. Highmark BCBS will send a determination letter within 30 business days of receiving all necessary information. If you're dissatisfied with the resolution, you may submit an appeal of the resolution within 30 calendar days of receipt of the notification. • File a payment dispute at: Highmark BCBS Payment Disputes P.O. Box 61599 Virginia Beach, VA 23466-1599
Provider Grievances	• Provider grievances should be submitted to: Highmark Blue Cross Blue Shield Provider Relations – Central Intake Unit Grievances and Appeals 9 Pine St., 14th Floor New York, NY 10005
Provider Changes	Providers should immediately submit any changes to demographics, specialty, practice information, TIN, billing, office hours or appointment scheduling phone number directly to Highmark BCBS. The *Practice Profile Form* can be downloaded from the provider website and sent via email to wnyprovupdates@elevancehealth.com.
Case Managers	Highmark BCBS case managers are available during normal business hours, Monday through Friday from 8 a.m. to 5 p.m. ET. For urgent issues, assistance is available after normal business hours and on weekends and holidays through Provider Services at **866-231-0847**.
Provider Service Representatives	For more information, contact Provider Services at **866-231-0847**.
Pharmacy	**866-231-0847**
24/7 NurseLine	**866-231-0847**
New York State Department of Health	**800-206-8125**
Behavioral Health Precertification	**866-231-0847**
New Baby, New Life program	**866-231-0847**

Plan Compliance Officer	**757-473-2737, ext. 31028**
Report fraud	**877-725-2702**
Disease Management Centralized Care Unit (DMCCU)	**888-830-4300**
WIC program	**www.health.state.ny.us/prevention/nutrition/wic**
Clinical Practice Guidelines	**866-231-0847**
Domestic Violence Coordinator	**866-231-0847**

PRIMARY CARE PROVIDERS

Primary Care Providers

The PCP is a provider who serves as the entry point into the health care system for the member. The PCP is responsible for the complete care of his or her patient, including but not limited to providing primary care, coordinating and monitoring referrals to specialty care, authorizing hospital services, and maintaining the continuity of care.

PCP responsibilities shall include, at a minimum:

- Managing the medical and health care needs of members to ensure all medically necessary services are made available in a timely manner.
- Monitoring and following up on care provided by other medical service providers for diagnosis and treatment to include services available under fee-for-service (FFS) Medicaid.
- Providing the coordination necessary for the referral of patients to specialists and for the referral of patients to services that may be available through FFS Medicaid.
- Maintaining a medical record of all services rendered by the PCP and other referral providers.
- Screening and treating patients for sexually transmitted diseases (STDs), reporting cases of STDs to the local public health agency, and cooperating in contact investigations in accordance with existing state and local laws and regulations.
- Educating patients about the risk and prevention of sexually transmitted diseases (STDs).

A PCP must be a physician or network provider/subcontractor who provides or arranges for the delivery of medical services, including case management, to ensure all services found to be medically necessary are made available in a timely manner. The PCP may practice in a solo or group setting or may practice in a clinic (for example, a federally qualified health center [FQHC] or rural health center [RHC]) or outpatient clinic.

We encourage enrollees to select a PCP who provides preventive and primary medical care, as well as authorization and coordination of all medically necessary specialty services. We encourage our members to make an appointment with their PCPs within 30 calendar days of their effective date of enrollment.

Provider Specialties

Physicians with the following specialties can apply for enrollment with us as a PCP:

- Family practitioner
- General practitioner
- General pediatrician
- General internist
- Nurse practitioners certified as specialists in a family practice or pediatrics
- FQHCs and RHCs
- Obstetrics/gynecology

To contract as a PCP, you must practice at the location listed in the enrollment agreement.

PCP Onsite Availability

We're dedicated to ensuring access to care for our members, and this depends upon the accessibility of network providers. Our network providers are required to abide by the following standards:

- Enrollees must have access to an after-hours live voice for PCP and OB/GYN emergency consultation and care.
- PCPs must offer 24 hour-a-day, 7 day-a-week telephone access for members.
- A 24-hour telephone service may be used if it is:
    - Answered by a designee such as an on-call physician or nurse practitioner with physician backup, or an answering service or answering machine. Note: If an answering machine is used, the message must direct the member to a live voice.
    - Maintained as a confidential line for member information and/or questions; an answering machine is **not** acceptable.
- The PCP or another physician/nurse practitioner must be available to provide medically necessary services.
- Covering physicians are required to follow the preauthorization guidelines.
- It is **not** acceptable to automatically direct the member to the emergency room when the PCP is not available.
- We encourage our PCPs to offer after-hours office care in the evenings and on weekends.

Member Enrollment

Member enrollment into Highmark BCBS is voluntary. Members who meet the state's eligibility requirements for participation in managed care are eligible to join Child Health Plus and Medicaid Managed Care through our health care plan. Eligible members are enrolled without regard to health status.

Nondiscrimination Statement

Highmark BCBS does not engage in, aid or perpetuate discrimination against any person by providing significant assistance to any entity or person that discriminates on the basis of race, color or national origin in providing aid, benefits or services to beneficiaries. Highmark BCBS does not utilize or administer criteria having the effect of discriminatory practices on the basis of gender or gender identity. Highmark BCBS does not select site or facility locations that have the effect of excluding individuals from, denying the benefits of or subjecting them to discrimination on the basis of gender or gender identity. In addition, in compliance with the Age Act, Highmark BCBS may not discriminate against any person on the basis of age, or aid or perpetuate age discrimination by providing significant assistance to any agency, organization or person that discriminates on the basis of age. Highmark BCBS provides health coverage to our members on a nondiscriminatory basis, according to state and federal law, regardless of gender, gender identity, race, color, age, religion, national origin, physical or mental disability, or type of illness or condition.

Members who contact us with an allegation of discrimination are informed immediately of their right to file a grievance. This also occurs when a Highmark BCBS representative working with a member identifies a potential act of discrimination. The member is advised to submit a verbal or written account of the incident and is assisted in doing so, if the member requests assistance. We document, track and trend all alleged acts of discrimination.

Members are also advised to file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights (OCR):

- Through the OCR complaint portal at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**
- By mail to: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201
- By phone at: **800-368-1019** (**TTY/TTD: 800-537-7697**)

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

Highmark BCBS provides free tools and services to people with disabilities to communicate effectively with us. Highmark BCBS also provides free language services to people whose primary language isn't English (for example, qualified interpreters and information written in other languages).These services can be obtained by calling the customer service number on their member ID card.

If you or your patient believe that Highmark BCBS failed to provide these services, or discriminated in any way on the basis of race, color, national origin, age, disability, gender or gender identity, you can file a grievance with our grievance coordinator via:

- Mail: Highmark Blue Cross Blue Shield, Member Complaint and Appeals Department, P.O. Box 62429, Virginia Beach, VA 23466-2429
- Phone: **866-231-0847** (**TTY/TDD: 711**)

Equal Program Access on the Basis of Gender

Highmark BCBS provides individuals with equal access to health programs and activities without discriminating on the basis of gender. Highmark BCBS must also treat individuals consistently with their gender identity, and is prohibited from discriminating against any individual or entity on the basis of a relationship with, or association with, a member of a protected class (that is, race, color, national origin, gender, gender identity, age or disability).

Highmark BCBS may not deny or limit health services that are ordinarily or exclusively available to individuals of one gender, to a transgender individual based on the fact that a different gender was assigned at birth, or because the gender identity or gender recorded is different from the one in which health services are ordinarily or exclusively available.

Americans with Disabilities Act Requirements

Our policies and procedures are designed to promote compliance with the Americans with Disabilities Act (ADA) of 1990. Providers are required to take reasonable actions to remove an existing barrier and/or to accommodate the needs of members who are qualified individuals with a disability. This action plan includes:

- Street-level access
- An elevator or accessible ramp into facilities
- Access to a lavatory that accommodates a wheelchair
- Access to an examination room that accommodates a wheelchair
- Handicap parking clearly marked, unless there is street-side parking

Health Plan Products and Benefits
Child Health Plus (CHPlus) is a New York state-sponsored, free or low-cost health insurance program available to members ages 0 to 19 of low-income families who are not eligible for Medicaid and do not have other health insurance.

Medicaid Managed Care is available to eligible Medicaid recipients residing within the Highmark BCBS service area.

Member Disenrollment
A member can be disenrolled from the health plan in limited circumstances. If you believe a member should be disenrolled for a medical reason or for noncompliance, please contact Member Services at **866-231-0847** for assistance.

Note: CHPlus is a voluntary program. A member may choose to disenroll from Highmark BCBS at any time.

Newborn Enrollment
We will enroll and provide coverage for eligible newborn children effective from the date of birth. Upon notification of the birth by the hospital, the New York State Department of Health (NYSDOH) will enroll the newborn in the mother's health care plan. If the newborn is not identified as SSI or SSI-related and therefore excluded from a health care plan pursuant to Section 2(b) (xi), the newborn will be retroactively enrolled to the first day of the month of birth.

Based on the transaction date of the enrollment of the newborn, the newborn will appear on either the next month's roster or the subsequent month's roster.

Member Eligibility Listing
You should verify each member receiving treatment in your office actually appears on your membership listing. Accessing your panel membership listing via our provider website is the most accurate way to determine member eligibility. You will have secure access to an electronic listing of your panel of assigned members, once registered and logged in to **www.bcbswny.com/stateplans** or through **https://www.availity.com**.

To request a hard copy of your panel listing be mailed to you, call Provider Services at **866-231-0847**.

Member Identification Cards
Our members are given identification (ID) cards identifying them as participants in our program within 14 calendar days of their effective dates of enrollment with us. To ensure immediate access to services, you must accept members' Medicaid Managed Care ID cards or the Highmark BCBS temporary member ID cards as proof of enrollment in Highmark BCBS until they receive Highmark BCBS member ID cards. The holder of the Highmark BCBS member ID card should be the member or the guardian of the member. The ID card will include:

- The member's ID number
- The member's name (first name, last name and middle initial)
- The member's date of birth
- The member's enrollment effective date
- Toll-free phone numbers for information and/or authorizations

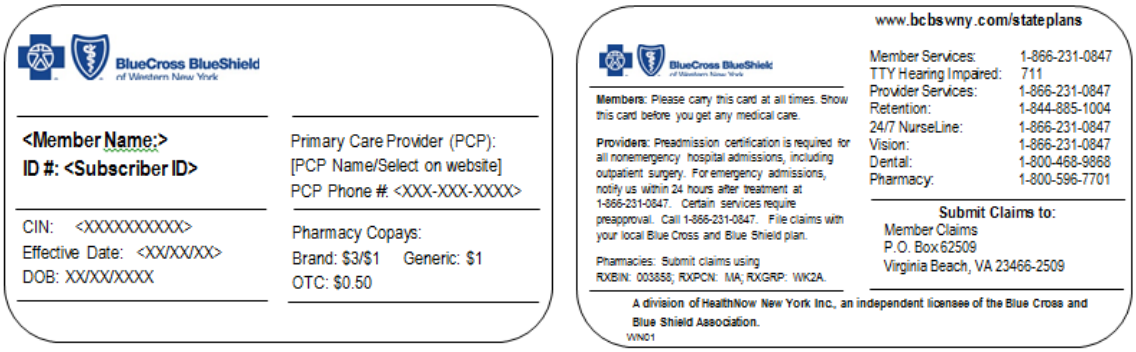
- Toll-free 24/7 NurseLine, available 24 hours a day, 7 days a week
- Descriptions of procedures to be followed for emergency or special services
- Highmark BCBS address and telephone number
- PCP name and telephone number

Our members also have access to:

- Print-on-demand ID cards: By logging in to our website, members can download and print their ID cards from home.
- Mobile ID card smartphone application: Via our new application, available for both iOS and Android users, members can download an image of their current ID cards and fax or email you a copy.

ID cards should be treated the same as you would treat the original plastic card. Remember to verify eligibility through our website at every visit, no matter which type of card a member presents.

The following is a sample of a Medicaid Managed Care member ID card:



Medically Necessary Services

Medically necessary health services are defined as health services that meet all or one of the following conditions:

- Services are essential to prevent, diagnose, prevent the worsening of, alleviate, correct or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, result in illness or infirmity of a member, or interfere with such person's capacity for normal activity.
- Services are provided at an appropriate facility and at the appropriate level of care for the treatment of the member's medical condition.
- Services are provided in accordance with generally accepted standards of medical practice.

Note: We do <u>not</u> cover the use of any experimental procedures or experimental medications except under certain preauthorized circumstances.

If experimental or investigational services are requested, the attending physician will:

- Certify that the member has a life-threatening or disabling condition for which:

- The standard service/procedure has been ineffective or would be medically inappropriate.
- A more beneficial standard service or procedure covered by the plan doesn't exist.
- There is a clinical trial that is open, the member is eligible to participate, and the member has or will likely be accepted.

- Attest that the service or procedure is likely to be more beneficial to the member than any standard service or procedure, based on two documents grounded in credible medical or scientific evidence (copies of these documents must be enclosed with the request).

Member Complaint Procedures

A complaint is an expression of dissatisfaction by a member or provider on a member's behalf about care and treatment that does not amount to a change in scope, amount or duration of service.

Filing a Complaint

A complaint may be issued verbally or in writing. Verbal complaints should be made by contacting us at **866-231-0847** or in writing at the following address:
Highmark Blue Cross Blue Shield
Member Complaint Specialist
Quality Management Department
P.O. Box 38
Buffalo, NY 14240-0038

We will designate one or more qualified staff members who were not involved in any previous level of review or decision-making to review the complaint, and if the complaint pertains to clinical matters, licensed, certified or registered health care professionals will be involved.

Complaints that can be immediately decided (the same day) to the member's satisfaction will not be responded to in writing. We will document the complaint and decision, and log and track the complaint and decision for quality improvement purposes. If the complaint cannot be decided immediately, we will determine if a complaint is to be expedited or standard.

Expedited complaints may be requested when we determine, or you indicate, that a delay in decision-making could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. A member may also request an expedited review of a complaint.

Expedited and Standard Complaints Time Frames

We must acknowledge the complaint in writing within 15 business days of receipt of the complaint. If a decision is reached before the written acknowledgement is sent, we may include the written acknowledgement with the notice of decision (one notice).

All complaints must be decided as fast as a member's condition requires, but no longer than the following time frames:

- **Expedited:** 48 hours from receipt of all necessary information, and no more than seven calendar days from the receipt of the complaint.
- **Standard:** 45 calendar days from receipt of all necessary information, and no more than 60 calendar days from receipt of the complaint.

The member or someone on behalf of the member has the right to file a complaint at any time with the NYSDOH at **800-206-8125**.

Appealing a Complaint Decision

If the member is not satisfied with the decision made concerning a complaint, the member may request a second review of his or her issue by filing a complaint appeal. The member must file a complaint appeal in writing within 60 business days of receipt of the initial decision. Once the written appeal is received, we establish if the appeal is expedited or standard. You or the member may also request an expedited review of a complaint appeal. The member will receive a written acknowledgement informing him or her of the name, address and telephone number of the individual designated to respond to the appeal within 15 business days of receiving his or her request for appeal. If a decision is reached before the written acknowledgement is sent, the plan may include the written acknowledgement with notice of decision.

All complaint appeals will be conducted by appropriate professionals at a higher level within Highmark BCBS than the person who made the complaint determination. Complaint appeal determinations with a clinical basis must be made by personnel qualified to review the appeal, including licensed, certified or registered health care professionals who did not make the initial determination, at least one of whom must be a clinical peer reviewer.

For standard appeals, the appeal decision is reached within 30 business days after we receive all necessary information to make the decision, or as fast as the member's condition requires. For expedited complaint appeals, the appeal decision is reached within two business days of receipt of necessary information, or as fast as the member's condition requires. For both standard and expedited complaint appeals, we will provide the member with written notice of the decision. The notice will include the detailed reasons for the decision and, in cases involving clinical matters, the clinical rationale for the decision.

A clinical reviewer other than the clinical reviewer who rendered the adverse determination will review expedited and standard appeals.

Documentation of Complaints and Complaint Appeals

We will maintain a file on each complaint and associated appeal, if any, that will at a minimum include:

- The date the complaint/complaint appeal was filed and a copy of the complaint/complaint appeal
- The date of receipt and a copy of the enrollee's acknowledgement letter, if any, of the complaint/complaint appeal
- All member/provider requests for expedited complaints/complaint appeals and plan decisions about the request
- Necessary documentation to support any extensions (no exceptions on complaint appeals)

- Our determination, including the date of the determination, titles and, in the case of a clinical determination, the credentials of our personnel who reviewed the complaint/complaint appeal

HIGHMARK BCBS HEALTH CARE BENEFITS

Highmark BCBS Covered Services

All services and benefits are subject to plan provisions and must be medically necessary. Services other than primary care, obstetrics-gynecology (OB-GYN), mental health/substance abuse, self-referral and free-access services may require precertification. Details about which services require precertification can be found on our website.

Where applicable, differences between the Medicaid Managed Care and Child Health Plus (CHPlus) covered services are discussed in this section. If no differentiation is made for a particular type of service, the coverage of those services can be considered equal for all of our products.

Physician Services

Physician services include the full range of preventive, primary care medical services and physician specialty services that fall within a licensed physician's scope of practice under New York state law. Physician's assistants' services are included within the scope of physician services, as they act as extenders to physician services.

In addition to the full range of medical services, the following benefits are also included:

- Certain specified laboratory procedures performed in the office during the course of treatment (refer to laboratory services)
- Family planning health services including diagnosis, treatment and related counseling furnished under the supervision of a physician (fertility services are not covered)
- Child/Teen Health Plan (C/THP) services (that is, comprehensive primary care services provided to children and adolescents under age 21 and behavioral health screening by PCPs for all members as appropriate)
- Physical examinations, including those necessary for employment, school and camp
- Physical and/or mental health or alcohol and substance abuse examinations as requested by the local Department of Social Services to fulfill its statutory responsibilities for the protection of children and adults and for children in foster care
- Health and mental health assessments for the purpose of making recommendations regarding a recipient's disability status for federal SSI applications
- Physical health and/or mental health or alcohol and substance abuse assessments for the purpose of making recommendations regarding a recipient's ability to work when requested by a local social services district; Medicaid requires psychosocial assessment to be conducted on each member to include economic, social, psychosocial and emotional problems, as well as domestic violence or sexual assault

Preventive Care
Preventive care means the evaluation and treatment to avert disease/illness and/or its consequences. There are three levels of preventive care: primary, such as immunizations for preventing disease; secondary, such as disease screening programs for early detection of disease; and tertiary, such as physical therapy for restoring function after disease has occurred. An accepted standard of professional/patient care services is required when treating Medicaid Managed Care members.

Prenatal Care Services
Prenatal and obstetrical services may be accessed directly by the member and/or after the PCP confirms a pregnancy and refers the member to a participating obstetrical provider. For Medicaid Managed Care, ongoing risk assessment for both maternal and fetal risk should occur for all pregnant women to include genetic, nutritional, psychosocial, historical, and emergency obstetrical and med-surgical risk factors. Pregnant women are also allowed up to eight smoking cessation counseling sessions within a 12-month period.

Gynecological Care Services
Gynecological services may be accessed by all female members without a PCP referral. For Medicaid Managed Care, covered services include one routine examination per member annually, treatment of all acute gynecological conditions and follow-up treatment visits.

Free Access Services: Family Planning and Reproductive Health Services
Medicaid Managed Care: Family planning/reproductive services for contraception, sterilization, screening and treatment for sexually transmitted diseases, and HIV pretest counseling with clinical recommendation of testing for all pregnant women are covered by the plan. Members and their newborns must have access to services for positive management of HIV disease, psychosocial support and case management for medical, social and addictive services. Members may self-refer to access family planning services from a Highmark BCBS provider or any provider who accepts Medicaid. Infertility services are not covered.

Emergency Services
Emergency services coverage includes services needed to evaluate or stabilize an emergency medical condition. Criteria used to define an emergency medical condition are consistent with the prudent layperson standard and comply with federal and state requirements.

Emergency medical condition: A physical or behavioral condition, the onset of which is sudden, manifesting itself by acute symptoms of sufficient severity (including severe pain) 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 the following:

- Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a pregnant woman, the health of the woman or her unborn child or, in the case of a behavioral condition, placing the health of the person or others in serious jeopardy
- Serious impairment to such person’s bodily functions
- Serious dysfunction of any bodily organ or part of such person
- Serious disfigurement of such person

Members do not need to call their PCP or Highmark BCBS before seeking emergency care. Members can access the nearest emergency room regardless of location or network participation. Precertification is not required for services in a medical or behavioral health emergency. Access to emergency services is not restricted, and emergency services may be obtained from nonparticipating providers without penalty. Members are required to notify us or their PCP within 48 hours after receiving emergency care and obtain precertification for any follow-up care delivered pursuant to the emergency. Nothing in this provider manual or policies and procedures precludes us from entering into contracts with providers or facilities that require providers or facilities to provide notification to us after members present for emergency services and are subsequently stabilized.

Inpatient Hospital Care
Inpatient stay pending alternate level of medical care means continued care in a hospital pending placement in an alternative lower medical level of care, consistent with provisions of 18 NYCRR 505.20 and 10 NYCRR, Part 85.

Acute care in a general hospital is covered up to 365 days a year, encompassing a full range of necessary diagnostic and therapeutic care, including surgical, medical, nursing, radiological and rehabilitative services. Precertification is required for elective inpatient hospital care and must be obtained at a minimum of 72 hours before the scheduled admission.

Outpatient Hospital Services
Outpatient hospital services are provided through ambulatory care facilities. Ambulatory care facilities include diagnostic and treatment centers, hospital outpatient departments and emergency rooms. These facilities may provide those necessary medical, surgical and rehabilitative services and items authorized by their operating certificates. Outpatient services (clinics) also include mental health, chemical dependency, alcohol, C/THP and family planning services provided by ambulatory care facilities.

Second Opinion Services
Members may be referred to other providers for second opinions within our provider network, for diagnosis of a condition, treatment and surgical procedures. Precertification is not required for in-network referrals.

Home Health Services
Home health services encompass services provided by a certified home health care agency in the member’s home and include therapeutic and preventive nursing, home health aides, medical supplies, equipment and appliances, rehabilitative therapies (that is, physical, occupational and speech), social work services, or nutritional services.

Home health coverage also includes two postpartum visits for high-risk infants and mothers, at least one visit to women who stay in the hospital less than 48 hours after birth and at least one visit to women who stay in the hospital less than 96 hours after a Cesarean delivery. In each case, the first visit is to occur within 48 hours of discharge.

Child Health Plus Home Health Care Benefits
Benefits are limited to 40 home health care visits per calendar year for services provided by a certified home health care agency. The service is covered only if the member would have to be admitted to a hospital or skilled nursing facility if home care was not provided. Four hours of home health aide services equals one visit.

All home health services require prior authorization.

Personal Care Services
Personal care services (PCS) are covered for members enrolled in the Temporary Assistance for Needy Families (TANF) and SSI programs only. PCS require precertification and a completed DOH-4359 (physician order). Upon receipt of the DOH-4359, a home assessment visit will be conducted to determine the level and type(s) of service(s) needed. A notice of determination will be sent to the member and provider and is subject to all applicable appeal rights should the determination differ from the services requested. Interim home-care services may be approved pending determination of PCS based on clinical information provided by the physician.

Consumer-Directed Personal Assistance Services (CDPAS)
CDPAS refers to the provision of some or total assistance with personal care services (PCS), home health aide services and skilled nursing tasks by a consumer-directed personal assistant under the instruction, supervision and direction of a consumer or the consumer's designated representative.

Consumers are defined as medical assistance recipients (enrollees) who are assessed by the health plan and determined to be eligible to participate in CDPAS. A completed DOH-4359 (physician order) is also required to participate in CDPAS.

Personal Emergency Response System (PERS)
PERS is covered when medically necessary and must be made in accordance and coordination with authorization for PCS or home care services.

Behavioral Health Services
Mental Health: Medicaid Managed Care Members' Scope of Benefit
All inpatient mental health services, including voluntary or involuntary admissions, are covered. Outpatient services are covered and may be provided in the member's home, in an office or in the community.

All members may self-refer for behavioral health and substance use services. Behavioral health services visits are coordinated by calling **866-231-0847**. Precertification is not required for some behavioral health services when provided by a network provider. A provider or hospital must be contracted with Highmark BCBS to provide these services. For questions on precertification requirements, please call **866-231-0847**.

Medicaid SSI members obtain their mental health benefits through the state's FFS program.

Detoxification: Medicaid Managed Care
Medically managed inpatient detoxification is covered on an inpatient basis. Specific services include, but are not limited to:

- Medical assessment within 24-hours of admission
- Medical supervision of intoxication and withdrawal conditions
- Biopsychosocial assessment
- Individual and group counseling and linkages to other services as necessary

Maintenance on methadone while a patient is being treated for withdrawal from other substances may be provided.

Treatment for moderate withdrawal on an outpatient basis is also covered.

Detoxification and withdrawal services are a covered benefit for all Medicaid Managed Care members, including SSI.

Chemical Dependency: Medicaid Managed Care
Chemical dependence inpatient rehabilitation and treatment services are covered and can be provided in a hospital or freestanding facility.

Screening, brief intervention and referral to treatment (SBIRT) for chemical dependency provided in hospital outpatient departments, freestanding diagnostic and treatment centers, and primary care settings must be in accordance with protocols issued by the New York State Department of Health (NYSDOH). SBIRT is considered a preventive/screening service. PCPs who offer these services must meet the Office of Alcohol and Substance Abuse Services required training and comply with documentation standards, which include information on services provided, patient screening-tool scores and a copy of the screening tool used.

Medicaid Managed Care Outpatient Chemical Dependency Services
Medically supervised ambulatory chemical dependence outpatient clinics programs, as well as medically supervised chemical dependence outpatient rehabilitation programs, are covered.

CHPlus Mental Health and Chemical Dependence Benefits
There are no limitations for inpatient or outpatient visits for CHPlus members. Both inpatient and outpatient mental health and substance abuse services in the CHPlus program are covered without limitations on the level of coverage.

Autism Spectrum Disorder (ASD) Screening, Diagnosis and Treatment
ASDs are pervasive developmental disorders defined in the most recent edition of the diagnostic and statistical manual of mental disorders, including:

- Autistic disorder (also called autism)
- Asperger’s disorder (or Asperger’s syndrome)
- Rett syndrome
- Childhood disintegrative disorder

- Pervasive developmental disorder
- Related disorders not otherwise specified

CHP members diagnosed with an ASD by a licensed physician or psychologist are eligible for:

- Behavioral health treatments
- Psychiatric care
- Psychological care
- Medical care provided by a licensed health care provider
- Therapeutic care, even if deemed habilitative or nonrestorative
    - Covered and may be provided in the member's home, an office or the community
    - Pharmacy care
    - Assistive communication devices
        - Covered when ordered or prescribed by a licensed physician or psychologist for members unable to communicate through speech or in writing
        - Communication boards and speech-generating devices may be rented or purchased and are subject to prior approval
        - Dedicated communication devices are not useful to a person in absence of communication impairment; laptops, desktops and tablet computers are not covered items, but the software and/or applications enabling them to function as a speech-generating device are covered under the Durable Medical Equipment benefit; use the Precertification Lookup tool on our website for specific requirements

The maximum applied behavioral health analysis benefit is $45,000 per calendar year.

Comprehensive Psychiatric Emergency Program (CPEP)
This licensed, hospital-based psychiatric emergency program establishes a primary entry point to the mental health system for individuals who may be mentally ill to receive emergency observation, evaluation, care and treatment in a safe and comfortable environment. Emergency visit services include provision of triage and screening, assessment, treatment, stabilization and referral, or diversion to an appropriate program. Brief emergency visits require a psychiatric diagnostic examination and may result in further CPEP evaluation or treatment activities, or discharge from the CPEP program. Full emergency visits, which result in a CPEP admission and treatment plan, must include a psychiatric diagnostic examination, psychosocial assessment and medication examination. Brief and full emergency visit services are reimbursable through Medicaid.

CPEP Crisis Intervention is one of four program components which, when provided together, form the OMH licensed Comprehensive Psychiatric Emergency Program (CPEP), and the code to which the license is issued. The other program components of the CPEP are:

- CPEP Extended Observation Beds (1920): Beds operated by the Comprehensive Psychiatric Emergency program, which are usually located in or adjacent to the CPEP emergency room, are available 24 hours a day, seven days a week to provide extended assessment and evaluation.
- CPEP Crisis Outreach: A mobile crisis intervention component of the CPEP offering crisis outreach and interim crisis service visits to individuals outside an emergency room

setting; the setting can be in the community in natural (for example, homes), structured (for example, residential programs), or controlled (for example, instructional) environments.
- CPEP Crisis Beds: A residential (24 hour/day) stabilization component of the CPEP, which provides supportive services for acute symptom reduction and the restoration of patients to a precrisis level of functioning.

The following services **do not** require prior authorization:
- ER services, crisis services and a CPEP
    - While there is no medical necessity review completed for ER or CPEP, providers are encouraged to notify Highmark BCBS to assist with discharge planning.
- Initial assessments and most outpatient clinic services
- Most outpatient mental health (OMH) and substance use disorder (SUD) services
- For opioid treatment (methadone maintenance), only notification is required.

Continued Day Treatment
A continuing day treatment program shall provide active treatment and rehabilitation designed to maintain or enhance current levels of functioning and skills, maintain community living, and develop self-awareness and self-esteem through the exploration and development of patient strengths and interests. A continuing day treatment program shall provide the following services: assessment and treatment planning, discharge planning, medication therapy, medication education, case management, health screening and referral, psychiatric rehabilitation readiness development, psychiatric rehabilitation readiness determination, and referral and symptom management.

Partial Hospitalization
A partial hospitalization program shall provide active treatment designed to stabilize and ameliorate acute symptoms, serve as an alternative to inpatient hospitalization, or reduce the length of a hospital stay within a medically supervised program. A partial hospitalization program shall provide the following services: assessment and treatment planning, health screening and referral, symptom management, medication therapy, medication education, verbal therapy, case management, psychiatric rehabilitation readiness determination and referral, crisis intervention services, activity therapy, discharge planning, and clinical support services.

Intensive Psychiatric Rehabilitation Treatment (IPRT)
The Intensive psychiatric rehabilitation treatment program is designed to assist persons in forming and achieving mutually agreed upon goals in living, learning, working and social environments with intervention, using psychiatric rehabilitation technologies to overcome functional disabilities and improve environmental supports.

Outpatient Mental Health
Refers to periodic visits to a psychiatrist or other behavioral health practitioner for consultation in his or her office, or at a community-based outpatient clinic for mental health treatment.

Outpatient Drug and Alcohol
Refers to assistance for individuals who suffer from chemical abuse or dependence and their family members and/or significant others. This includes outpatient rehabilitation services, which are designed to serve individuals with more chronic conditions who have inadequate support systems and either have substantial deficits in functional skills or health care needs requiring attention or monitoring by health care staff.

Personalized Recovery-Oriented Services (PROS)
PROS is a comprehensive recovery-oriented program for individuals with severe and persistent mental illness. The goal of the program is to integrate treatment, support and rehabilitation in a manner that facilitates the individual's recovery. Goals for individuals in the program are to: improve functioning, reduce inpatient utilization, reduce emergency services, reduce contact with the criminal justice system, increase employment, attain higher levels of education and secure preferred housing. A Limited License PROS program provides only ongoing rehabilitation and support and intensive rehabilitative services.

Assertive Community Treatment (ACT) Teams
ACT teams provide mobile intensive treatment and support to people with psychiatric disabilities. The focus is on improving an individual's quality of life in the community and reducing the need for inpatient care by providing person-centered, intense community-based treatment services by an interdisciplinary team of mental health professionals. Building on the successful components of the Intensive Case Management (ICM) program, the ACT program has low staff-outpatient ratios; 24/7 availability; enrollment of consumers and flexible service dollars. Treatment is focused on individuals who have been unsuccessful in traditional forms of treatment.

Intensive Case Management/Supportive Case Management
Intensive case management (ICM) promotes optimal health and wellness for adults diagnosed with severe mental illness and children diagnosed with severe emotional disorders. Wellness and recovery goals are attained by implementing a person-centered approach to service delivery and ensuring linkages to and coordination of essential community resources. With respect to and affirmation of recipients' personal choices, case managers foster hope where there was little before. Case managers work in partnership with recipients to advance the process of individuals gaining control over their lives and expanding opportunities for engagement in their communities. All case management programs are organized around goals aimed at providing access to services that encourage people to:

- Resolve problems that interfere with their attainment or maintenance of independence or self-sufficiency
- Maintain themselves in the community rather than in an institution

Health Home Care Coordination and Management
Health home care managers provide comprehensive, integrated medical and behavioral health care management to Medicaid-enrolled adults with chronic conditions to ensure access to appropriate services, improve health outcomes, prevent hospitalizations and emergency room visits, and avoid unnecessary care. HHCM services include person-centered, recovery-focused care plans that may include health promotion; transitional care, including appropriate

follow-up from inpatient to other settings; patient and family support; and referral to community and social support services.

Inpatient Psychiatric Services - Inpatient Hospital Stay to Treat Psychiatric Disorders SUD Services
Participant-centered inpatient services consistent with the beneficiary's assessed treatment needs, with a rehabilitation and recovery focus designed to promote skills for coping with and managing psychiatric and SUD symptoms and behaviors.

Medically Supervised Outpatient Withdrawal

- **Outpatient SUD services (OASAS BH solo/group practice)**: Outpatient services include participant-centered services consistent with the individual's assessed treatment needs with a rehabilitation and recovery focus designed to promote skills for coping with and managing symptoms and behaviors associated with substance use disorders. These services are designed to help individuals achieve and maintain recovery from SUDs. Services should address an individual's major lifestyle and attitudinal/behavioral problems that have the potential to undermine the goals of treatment. Outpatient services are delivered on an individual, family or group basis in a wide variety of settings, including site-based facility, in the community or in the individual's place of residence.
    - These services may be provided on site or on a mobile basis as defined by the New York State Office of Alcoholism and Substance Abuse Services (OASAS).
- **Opioid treatment program (OPT) — methadone maintenance**: OTPs are federally regulated programs that include direct administration of daily medication (opioid agonists: methadone or buprenorphine or antagonists following a successful agonist taper: naltrexone and injectable (Vivitrol) as well as a highly structured psychosocial program that addresses major lifestyle and attitudinal/behavioral issues that could undermine recovery-oriented goals. The participant does not have a prescription for the methadone or buprenorphine, but receives daily medication from the OTP.

Rehabilitation Services for Residential SUD Treatment Supports (OASAS Service)
In this setting, medical staff is available in the residence. However, it is not staffed with 24-hour medical/nursing services. This setting provides medical and clinical services including: medical evaluation, ongoing medication management and limited medical intervention, medication-assisted substance use treatment when medically necessary, psychiatric evaluation and ongoing management, group, individual and family counseling focused on rehabilitation and increasing coping skills until the patient is able to manage feelings, urges and cravings, and co-occurring psychiatric symptoms and medical conditions within the community. The treatment includes at least 30 hours of structured treatment of which at least 10 hours are individual, group or family counseling. Programs are characterized by their reliance on the treatment community as a therapeutic agent. It is also to promote abstinence from substance use and interpersonal behaviors to effect a global change in participants' lifestyles, attitudes, and values. Individuals typically have multiple functional deficits, which may include substance-related disorders, criminal activity, psychological problems, impaired functioning and disaffiliation from mainstream values. Level-of-Care Alcohol and Drug Treatment Referral (LOCADTR) criteria are used to determine level of care.

Rehabilitation Services for Residents of Community Residences (Year 2 – OMH Service)
Refers to service-enriched, licensed, extended-stay housing with on-site services for individuals who want private living units but who have minimal self-maintenance and socialization skills. Living units are usually designed as studio apartments or as suites with single bedrooms around shared living spaces. A CR/SRO must maintain 24-hour front desk security and make services available (for example, case management, life skills training, etc.).

Rehabilitation

- **Psychosocial Rehabilitation**: PSR services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their behavioral health condition (that is, SUD and/or mental health). Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's Recovery Plan. The intent of PSR is to restore the individual's functional level to the fullest possible (that is, enhancing SUD resilience factors), and as necessary for integration of the individual as an active and productive member of his or her family.
- **Crisis Intervention**: Crisis intervention services are provided as part of a comprehensive specialized psychiatric services program available to all Medicaid-eligible adults with significant functional impairments meeting the need levels in the 1915(i)-like authority resulting from an identified mental health or co-occurring diagnosis. Crisis Intervention services are provided to a person who is experiencing or is at imminent risk of having a psychiatric crisis and are designed to interrupt and/or ameliorate a crisis, including a preliminary assessment, immediate crisis resolution and de-escalation. Services will be geared toward preventing the occurrence of similar events in the future and keeping the person as connected as possible with the environment/activities. The goals of Crisis Intervention services are engagement, symptom reduction and stabilization. All activities must occur within the context of a potential or actual psychiatric crisis.

Eye Care and Low-Vision Services
For a list of providers, please contact **866-231-0847** or visit **www.bcbswny.com/stateplans**. The vision benefit allows for an exam by a participating optometrist once every 24 months or as medically necessary. Standard eyeglasses may be obtained once every two years or as medically necessary when the optometrist prescribes them for the member. Our members can pay as private customers for nonstandard lenses, which are not covered.

Coverage for contact lenses and low-vision aids are limited to specific medically appropriate conditions. No referral is necessary for optometry visits. A member who is diagnosed with diabetes is eligible for an annual dilated eye (retinal) examination.

Members are financially responsible for upgrades of frames and/or lenses not medically necessary (for example, personal preference upgrades).

Optometry services are also provided by Article 28 clinics affiliated with the College of Optometry of the State University of New York. Enrollees may access optometry services directly without prior approval and without regard to network participation.

CHPlus — Eye Care and Low-Vision Services: The CHPlus vision benefit is as described above, except vision examinations and eyeglasses are covered every 12 months. Eyeglasses may be obtained once every 24 months unless otherwise justified as medically necessary.

Hearing Services
Hearing evaluations, diagnostic tests and selective amplification procedures necessary to certify an individual for a hearing aid device, hearing aids and repair services are included. Hearing aid services are available by PCP referral to participating providers. Hearing aid batteries are also included as part of this benefit.

Ambulatory Rehabilitation Therapies
Physical, occupational and speech therapy are covered for the reduction of disability and the restoration of best functional level. Precertification is required for these services. Limitations apply based on line of business. Refer to “Therapy” under the *Other Covered Services* section below.

Durable Medical Equipment, Prosthetics/Orthotics
Durable medical equipment (DME) is defined as devices and equipment in the home (other than medical/surgical supplies, enteral formula, and prosthetic or orthotic appliances) for repeated use for the purpose of aiding in treating illness and improving the function of a body part.

- DME and rehabilitative equipment require precertification.
- Coverage includes all items listed on the NYS Fee Schedule.
- Coverage includes equipment servicing but excludes disposable medical supplies.
- DME is not indicated in the absence of illness or injury.
- Orthotic devices are those which are used to support a weak or deformed body or to restrict or eliminate motion in a diseased or injured part of the body.
- Prosthetic appliances are those appliances and devices ordered by a qualified practitioner that replace any missing part of the body.
- This benefit also includes software or computer applications, allowing devices to generate speech for CHP members diagnosed with ASDs; it does not cover the devices (for example, laptops, tablets or desktop computers) themselves.

Enteral Formula and Nutritional Supplements
Enteral formula and nutritional supplements are covered for:

- Children who have metabolic or absorption disorders
- Children who require medical formulas due to mitigating factors in growth and development.
- Individuals who have rare, inborn metabolic disorders
- Tube-fed individuals who cannot chew or swallow

Enteral formula and nutrition supplements will only be covered under the DME benefit. It requires prior authorization and must be obtained through a DME provider rather than a pharmacy.

Laboratory, Diagnostic and Radiology Services

Only participating laboratories and radiology services may be authorized by the PCP. A referral form is required. Participating laboratory testing sites providing services must have a permit issued by the NYSDOH *and* a Clinical Laboratory Improvement Act (CLIA) identification number in addition to one of the following: a CLIA certificate of waiver, a Physician-Performed Microscopy Procedures (PPMP) certificate or a certificate of registration. Those laboratories with certificates of waiver or a PPMP certificate may perform only those specific tests permitted under the terms of the waiver. Laboratories with certificates of registration may perform a full range of laboratory tests for which they have been certified. Physicians providing laboratory testing may perform only those specific limited laboratory procedures identified in the *Physician's Medicaid Management Information Systems* (MMIS) manual. Radiology services include the provision of diagnostic radiology, diagnostic ultrasound, nuclear medicine, radiation oncology and MRI. These services may only be performed upon the order of a qualified medical professional, including dentists. Refer to the Precertification Lookup Tool online, as these services may require precertification and clinical review.

Note: Mammograms do not require precertification.

Podiatry Services

Services include routine foot care when the enrollee's physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot or when performed as a necessary and integral part of the treatment of diabetes, ulcers and infections.

Covered podiatry services exclude routine foot care, the treatment of corns and calluses, nail trimming and other foot-related hygienic care in the absence of a pathological condition, unless precertified.

Private Duty Nursing Services

Private duty nursing services must be provided in the home and are covered only if authorized as medically necessary by the PCP and upon precertification from us. Private duty nursing is a noncovered benefit for CHP members. Custodial care is not covered by the plan.

Dental Services — Healthplex of New York, Inc.

Dental care for members will be handled through Healthplex. Healthplex will assign your patient to a primary care dentist who will be responsible for all of their general dental needs. This includes checkups, cleanings, routine fillings, extractions and referrals for necessary specialty care. Dental procedures requiring anesthesia and/or planned inpatient admissions or services at an outpatient ambulatory center must first be approved by Healthplex. Upon completion of treatment, all facility and anesthesia charges must be billed separately to us. For benefit information, contact the Healthplex Provider Hotline at **888-468-2183**.

Emergent and Nonemergent Transportation: Medical Answering Services, LLC (MAS)
In an emergency, members are instructed to call **911**. Emergency transportation by air or ambulance is covered without precertification for all members. Planned air transportation (airplane or helicopter) requires precertification.

We and the state of New York partner with MAS to coordinate nonemergency transportation appointments and provide routine transportation to our members in New York. Contact MAS regarding transportation needs for our members in your care. Members can work directly with MAS to ensure they fulfill their scheduled, nonemergent appointments.
Medicaid Managed Care: Emergency and nonemergency transportation services are provided by MAS and covered by regular Medicaid. To arrange nonemergency transportation for a member, you or the member should call MAS at **866-932-7740**. If possible, call MAS at least **three days** before the medical appointment and provide:

- Member's Medicaid identification number (that is, AB12345C)
- Member's appointment date and time
- Name and address of the provider the member is seeing

For more information, you may also visit their website at **https://www.medanswering.com**.
For county-specific phone numbers, call:

- Allegany County: **866-271-0564**
- Cattaraugus County: **866-371-4751**
- Chautauqua County: **855-733-9405**
- Erie County: **800-651-7040**
- Orleans County: **866-260-2305**
- Wyoming County: **855-733-9403**

The enrollee may have to pay for any service that includes:

- Noncovered services
- Unauthorized services
- Services provided by nonparticipating providers

Pharmacy Services
Highmark BCBS has contracted with Express Scripts (ESI) as our pharmacy benefits manager for Medicaid Managed Care and CHPlus members. CHPlus members should obtain their prescription/nonprescription drugs through the appropriate Highmark BCBS preferred drug list. See the Pharmacy section under Highmark BCBS covered benefits for more details.

Our pharmacy benefit covers medically necessary medications from licensed prescribers for the purpose of saving lives in emergency situations or during short-term illness, sustaining life in chronic or long-term illness, or limiting the need for hospitalization. Please note certain medication requires prior authorization. Our members have access to most national pharmacy chains and many independent retail pharmacies. Our pharmacy network consists of over 200 pharmacies in Allegany, Cattaraugus, Chautauqua, Erie, Orleans and Wyoming counties. It includes CVS Pharmacy, Rite Aid, Tops Pharmacy, Wegmans Pharmacy, and national chains and independent retailers throughout the state.

We have contracted with Express Scripts as our pharmacy benefits manager for all members. All members must use a Highmark BCBS network pharmacy when filling prescriptions in order for benefits to be covered. To locate a network pharmacy, go to: **www.express-scripts.com/wnypharmacysearch**.

For specialty drugs, please refer to the Specialty Drug Program section below.

Monthly Limits
All prescriptions are limited to a maximum 30-day supply per fill.

Covered Drugs
Our pharmacy program uses a *Preferred Drug List (PDL)*, a list of preferred drugs within the most commonly prescribed therapeutic categories. The *PDL* is comprised of drug products reviewed and approved by our Pharmacy and Therapeutics (P&T) committee. The P&T committee is comprised of network physicians, pharmacists and other health care professionals who evaluate safety, efficacy, adverse effects, outcomes and total pharmacoeconomic value for each drug product reviewed. Over-the-counter (OTC) medications specified in the NYS Medicaid plan are included in the *PDL* and are covered if prescribed by a physician.

The *PDL* is posted on our provider self-service site. For a hard copy, contact the Pharmacy department at **866-231-0847**.

The following are examples of the covered items:

- Legend drugs
- Insulin
- Disposable insulin needles/syringes
- Disposable blood/urine and glucose/acetone testing agents
- Lancets and lancet devices
- Compounded medication of which at least one ingredient is a legend drug and listed on the Highmark BCBS *PDL*
- Any other drug listed on the Highmark BCBS *PDL* which, under applicable state law, may only be dispensed upon the written prescription of a physician or other lawful prescriber
- *PDL*-listed legend contraceptives may be dispensed up to a 90-day supply

Prior Authorization Drugs
We strongly encourage you to write prescriptions for preferred products as listed on the appropriate *PDL*. If, for medical reasons, a member cannot use a preferred product, you're required to contact Pharmacy Services to obtain prior authorization (PA).

PA may be requested by calling Provider Services at **866-231-0847**. Be prepared to provide relevant clinical information regarding the member's need for a nonpreferred product or a medication requiring PA. Decisions are based on medical necessity and are determined according to certain established medical criteria.

Please use the appropriate telephone number, as outlined above, to obtain a *Prior Authorization Form*. A *Prior Authorization Form* can also be found on our website at **www.bcbswny.com/stateplans**.

Over-the-Counter (OTC) Drugs
We have an OTC medication benefit. Our members may obtain a prescription for OTC or nonlegend drugs. The following are examples of OTC medication classes covered. Please refer to our *PDL* for a list of covered items.

- Analgesics/antipyretics
- Antacids
- Antibacterials, topical
- Antidiarrheals
- Antiemetics
- Antifungals, topical
- Antifungals, vaginal
- Antihistamines
- Contraceptives
- Cough and cold preparations
- Decongestants
- Laxatives
- Pediculocides
- Respiratory agents (including spacing devices)
- Topical anti-inflammatories

Excluded Drugs
The following drugs are examples of medications that are **excluded** from the pharmacy benefit:

- Weight control products (except Alli)
- Anti-wrinkle agents (for example, Renova)
- Drugs used for cosmetic reasons or hair growth
- Experimental or investigational drugs
- Growth hormones used for idiopathic short stature (ISS)
- Drugs used for experimental or investigational indication
- Immunizing agents – except influenza vaccine, pneumococcal vaccine and Synagis
- Infertility medications
- Implantable drugs and devices (Norplant, Mirena IUD)
- Erectile dysfunction drugs to treat impotence
- Nonlegend drugs other than those listed above or specifically listed covered nonlegend drugs

Specialty Drug Program
For legacy Highmark BCBS members, we have contracted with Accredo to be our Preferred Specialty Pharmacy Vendor for high-cost, specialty/injectable drugs that treat a number of chronic or rare conditions. To schedule delivery for specialty medications, you can contact Accredo at **800-803-2523**.

The list of approved specialty pharmacy providers is subject to changes.

Whether you call in your order or fax in the form, you must also call or fax in a valid New York state prescription to the pharmacy you have chosen.

Certain medical injectables require prior authorization. To determine whether the medical injectable you are prescribing requires prior authorization, please refer to the Precertification Lookup tool online at
www.bcbswny.com/stateplans.

Nurse Practitioner Services

Nurse practitioners may provide preventive services, diagnose illness and physical conditions and perform therapeutic and corrective measures. A nurse practitioner must have a collaborative agreement and practice protocols with a licensed physician in accordance with the requirements of the NYS Department of Education. A certified nurse practitioner may be used as a PCP.

Other Covered Services

Therapy

Occupational, physical and speech rehabilitation services rendered for the purpose of maximum reduction of physical or mental disability and restoration of the member to his or her best functional level are covered. Rehabilitation services include care and services rendered by occupational therapists, physical therapists and speech-language pathologists.

Coverage of outpatient physical, occupational and speech therapies for Medicaid Managed Care and Highmark BCBS members are limited to 20 visits per service type per calendar year except for children younger than 21 years of age, members with developmental disabilities and those with brain injuries. Precertification is not required for outpatient therapy services.

Midwife Services

These services apply to the health care management of mothers and newborns throughout the maternity cycle (normal pregnancy, childbirth and the immediate postpartum period of six weeks) and to primary preventive reproductive health care as specified in a written practice agreement, including newborn evaluation, resuscitation and referral for infants. Prenatal and postpartum care may be provided in a hospital on an inpatient basis or outpatient basis, in a diagnostic and treatment center, in the office of the midwife or collaborating physician, or in the member’s home, as appropriate. Deliveries must take place in a hospital setting. The certified nurse midwife must be licensed in accordance with the current NYS rules and regulations governing a midwifery practice.

Refer to your individual contract for further details on covered services related to capitation or inclusive agreements.

Hearing Aid Services

Hearing aid devices furnished to alleviate disability caused by the loss or impairment of hearing.

Court-Ordered Services
We will provide any benefit package services to members as ordered by a court of competent jurisdiction, regardless of whether such services are provided by participating providers within the plan or by a nonparticipating provider in compliance with such court order. We will reimburse the nonparticipating provider at the Medicaid fee schedule. We're responsible for court-ordered services to the extent that such court-ordered services are covered by and reimbursable by Medicaid.

Federally Qualified Health Center Services
Services provided by a federally qualified health center (FQHC) in accordance with care delivery policies and coverage as outlined in this manual.

Prescription Footwear
The prescription footwear benefit covers the following:

- Orthopedic footwear required by children under 21
- Shoes attached to a lower-limb orthotic brace
- Footwear that is a component of a comprehensive diabetic treatment plan to treat amputation, ulcerations, preulcerative calluses, peripheral neuropathy with evidence of callous formation, foot deformities or poor circulation

Compression Stockings
Specific gradient compression stockings are covered when prescribed:

- As treatment for open venous ulcers
- For pregnant members

Smoking Cessation Counseling (SCC)
SCC is now a covered benefit for all enrollees who smoke. Each Medicaid Managed Care member is allowed eight counseling sessions during any 12 continuous months, which must be provided on a face-to-face basis. SCC complements the use of prescription and nonprescription smoking cessation products. These products are also covered by Medicaid.

Blood Lead Screening
Providers will furnish a screening program for the presence of lead toxicity in pregnant women and children that consists of a screening and blood test. During every well-child visit for children between the ages of 6 months and 6 years old, the PCP will screen each child for lead poisoning. A blood test will be performed at 12 months and 24 months of age to determine lead exposure and toxicity. In addition, children over the age of 24 months up to 72 months should receive a blood lead screening if there is not a past record of a test. Individual and group private practices must be certified as Physician Office Laboratories (POLs); facilities must be registered as Limited Services Laboratories (LSLs) to be authorized to conduct blood lead testing onsite and receive reimbursement. LSLs and POLs must bill the health plan for in-office lead testing using CPT-4 procedure code 83655. Reimbursement will be in accordance with agreements between the provider and the health plan.

Outpatient Laboratory and Radiology Services
All outpatient laboratory tests, except for CLIA-approved office tests, should be performed at a network facility outpatient lab or at one of the Highmark BCBS preferred network labs (LabCorp or Quest Diagnostics). Visit the CMS website at **www.cms.hhs.gov** for a complete list of approved accreditation organizations under CLIA.

Noncovered Services
The following services are not covered:

- Certain noncovered behavioral health services
- Certain noncovered mental health services
- Certain rehabilitation services provided to residents of the Office of Mental Health licensed community residences and family-based treatment programs
- Office of Mental Retardation Developmental Disabilities services
- The following pharmacy services:
    - Hemophilia blood factors for TANF, CHPlus members
    - Hemophilia blood factors, risperidone microspheres (Risperdal Consta), paliperidone palmitate (Invega Sustenna) and olanzapine (Zyprexa Relprevv) for SSI members
- Preschool supportive health services
- School supportive health services
- Comprehensive Medicaid case management

Infertility services are not covered by Highmark BCBS (also stated under the Excluded Drugs Section) or by FFS Medicaid.

Note: The coverage of any experimental procedures or experimental medications is determined on a case-by-case basis.

New Baby, New Life℠ Program
New Baby, New Life is a proactive case management program for all expectant mothers and their newborns. It identifies pregnant women as early in their pregnancies as possible through review of state enrollment files, claims data, lab reports, hospital census reports, provider notification of pregnancy and delivery notification forms, and self-referrals. Once pregnant members are identified, we act quickly to assess obstetrical risk and ensure appropriate levels of care and case management services to mitigate risk.

Experienced case managers work with members and providers to establish a care plan for our highest risk pregnant members. Case managers collaborate with community agencies to ensure mothers have access to necessary services, including transportation, WIC, home-visitor programs, breastfeeding support and counseling. When it comes to our pregnant members, we are committed to keeping both mom and baby healthy.

All identified pregnant women receive:

- Individualized, one-on-one case management support for women at the highest risk.
- Care coordination for moms who may need a little extra support.
- Educational materials and information on community resources.

- Rewards to keep up with prenatal and postpartum checkups and well-child visits after the baby is born.

As part of the New Baby, New Life program, members are also offered the My Advocate™ program. This program provides pregnant women proactive, culturally appropriate outreach and education through interactive voice response (IVR), text or smart phone application. This program does not replace the high-touch case management approach for high-risk pregnant women; however, it does serve as a supplementary tool to extend our health education reach. The goal of the expanded outreach is to identify pregnant women who have become high-risk, to facilitate connections between them and our case managers and improve member and baby outcomes. Eligible members receive regular calls with tailored content from a voice personality (Mary Beth). For more information on My Advocate visit **https://myadvocatehelps.com**.

You and Your Baby in the NICU

For parents with infants admitted to the neonatal intensive care unit (NICU), we offer the You and Your Baby in the NICU program. Parents receive education and support so they're involved in the care of their babies, visit the NICU, interact with hospital care providers and prepare for discharge. Parents are provided with an educational resource outlining successful strategies they may deploy to collaborate with the care team.

Notification at **866-231-0847** is required at the first prenatal visit. You can also arrange to notify the health plan directly on a weekly basis. Ask your Provider Relations representative how to get started.

Self-Referral Services

The following services do not need a referral from a PCP:

- Emergency care (regardless of network status with Highmark BCBS)
- Family planning (Medicaid Managed Care members have free access to either network or non-network FFS providers. CHPlus members have direct access to network providers)
- Behavioral health assessments (nonparticipating providers must seek prior approval from Highmark BCBS)
- OB care (nonparticipating providers must seek prior approval from Highmark BCBS)
- Well-woman/GYN care (nonparticipating providers must seek prior approval from Highmark BCBS)
- EPSDT/well-child (nonparticipating providers must seek prior approval from Highmark BCBS)
- Tuberculosis, STD, HIV/AIDS testing and counseling services (regardless of network status with Highmark BCBS)

Restricted Recipient Program

Highmark BCBS and the other MCOs in New York are responsible for managing members in the state's Restricted Recipient Program (RRP) for enrollees who have been identified as abusing the Medicaid system in some way.

These members will have one or more of the following restrictions in place:

- Primary medical provider (this can be a physician, physician group or clinic)
- Primary pharmacy (an additional pharmacy can be added if the member needs a specialty item available only at said pharmacy)

- Primary hospital provider
- Primary dental provider (may be a dental clinic or a dentist)
- Primary DME provider
- Primary podiatrist (rarely used)

Who is a Restricted Recipient?
Enrollees are identified as restricted recipients if they have demonstrated a pattern of abusing or misusing covered services. Some of the members may be restricted for engaging in fraudulent or unwarranted pharmacy utilization. Restricted recipients may be enrolled in TANF, SSI and within a New York Medicaid program. Enrollees may be restricted to one or more RRP providers for receipt of medically necessary services included in the benefit package.

For example, if a restricted recipient has excessive visits with multiple primary care providers, the restricted recipient will be assigned to one primary care provider for a determined time frame. **A member may have more than one restriction.**

Restricted Recipients and Continuity of Care
We will manage the member's restriction. Highmark BCBS restricts the member to the PCP, pharmacy or provider and duration of the restriction.

For members receiving services from nonparticipating providers, Highmark BCBS will authorize continued visits for the 60-day provision. Members will then be transitioned and restricted to an in-network provider.

Members will have access to providers outside the specific provider restriction type. The member's PCP will manage his or her care and provide referrals as appropriate.

Please note: Restrictions can be placed by an MCO such as Highmark BCBS or the Office of the Medicaid Inspector General; therefore, Highmark BCBS providers must check EPACES prior to rendering services to verify eligibility and identify any restriction a member may have.

Member Rights and Responsibilities
Members have rights and responsibilities when participating with an MCO. Our Member Services representatives serve as advocates for Highmark BCBS members. The following lists the rights and responsibilities of members.

Members have the right to:

- Be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status or sexual orientation. If you have any questions or concerns about this right, call **866-231-0847** or visit **www.bcbswny.com/stateplans**.
- Be told where, when and how to get the services they need from Highmark BCBS.
- Be told by their PCP what is wrong, what can be done for them and what will likely be the result, in a language they understand.
- Get a second opinion about their care.

- Give their approval to any treatment or plan for their care after that plan has been fully explained to them.
- Refuse care and be told what the risks are if they refuse care.
- Get a copy of their medical records, talk about it with their PCP and ask that their medical record be amended or corrected, if needed.
- Be sure their medical records are private and will not be shared with anyone except as required by law, contract or with their approval.
- Get a copy of the Notice of Privacy Practices that explains patient rights on Protected Health Information (PHI) and the responsibility of Highmark BCBS to protect PHI. This includes the right to know how Highmark BCBS handles, uses and gives out PHI.

- PHI is defined by HIPAA Privacy Regulations as information that:
  - Identifies a member or can be used to identify a member.
  - Comes from a member or has been created or received by a health care provider, a health plan, employer or a health care clearinghouse.
  - Has to do with physical or mental health condition, providing health care to a member, or paying for providing health care to a member.
- Use the Highmark BCBS complaint system to settle any complaints or to complain to the NYSDOH or the local Department of Social Services anytime a member feels he or she has not been treated fairly.
- Use the state fair hearing system (except for CHPlus members).
- File an action appeal as a result of Highmark BCBS denying a service authorization request from a member or their doctor.
- Appoint someone (relative, friend, lawyer, etc.) to speak for them if they are unable to speak for themselves about their care and treatment or if they simply want someone else to speak for them.
- Have access to a PCP or a backup PCP 24 hours a day, 365 days a year for urgent care; this information is on their Highmark BCBS member ID card.
- Choose a PCP, choose a new PCP and have privacy during a visit with a health care provider.
- Be referred to a non-network provider if Highmark BCBS does not have an appropriately trained provider in our network.
- Receive needed medical services within a reasonable amount of time.
- Take part in making decisions about their health care with their health care provider.
- Receive information on available treatment options and alternatives, regardless of cost or benefit coverage.
- Receive considerate, respectful care in a clean, safe environment free of unnecessary restraints.
- Choose any of our Highmark BCBS network specialists after getting a referral from their PCP.
- Be referred to specialists who are experienced in treating disabilities, if needed.
- Receive information about Highmark BCBS, its services, policies and procedures, providers, member rights and responsibilities, and any changes made.

- Know about all benefits and medical services available from Highmark BCBS.
- Request information about the plan, including clinical review criteria used by the plan in a utilization review decision on a specific disease or condition.
- Get a current directory of providers within the Highmark BCBS network.
- Know how Highmark BCBS pays providers so members know if there are financial incentives or disincentives tied to medical decisions.
- Decide ahead of time the kind of care they want if they become sick, injured or seriously ill by making a living will.
- If younger than age 18, expect they will be able to participate in and make decisions about their own and their child's health care if they are married.
- Continue as members of Highmark BCBS despite their health status or need for care.
- Call our 24/7 NurseLine toll free at **866-231-0847**.
- Call our Member Services department toll free at **866-231-0847** from 8:30 a.m. to 6 p.m. ET Monday through Friday (except for state holidays).
- Discuss questions they may have about their medical care or services with Highmark BCBS by calling Member Services at **866-231-0847**.
- Get help from someone who speaks their language.
- Make suggestions about the Highmark BCBS member rights and responsibilities policy.

Members have the responsibility to:

- Learn about how their health care plans work.
- Carry their Highmark BCBS ID cards at all times; members should report any lost or stolen cards to Highmark BCBS immediately and contact Highmark BCBS if card information is wrong or if their name, address or marital status changes.
- Show their ID cards to providers and tell Highmark BCBS about any providers they are currently seeing.
- Work with their PCPs to guard and improve their health.
- Give Highmark BCBS and their PCPs the information they need to take care of their medical needs.
- Listen to advice from their PCPs and ask questions when they are in doubt.
- Know and get involved in their health care; members should talk with their PCPs about recommended treatment and follow the plans and instructions for care agreed upon.
- Get information and understand their health problems and consider treatments so they can participate in developing mutually agreed upon treatment goals before services are performed.
- Call or go back to their PCPs if they do not get better.
- Ask for a second opinion.
- Treat health care staff with the same respect the member expects.
- Tell Highmark BCBS if they have problems with any health care staff by calling Member Services.
- Keep their appointments; if they must cancel, call as soon as they can.
- Only use emergency rooms for true emergencies.

- Receive their covered, nonemergency medical services from Highmark BCBS providers.
- Call their PCPs when they need medical care, even if it is after office hours.
- Get PCP referrals before they go to or take their children to a hospital or a specialist (except for emergencies and self-referral services).
- Know how to take their medicines the right way.
- Be responsible for copays as described in their member handbook.
- Be aware that refusing the treatment suggested by their providers may have serious consequences for their health or the health of their children.
- Inform their PCPs about their health or the health of their children.
- Authorize PCPs to get copies of their medical records and those of their children.
- Learn about and follow Highmark BCBS health plan membership rules.
- Clearly state their complaints or concerns.

BEHAVIORAL HEALTH SERVICES

Overview

The Highmark BCBS Behavioral Health program was created to manage the needs of members seeking treatment for substance abuse and mental health problems. Each member's treatment should be individualized and focused on improving the member's overall well-being. This should involve coordination of care with the member's PCP, other treating providers and referrals for community support services when necessary. Members do not need a referral from their PCP to access behavioral health services; however, the PCP should actively engage in identifying the need for behavioral health services for their patients and remain involved in treatment planning for all patients with behavioral health issues. If a member is using a behavioral health clinic that also provides primary care services, the member may select the lead provider to be his or her PCP. Providers must use the Level-of-Care for Alcohol and Drug Treatment Referral (LOCADTR) 3 assessment tool for level-of-care determination or Office of Alcoholism and Substance Abuse Services (OASAS). For all mental health services, Wellpoint Partnership Plan, LLC on behalf of Highmark Blue Cross Blue Shield medical necessity criteria will be used to assess medical necessity. For all substance use services, state approved LOCADTR 3 criteria will be used.

PCPs must actively collaborate and maintain documentation of these efforts with behavioral health practitioners when:

- The PCP is prescribing psychotropic medication.
- A medical condition exists that complicates a behavioral condition.
- There is a potential for adverse reaction between prescribed medications.
- The treating psychiatrist is prescribing a psychotropic medication that requires medical monitoring.

Collaboration is strongly encouraged to provide optimal care and successfully identify and ensure the safety of the patient. Without collaboration, members may remain untreated if PCPs do not recognize members at risk for, or with, active mental or addictive disorders. Effective working relationships between providers and other treatment partners and service sites will result in improved continuity and coordination of care, increased member satisfaction and higher quality, efficiency and effectiveness of services. All collaboration efforts should be documented in the medical record.

Behavioral health care practitioners should communicate with the member's PCP:

- For the exchange of clinical information, when necessary, that may aid in diagnosis and/or treatment
- When the PCP's support for a treatment plan would enhance member satisfaction and/or compliance
- When there are possible medical comorbidities and/or medication interactions that need to be considered
- When the PCP has requested immediate feedback

Highmark BCBS will be conducting annual site visits at select providers' offices to provide education and to perform a chart review to verify that collaboration of care and clinical documentation is occurring.

Behavioral Health Prior Authorization
Many behavioral health services do not require prior authorization but do require either notification or concurrent reviews. The following services require prior authorization after January 1, 2017:

- All inpatient services
- All residential services
- Community day treatment
- PROS
- ACT
- Partial hospitalization
- Intensive outpatient treatment
- Psychological and neuropsychological testing
- Intensive psychiatric rehabilitation
- Some rehabilitation services
- Some outpatient services
- Applied behavior analysis (ABA) services (CHPlus)

Services will be authorized based on medical necessity. Highmark BCBS case managers will assist providers with linking members to lower levels of care when a member is ready for discharge. If a member is ready for discharge and an alternate level has been identified, the provider is expected to discharge the member. In the event the discharge does not happen, a denial may be issued after the doctor reviews.

The following services **do not** require prior authorization:

- ER services, crisis services and a CPEP
    - While there is no medical necessity review completed for ER or CPEP, providers are encouraged to notify Highmark BCBS to assist with discharge planning.
- Initial assessments and some outpatient clinic services
- Some outpatient mental health (OMH) and substance use disorder (SUD) services
- Opioid treatment (methadone maintenance) –notification only

The following table provides guidance for OMH Clinical Standards of Care and OASAS Clinical Guidance:

Service	**Prior authorization required?**	**Concurrent review authorization**	**Additional guidance**
Outpatient mental health office and clinic services including: initial assessment; psychosocial assessment; and	No	Yes	

individual, family/collateral and group psychotherapy			
Outpatient mental health office and clinic services: psychiatric assessment; medication treatment	No	No	
Outpatient mental health office and clinic services: off-site clinic services	Yes	Yes	OMH will issue further guidance regarding off-site clinic services.
Psychological or neuropsychological testing	Yes	N/A	
Personalized recovery-oriented services (PROS) preadmission status	No	No	Begins with initial visit and ends when an initial service recommendation (ISR) is submitted to the plan. Providers bill the monthly preadmission rate, but add-ons are not allowed. Preadmission is open-ended with no time limit.
PROS admission: individualized recovery planning	Yes	No	Admission begins when ISR is approved by the plan. The initial individualized recovery plan (IRP) must be developed within 60 days of the admission date. Upon admission, providers may offer additional services and bill add-on rates accordingly for: • Clinical treatment; • Intensive rehabilitation (IR); or • Ongoing rehabilitation and supports (ORS) Prior authorization will ensure individuals are not receiving duplicate services from other clinical providers.
PROS active rehabilitation	Yes	Yes	Begins when the IRP is approved by the plan. Concurrent review and authorizations should occur at 3-month intervals for IR and ORS services and at 6-month intervals for clinic treatment and base/community rehabilitation and support (CRS).

Mental health continuing day treatment (CDT)	Yes	Yes	
Mental health intensive outpatient (*Note: not state plan*)	Yes	Yes	
Mental health partial hospitalization	Yes	Yes	
Assertive community treatment (ACT)	Yes	Yes	New ACT referrals must be made through local single point of access (SPOA) agencies. The plan will collaborate with SPOA agencies around determinations of eligibility and appropriateness for ACT following forthcoming NYS guidelines.
OASAS-certified part 822 clinic services, including off-site clinic services	No	Yes	See OASAS guidance regarding use of LOCADTR tool to inform level of care determinations. OASAS encourages plans to identify individual or program service patterns that fall outside of expected clinical practice but will not permit regular requests for treatment plan updates for otherwise routine outpatient and opioid service utilization (30-50 visits per year are within an average expected frequency for OASAS clinic visits). The contractor will allow enrollees to make unlimited self-referrals for SUD assessment from participating providers without requiring prior authorization or referral from the enrollee's PCP.
Medically supervised outpatient substance withdrawal	No	Yes	Notification through a completed LOCADTR report for admissions to this service may be required within a reasonable time frame.
OASAS-certified part 822 opioid treatment program (OTP) services	No	Yes	OASAS encourages plans to identify individual or program service patterns that fall outside of expected clinical practice but will not permit regular requests for treatment plan updates for otherwise routine outpatient and opioid service utilization (150-200 visits per year are within an average expected frequency for opioid treatment clinic visits). The contractor will allow enrollees to make unlimited self-referrals for SUD

			assessment from participating providers without requiring prior authorization or referral from the enrollee's PCP.
OASAS-certified part 822 outpatient rehabilitation	Notification only	Yes	Plans may require notification through a completed LOCADTR report for admissions to this service within a reasonable time frame. The contractor will allow enrollees to make unlimited self-referrals for SUD assessment from participating providers without requiring prior authorization or referral from the enrollee's PCP.

Emergency Pharmacy Protocols
Except where otherwise prohibited by law, for members with a behavioral health condition we will:

- Allow immediate access, without prior authorization, to a 72-hour emergency supply of a prescribed drug or medication when the member experiences an emergency condition, as defined within this manual.
- Immediately authorize a seven-day supply of a prescribed drug or medication associated with the management of opioid withdrawal and/or stabilization.

For additional information regarding Pharmacy covered services, please see Chapter 5 of this manual.

Member Services
Member Services is available Monday to Friday, 8:30 a.m. to 6 p.m. ET. After 6 p.m., providers can call and get authorizations for inpatient behavioral health services. Members can also call, and our clinicians are available to assess and direct members to the needed supports.

Behavioral Health Access and Availability
All providers are expected to meet the federal and state accessibility standards and those defined in the Americans with Disabilities Act (ADA) of 1990. Health care services provided through Highmark BCBS must be accessible to all members.

Highmark BCBS is dedicated to arranging access to care for our members. Highmark BCBS's ability to provide quality access depends upon the accessibility of network providers. Providers are required to adhere to the following access standards:

Appointment type	Appointment standard
Emergent or emergency visits	Immediately upon presentation
Urgent visits	Within 24 hours of request or sooner as clinically indicated
Nonurgent symptomatic visits	Within 48 to 72 hours of request or sooner as clinically indicated
Routine nonurgent, preventive appointments	Within four weeks of request or sooner, as clinically indicated

Appointment type	Appointment standard
Specialist referrals (not urgent)	Within four to six weeks of request
Adult baseline, routine physicals	Within 12 weeks from enrollment
Well-child care visit	Within four weeks of request
Initial family planning visit	Within two weeks of request
Pursuant to an emergency or hospital discharge, mental health or substance follow-up visits with a participating provider (as included in the benefit package)	Within five days of request or as clinically indicated
Nonurgent mental health or substance abuse visits with a participating provider (as included in the benefit package)	Within two weeks of request
Initial PCP office visit for newborns	Within two weeks of hospital discharge
Provider visits to make health, mental health and substance abuse assessments for the purpose of making recommendations regarding a recipient's ability to perform work when requested by an LDSS	Within 10 days of request by a Highmark BCBS member
For CPEP, inpatient mental health, inpatient detoxification SUD services and crisis intervention services	Immediately upon presentation at a service delivery site
Urgently needed SUD inpatient rehabilitation services, stabilization treatment services in OASAS-certified residential setting and mental health or SUD outpatient clinics, assertive community treatment (ACT) personalized recovery oriented services (PROS) and opioid treatment programs	Within 24 hours of request
Behavioral health specialist referrals (nonurgent): CDT, IPRT, and rehabilitation services for residential SUD treatment services PROS programs other than clinic services	Within two to four weeks of request Within two weeks of request
Following an emergency, hospital discharge or release from incarceration, if known, follow-up visits with a behavioral health participating provider (as included in the benefit package)	Within five days of request or as clinically indicated.
Nonurgent mental health or SUD with a participating provider that is a mental health and/or SUD outpatient clinic, including a PROS with clinical treatment	Within one week of request
Short-term and intensive crisis respite	Within 24 hours of request
Psychosocial rehabilitation, community psychiatric support and treatment, habilitation services, family support and training	Within two weeks of request (unless appointment is pursuant to an emergency, hospital discharge or

Appointment type	Appointment standard
	release from incarceration – within five days of request)
Education and employment support services	Within two weeks of request
Peer support services	Within one week of request (unless appointment is pursuant to emergency or hospital discharge, in which case the standard is five days; if peer support services are needed urgently for symptom management, the standard is 24 hours.)

Behavioral Health Case Management
Highmark BCBS offers case management services. Providers can refer members who may benefit from case management to Highmark BCBS. Typically, members who are in case management are those members who have complex needs or are in need of community supports to support their plan of care. If a member is in need of case management and is enrolled in a Health Home, the plan will link the member to the Health Home or will work with the provider to ensure this happens. Members who are experiencing homelessness, are restricted, have had their first break (FEP), are transitioning from foster care or aging out of the children's system (TAY) are some of the members who are offered case management services. Providers are expected to link these members who have complex needs to supports. If the provider is unable to link a member to these supports directly, the provider is expected to reach out to the health plan to ensure member needs are met.

The plan expects providers to work with Health Homes if a member is enrolled with a Health Home. If there are challenges, the plan will coordinate with the provider and the Health Home as needed. Some examples when this type of coordination should occur are when a member is discharged from an IP stay and when there are gaps in a member’s care.

The plan of care is expected to be person-centered, strength-based and recovery-focused, and is expected to take member’s wishes and choices into consideration. The health plan will work with Health Homes to collaborate and support them to improve member outcomes.

Behavioral Health Credentialing
Highmark BCBS credentials OMH- and OASAS-licensed providers. We will accept OMH and OASAS licenses and certifications in place of any credentialing process for individual employees, subcontractors or agents of such providers. The provider shall collect, and will accept, program integrity-related information as part of the licensing and certification process.

We require all OMH- and OASAS-licensed providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

Highmark BCBS requires that such providers do not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

For additional information regarding the credentialing process, please see Chapter 11 of this manual.

Behavioral Health Quality Management

We maintain a comprehensive Behavioral Health Quality Management program to objectively monitor and systematically evaluate the care and service provided to members. The scope and content of the program reflects the demographic and epidemiological needs of the population served. Members and providers have opportunities to make recommendations for areas of improvement.

The plan's Utilization and Quality Management program description and work plan speaks to the Utilization Management and Quality Management activities that the plan focuses on for the year. The work plan activities, including those by the Behavioral Health Quality Management committee, are monitored and reported to the Medical Advisory and Quality Management committees. Providers, peer specialists and members are part of the committees and guide and provide feedback on our activities.

Quality Services

Highmark BCBS encourages all of our providers to review the clinical practice guidelines the plan develops and posts on our website. Highmark BCBS follows behavioral health guidelines recommended by the American Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP). When developing or updating our behavioral health clinical practice guidelines, Highmark BCBS uses the following sources:

- Substance and Mental Health Services Administration (SAMHSA)
- National Institute of Mental Health (NIMH)
- American Society of Addiction Medicine
- National Institute on Drug Abuse
- National Alliance of Mental Illness
- United States Department of Health and Human Services

Highmark BCBS applies current, relevant and researched recommendations across the states we serve. We disseminate and monitor fidelity to clinical practice guidelines through our ongoing care management process and peer-to-peer engagement with providers. Through this process, care managers:

- Assess whether a member's care meets clinical practice guidelines and then address concerns with providers.
- Engage providers to access CPGs on the provider website and in newsletters.
- Discuss specific guidelines with providers and Health Homes.
- Host periodic, topic-specific provider webinars to address identified trends.
- Maintain ongoing contact with members, their families, caregivers, treating providers and Health Homes to monitor progress and refine the plan of care.
- Deliver and monitor interventions to meet care plan goals and share member progress toward achieving those goals.

Highmark BCBS enlists all providers to participate in our care planning process. During this process, our care manager engages the member's PCP and any other treating providers by calling them to gather information on the member's history and health care needs and solicit input into the care plan. Our care managers maintain communication and collaboration with the member's PCP, other active specialty providers, and other members of the health care team to assess progress in meeting care plan goals.

Providers are encouraged to use existing training resources such as web-based evidence-based practice training available through New York's Center for Practice Innovations (CPI) at Columbia University.
Trainings can be completed by Highmark BCBS on these guidelines when requested by the provider. PCPs should screen for behavioral health conditions (screening tools are posted on our website), and members should be linked to in-network behavioral health providers.

Highmark BCBS expects providers to support the state and Highmark BCBS on transforming the behavioral health system. Providers are expected to adopt and offer services that are person-centered and recovery-focused. Providers are expected to follow the evidenced-based practice for First Episode Psychosis for members who experience their first break.

Providers are required to develop policies and procedures that cover the following topics and assure confidentiality of mental health and substance use-related information. The policies and procedures must include:

- Initial and annual in-service education of staff, contractors
- Identification of staff allowed access and limits of access
- Procedure to limit access to trained staff (including contractors)
- Protocol for secure storage (including electronic storage)
- Procedures for handling requests for behavioral health and substance use information protocols to protect persons with behavioral health and/or substance use disorder from discrimination
- Members who present for unscheduled nonurgent care, with the aim of promoting enrollee access to appropriate care

We are required to submit a quarterly report of any deficiencies in performance and corrective action taken to OMH and OASAS, with respect to OMH- and OASAS-licensed, certified or designated providers. Highmark BCBS will report any serious or significant health and safety concerns to OMH and OASAS immediately upon discovery.

Behavioral Health Claims

Electronic Claims Submission

Providers have the option to submit claims electronically with these payer IDs:

- Emdeon: 27514
- Capario: 28804
- Availity: 2637

To initiate the electronic claims submission process or obtain additional information, please contact the EDI Hotline at **800-470-9630**. If filing electronically, check the confirmation reports for acceptance of the claim you receive from your EDI or practice management vendor.

Paper Claims Submission

Providers also have the option of submitting paper claims. Highmark BCBS uses optical character reading (OCR) technology as part of our front-end claims processing procedures. To use OCR technology, claims must be submitted on original red claim forms (not black and white or photocopied forms), and laser printed or typed (not handwritten) in a large, dark font. You must submit a properly completed *UB-04* or *CMS-1500* (current form) within 90 days from the date of service.

Highmark BCBS cannot accept claims with alterations to billing information. Claims that have been altered will be returned with an explanation of the reason for the return. We will not accept entirely handwritten claims. Paper claims must be submitted within 90 days of the date of service and submitted to the following address:
Highmark Blue Cross Blue Shield
New York Claims
P.O. Box 62509
Virginia Beach, VA 23466-2509

Facility claims must be submitted with the following:

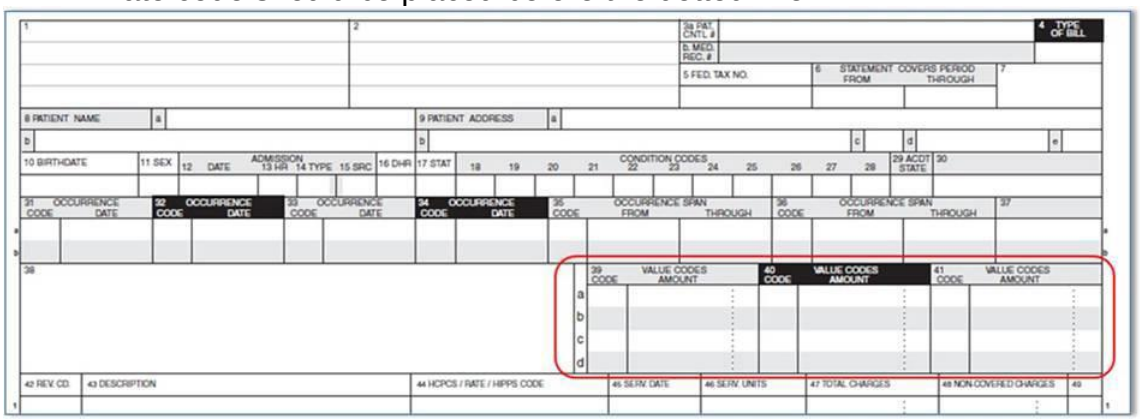
- Form type for Medicare and Medicaid: UB-04 submission
- Valid value code, if applicable
- Valid rate code, if applicable
- Valid revenue code
- Valid CPT code
- Valid diagnosis code that falls within the mental health category
- Bill type, which must be 731 for initial claims or 737 for corrected claims

Individual/group practice claims must be submitted with the following:

- Form type for Medicare and Medicaid: *UB-1500* submission
- Valid CPT code

Placement of value and rate codes:

- Value code is 24 (39a.)
- Rate code should be placed before the dotted line



Rejected and Denied Claims
Providers will receive a notice if a claim is rejected or denied. A rejected claim is a claim that does not enter the adjudication system due to missing or incorrect information. A denied claim is a claim that goes through the adjudication process but is denied for payment.

Routine Claim Inquiries
Highmark BCBS's Provider Experience Program ensures provider claim inquiries are handled efficiently and in a timely manner. Calls are handled by a specially trained call agent in Provider Services. Providers may call **866-231-0847** for claims inquiries.

Electronic Remittance Advices (ERA) and Electronic Funds Transfers (EFT)
If you sign up for ERA/EFT, you can:

- Start receiving ERAs and import the information directly into your patient management or patient accounting system.
- Route EFTs to the bank account of your choice.
- Create your own custom reports within your office.
- Access reports 24/7.

Behavioral Health Denials, Grievances and Appeals
All denial, grievance and appeal decisions are conducted by a peer and are subject to specific behavioral health requirements, including:

- A physician board-certified in general psychiatry at the plan reviews all inpatient level of care denials for psychiatric treatment
- A physician certified in addiction treatment reviews all inpatient level of care denials for SUD treatment

Highmark BCBS will not deny coverage of an ongoing course of care unless an appropriate provider of alternate level care is approved. **For additional information on the denial, grievance and appeals processes, please see Chapter 9 of this manual.**

MEMBER MANAGEMENT SUPPORT

Welcome Call

As part of our member management strategy, we offer a welcome call to new members. During the welcome call, new members who have been identified through their health risk assessment as possibly needing additional services are educated regarding the health plan and available services. Additionally, Member Services representatives offer to assist the member with any current needs, such as scheduling an initial checkup, assisting new members whose health care provider is not a member of the network and requesting to continue an ongoing course of treatment with the member's current provider. Circumstances would include if the member has:

- A life-threatening disease or condition or a degenerative and disabling disease or condition (the transitional period is up to 60 days).
- Entered the second trimester of pregnancy at the effective date of enrollment (the transitional period includes provision of postpartum care related to the delivery).

Appointment Scheduling

Highmark BCBS, through our participating providers, ensures members have access to primary care services for routine, urgent and emergency services and to specialty care services for chronic and complex care. Providers will respond to a Highmark BCBS member's needs and requests in a timely manner. The PCP should make every effort to schedule Highmark BCBS members for appointments using the guidelines outlined in the PCP Access and Availability section of this manual.

24/7 NurseLine

The Highmark BCBS 24/7 NurseLine is a service designed to support the provider by offering information and education about medical conditions, health care and prevention to members after normal physician practice hours. The 24/7 NurseLine provides triage services and helps direct members to appropriate levels of care. The Highmark BCBS 24/7 NurseLine telephone number is **866-231-0847** and is listed on the member's ID card. This ensures members have an additional avenue of access to health care information when needed. Features of the 24/7 NurseLine include:

- Constant availability — 24 hours a day, 7 days a week
- Access to information based upon nationally recognized and accepted guidelines
- Free translation services for 200 different languages and for members with difficulty hearing
- Education for members about appropriate alternatives for handling nonemergent medical conditions
- Provider updates — A nurse faxes the member's assessment report to the provider's office within 24 hours of the call

Emergency Behavioral Health Calls

When a member in crisis contacts Highmark BCBS using the toll-free number, the member may bypass the prompts and be connected directly to a call center agent. The member in crisis is then connected to the first available behavioral health agent. If the member does not choose this option, the member has the option to select the type of assistance needed – either physical or behavioral health. If the member chooses the physical health option and the Member Services agent determines the member may be in crisis, the call is then transferred to a Behavioral Health agent.

The Behavioral Health agent will determine if the call is a true crisis situation. In the event it is a crisis, the call is transferred to a licensed clinician to handle the call. The member is kept on the phone until a clinician comes on the line. The clinician engages the member and based on the discussion, the clinician may determine the member needs to be screened at the emergency room. If the clinician makes the determination that the member needs to be screened, the clinician will obtain the assistance of a backup clinician or agent to assist with the call to 911 while the clinician keeps the member on the phone until emergency services arrive to assist the member.

The clinician who services the call will document the call and contact the health plan case manager, or the case management manager if the member is in Case Management, for further assistance. This allows the member to receive additional follow-up and services as needed to prevent future crisis situations.

Crisis calls are handled the same way during normal business hours, after-hours and weekends. All crisis calls are answered by a live person.

Interpreter Services

Interpreter services are available for our members if needed. Contact your Provider Relations representative for details.

Health Promotion

Highmark BCBS strives to improve healthy behaviors, reduce illness and improve the quality of life for our members through comprehensive programs. Educational materials are developed or purchased and disseminated to our members, and health education classes are coordinated with community organizations and network providers who are contracted with Highmark BCBS.

Highmark BCBS manages projects that offer our members education and information regarding their health. Ongoing projects include:

- Member newsletter
- Creation and distribution of *Health Tips*, the Highmark BCBS health education tool used to inform members of health promotion issues and topics
- Health Tips on Hold (educational telephone messages while the member is on hold)
- Development of health education curricula and procurement of other health education tools (for example, breast self-exam cards)
- Relationship development with community-based organizations to enhance opportunities for members

Health Home

A Health Home is a care management service model whereby all of a patient's caregivers communicate with one another so that all needs are addressed in a comprehensive manner. This is done primarily through a dedicated care manager who oversees and provides access to all of the services the patient needs to ensure he or she receives everything necessary to stay healthy, out of the emergency room and out of the hospital. Health records are shared (either electronically or on paper) among providers so that services are not duplicated or neglected. The Health Home services are provided through a network of organizations — providers, health plans and community-based organizations. When all the services are considered collectively, they become a virtual Health Home.

New York state (NYS), following CMS approval, initiated a Health Home program for Medicaid members with chronic medical and behavioral conditions. Health home eligibility criteria requires members to have one or more of the following:

- Two or more chronic conditions (for example, mental health condition, substance use disorder, asthma, diabetes, heart disease, BMI over 25 or other chronic conditions)
- HIV/AIDS as a single qualifying condition
- One serious mental illness

Case Management

Case management is designed to proactively respond to a member's needs when conditions or diagnoses require care and treatment for long periods of time. When a member is identified (usually through precertification, admission review and/or provider or member request), the case manager (a Highmark BCBS nurse or social worker) helps to identify medically appropriate alternative methods or settings in which care may be delivered.

A provider, on behalf of the member, may request participation in the program. The case manager will work with the member, provider and/or hospital to identify the necessary:

- Intensity level of case management services needed
- Appropriate alternate settings where care may be delivered
- Health care services required
- Equipment and/or supplies required
- Community-based services available
- Communication required (that is, between member and PCP)

The Highmark BCBS case manager will assist the member, Utilization Review team and PCP and/or hospital in developing the discharge plan of care, ensuring the member's medical needs are met and linking the member with community resources and Highmark BCBS programs for outpatient case and/or disease management. Highmark BCBS case managers are available from 8 a.m. to 5 p.m. ET. For more information regarding case management services or to refer a member, contact Provider Services at **866-231-0847**.

A member or a member designee can request case management services by calling Member Services at **866-231-0847**.

Disease Management Centralized Care Unit

The Highmark BCBS Disease Management Centralized Care Unit (DMCCU) is based on a system of coordinated care management interventions and communications designed to assist physicians and other health care professionals in managing members with chronic conditions. DMCCU services include a holistic, member-centric care management approach that allows care managers to focus on multiple needs of members. Our disease management programs include:

- Asthma
- Bipolar disorder
- Chronic obstructive pulmonary disease
- Coronary artery disease
- Congestive heart failure
- Diabetes

- HIV/AIDS
- Hypertension
- Major depressive disorder
- Schizophrenia
- Substance use disorder

In addition to these condition-specific programs, our member-centric, holistic approach allows us to assist members with managing their weight. DMCCU also offers smoking cessation services.

Program features include:

- Proactive population identification processes
- Evidence-based national practice guidelines
- Collaborative practice models to include physician and support-service providers in treatment planning for members
- Continuous patient self-management education, including primary prevention, behavior modification programs and compliance/surveillance, as well as home visits and case management for high-risk members
- Ongoing process and outcomes measurement, evaluation and management
- Ongoing communication with providers regarding patient status

The Highmark BCBS disease management programs are based on nationally approved evidence-based clinical practice guidelines located at **www.bcbswny.com/stateplans**. To view these guidelines, simply log in to the secure site by entering your username and password and select the **Clinical Practice Guidelines** link from the *Clinical Policy and Guidelines* section on the top navigation menu. You can print a copy of the guidelines right from the site, or you can request a hard copy by calling Provider Services at **866-231-0847**.

Who is Eligible?

All Highmark BCBS members with the above diagnoses are eligible for DMCCU services. Members are identified through continuous case finding efforts to include but not be limited to case finding welcome calls, claims-mining and referrals. Providers can also refer patients who can benefit from additional education and care management support. Members identified for participation in any of the programs are assessed and stratified based on the severity of their diseases. Once enrolled in a program, the member is provided with continuous education on self-management concepts, which include primary prevention, behavior modification, and compliance/surveillance, as well as care management for high-risk members. Program evaluation outcome measurement and process improvement are built into all the programs. Providers are given updates regarding patient status and progress.

DMCCU Provider Rights and Responsibilities

The provider has the right to:

- Have information about Highmark BCBS services, its staff's qualifications and any contractual relationships.

- Decline to participate in or work with Highmark BCBS programs and services for their patients, if the client's contract allows.
- Be informed of how Highmark BCBS coordinates interventions and treatment plans for individual patients.
- Know how to contact the person responsible for managing and communicating with the provider's patients.
- Be supported by the organization when interacting with patients to make decisions about their health care.
- Receive courteous and respectful treatment from Highmark BCBS staff.
- Communicate complaints to Highmark BCBS.

Hours of Operation
Highmark BCBS care managers are licensed nurses/social workers and are available from 8:30 a.m. to 5:30 p.m. ET, Monday through Friday. Confidential voicemail is available 24 hours a day. The 24/7 NurseLine is available for our members 24 hours a day, 7 days a week.

Contact Information
You can call a DMCCU team member at **888-830-4300**. Members and providers can find out more about our DMCCU programs by visiting **www.bcbswny.com/stateplans**. Printed copies of the content are available upon request.

Health Education Advisory Committee
The health education advisory committee provides advice to Highmark BCBS regarding health education and outreach-related program development. The committee strives to ensure materials and programs meet cultural competency requirements and are both understandable to the member and address the member's health education needs.

The health education advisory committee's responsibilities are to:

- Identify health education needs of the membership based on review of demographic and epidemiologic data.
- Identify cultural values and beliefs that must be considered in developing a culturally competent health education program.
- Assist in the review, development, implementation and evaluation of the member health education tools for the outreach program.
- Review the health education plan and make recommendations on health education strategies.

Women, Infants and Children Program
The mission of the Division of Women, Infants and Children (WIC) Services in the Bureau of Maternal and Child Health is to provide leadership that assures the health and well-being of women, infants and children.

The WIC program impacts the health of mothers and children in the medically needy population. Optimal nutritional status during pregnancy and early childhood provides the best chance for the future of New York residents. For more information, please visit **www.health.state.ny.us/prevention/nutrition/wic**. Network providers are expected to coordinate with the WIC program. Coordination includes referring potentially eligible women, infants and children and reporting appropriate medical information to the WIC program.

PROVIDER RESPONSIBILITIES

Medical Home

The PCP is the foundation of the medical home, responsible for providing, managing and coordinating all aspects of the member's medical care and providing all care that is within the scope of his or her practice. The PCP is responsible for coordinating member care with specialists and conferring and collaborating with the specialists, using a collaborative concept known as a medical home.

Highmark BCBS promotes the medical home concept to all of our members. The PCP is the member and family's initial contact point when accessing health care. The PCP, member and member's family — together with the health care practitioners within the medical home and the extended network of consultants and specialists with whom the medical home works — have an ongoing and collaborative contractual relationship. The providers in the medical home are knowledgeable about the member and family's special, health-related social and educational needs and are connected to necessary resources in the community that will assist the family in meeting those needs. When a member is referred for a consultation or specialty/hospital services or health and health-related services by the PCP through the medical home, the medical home provider maintains the primary relationship with the member and family. He or she keeps abreast of the current status of the member and family through a planned feedback mechanism with the PCP who receives them into the medical home for continuing primary medical care and preventive health services.

Responsibilities of the PCP

The PCP is a network physician who has the responsibility for the complete care of his or her members, whether providing it himself or herself or by referral to the appropriate provider of care within the network. Federally qualified health centers (FQHCs) and rural health clinics (RHCs) may be included as PCPs.

The PCP shall:

- Manage the medical and health care needs of members, including monitoring and following up on care provided by other providers (including FFS).
- Coordinate referrals to specialists and FFS providers (both in- and out-of-network); and maintain a medical record of all services rendered by the PCP and other providers.
- Provide 24-hour-a-day, 7-day-a-week coverage; regular hours of operation should be clearly defined and communicated to members.
- Provide services ethically and legally, provide all services in a culturally competent manner and meet the unique needs of members with special health care needs.
- Participate in any system established by Highmark BCBS to facilitate the sharing of records, subject to applicable confidentiality and HIPAA requirements.
- Make provisions to communicate in the language or fashion primarily used by his or her membership.
- Participate and cooperate with Highmark BCBS in any reasonable internal and external quality assurance, utilization review, continuing education and other similar programs established by Highmark BCBS.
- Participate in and cooperate with the Highmark BCBS complaint and grievance procedures (Highmark BCBS will notify the PCP of any member grievance).

- Not balance-bill members; however, the PCP is entitled to collect applicable copayments, coinsurance or permitted deductibles for certain services.
- Continue care in progress during and after termination of his or her contract for up to 90 days until a continuity-of-care plan is in place to transition the member to another provider or through 60 days postpartum care for pregnant members in accordance with applicable state laws and regulations.
- Comply with all applicable federal and state laws regarding the confidentiality of patient records
- Develop and have an exposure control plan in compliance with Occupational Safety and Health Administration standards regarding blood-borne pathogens.
- Establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act.
- Support, cooperate and comply with the Highmark BCBS Quality Improvement Program initiatives and any related policies and procedures and provide quality care in a cost-effective and reasonable manner.
- Inform Highmark BCBS if a member objects to provisions of any counseling, treatments or referral services for religious reasons.
- Treat all members with respect and dignity.
- Provide members with appropriate privacy and treat member disclosures and records confidentially, giving the members the opportunity to approve or refuse their release.
- Provide members with complete information concerning their diagnosis, evaluation, treatment and prognosis and give members the opportunity to participate in decisions involving their health care. Except when contraindicated for medical reasons, the information will be made available to an appropriate person acting on the member's behalf.
- Advise members about their health status, medical care or treatment options, regardless of whether benefits for such care are provided under the program, and advise members on treatments that may be self-administered.
- When clinically indicated, contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings.
- Have a policy and procedure to ensure proper identification, handling, transport, treatment and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection.
- Agree to maintain communication with the appropriate agencies such as local police, social services agencies and poison control centers to provide high-quality patient care.
- Agree that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention as part of the clinical research shall be clearly contrasted with entries regarding the provision of non-research-related care.

Note: Highmark BCBS does not cover the use of any experimental procedures or experimental medications except under certain preauthorized circumstances.

PCP Access and Availability

All providers are expected to meet the federal and state accessibility standards and those defined in the Americans with Disabilities Act (ADA) of 1990. Health care services provided through Highmark BCBS must be accessible to all members.

Highmark BCBS is dedicated to arranging access to care for our members. The ability of Highmark BCBS to provide quality access depends upon the accessibility of network providers. Providers are required to adhere to the following access standards:

Appointment Type	Appointment Standard
Emergent or emergency visits	Immediately upon presentation
Urgent visits	Within 24 hours of request or sooner as clinically indicated
Nonurgent symptomatic visits	Within 48 to 72 hours of request or sooner as clinically indicated
Routine nonurgent, preventive appointments	Within four weeks of request or sooner, as clinically indicated
Specialist referrals (not urgent)	Within four to six weeks of request
Adult baseline, routine physicals	Within 12 weeks from enrollment
Well-child care visit	Within four weeks of request
Initial family planning visit	Within two weeks of request
Pursuant to an emergency or hospital discharge, mental health or substance follow-up visits with a participating provider (as included in the benefit package)	Within five days of request or as clinically indicated
Nonurgent mental health or substance abuse visits with a participating provider (as included in the benefit package)	Within two weeks of request
Initial PCP office visit for newborns	Within two weeks of hospital discharge
Provider visits to make health, mental health and substance abuse assessments for the purpose of making recommendations regarding a recipient's ability to perform work when requested by an LDSS	Within 10 days of request by a Highmark BCBS member

Initial Prenatal Visit	Appointment Standard
First trimester	Within three weeks
Second trimester	Within two weeks
Third trimester	Within one week

Office Waiting Time	Appointment Standard
Routine scheduled appointments	No longer than one hour past scheduled appointment time
Walk-in for nonurgent needs	Within two hours of presentation to the office
Walk-in for urgent needs	Within one hour of presentation to the office or as clinically indicated

24-Hour Access to PCP and OB-GYN (After Hours)	Appointment Standard

Call/contact with service/office representative	Enrollees must have access to an after-hours live voice for PCP and OB/GYN emergency consultation and care (if the provider uses an answering machine, the message must direct the enrollee to a live voice).

Providers may not use discriminatory practices such as preference to other insured or private pay patients and/or separate waiting rooms or appointment days.

Highmark BCBS will routinely monitor providers' adherence to the access to care standards.

To ensure continuous 24-hour coverage, PCPs must maintain one of the following arrangements for their members to contact the PCP after normal business hours:

- Have the office telephones answered after-hours by an answering service, which can contact the PCP or another designated network medical practitioner. Have the office telephone answered after normal business hours by a recording in the language of each of the major population groups served by the PCP, directing the member to call another number to reach the PCP, or another provider designated by the PCP. Someone must be available to answer the designated provider's telephone; another recording is not acceptable.
- Have the office telephone transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or a designated Highmark BCBS network medical practitioner.

The following telephone answering procedures are not acceptable:

- Office telephone is only answered during office hours.
- Office telephone is answered after hours by a recording that tells members to leave a message.
- Office telephone is answered after hours by a recording which directs members to go to an emergency room for any services needed.

Appointment Access and Availability Studies

NYSDOH requires Highmark BCBS to conduct access and availability studies quarterly to ensure appointment and access standards are met. A random sample is periodically selected from our provider network. Highmark BCBS staff place calls to the selected providers' offices both during and after hours to ensure our members (your patients) may access care within state-mandated guidelines.

Highmark BCBS always studies and records the results of the study at the end of the call. A passing score denotes the office has met or exceeded the standard for a particular appointment type or after-hours coverage. In the event a provider fails to meet the established guidelines at the time of the study (meaning the appointment was not scheduled within the prescribed time), Highmark BCBS issues a written notice. The notice requests a written explanation of the provider's policy on 24-hour coverage and appointment availability, as well as a plan of correction addressing the specific measure(s) failed. Highmark BCBS reviews the correction plan and resurveys the provider for compliance within two months. If a provider is

found to be noncompliant on the second survey, the provider's panel is immediately closed to new members. A plan of correction is requested, and a third survey is conducted. Failure of the third compliance survey results in the immediate termination of the provider.

PCP Panel Capacity

Physicians operating as PCPs within the Highmark BCBS provider network may not have more than 1,500 members assigned to their panels. Highmark BCBS monitors our provider network monthly to ensure no practice location exceeds the aforementioned limit. When a physician reaches 1,250 members, a letter is sent to the physician advising him or her of the 1,500-patient threshold.

A physician who employs a registered physician assistant (PA) or a certified nurse practitioner (NP) is able to increase his or her panel threshold to 2,400 patients. The physician should alert Highmark BCBS of the presence of a PA or an NP at the time of credentialing via the standard application. If the PA or NP is employed after the initial credentialing date, the physician must notify Highmark BCBS by letter.

NPs acting as PCPs are able to service a panel of 1,000 members. The same procedure applies for panel capacity, except that the practitioner is notified when his or her panel reaches 750 members. **An NP is not able to increase panel capacity by employing a PA.**

Member Missed Appointments

Highmark BCBS members may sometimes cancel or not appear for necessary appointments and fail to reschedule the appointment. This can be detrimental to their health. Highmark BCBS requires providers to attempt to contact members who have not shown up for or canceled an appointment without rescheduling the appointment. The contact must be by telephone and should be designed to educate the member about the importance of keeping appointments and to encourage the member to reschedule the appointment.

Highmark BCBS members who frequently cancel or fail to show up for an appointment without rescheduling the appointment may need additional education in appropriate methods of accessing care. In these cases, please call your Provider Relations representative. Highmark BCBS staff will contact the member and provide more extensive education and/or case management as appropriate. Our goal is for members to recognize the importance of maintaining preventive health visits and to adhere to a plan of care recommended by their PCP.

Noncompliant Highmark BCBS Members

Highmark BCBS recognizes providers may need help in managing nonadherent members. If you have an issue with a member regarding behavior, treatment cooperation and/or completion of treatment and/or making or appearing for appointments, please contact Provider Services at **866-231-0847**.

Highmark BCBS will contact the member by telephone, or a Highmark BCBS representative will visit the member to provide the education and counseling to address the situation. We will report the outcome of any counseling efforts to you.

PCP Transfers
To maintain continuity of care, Highmark BCBS encourages members to remain with their PCP. However, members may request to change their PCP for any reason by contacting Member Services at **866-231-0847**. The member's name will be provided to the PCP on the membership roster.

Members can call to request a PCP change any day of the month. PCP change requests will be processed generally on the same day or by the next business day. Members will receive a new ID card within 10 days.

Note: Members who have been placed on a PCP restriction can change PCP without cause every three months.

Continuity of Care (Provider Termination)
Continuity of care (provider termination) applies in its entirety to all programs, including CHPlus and Medicaid Managed Care products.

If a provider leaves the network for reasons other than a determination of fraud, imminent harm to patient care or a final disciplinary action by a state licensing board that impairs the health professional's ability to practice, Highmark BCBS will permit a member to continue an ongoing course of treatment with that provider under the following circumstances:

- If the member has a life-threatening, disabling or degenerative condition, a rare disease, or is in an ongoing course of treatment, he or she may see the provider for 90 days from when the provider's contract expires.
- If the member is in the second or third trimester of pregnancy, she may see the provider for all prenatal, delivery and postpartum care directly related to the pregnancy.

In all cases, the provider must agree to Highmark BCBS policies, procedures and reimbursement rates.

Highmark BCBS will immediately remove any provider from the network who is unable to provide health care services due to final disciplinary action. Medicaid Managed Care providers who are sanctioned by the DOH's Medicaid program will be excluded from participation in the Highmark BCBS Medicaid panel.

Covering Physicians
During a provider's absence or unavailability, the provider needs to arrange for coverage for his or her members. The provider will either make arrangements with:

- One or more network providers to provide care for his or her members
- Another similarly licensed and qualified provider who has appropriate medical staff privileges at the same network hospital or medical group, as applicable, to provide care to the members in question

In addition, the covering provider will agree to the terms and conditions of the Network Provider Agreement, including, without limitation, any applicable limitations on compensation, billing and participation. Providers will be solely responsible for a non-network provider's adherence to such provisions. Providers will be solely responsible for any fees or monies due

and owed to any non-network provider, providing substitute coverage to a member on the provider's behalf.

Specialists as PCPs

Under certain circumstances, when a member requires the regular care of a specialist, a specialist may be approved by Highmark BCBS to serve as a member's PCP. The criteria for a specialist to serve as a member's PCP include the member having a chronic, life-threatening illness or condition of such complexity whereby:

- The need for multiple hospitalizations exists.
- The majority of care needs to be given by a specialist.
- The administrative requirements arranging for care exceed the capacity of the nonspecialist PCP; this includes members with complex neurological disabilities, chronic pulmonary disorders, HIV/AIDS, complex hematology/oncology conditions, cystic fibrosis, etc.

The specialist must meet the requirements for PCP participation (including contractual obligations and credentialing), provide access to care 24 hours a day, 7 days a week and coordinate the member's treatment plan, including preventive care along with the member's PCP and Highmark BCBS. When such a need is identified, the member or specialist must contact the Highmark BCBS Case Management department and complete a *Specialist as PCP Request* form. A Highmark BCBS case manager will review the request and submit it to the Highmark BCBS medical director. Highmark BCBS will notify the member and the provider of our determination in writing within 30 days of receiving the request. Should Highmark BCBS deny the request, Highmark BCBS will provide written notification to the member and provider outlining the reason(s) for the denial of the request within one day of the decision. If the specialist or other health care provider needed to provide ongoing care for a specific condition is not available in the Highmark BCBS network, the referring physician will request authorization from Highmark BCBS for services outside the network.

The referral must be approved by Highmark BCBS and will be made pursuant to an approved treatment plan approved by Highmark BCBS, the member's PCP and nonparticipating physician. The member may not use a nonparticipating specialist unless there is no specialist in the network that can provide the requested treatment. Specialists serving as PCPs will continue to be paid FFS while serving as the member's PCP. The designation cannot be retroactive.

Members may self-refer for unlimited behavioral health and substance use assessments (except for Assertive Community Treatment [ACT], inpatient psychiatric hospitalization, partial hospitalization and HCBS services). Visits for behavioral health services are coordinated by calling **866-231-0847**. A provider or hospital must be contracted with Highmark BCBS to provide these services; precertification is not required for behavioral health services when provided by a network provider.

Specialty Referrals

To reduce the administrative burden on the provider's office staff, Highmark BCBS has established procedures designed to permit a member with a condition requiring ongoing care from a specialist physician or other health care provider to request an extended authorization.

The provider can request an extended referral authorization by contacting the member's PCP. The provider must supply the necessary clinical information that will be reviewed by the PCP to complete the authorization review.

On a case-by-case basis, an extended authorization will be approved. In the event of termination of a contract with the treating provider, the continuity of care provisions in the provider's contract with Highmark BCBS will apply. The provider may renew the authorization by submitting a new request to the PCP. Additionally, Highmark BCBS requires the specialist physician or other health care provider to provide regular updates to the member's PCP (unless acting also as the designated PCP for the member). Should the need arise for a secondary referral, the specialist physician or other health care provider must contact Highmark BCBS for a coverage determination.

If the specialist or other health care provider needed to provide ongoing care for a specific condition is not available in the Highmark BCBS network, the referring physician shall request authorization from Highmark BCBS for services outside the network. Access will be approved to a qualified non-network health care provider within a reasonable distance and travel time at no additional cost if medical necessity is met.

If a provider's application for an extended authorization is denied, the member (or the provider on behalf of the member) may appeal the decision through the Highmark BCBS medical appeal process. See the Adverse Determinations/Reconsideration/Appeals section of this manual for more information.

Specialty Care Center Referrals
Highmark BCBS will authorize members with either a life-threatening or a degenerative and disabling condition/disease, which requires prolonged specialized medical care, to receive a referral to an accredited or designated specialty care center with expertise in treating the life-threatening or degenerative and disabling disease/condition.

Second Opinions
A member, parent and/or legally appointed representative or the member's PCP may request a second opinion in any situation where there is a question concerning a diagnosis or the options for surgery or other treatment of a health condition. The second opinion will be provided at no cost to the member.

The second opinion must be obtained from a network provider (see the provider referral directory), or a non-network provider, if there is no network provider with the expertise required for the condition. Authorization is required only if the provider is out-of-network. The PCP will notify the member of the date and time of the appointment and forward copies of all relevant records to the consulting provider. The PCP will notify the member of the outcome of the second opinion.

Highmark BCBS may also request a second opinion at our own discretion. This may occur under the following circumstances:

- Whenever there is a concern about care expressed by the member or the provider
- Whenever potential risks or outcomes of recommended or requested care are discovered by the plan during its regular course of business
- Before initiating a denial of coverage of service
- When denied coverage is appealed
- When an experimental or investigational service is requested

When Highmark BCBS requests a second opinion, we will make the necessary arrangements for the appointment, payment and reporting. Highmark BCBS will inform the member and the PCP of the results of the second opinion and the consulting provider's conclusion and recommendation(s) regarding further action.

Specialty Care Providers

To participate in the Medicaid Managed Care model, the provider must have applied for enrollment and be a licensed provider by the state before signing a contract with Highmark BCBS.

Highmark BCBS contracts with a network of provider specialty types to meet the medical specialty needs of members and provide all medically necessary covered services. The specialty care provider is a network physician who is responsible for providing specialized care for members, usually upon appropriate referral from a PCP within the network. (See the Role and Responsibility of the Specialty Care Provider section of this manual for more information.) In addition to sharing many of the same responsibilities to members as PCPs (see Responsibilities of the PCP section), the specialty care provider offers services that include:

- Allergy and immunology services
- Burn services
- Community behavioral health (for example, mental health and substance abuse) services
- Cardiology services
- Services provided by behavioral health clinical nurse specialists, psychologists and clinical social workers
- Critical care medical services
- Dermatology services
- Endocrinology services
- Gastroenterology services
- General surgery
- Hematology/oncology services
- Neonatal services
- Nephrology services
- Neurology services
- Neurosurgery services
- Ophthalmology services
- Orthopedic surgery services
- Otolaryngology services
- Perinatal services
- Pediatric services
- Psychiatry (adult) assessment services
- Psychiatry (child and adolescent) assessment services
- Trauma services
- Urology services

Role and Responsibilities of the Specialty Care Provider

Specialty care providers will only treat members who have been referred to them by network PCPs (with the exception of mental health and substance abuse providers and services for which the member may self-refer) and will render covered services only to the extent and

duration indicated on the referral. Obligations of specialty care providers include but are not limited to:

- Complying with all applicable statutory and regulatory requirements of the Medicaid program
- Accepting all members referred to them
- Submitting required claims information to Highmark BCBS, including source of referral
- Arranging for coverage with network providers while off-duty or on vacation
- Verifying member eligibility and precertification of services (if required) at each visit
- Providing consultation summaries or appropriate periodic progress notes to the member's PCP on a timely basis following a referral or routinely scheduled consultative visit
- Notifying the member's PCP when scheduling a hospital admission or scheduling any procedure requiring the PCP's approval
- Coordinating care, as appropriate, with other providers involved in providing care for members, especially in cases where there are medical and behavioral health comorbidities or co-occurring mental health and substance abuse disorders

The specialist shall:

- Manage the medical and health care needs of members, including monitoring and following up on care provided by other providers, including those engaged on an FFS basis; provide coordination necessary for referrals to other specialists and FFS providers (both in and out of network); and maintain a medical record of all services rendered by the specialist and other providers.
- Provide 24-hour-a-day, 7-day-a-week coverage and maintain regular hours of operation that are clearly defined and communicated to members.
- Provide services ethically and legally, in a culturally competent manner and meet the unique needs of members with special health care requirements.
- Participate in the systems established by Highmark BCBS that facilitate the sharing of records, subject to applicable confidentiality and HIPAA requirements.
- Participate and cooperate with Highmark BCBS in any reasonable internal or external quality assurance, utilization review, continuing education or other similar programs established by Highmark BCBS.
- Make reasonable efforts to communicate, coordinate and collaborate with other specialty care providers, including behavioral health providers involved in delivering care and services to consumers.
- Participate in and cooperate with the Highmark BCBS complaint and grievance processes and procedures (Highmark BCBS will notify the specialist of any member grievance brought against the specialist).
- Not balance bill members.
- Continue care in progress during and after termination of his or her contract for up to 90 days until a continuity of care plan is in place to transition the member to another provider or through 60 days postpartum care for pregnant members in accordance with applicable state laws and regulations.
- Comply with all applicable federal and state laws regarding the confidentiality of patient records.

- Develop and have an exposure control plan regarding blood-borne pathogens in compliance with Occupational Safety and Health Administration (OSHA) standards.
- Make best efforts to fulfill the obligations under the ADA applicable to his or her practice location.
- Support, cooperate and comply with the Highmark BCBS Quality Improvement Program initiatives and any related policies and procedures designed to provide quality care in a cost-effective and reasonable manner.
- Inform Highmark BCBS if a member objects for religious reasons to the provision of any counseling, treatment or referral services.
- Treat all members with respect and dignity.
- Provide members with appropriate privacy and treat member disclosures and records confidentially, giving members the opportunity to approve or refuse their release as allowed under applicable laws and regulations.
- Provide members complete information concerning their diagnosis, evaluation, treatment and prognosis and give members the opportunity to participate in decisions involving their health care; except when contraindicated for medical reasons, the information will be made available to an appropriate person acting on the member's behalf.
- Advise members about their health status, medical care or treatment options, regardless of whether benefits for such care are provided under the program, and advise members on treatments that may be self-administered.
- When clinically indicated, contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings.
- Have a policy and procedure to ensure proper identification, handling, transport, treatment and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection.
- Agree to maintain communication with the appropriate agencies such as local police, social services agencies and poison control centers to provide quality patient care.
- Agree that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention that is part of a clinical research study is clearly distinguished from entries pertaining to nonresearch-related care.

Note: Highmark BCBS does not cover the use of any experimental procedures or experimental medications except under certain preauthorized circumstances.

Specialty Care Providers' Access and Availability

Highmark BCBS will maintain a specialty network to ensure access and availability to specialists for all members. A provider is considered a specialist if he or she has a provider agreement with Highmark BCBS to provide specialty services to members.
Specialists must adhere to the following access guidelines:

Service	Access Requirement
Urgent visit	Within 24 hours of request or sooner as clinically indicated
Nonurgent, nonemergency visits	Within 48 to 72 hours of request or sooner as clinically indicated

Routine nonurgent, preventive appointments	Within four to six weeks of request or sooner as clinically indicated
Prenatal care	Within two weeks of request

Obstetrical and/or Gynecological Providers

Obstetrical and/or gynecological (OB-GYN) providers may be any obstetrician, gynecologist, certified nurse midwife or family practitioner with training in obstetrics and gynecology who has been credentialed by Highmark BCBS to provide OB-GYN services. While an OB-GYN provider is not a PCP, members may choose to have an OB-GYN provider as their primary source of care. Members can access an OB-GYN provider for their reproductive health needs without a referral from their PCP.

All female members are eligible to receive two well-woman examinations each calendar year from the member's provider of choice within the Highmark BCBS network, treatment for acute gynecological conditions, follow-up services related to these primary and preventive services, and pregnancy-related care without a referral from their PCP. The OB-GYN must notify the member's PCP of the pregnancy and must notify Highmark BCBS at **866-231-0847**. This will register the member in our New Baby, New Life^{SM} program.

Pregnancy testing and termination of pregnancy are considered care directly related to pregnancy and are therefore accessed directly. Highmark BCBS also requires that participating providers comply with the informed consent procedures for hysterectomy and sterilization specified in 42 CFR, Part 441, sub-part F and 18 NYCRR Section 505.14. OB-GYN providers must also comply with a prenatal care evidence-based standard of practice, such as the American Congress of Obstetricians and Gynecologists (ACOG) practice guidelines.

Risk Assessment

Every pregnant woman shall receive ongoing assessment of both maternal and fetal risk throughout the prenatal period. Such risk assessment shall include but not be limited to an analysis of individual characteristics affecting pregnancy, such as genetic, nutritional, psychosocial, historical and emerging obstetrical/fetal and medical-surgical risk factors. At the time of registration, a standardized written risk assessment shall be conducted using established criteria for determining high-risk pregnancies, based upon generally accepted standards of practice. This risk assessment shall be:

- Reviewed at each visit
- Formally repeated early in the third trimester
- Linked to the plan of care and clearly documented in the medical record
- A development of the care plan and coordination of care

A care plan that addresses the proper implementation and coordination of all services required by the pregnant woman shall be developed, routinely updated and implemented jointly by the pregnant woman and her family, mutually agreeable to the woman and all appropriate members of the health care team.

Care shall be coordinated to:

- Ensure relevant information is exchanged between the prenatal care provider and other providers or sites of care, including the anticipated birthing site.
- Ensure the pregnant woman and her family, with her consent, have continued access to information resources and are encouraged to participate in decisions involving the scope and nature of care and services being provided.
- Encourage and assist the pregnant woman in obtaining necessary medical, nutritional, psychosocial, drug and substance abuse services appropriate to her identified needs and provide follow-up to ensure ongoing access to services.
- Provide the pregnant woman with an opportunity to receive prenatal or postpartum home visitation when the woman may derive medical or psychosocial benefit from such visits, which shall identify familial and environmental factors that may produce increased risk to the woman or fetus. The relevant findings shall be incorporated into the care plan, and the pregnant woman will be provided or referred for needed services, including:
  - Inpatient care, specialty physician and clinical services which are necessary to ensure a healthy delivery and recovery
  - Genetic services
  - Drug treatment and screening services
  - Dental services
  - Mental health and related social services
  - Emergency room services
  - Home care
  - Pharmaceuticals
  - Transportation
- Provide special tests and services as may be recommended or required by the Commissioner of Health, who shall require such tests and/or services when necessary to protect maternal and/or fetal health. Women shall be provided appropriate medical care, counseling and education based on test results.
- Encourage continuity of care and client follow-up, including rescheduling of missed visits throughout the prenatal and postpartum period.

Nutrition Services

Prenatal providers will establish and implement a program of nutrition screening and counseling which includes:

- Individual nutrition risk assessment, including screening for specific nutritional risk conditions at the initial prenatal care visit and continuing reassessment as needed
- Professional nutrition counseling, monitoring and follow-up of all pregnant women at nutritional risk by a nutritionist or registered dietitian
- Documentation of nutrition assessment, risk status and nutrition care plan in the patient medical record
- Arrangements for services with funded nutrition programs available in the community, including provision for enrollment of all eligible women and infants in the Supplemental Food Program for Women, Infants and Children (WIC), at the initial visit

Provision of basic nutrition education and counseling for each pregnant woman should include the following topics:

- Appropriate dietary intake and recommended dietary allowances during normal pregnancy
- Appropriate weight gain
- Infant feeding choices, including individualized counseling regarding the advantages and disadvantages of breastfeeding

Health Education
Health and childbirth education services are given to each pregnant woman based on an assessment of her individual needs. Appropriate educational materials, including video and written information, are used. Cultural and language factors are taken into account, including the ability of the pregnant woman to comprehend the information. Such services will be provided by professional staff, documented in the medical record and include but not be limited to the following:

- Orientation to procedures at prenatal facilities and at the expected site of birth
- Rights and responsibilities of the pregnant woman
- Signs of complications of pregnancy
- Physical activity and exercise during pregnancy
- Avoidance of harmful practices and substances, including alcohol, drugs, nonprescribed medications and nicotine
- Sexuality during pregnancy
- Occupational concerns
- Risks of HIV infection and risk reduction behaviors
- Signs of labor
- Labor and delivery process
- Relaxation techniques in labor
- Obstetrical anesthesia and analgesia
- Preparation for parenting, including infant development and care and options for feeding
- The newborn screening program with the distribution of newborn screening educational literature

Family Planning
A psychosocial assessment shall be conducted and shall include:

- Screening for social, economic, psychological and emotional problems
- Referral to the local Department of Social Services, community mental health resources, support groups or social/psychological specialists (as appropriate) for the needs of the woman or fetus

Prenatal Diagnostic and Treatment Services
Prenatal diagnostic and treatment services shall be provided by a qualified physician practicing in accordance with Article 131 of the NYS Education Law, a licensed midwife practicing in accordance with Article 140 of the NYS Education Law, a qualified nurse practitioner practicing in accordance with Article 139 of the NYS Education Law or a registered physician’s assistant practicing in accordance with Part 94 of this Title, Article 37 of the NYS Public Health Law and Article 131 of the NYS Education Law. Such services shall meet generally accepted standards of professional patient care and services.

Prenatal diagnostic and treatment services provided include the following:

- An initial comprehensive assessment, including history, review of systems and physical examination
- Standard laboratory tests and procedures
- Needed special laboratory tests as indicated by comprehensive assessment and initial or preliminary test findings
- Evaluation of risk
- Discussion of options for treatment, care and technological support expected to be available at the time of labor and delivery, together with the advantages and disadvantages of each option
- Obtaining the pregnant woman's informed choice of mode of treatment, care and technological support expected
- Postpartum counseling, evaluation and referral to professional care and services, as required, to include preconception counseling as appropriate
- Establishing arrangements for availability of after-hours and emergency consultation and care for pregnant women

The prenatal provider shall develop and implement written agreements with planned sites of delivery, which address, at a minimum:

- Prebooking of women for delivery at 34 to 36 weeks gestation for low-risk pregnancies and 26 weeks gestation for high-risk pregnancies
- Arrangements for referral of women and neonates to appropriate alternate care sites for medically indicated care
- Special tests and procedures which may be required
- A plan detailing how hospitalization for medical or obstetrical problems will occur
- Arrangements with facilities for postpartum services
- A system for sharing medical records with the delivery site and for receiving information from referral sources and delivery sites

Prenatal providers will develop and implement written policies and procedures, designating the requirements for consultation with a qualified physician or other health care specialist when necessitated by specific medical conditions.

Prenatal providers will designate in writing those situations that require the transfer of the primary responsibility for patient care from a primary care professional who is a family practice physician, physician's assistant, licensed midwife or qualified nurse practitioner to a qualified obstetrician.

HIV Services

The prenatal provider will:

- Routinely provide the pregnant woman with HIV counseling and education.
- Routinely offer the pregnant woman confidential HIV testing.

- Routinely recommend the pregnant woman to HIV counseling and testing as early as possible in the pregnancy, including a repeat third trimester test (preferably at 34-36 weeks).
- Provide the HIV-positive woman and her newborn infant the following services or make the necessary referrals for these services:
    - Management of HIV status
    - Psychosocial support
    - Case management to assist in coordination of necessary medical, social and drug treatment services

Records and Reports
The prenatal provider shall create and maintain records and reports in accordance with this subdivision that are complete, legible, retrievable and available for review by representatives of the Commissioner of Health upon request. Such records and reports shall include:

- A comprehensive prenatal care record for each pregnant woman, which documents the provision of care and services required by this section and is maintained in a manner consistent with medical record confidentiality requirements
- Special reports and data summaries necessary for the Commissioner of Health to evaluate the provider's delivery of prenatal services
- Program reports, including financial, administrative, utilization and patient care data maintained in such a manner as to allow the identification of expenditure, revenue, utilization and patient care data associated with health care provided to prenatal clients
- Records of all internal quality assurance activities
- All written policies and procedures required by this section

Internal Quality Assurance
The prenatal provider shall develop and implement written policies and procedures establishing an internal quality assurance program to identify, evaluate, resolve and monitor actual and potential problems in patient care. Components of this program shall include but not be limited to:

- A documented and filed prenatal chart audit performed periodically on a statistically significant number of current prenatal client records
- An annual written summary evaluation of all components of such audits
- A system for determining patient satisfaction and for resolving patient complaints
- A system for developing and recommending corrective actions to resolve identified problems
- A follow-up process to assure that recommendations and plans of correction are implemented and are effective
- Safeguards to prevent the inappropriate breach of patient confidentiality requirements

Postpartum Services
The prenatal provider shall coordinate with the neonatal care provider to arrange for the provision of pediatric care services in accordance with generally accepted standards of practice and patient services. A postpartum visit with a qualified health professional shall be scheduled and conducted between 21 and 56 days after delivery. For the interim between

delivery and the postpartum visit, the prenatal provider shall furnish each woman with a means of contacting the provider in case postpartum questions or concerns arise. The postpartum visit shall include but not be limited to:

- Identifying any medical, psychosocial, nutritional, alcohol treatment and/or drug treatment needs of the mother or infant that are not being met
- Referring the mother or other infant caregiver to resources available for meeting such needs and providing assistance in meeting such needs where appropriate
- Assessing family planning needs and providing advice, services or referral, where indicated
- Providing preconception counseling and encouraging a preconception visit prior to subsequent pregnancies for women who might benefit from such a visit
- Referring infants to preventive and special care services appropriate to their needs
- Advising the mother of the availability of Medicaid eligibility for infants

For specific requirements regarding OB-GYN appointment access scheduling, office waiting time, telephone access after business hours and on-call coverage standards, please see the Specialty Care Providers Access and Availability section of this manual.

Cultural Competency

Cultural competency is the integration of congruent behaviors, attitudes, structures, policies and procedures that come together in a system, agency or among professionals to enable effective work in cross-cultural situations. Cultural competency assists providers and members to:

- Acknowledge the importance of culture and language
- Embrace cultural strengths with people and communities
- Assess cross-cultural relations
- Understand cultural and linguistic differences
- Strive to expand cultural knowledge

The quality of the patient-provider interaction has a profound impact on the ability of a patient to communicate symptoms to his or her provider and to adhere to recommended treatment. Some of the reasons that justify a provider's need for cultural competency include but are not limited to:

- The perception that illness, disease and their causes vary by culture
- The belief systems related to health, healing and wellness are very diverse
- Culture often influences help-seeking behaviors and attitudes toward health care providers
- Individual preferences affect traditional and nontraditional approaches to health care
- Patients must overcome their personal biases within health care systems
- Health care providers from culturally and linguistically diverse groups are underrepresented in the current service delivery system

Cultural barriers between the provider and member can impact the patient-provider relationship in many ways, including but not limited to:

- The member's level of comfort with the practitioner and the member's fear of what might be found upon examination

- The differences in understanding amongst the diverse consumers in the U.S. health care system
- A fear of rejection of personal health beliefs
- The member's expectation of the health care provider and of the treatment

Cultural Awareness, Knowledge and Skills Needed
To be culturally competent, Highmark BCBS expects providers serving members within this geographic location to demonstrate the following:

Cultural Awareness
- The ability to recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior
- The ability to modify one's own behavioral style to respond to the needs of others, while at the same time maintaining one's objectivity and identity
- Acceptance of ethnic differences among people and an understanding of how these differences affect the treatment process

Knowledge
- Culture plays a crucial role in the formation of health or illness beliefs.
- Culture is generally behind a person's rejection or acceptance of medical advice.
- Different cultures have different attitudes about seeking help.
- Feelings about disclosure are culturally unique.
- There are differences in the acceptability and effectiveness of treatment modalities in various cultural and ethnic groups.
- Verbal and nonverbal language, speech patterns and communication styles vary by culture and ethnic groups.
- Resources, such as formally trained interpreters, should be offered to and utilized by members of various cultural and ethnic backgrounds.

Skills
- The ability to understand the basic similarities and differences between and among the cultures of the persons served
- The ability to recognize the values and strengths of different cultures
- The ability to interpret diverse cultural and nonverbal behavior
- The ability to develop perceptions and understanding of other's needs, values and preferred means of having those needs met
- The ability to identify and integrate the critical cultural elements of a situation to make culturally consistent inferences and demonstrate consistency in actions
- The ability to recognize the importance of time and the use of group process to develop and enhance cross-cultural knowledge and understanding
- The ability to withhold judgment, action or speech in the absence of information about a person's culture
- The ability to listen with respect
- The ability to formulate culturally competent treatment plans
- The ability to use culturally appropriate community resources

- The ability to know when and how to use interpreters and to understand the limitations of using interpreters
- The ability to treat each person uniquely
- The ability to recognize racial and ethnic differences and know when to respond to culturally-based cues
- The ability to seek out information
- The ability to use agency resources
- The capacity to respond flexibly to a range of possible solutions
- A willingness to work with clients of various ethnic minority groups

Member Records

Using nationally recognized standards of care, Highmark BCBS works with providers to develop clinical policies and guidelines of care for our membership. The medical advisory committee (MAC) oversees and directs Highmark BCBS in formalizing, adopting and monitoring guidelines. Highmark BCBS requires medical records to be maintained in a manner that is current, detailed, organized and permits effective and confidential patient care and quality review. Highmark BCBS, NYSDOH, CMS and Learning Development and Support Services (LDSS) may have the right to access members' medical records for utilization review and quality management at any time.

Providers are required to maintain medical records that conform to good professional medical practice and appropriate health management. A permanent medical record will be maintained at the primary care site for every member and be available to the PCP and other providers. Medical records must be kept in accordance with Highmark BCBS and state standards as follows.

Medical Record Standards

The records reflect all aspects of patient care, including ancillary services. Documentation of each visit must include:

1. Date of service
2. Grievance or purpose of visit
3. Diagnosis or medical impression
4. Objective finding
5. Assessment of patient's findings
6. Plan of treatment, diagnostic tests, therapies and other prescribed regimens
7. Medications prescribed
8. Health education provided
9. Signature and title, or initials, of the provider rendering the service; if more than one person documents in the medical record, there must be a record on file as to what signature is represented by which initials

These standards will, at a minimum, meet the following medical record requirements:

1. **Patient identification information**: Each page or electronic file in the record must contain the patient's name or patient ID number.
2. **Personal/biographical data**: The record must include age, sex, address, employer, home and work telephone numbers, and marital status.
3. **Date and corroboration**: All entries must be dated with the author identified.

4. **Legibility**: Each record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.
5. **Allergies**: Medication allergies and adverse reactions must be prominently noted on the record. Absence of allergies must be noted in an easily recognizable location (that is, no known allergies [NKA]).
6. **Past medical history** (for patients seen three or more times): Past medical history must be easily identified, including serious accidents, operations and illnesses. For children, the history must include prenatal care of the mother and birth.
7. **Immunizations**: For pediatric records age 13 and younger, a completed immunization record or a notation of prior immunization must be recorded, including vaccines and their dates of administration when possible.
8. **Diagnostic information**
9. **Medication information** (includes medication information/instruction to patient)
10. **Identification of current problems**: Significant illnesses, medical and behavioral health conditions and health maintenance concerns must be identified in the medical record.
11. **Instructions**: The record must include evidence that the patient was provided with basic teaching and instruction regarding physical and/or behavioral health condition.
12. **Smoking/alcohol/substance abuse**: A notation concerning cigarettes and alcohol use and substance abuse must be stated if present for patients age 12 and older. Abbreviations and symbols may be appropriate.
13. **Consultations, referrals and specialist reports**: Notes from any referrals and consultations must be in the record. Consultation, lab and X-ray reports filed in the chart must have the ordering physician's initials or other documentation signifying review. Consultation and any abnormal lab and imaging study results must have an explicit notation in the record of follow-up plans.
14. **Emergencies**: All emergency care provided (directly by the contracted provider or through an emergency room) and the hospital discharge summaries for all hospital admissions while the patient is part of the PCP's panel must be noted.
15. **Hospital discharge summaries**: Discharge summaries for all hospital admissions that occur while the patient is enrolled and for prior admissions, as appropriate. Prior admissions that may have occurred before the patient was enrolled may be pertinent to the patient's current medical condition.
16. **Advance directive**: For adult patients, record whether or not the individual has executed an advance directive. An advance directive is a written instruction, such as a living will or durable power of attorney, which directs health care decision-making for individuals who are incapacitated.
17. **Security**: Providers must maintain a written policy as required to ensure that medical records are safeguarded against loss, destruction or unauthorized use. Additionally, a provider must develop policies and procedures for his or her staff to ensure confidentiality of HIV-related information. The policy and procedure for HIV must include:
    - Initial and annual in-service education of staff and/or contractors
    - Identification of staff allowed access and limits of access
    - Procedures to limit access to trained staff (including contractors)
    - Protocol for secure storage (including electronic storage)

- Procedures for handling requests for HIV-related information
- Protocols to protect persons with or suspected of having HIV infection from discrimination.

18. **Release of information**: Written procedures are required for the release of information and obtaining consent for treatment.
19. **Documentation**: Documentation is required, setting forth the results of medical, preventive and behavioral health screening, all treatment provided, and results of such treatment.
20. **Multidisciplinary teams**: Documentation is required of the team members involved in the multidisciplinary team of a patient needing specialty care.
21. **Integration of clinical care**: Documentation of the integration of clinical care in both the physical and behavioral health records is required. Such documentation must include:
    - Screening for behavioral health conditions (including those which may be affecting physical health care and vice versa) and referral to behavioral health providers when problems are indicated
    - Screening and referral by behavioral health providers to PCPs when appropriate
    - Receipt of behavioral health referrals from physical medicine providers and the disposition/outcome of those referrals
    - A summary of the status/progress from the behavioral health provider to the PCP, at least quarterly (or more often if clinically indicated)
    - A written release of information that will permit specific information sharing between providers
    - Documentation that behavioral health professionals are included in primary and specialty care service teams described in this contract when a patient with disabilities or chronic or complex physical or developmental conditions has a co-occurring behavioral disorder
22. **Provider reporting obligations**: Documentation of reasonable efforts to assure timely and accurate compliance with NYC public health reporting requirements in the following areas:
    - Infants and toddlers suspected of having a developmental delay or disability
    - Suspected instances of child abuse
    - Immunization Registry and Blood Lead Registry
    - Communicable disease and conditions mandated in the New York City Health Code, pursuant to 24 RCNY§ 11.03-11.07 and Article 21 of the NYS Public Health Law

Patient Visit Data

Documentation of individual encounters must provide adequate evidence of (at a minimum):

1. A history and physical exam that includes appropriate subjective and objective information obtained for the presenting complaints
2. For patients receiving behavioral health treatment, documentation that includes at-risk factors (danger to self/others, ability to care for self, affect, perceptual disorders, cognitive functioning and significant social health)
3. An admission or initial assessment that must include current support systems or lack of support systems

4. For patients receiving behavioral health treatment, a documented assessment that is done with each visit relating to client status/symptoms to the treatment process and that may indicate initial symptoms of the behavioral health condition as decreased, increased or unchanged during the treatment period
5. A plan of treatment that includes activities/therapies and goals to be carried out
6. Diagnostic tests
7. Documented therapies and other prescribed regimens for patients who receive behavioral health treatment, including evidence of family involvement and evidence the family was included in therapy sessions, each as applicable
8. For follow-up care encounter forms or notes with a notation indicating follow-up care, a call or a visit that must note in weeks or months the specific time to return with unresolved problems from any previous visits being addressed in subsequent visits
9. Referrals and results, including all other aspects of patient care, such as ancillary services

Highmark BCBS will systematically review medical records to ensure compliance with the standards. We will institute actions for improvement when standards are not met.

Highmark BCBS maintains an appropriate recordkeeping system for services to members. This system will collect all pertinent information relating to the medical management of each member and make that information readily available to appropriate health professionals and appropriate state agencies. All records will be retained in accordance with the record retention requirements. A member's medical record must be retained by his or her provider for six years after the date of service rendered to the member, and in the case of a minor, for three years after majority or six years after the date of the service, whichever is later. Prenatal care medical records will be centralized and for all other services.

Clinical Practice Guidelines

Using nationally recognized standards of care, Highmark BCBS works with providers to develop clinical policies and guidelines for the care of our membership. The medical advisory committee oversees and directs Highmark BCBS in formulating, adopting and monitoring guidelines.

Highmark BCBS selects at least four evidence-based clinical practice guidelines that are relevant to the member population. We will measure performance against at least two important aspects of each of the four clinical practice guidelines annually. The guidelines must be reviewed and revised at least every two years, or whenever the guidelines change.

To access the Clinical Practice Guidelines online, navigate to our website at **www.bcbswny.com/stateplans**. You can contact Provider Services at **866-231-0847** to receive a printed copy.

Highmark BCBS Clinical and Network staff is available to review these practices and guidelines. These reviews can occur in a group setting, via WebEx or in person.

Periodically, the plan's quality team will request charts to ensure all providers (PCPs, behavioral health providers and all specialists) are following the guidelines and are

incorporating evidence-based practices. Results of these audits and next steps will then be reviewed and shared with the provider.

Advance Directives

Highmark BCBS respects the right of the member to control decisions relating to his or her own medical care, including the decision to have provided, withheld or withdrawn the medical or surgical means or procedures calculated to prolong his or her life. This right is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession.

Highmark BCBS adheres to the Patient Self-Determination Act and maintains written policies and procedures regarding advance directives. Advance directives are documents signed by a competent person giving direction to health care providers about treatment choices in certain circumstances. There are two types of advance directives: 1) a durable power of attorney for health care, and; 2) a living will. A durable power of attorney for health care (durable power) allows the member to name a patient advocate to act on behalf of the member. A living will allows the member to state his or her wishes in writing but does not name a patient advocate.

Member Services and Outreach associates encourage members to request an advance directive form and education from their PCP at their first appointment.

Members older than 18 years of age and emancipated minors are able to make advance directives. His or her response is to be documented in the medical record. Highmark BCBS will not discriminate or retaliate based on whether a member has or has not executed an advance directive.

While each member has the right without condition to formulate an advance directive within certain limited circumstances, a facility or an individual physician may conscientiously object to an advance directive.

Member Services and Outreach associates will assist members regarding questions about advance directives; however, no associate of Highmark BCBS may serve as witness to an advance directive or as a member’s designated agent or representative.

Highmark BCBS notes the presence of advance directives in the medical records when conducting medical chart audits.

First Line of Defense Against Fraud

General Obligation to Prevent, Detect and Deter Fraud, Waste and Abuse

As a recipient of funds from state and federally sponsored health care programs, we each have a duty to help prevent, detect and deter fraud, waste and abuse. Our commitment to detecting, mitigating and preventing fraud, waste and abuse is outlined in our Corporate Compliance program. As part of the requirements of the federal Deficit Reduction Act, each Highmark BCBS provider is required to adopt Highmark BCBS policies on detecting, preventing and mitigating fraud, waste and abuse in all the federally and state funded health care programs in which Highmark BCBS participates.

As a Highmark BCBS provider and a participant in government-sponsored health care, you and your staff are obligated to report suspected fraud, waste and abuse. We encourage our members and providers to report suspected instances by:

- Anonymously submitting a report via **www.bcbswny.com/stateplans**.
- Calling Highmark BCBS Customer Service at **866-231-0847**.
- Calling the fraud hotline at **877-725-2702**.
- Calling Andre Acosta, the Highmark BCBS plan compliance officer, at **757-473-2737, ext. 31028**.

No individual who reports violations or suspected fraud, waste or abuse will be retaliated against, and Highmark BCBS will make every effort to maintain anonymity and confidentiality.

In order to meet the requirements under the Deficit Reduction Act, you must adopt the Highmark BCBS fraud, waste and abuse policies and distribute them to any staff members or contractors who work with Highmark BCBS. If you have questions or would like more details concerning our fraud, waste and abuse detection, prevention and mitigation program, please contact the Highmark BCBS plan compliance officer.

Electronic copies of our policy and the *Highmark BCBS Code of Business Conduct and Ethics* are available at **www.bcbswny.com/stateplans**.

Importance of Detecting, Deterring and Preventing Fraud, Waste and Abuse
Health care fraud costs taxpayers increasingly more money every year. There are state and federal laws designed to crack down on these crimes and impose strict penalties. Fraud, waste and abuse in the health care industry may be perpetuated by every party involved in the health care process. There are several stages to inhibiting fraudulent acts, including detection, prevention, investigation and reporting. In this section, we educate providers on how to help prevent member and provider fraud by identifying the different types, so you can be the first line of defense.

Types of Fraud, Waste and Abuse
Examples of provider fraud, waste and abuse include:

- Billing for services not rendered
- Billing for services not medically necessary
- Double-billing
- Unbundling
- Upcoding

Providers can help prevent fraud, waste and abuse by ensuring the services rendered are medically necessary, accurately documented in the medical records and billed according to American Medical Association (AMA) guidelines.

Examples of member fraud, waste and abuse include:

- Benefit sharing
- Collusion

- Drug trafficking
- Forgery
- Illicit drug seeking
- Impersonation fraud
- Misinformation and/or misrepresentation
- Subrogation and/or third-party liability fraud
- Transportation fraud

Reporting Critical Incidents
Highmark BCBS monitors critical incidents and reports any occurrences and investigations of incidents to the state. This includes reports of wrongful death, restraints and medication errors resulting in injury. To report critical incidents, use any of the above listed methods for reporting suspected fraud, waste and abuse.

What can you do to help prevent fraud, waste and abuse?

- Carefully review each member's Highmark BCBS member ID card to ensure the cardholder is the person named on the card; this is the first line of defense against fraud.
    - Note: Highmark BCBS may not accept responsibility for the costs incurred by providers rendering services to a patient who is not a member, even if that patient presents a Highmark BCBS member ID card.
- Educate members about the types of fraud and the penalties levied.
- Spend time with patients and review their records for prescription administration.
- Encourage members to protect their cards as they would a credit card or cash, carry their Highmark BCBS member ID card at all times, and report any lost or stolen cards to Highmark BCBS as soon as possible.

Highmark BCBS believes awareness and action are vital to keeping the state and federal programs safe and effective. Understanding the various opportunities for fraud, waste or abuse and working with members to protect their Highmark BCBS identification cards can help prevent fraud, waste and abuse.

False Claims Act
We are committed to complying with all applicable federal and state laws, including the federal False Claims Act (FCA). The FCA is a federal law allowing the government to recover money stolen through fraud by government contractors. Under the FCA, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages or loss to the government plus civil penalties of $5,500 to $11,000 per false claim.

The FCA also contains Qui Tam or "whistleblower" provisions. A "whistleblower" is an individual who reports in good faith an act of fraud or waste to the government, or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under Qui Tam provisions in the FCA and may be entitled to a percentage of the funds recovered by the government.

Employee Education about the False Claims Act

As a requirement of the Deficit Reduction Act of 2005, contracted providers who receive Medicaid payments of at least five million dollars (cumulative from all sources), must comply with the following:

- Establish written policies for all employees, managers, officers, contractors, subcontractors and agents of the network provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws as described in Section 1902(a)(68)(A).
- Include as part of such written policies detailed provisions regarding policies and procedures for detecting and preventing fraud, waste and abuse.
- Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and policies and procedures for detecting and preventing fraud, abuse and waste.

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA, also known as the Kennedy-Kassebaum bill, was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of health care fraud and simplifies the administration of health insurance.

Highmark BCBS strives to ensure both Highmark BCBS and contracted participating providers conduct business in a manner that safeguards patient/member information in accordance with the privacy regulations enacted pursuant to HIPAA. Contracted providers shall have the following procedures implemented to demonstrate compliance with HIPAA privacy regulations.

Highmark BCBS recognizes our responsibility under HIPAA privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose. Conversely, network providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting Highmark BCBS. However, please note that the privacy regulations allow the transfer or sharing of member information, which may be requested by Highmark BCBS to conduct business and make decisions about care, such as a member's medical record, to make an authorization determination or resolve a payment appeal. Such requests are considered part of the HIPAA definition of treatment, payment or health care operations.

Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with access that is restricted to individuals who need member information to perform their jobs. When faxing information to Highmark BCBS, verify the receiving fax number is correct, notify the appropriate staff at Highmark BCBS and verify the fax was appropriately received.

Email (unless encrypted) should not be used to transfer files containing member information to Highmark BCBS (for example, Excel spreadsheets with claim information). Such information should be mailed or faxed.

Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked confidential and addressed to a specific individual, post office box or department at Highmark BCBS.

The Highmark BCBS voice mail system is secure and password protected. When leaving messages for Highmark BCBS associates, providers should only leave the minimum amount of member information required to accomplish the intended purpose.

When contacting Highmark BCBS, please be prepared to verify the provider's name, address, TIN, NPI or Highmark BCBS provider number.

MEDICAL MANAGEMENT

Medical Review Criteria

Wellpoint Partnership Plan, LLC on behalf of Highmark Blue Cross Blue Shield medical policies, which are publicly accessible at the Highmark BCBS website, are the primary benefit plan policies for determining whether services are considered to be a) investigational/experimental, b) medically necessary, and c) cosmetic or reconstructive.

McKesson InterQual criteria will be used for non-behavioral health emergency and concurrent inpatient reviews. Highmark BCBS clinical utilization management (UM) guidelines will be used when no specific Highmark BCBS medical policies exist for elective inpatient and precertification reviews. A list of the specific Highmark BCBS clinical UM guidelines used will be posted and maintained on the Highmark BCBS website and can be obtained in hard copy by written request. The policies described above will support precertification requirements, clinical-appropriateness claims edits and retrospective review.

Federal law, state law, and contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first when determining eligibility for coverage. As such, in all cases, state Medicaid contracts or CMS requirements will supersede both McKesson InterQual and Highmark BCBS medical policy criteria. Medical technology is constantly evolving, and we reserve the right to review and periodically update medical policy and utilization management criteria.

Highmark BCBS follows established procedures for applying medical necessity criteria based on individual member needs and an assessment of the availability of services within the local delivery system. These procedures apply to precertification, concurrent reviews and retrospective reviews. Utilization Management (UM) clinicians collect and review relevant clinical information to determine if the level of service requested meets medical necessity criteria. Criteria can be accessed via criteria-specific software and/or Web applications.

Highmark BCBS, as a corporation and as individuals involved in Utilization Management (UM) decisions, is governed by the following statements:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- Highmark BCBS does not specifically reward practitioners or other individuals for issuing denial of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support, denials of benefits.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization, or create barriers to care and service.

Highmark BCBS does not employ utilization controls or other coverage limits to automatically place limits on the length of stay for members requiring hospitalization or surgery. Length of stay for a member’s request for hospitalization or surgery is based on the needs of the member rather than on arbitrary limits. Members who are hospitalized or receiving surgical services are managed by an assigned utilization manager. The clinical review for these services will specify authorization for coverage limits as determined by clinical guidelines and

individual needs. Subsequently, the utilization manager working with the hospital, PCP/attending physician and other parties will monitor and continually review the case to determine discharge readiness and facilitate discharge planning. For members found to require extended benefits, as identified by the concurrent review of individual needs, severity of illness and services being rendered, the utilization manager has the authority to extend the hospital stay or other services as needed.

In the application of criteria, it is generally understood that these criteria are designed for uncomplicated patients and for a complete delivery system. This may not be appropriate for patients with complications or for a delivery system with insufficient alternatives for care. Highmark BCBS will consider the following when applying criteria to a given individual:

- Age
- Comorbidities
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment when applicable

The characteristics of the local delivery system available for specific patients will also be considered, such as:

- Availability of skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the patient after hospital discharge
- Coverage of benefits for alternative levels of care when needed
- Provider ability to provide all recommended services within the estimated length of stay

Utilization managers are required to discuss all cases with the medical director in which medical necessity is not met using established criteria, or in which there is a failure of the local delivery system to provide care for final review determination. Utilization managers can only make determinations for approvals of care, and only a licensed medical director makes any adverse determinations. Trained nonclinical associates under the direct supervision of licensed clinical team members have the authority to approve services under procedures designated by the health plan. Highmark BCBS health plans monitor the accuracy and consistency of review decisions through health plan audits and corporate annual Inter-Rater Reliability audits. Requests that do not meet criteria are referred to the medical director or clinical peer designee. All UM criteria used in rendering decisions are available upon request. Providers may request copies of criteria by calling Provider Services at **866-231-0847**.

Medical necessity determinations are based on approved clinical criteria and are made by appropriate clinical staff with unrestricted licensure. Highmark BCBS expects nurses and physicians who make decisions on coverage of care and services to:

- Make decisions based on the right care and services the benefit covers.
- Understand Highmark BCBS does not reward providers or others if they deny coverage of care or services.
- Make sure the money paid to decision-makers does not end in the misuse of needed health care.

Authorization Request Process
Highmark BCBS may require members to obtain a referral from their PCP prior to accessing specialty care and out-of-network services. Highmark BCBS may also require providers to complete a notification or precertification process prior to providing certain medically necessary services to members. Medically necessary services are those health care services necessary to prevent, diagnose, manage or treat conditions that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity or threaten some significant handicap. Providers may verify which services require notification or precertification by calling **866-231-0847** or visiting our website and using the Precertification Lookup tool online (PLUTO).

All precertification requests must be made within a minimum of 72 hours before service is scheduled to be rendered, or risk precertification denial. Highmark BCBS is available to respond to questions or provide specific information regarding requests for authorization Monday through Friday, between 8 a.m. and 5 p.m. ET. Voice messages left after business hours will be returned on the next business day.

Utilization Review Delegation
Highmark BCBS may delegate utilization review (UR) activities for select services to an approved, accredited UR agent.

In those instances, providers should refer to the provider web portal to confirm the appropriate agent and contact information to initiate the authorization request process. All delegated agents follow the Highmark BCBS UR processing guidelines, including time frames and notification for authorization, in adherence with the state Medicaid contract.

Notification
Notification is defined as the requirement for the provider to notify Highmark BCBS by telephone or fax of the intent to render covered medical services to a member. Member eligibility and provider status (participating and nonparticipating) are verified. Notifications can be called in to **866-231-0847** or faxed to **800-964-3627**.

Review/Determination Time Frames
Time frames summarized in the paragraph section below are Article 49 NYS regulatory requirements. As a quality-focused organization, Highmark BCBS has elected to attain NCQA accreditation. NCQA time frames differ from NYS regulatory requirements; therefore, in order to meet both NCQA and NYS regulatory requirements, Highmark BCBS will follow the most stringent time frames. See Tables 1 and 2 at the end of this section for a comparison between time frames.

Precertification
Precertification is the prospective process whereby licensed clinical associates apply designated criteria sets against the intensity of services to be rendered, a member's severity of illness, medical history and previous treatment to determine the medical necessity and appropriateness of a given coverage request.

Prospective means the coverage request occurred prior to the service being provided. Medically necessary care is defined as services and supplies that are necessary to prevent, diagnose, correct or cure conditions in an individual that cause acute suffering, endanger life, result in illness or infirmity, interfere with such a person's capacity for normal activity, or threaten some significant handicap.

Precertification requests can be submitted by phone at **866-231-0847**, via fax to **800-964-3627** or via our website at **www.bcbswny.com/stateplans**. In the case of a standard or nonexpedited request, a decision and notification will be made within three business days of receipt of the necessary information but no later than 14 days after the receipt of the request.

Precertification requests must be submitted, at a minimum, within 72 hours prior to the scheduled service/procedure. Failure to comply with procedure will result in an administrative denial.

Expedited Review
Expedited review of a precertification request must be conducted when Highmark BCBS or the provider indicates the delay would seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum functions. Members have the right to request an expedited review, but Highmark BCBS may deny and notify the member that the review will be processed under standard review time frames. In the case of an expedited review, a decision and notification will be made as fast as the member's condition requires and no later than three calendar days after receipt of the request

Continued Services Review
A review for continued services is the review of a request for continued, extended or more of an authorized service than what is currently authorized by Highmark BCBS. Continued services review requests can be submitted:

- By phone at **866-231-0847**
- Via fax to **844-765-5162**
- Via our website at **www.bcbswny.com/stateplans**

In the case of a standard, nonurgent continued service review, a decision and notification will be made within one business day of receipt of the necessary information but no more than 14 days after receipt of the request. Expedited review of a continued service review request must be conducted when Highmark BCBS or the provider indicate the delay would seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum functions. Members have the right to request an expedited review, but Highmark BCBS may deny and notify the member the review will be processed under standard review time frames. In the case of an expedited continued service review, a decision and notification will be made within one business day of receipt of the necessary information, but no more than three business days after receipt of the request when additional information is requested. Notice of determination shall include the number of continued or extended services approved, the new total of approved services, the date of onset of services and the next review date.

In cases of requests for home health care services following an inpatient hospital admission, notice of determination must be sent within one business day after receipt of the necessary information, except when the day subsequent to the request falls on a weekend or holiday, 72 hours after receipt of necessary information, but no more than three business days after receipt of the request. In all other cases, within one business day of receipt of necessary information, but no more than 14 days after receipt of the service authorization.

Retrospective Review
A retrospective review is the review of a request for services already rendered. Retrospective reviews will be processed by the claims department for services that were not precertified. A decision will be made within 24 hours of receipt of the necessary information, but no more than 30 days after receipt of the request. Notification will be mailed to the member on the date of a payment denial, in whole or in part.

Retrospective Review of Preauthorized Services
Highmark BCBS may reverse a preauthorized treatment, service or procedure when and if **all** of the following occur:

- Relevant medical information presented to Highmark BCBS or the Utilization Review (UR) agent upon retrospective review is materially different from the information that was presented during the precertification review.
- Information existed at the time of the precertification review but was withheld or not made available.
- Highmark BCBS or the UR agent was not aware of the existence of the information at the time of the precertification review.
- Highmark BCBS *had* been aware of the information, the treatment, service or procedure being requested would not have been authorized.

Extension of expedited and standard review time frames for precertification and concurrent review requests may occur if the member, member's designee or provider requests an extension, or if Highmark BCBS can demonstrate a need for more information and the extension is in the member's best interest. An extension will extend the review turnaround time by 14 days. An extension notification will be mailed to the member. Failure to meet the service authorization request time frames as noted above is deemed to be an adverse determination subject to appeal. Highmark BCBS must send a notice of denial on the date the review time frames expire.

Table 1: Standard Time Frames for Completion of Authorization Requests for UM Decision Making and Notification (including behavioral health and non-behavioral health)

Type of Request	**Decision and Electronic/Written Notification NCQA Standard Time Frame**	***NYS Article 49 Regulatory Notification Time Frame** (§ 4903 UR Determinations)
Preservice/Prospective		
Urgent	Within 72 hours (three calendar days) from receipt of request	As fast as the enrollee's condition requires, but no more than three (3) business days

		from the request date. Notice is sent to the enrollee and provider by phone and in writing.
Nonurgent	Within 14 calendar days from receipt of request	Within three (3) business days of receipt of the necessary information but no more than 14 days after receipt of the service authorization request. Notice is sent to the enrollee and provider by phone and in writing.
Concurrent		
Urgent	Within 24 hours (one calendar day) from receipt of request extended to 72 hours (3 calendar days) when additional clinical information is requested	As fast as the enrollee's condition requires and no more than one (1) business day of receipt of necessary information but no more than three (3) business days from the request date. Notice is sent to the enrollee and provider by phone and in writing.
Nonurgent	N/A	Within one (1) business day of receipt of the necessary information but no more than 14 days after receipt of the services authorization request. Notice is sent to the enrollee and provider by phone and in writing.
Post-service/Retrospective		
N/A	Within 30 calendar days from receipt of request	Within 30 calendar days from receipt of the necessary information.
Post-stabilization Care Services (Emergency Care)		
N/A	Within one hour of a request for preapproval of further care to maintain the stabilized condition, or under certain conditions, to improve or resolve the stabilized condition	N/A

*Expedited Request

Table 2: NCQA Extension Time Frames for Completion of Authorization Requests Lacking Necessary Information (including Behavioral Health and Nonbehavioral Health UM)

Type of Request	Frequency	Decision and Electronic/Written Notification Extension Time Frame
Lack of necessary information or matters beyond control of Highmark BCBS		
Urgent, Concurrent	Once • Request not made at least 24 hours to expiration	Within 72 hours (three calendar days) from receipt of request

	• Request to approve additional days for urgent, concurrent care is related to care not previously approved, and at least one attempt was made to obtain additional info within initial 24 hours of request • Member voluntarily agrees to extend the decision-making time frame	
Urgent, Preservice	Once • Must give notification within 24 hours of what specific information is needed • Must give 48 hours to provide the information	Within 48 hours of receiving the information or within 48 hours of the expiration of the specified time period to provide the information
Nonurgent, Preservice	Once	Within 14 calendar days of receiving information
Post service/Retrospective	Once	Within 14 calendar days of receiving information

In the event we're unable to make a nonurgent preservice or post-service decision due to matters beyond our control, or due to the lack of necessary information, we may extend the decision time frame once if we notify the member or member's authorized representative within:

- Fourteen (14) calendar days of a preservice request; **or**
- Thirty (30) calendar days of a post-service request, including date by which we expect to make a decision

In accordance with the New York state Medicaid contract, time frames for preservice and concurrent review determination for both standard and expedited request may be extended for up to 14 days if:

- The enrollee, the enrollee's designee or the provider request an extension orally or in writing; **or**
- We demonstrate or substantiate there is a need for additional information, and the extension is in the member's best interest. We will ensure there is supportive documentation to demonstrate justification for the extension and that it is made available upon NYSDOH request.

Adverse Determinations/Reconsideration/Peer-to-Peer/Appeals

Adverse Determination

An adverse determination is the denial of a service authorization request or the approval of a service authorization request in an amount, duration or scope that is less than what was requested. Adverse determination decisions are made by a clinical peer reviewer. Written notice of an initial adverse determination will be sent to the member and provider and will include:

- A description of the action taken or to be taken

- The reason for the decision, including any clinical rationale
- The member's right to file an internal appeal, including a statement that Highmark BCBS will not retaliate or take discriminatory action against a member if an appeal is filed and a statement that the member has the right to designate someone to file an appeal on their behalf
- The process and time frame for filing an appeal, including an explanation that an expedited review can be requested
- A description of what additional information, if any, must be obtained by Highmark BCBS in order to make a decision on an appeal
- The time frames, including possible extensions of when the appeal decision must be made
- The notice entitled "Managed Care Action Taken" for denial of benefits or for termination or reduction in benefits, as applicable, containing the member's fair hearing and aid continuing rights (for Medicaid and FHP members only)
- Notice of the availability, upon request by the member or member's designee to obtain the review criteria or benefit provision used to make the decision
- Specification of what, if any, additional information must be provided to or obtained by Highmark BCBS to make a decision on an appeal
- Appeals will be reviewed by a person not involved in the initial determination
- The member's right to contact the NYSDOH at **800-206-8125** to file a complaint at any time
- A fair hearing notice, including aid to continue rights if applicable
- Statement that the notice is available in other languages and formats for special needs and how to access these formats

Reconsideration
Reconsideration of an adverse determination can be made when a decision is made without provider input. The reconsideration will occur within one business day of receipt of the request and shall be conducted by the member's health care provider and the clinical peer reviewer who made the initial decision. Reconsiderations cannot be done for retrospective services.

Peer-to-Peer Review
If a request for authorization results in an adverse determination, the servicing/treating provider may discuss the decision with the physician reviewer. To arrange such a review, providers can call **877-269-5515** within seven business days of the date of the notice of action.

Appeals
A member or a member's designee has 90 calendar days from the date of the notice of action to file an internal appeal. In cases of retrospective services, a provider may file an appeal on their own behalf. An appeal may be filed verbally by calling Member Services at **866-231-0847**, or in writing to:

Medical Appeals
P.O. Box 62429
Virginia Beach, VA 23466-2429

All standard verbal appeal requests must be followed up with a written request.

Appeals of adverse determinations may be processed under expedited or standard time frames. The time frame for Highmark BCBS to make an appeal decision begins when Highmark BCBS receives the necessary information. The clinical peer reviewer for all appeal reviews will not be the same clinical peer reviewer that made the initial decision. Highmark BCBS will send a written acknowledgment of the appeal within fifteen calendar days of receipt of the appeal request. If a decision is made before the written acknowledgement is sent, the written acknowledgement may be included with the notice of appeal determination. Members will be given the opportunity to present evidence both before and during the appeal process and will be allowed to examine their case file and receive a free copy of their case file upon request.

Expedited Review and Time Frames
An appeal will automatically be processed as expedited if any of the following types of denials are issued:

- Denial for concurrent services or denial of an extension for concurrent services
- Denial for services that are part of a specific treatment plan as prescribed by the member's physician
- Denial of a hospital admission while the member is still in-house at the time of the denial
- Denial of home care services following an admission to the hospital
- Denial of services that the member or member's physician feel are urgent, and a delay in review would jeopardize the member's life, health or the ability to attain, maintain or regain maximum function

Members have the right to request an expedited appeal, but Highmark BCBS may deny and notify the member immediately by phone, and also in writing within two days of the decision to deny an expedited review request, that the appeal will be processed under standard appeal time frames. If Highmark BCBS requires additional information to process the appeal, Highmark BCBS will immediately notify the member and the member's health care provider by phone or fax, followed by a written notice.

An expedited appeal decision will be made as fast as the member's condition requires and within two business days of receipt of the necessary information but no more than three business days after receipt of the appeal. A member may be eligible to file an external expedited appeal at the same time. Expedited appeals not resolved to the satisfaction of the appealing party may be reappealed via the standard appeal process or through an external appeal process. Written notification of an expedited appeal decision will be sent within 24 hours of rendering the decision. Highmark BCBS will make a reasonable effort to provide oral notice to the member and the provider at the time the decision is made.

Standard Review and Time Frames
A standard appeal decision will be made as fast as the member's condition requires but no later than 30 days from receipt of the appeal.

If Highmark BCBS requires additional information to process the appeal, Highmark BCBS will notify the member and the member's health care provider, in writing, within 15 days of receipt of the appeal of the need for additional information. In the case that only a portion of the necessary information is received, Highmark BCBS will request the missing information, in writing, within five business days of receipt of the partial information. Turnaround time for an appeal decision, whether expedited or standard, may be extended for up to 14 days when the member, member's designee or provider requests an extension; or Highmark BCBS can demonstrate a need for more information and the extension is in the member's best interest. An extension notification will be mailed to the member.

Written Notification of Appeal Decisions
Written notification of an appeal decision will be sent to the member, member's designee and provider within two business days of rendering the decision. The written notification will include:

- The date, basis and clinical rationale for the decision
- The words "final adverse determination"
- The Highmark BCBS contact person and phone number
- The member's coverage type
- The UR agent's name, address, contact person and phone number
- The service that was denied, including facility/provider and developer/manufacturer of service as available
- A statement that the member may be eligible for an external appeal and the time frames for an external appeal
- A statement indicating that if a second level of internal appeal is offered, the member cannot be required to exhaust both levels and has only four months from receipt of the final adverse determination to file an external appeal. Note: Choosing to file for a second level of internal appeal may cause the time frame to file an external appeal to expire (Highmark BCBS does not offer a second level of internal appeal)
- The standard description of the external appeal process
- A summary of appeal and date filed
- The date appeal process was completed
- A description of the member's fair hearing rights (if not included with the original denial; CHPlus members do not have fair hearing rights)
- The member's right to contact the NYSDOH at **800-206-8125** and complain
- A statement that the notice is available in other languages and formats for special needs and how to access these formats

Failure to make an appeal decision within the time frames noted above is deemed to be a reversal (approval) of the adverse determination. Highmark BCBS and the member may jointly agree to waive the internal appeal process. If this occurs, Highmark BCBS will inform the

member of the process to request an external appeal in writing within 24 hours of the agreement to waive the internal appeal process.

In order to comply with both NYS regulatory requirements and NCQA standards, Highmark BCBS will follow the most stringent time frames for appeals. See the following table for comparison:

Appeals Standard Time Frames

Appeal Type	**Filing an Appeal**	**Decision Notification: NCQA Time Frames**	***NYS Article 49 Regulatory Notification Time Frame** (§ 4903 UR Determinations)
Preservice			
Expedited (Urgent)	ASAP	Within 72 hours of receipt of the appeal request	Clinical peer reviewer must be available within one business day. A determination will be made within two (2) business days of receipt of necessary information but no longer than three (3) business days of appeal request. If time frame is not adhered to, automatic approval is granted. Final adverse determination notification is transmitted to the enrollee/enrollee's designee and provider within 24 hours of determination.
Standard	Between 20 and 90 calendar days (NYS-specific: no less than 60 business days and no more than 90 days from the date of the notice of action)	Within 30 calendar days of receipt of the appeal request	Acknowledgment letter to appealing party is sent within 15 days of filing. Enrollee and provider are notified if additional information is needed. If partial information is received, Highmark BCBS will request missing information in writing within five (5) business days of receipt of partial information. A different peer clinical reviewer makes the determination no later than 30 days from the date of the appeal request. If time frames are not adhered to, automatic approval is granted. Final adverse determination notice is sent to enrollee/enrollee's designee and provider within two

Appeal Type	**Filing an Appeal**	**Decision Notification: NCQA Time Frames**	***NYS Article 49 Regulatory Notification Time Frame** (§ 4903 UR Determinations)
			(2) business days of the decision.
Retrospective/post-service			
N/A	Between 20 and 90 calendar days (NYS-specific: no less than 60 business days and no more than 90 days from the date of the notice of action)	Within 60 calendar days of receipt of the appeal request	Same as standard time frame

External Appeal Process

As the provider, you may be eligible to request an external appeal, an independent review of a coverage denial made by a third-party agent known as an External Review agent. You may request an external appeal if one of the following applies:

- The denial issued was based upon lack of medical necessity, and the member has exhausted the internal action appeal process through Highmark BCBS, or the member and Highmark BCBS both agree to waive the internal action appeal process.
- The denial was issued because the service is considered experimental or investigational, and the member has exhausted the internal action appeal process through Highmark BCBS, or the member and Highmark BCBS both agree to waive the internal action appeal process. In this case, a physician must certify that the member has a life-threatening or disabling disease or condition or a rare disease for which:
    - Standard medical treatment is not effective or medically inappropriate
    - Standard medical treatment does not exist
    - A licensed, board-certified or board-eligible doctor recommends either:
        1. A treatment or medication which, based on two documents of medical and scientific evidence, is likely to be more beneficial to the member than any covered standard treatment
        2. In the case of a rare disease, a treatment whose benefits to the member outweigh the risks
        3. In the case of a rare disease, a clinical trial for which the member is eligible
- The denial was issued because the service is being done by an out-of-network provider (outside of the Highmark BCBS network) and the member has exhausted the internal action appeal process through Highmark BCBS, or the member and Highmark BCBS both agree to waive the internal action appeal process. In this case, a physician must certify that:

- The out-of-network service is materially different than the recommended in-network service.
- A licensed, board-certified or board-eligible doctor recommends an out-of-network treatment or medication which, based on two documents of medical and scientific evidence, is likely to be more beneficial to the member than any covered in-network treatment and whose benefits to the member outweigh the risks.

Providers may request an external appeal no later than 60 days from the date of the final adverse determination. A member has up to four months to request an external appeal.

Please note that in cases concerning ongoing (concurrent) services or services already provided to the member (retrospective), you may be eligible to request an external appeal on the member's behalf.

Medically Necessary
Medically necessary health services are defined as health services that meet all or one of the following conditions:

- Services are essential to prevent, diagnose, prevent the worsening of, alleviate, correct or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, result in illness or infirmity of a member or interfere with such person's capacity for normal activity.
- Services are provided at an appropriate facility and at the appropriate level of care for the treatment of the member's medical condition.
- Services are provided in accordance with generally accepted standards of medical practice.

Note: We do <u>not</u> cover the use of any experimental procedures or experimental medications, except under certain preauthorized circumstances.
Fair Hearing Process
A member or their designee may ask for a fair hearing and/or an external appeal. However, the decision of the fair hearing officer will supersede any external appeal decision. A member or their designee can request a fair hearing by sending a written request within 60 days from the adverse determination to:

New York State Office of Temporary and Disability Assistance
Fair Hearings
P.O. Box 22023
Albany, NY 12201-2023

They may also call toll-free at **800-342-3334** or fax to **518-473-6735**.
Continuation of Benefits (Aid Continuing)
Highmark BCBS members may request a continuation of their benefits during the appeal process by contacting Highmark BCBS Member Services at **866-231-0847**. To ensure continuation of currently authorized services, the member or person acting on behalf of the

member must file a medical appeal on or before 10 calendar days following Highmark BCBS mailing the Notice of Action, or the intended effective date of the Action.

Highmark BCBS will continue the member's coverage of benefits if the following conditions are met:

- The member or the provider files the appeal timely (as defined above).
- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment.
- The services were ordered by an authorized provider.
- The original period covered by the original authorization has not expired.
- The member requests extension of benefits.

If, at the member's request, Highmark BCBS continues or reinstates the member's benefits while the appeal is pending, the benefits will be continued until one of the following occurs:

- The member withdraws the medical appeal or request for the state fair hearing.
- Ten calendar days pass after Highmark BCBS mails the medical appeal determination letter, unless the member has, within the 10 calendar days, requested a state fair hearing with continuation of benefits until a state fair hearing decision is reached.
- The time period or service limit of a previously authorized service has been met.

The member may be responsible for the continued benefits if the final determination of the appeal is not in the member's favor. If the final determination of the medical appeal is in the member's favor, Highmark BCBS will authorize coverage of and arrange for disputed services promptly and as expeditiously as the member's health condition requires. If the final determination is in the member's favor and the member received the disputed services, Highmark BCBS will pay for those services.

HOSPITAL AND ELECTIVE ADMISSION MANAGEMENT

Overview

Highmark BCBS requires precertification of all inpatient elective admissions. The referring primary care or specialist physician is responsible for precertification. The referring physician identifies the need to schedule a hospital admission and must submit the request to the Highmark BCBS Medical Management department.

Requests for precertification with all supporting documentation must be submitted at a minimum of 72 hours prior to the scheduled admission. Failure to comply with notification rules will result in an administrative denial.

Administrative denial: a denial of services based on reasons other than medical necessity Administrative denials are made when a contractual requirement is not met, such as late notification of admissions, lack of precertification or failure by the provider to submit clinical information when requested. Appeals for administrative denials must address the reason for the denial (that is, why precertification was not obtained or why clinical information was not submitted). If Highmark BCBS overturns its administrative decision, the case will be reviewed for medical necessity. If approved, the claim will be reprocessed or the requestor will be notified of the action that needs to be taken.

This will allow Highmark BCBS to verify benefits and process the precertification request. For services that require precertification, Highmark BCBS makes case-by-case determinations that consider the individuals' health care needs and medical histories in conjunction with InterQual criteria.

The hospital can confirm that an authorization is on file by calling **866-231-0847** (see Chapter 13 of this manual for instructions). If coverage of an admission has not been approved, the facility should call Highmark BCBS at **866-231-0847**. Highmark BCBS will contact the referring physician directly to resolve the issue.

Highmark BCBS is available 24 hours a day, 7 days a week to accept precertification requests. When a request is received from the physician via telephone or fax for medical services, the care specialist will verify eligibility and benefits. This information will be forwarded to the precertification nurse.

The precertification nurse will review the coverage request and the supporting medical documentation to determine the medical appropriateness of diagnostic and therapeutic procedures. When appropriate, the precertification nurse will assist the physician in identifying alternatives for health care delivery as supported by the medical director.

When the clinical information received is in accordance with the definition of medical necessity and in conjunction with InterQual criteria, a Highmark BCBS reference number will be issued to the referring physician. All utilization guidelines must be supported by an individualized determination of medical necessity based on the member's needs and medical history.

If the precertification documentation is incomplete or inadequate, the precertification nurse will not approve coverage of the request but will notify the referring provider to submit the additional necessary documentation.

If the medical director denies coverage of the request, the appropriate denial letter (including the member's appeal rights) will be mailed to the requesting provider, the member's PCP and the member.

Emergent Admission Notification Requirements

Highmark BCBS prefers immediate notification by network hospitals of emergent admissions. All hospitals must notify Highmark BCBS of emergent admissions within one business day of admission or post-stabilization. Failure to comply with notification rules will result in an administrative denial. Highmark BCBS Medical Management staff will verify eligibility and determine benefit coverage.

Highmark BCBS is available 24 hours a day, 7 days a week to accept emergent admission notification at **866-231-0847**.

Coverage of emergent admissions is authorized based on review by a concurrent review nurse. When the clinical information received meets InterQual criteria, a Highmark BCBS reference number will be issued to the hospital.

If the notification documentation provided is incomplete or inadequate, Highmark BCBS will not approve coverage of the request and will notify the hospital to submit the additional necessary documentation.

If the medical director denies coverage of the request, the appropriate denial letter will be mailed to the hospital, the member's PCP and the member.

Nonemergent Outpatient and Ancillary Services: Precertification/ Notification Requirements

Highmark BCBS requires precertification for coverage of selected nonemergent outpatient and ancillary services (see chart below). To ensure timeliness of the authorization, the facility and/or provider is expected to provide the following:

- Member name and ID
- Name, telephone number and fax number of physician performing the elective service
- Name of the facility and telephone number where the service is to be performed
- Date of service
- Member diagnosis
- Name of elective procedure to be performed with CPT-4 code
- Medical information to support requested services (medical information includes current signs/symptoms, past and current treatment plans, response to treatment plans and medications)

The provider must advise the member prior to initiating care if a service is not covered by Highmark BCBS and state the cost of the service.

If precertification is required, the request must be submitted, at a minimum, within 72 hours of the scheduled admission. Failure to comply with notification rules will result in an administrative denial.

Precertification and Notification Requirement Guidelines

Service	Requirement	Comments

Behavioral Health/ Substance Abuse	Precertification	• Inpatient psychiatric, inpatient detoxification, inpatient substance abuse rehabilitation and ambulatory detoxification treatment require precertification and concurrent review.
		• No precertification is required for participating providers for coverage of traditional outpatient services such as individual, group and family therapy.
		• Precertification is required for coverage of psychological and neuropsychological testing.
		• Electroconvulsive therapy requires precertification.
		• Partial hospitalization – requires precertification
		• Rehabilitation services for residential SUD treatment supports (OASAS service)
		• Rehabilitation services for residents of community residences (year 2)
		• Precertification is required for the following services:
		  ○ Continuing day treatment
		  ○ PROS
		  ○ ACT
		  ○ Psychosocial rehabilitation
		  ○ Community psychiatric support and treatment (CPST)
		• No precertification required for the following:
		  ○ Medically supervised outpatient withdrawal – Ambulatory Detox
		  ○ Outpatient SUD Services (OASAS BH Solo/ group practice)
		  ○ Opioid treatment program / Methadone Maintenance (OTP services)
		  ○ Outpatient services – MH (OMH services, BH solo/group practice)
		  ○ Comprehensive psychiatric emergency program
		  ○ Intensive case management/supportive case management
		  ○ Health Home care coordination and management

Biofeedback		Precertification is not required.
Point-of-care Blood Lead Testing		Covered for pregnant women and children age 6 and younger. Physician office laboratories and limited-service laboratories must bill for in-office testing using CPT-4 procedure code 83655.

Service	Requirement	Comments
Cardiac Rehabilitation	Precertification	Precertification is required.
Chemotherapy		No precertification is required for outpatient chemotherapy services when performed in a participating facility, provider's office or ambulatory surgery center. Precertification is required for coverage of inpatient chemotherapy services and for certain chemotherapy drugs. For information on coverage of chemotherapy drugs, please see the Pharmacy section of this grid.
Chiropractic Services		Chiropractic is not a covered service for adults. This is a covered benefit under the FFS Medicaid program for children younger than age 21 as part of the EPSDT program, and only when ordered by a physician.
Clinical Trials		• **Medicaid Managed Care members**: Experimental and investigational treatment is covered on a case-by-case basis. • **CHPlus members**: This is not a covered benefit.
Court-ordered Services	Precertification	Precertification is required.
Dental Services		• Members may self-refer for dental checkups and cleaning exams. Dental benefits are administered through a network vendor, Healthplex. Dental procedures requiring anesthesia and/or planned inpatient admission or services at an outpatient ambulatory center must first be approved by Healthplex. If approved, a follow-up call to Highmark BCBS is required by the provider for precertification. For TMJ services, see the Plastic/Cosmetic/Reconstructive Surgery section of this grid. • Orthodontic care is covered for Medicaid Managed Care members. See the Orthodontic Care section of this grid. • **Medicaid Managed Care members**: Managed care members may self-refer to Article 28 clinics not in our network operated by academic dental centers to obtain covered dental services. Also includes up to four annual fluoride varnish treatments for children from birth until 7 years of age when applied by a dentist, physician or nurse practitioner. • **CHPlus members**: All necessary procedures requiring dental anesthesia for simple extractions and other routine dental surgery that do not require hospitalization are covered and include in-office conscious sedation. • Providers may call Healthplex at **888-468-2183** for the following:

Service	Requirement	Comments
		○ Emergency Referral Unit, select prompt 2 ○ Provider Services Unit, select prompt 3 ○ Provider Relations, select prompt 4
Dermatology Services	No precertification required for network provider for E&M, testing and procedures	Services considered cosmetic in nature are not covered. Services related to previous cosmetic procedures are not covered. See the Diagnostic Testing section of this grid.
Diagnostic Testing	Precertification	• No precertification is required for routine diagnostic testing. • Precertification is required for coverage of MRA, MRI, CAT scans, nuclear cardiac, PET scans and video EEG. • Contact AIM at**800-714-0040**.
Durable Medical Equipment	Precertification and certificate of medical necessity	• Durable Medical Equipment (DME) are devices and equipment that can withstand repeated use for a protracted period of time; is primarily and customarily used for medical purposes; is generally not useful to a person in the absence of illness or injury; and is usually not fitted, designed or fashioned for a particular individual's use. Where equipment is intended for use by only one person, it may be either custom made or customized. • No precertification is required for coverage of preferred glucometers and nebulizers, dialysis and ESRD equipment, gradient pressure aid, infant photo/light therapy, sphygmomanometers, walkers and orthotics for arch support, heels, lifts, shoe inserts and wedges by network provider. • All DME billed with an RR modifier (rental) requires precertification. • Precertification is required for coverage of certain DME. Certain items are considered comfort items and are not covered. For code-specific precertification requirement for DME, please visit our website, go to the Quick Tools menu and click on Precertification Lookup. • Precertification of DME items costing $1,500 or more require the medical director's review. Items costing $3,000 or more require the National DME consultant's review.

Service	Requirement	Comments
		• Precertification may be requested by completing a Certificate of Medical Necessity (CMN) — available on our website — or by submitting a physician order and Highmark BCBS Referral and Authorization Request form. A properly completed and physician-signed CMN must accompany each claim for the following services: hospital beds, support surfaces, motorized wheelchairs, manual wheelchairs, Continuous Positive Airway Pressure (CPAP), lymphedema pumps, osteogenesis stimulators, Transcutaneous Electrical Nerve Stimulators (TENS), seat lift mechanisms, power-operated vehicles (POVs), external infusion pump, parenteral nutrition, enteral nutrition and oxygen. Highmark BCBS and provider must agree on HCPCS and/or other codes for billing covered services. • See the Disposable Medical Supplies section of this grid for guidelines relating to disposable medical supplies.
Early and Periodic Screening, Diagnosis, and Treatment Visit	Self-referral	• Utilize EPSDT schedule and document visits. Vaccine serum is received under the Vaccines for Children (VFC) Program. • **Medicaid Managed Care members**: Chiropractic services are covered for children under age 21 as part of the EPSDT program only when ordered by a physician. • **CHPlus members**: Services are covered according to the medical need and visitation schedules established by the American Academy of Pediatrics.
Educational Consultation		No notification or precertification is required.
Emergency Room	Self-referral	No notification is required for emergency care given in the ER. If emergency care results in admission, notification to Highmark BCBS is required within 24 hours or the next business day. For observation precertification requirements, see the Observation section of this grid.
Enteral Formula	Precertification	• Enteral formula and nutritional supplements are covered under DME benefit and must be obtained through a DME provider rather than a pharmacy. • **Medicaid Managed Care members:** Covered for tube-fed individuals who cannot chew or swallow food, those with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through other means, and children who require medical formulas due to mitigating factors in growth and development.

Service	Requirement	Comments
		• **CHPlus members:** Coverage based on medical necessity for treatment of specific diseases; $2500 per calendar year for modified solid food products that contain low or modified protein used to treat inherited diseases of amino acid and organic acid metabolism.
Family Planning/STD Care	Self-referral	• **Medicaid Managed Care members**: May self-refer to an in-network or out-of-network provider. • Covered services include pelvic and breast examinations, lab work, drugs, biological, genetic counseling, and devices and supplies related to family planning (for example, IUD). • Infertility services and treatment are not covered.
Gastro-enterology Services	No precertification required for network provider for E&M, testing and procedures	Precertification is required for bariatric surgery, including insertion, removal and/or replacement of adjustable gastric restrictive devices and subcutaneous port components, and all endoscopies. See the Diagnostic Testing section of this grid.
Gynecology	Self-referral	• Self-referral to a network provider. • No precertification is required for E&M, testing and procedures.
Hearing Aids		• Precertification is required for digital hearing aids. • **CHPlus members**: Hearing aids, including batteries and repairs, are covered. • **Medicaid Managed Care members**: Hearing aid and batteries are covered.
Hearing Screening		• Simple hearing exams require PCP referral only. No notification or precertification is required for coverage of diagnostic and screening tests, hearing aid evaluations or counseling. • **CHPlus members**: One hearing examination per calendar year is covered. If an auditory deficiency requires additional hearing exams and follow-up exams, these exams will be covered.
Home-Delivered Meals		• **Medicaid Managed Care members**: This is not a covered benefit. • **CHPlus members**: This is not a covered benefit.
Home Health Care (including Behavioral Health)	Precertification	• Precertification is required. • Covered services include skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, social work services and telehealth services when provided by NYSDOH-approved agencies.

Service	Requirement	Comments
		• **CHPlus members**: Home care services are limited to 40 visits per year for all types of service combined. Private duty nursing is not a covered benefit.
Home Modifications		• **Medicaid Managed Care members:** This is not a covered benefit. • **CHPlus members**: This is not a covered benefit.
Hospital Admission	Precertification	• Emergency admissions require notification within 24 hours or the next business day. • To be covered, preadmission testing must be performed by a Highmark BCBS preferred lab vendor. See the provider referral directory for a complete listing of participating vendors. • Precertification required for same-day/ambulatory surgeries • No coverage for personal comfort and convenience items and services and supplies not directly related to the care of the patient (such as telephone charges, take-home supplies and similar costs).
Laboratory Services (Outpatient)	Precertification	• All laboratory services furnished by non-network providers require precertification by Highmark BCBS, except for hospital laboratory services in the event of an emergency medical condition. • For offices with limited or no office laboratory facilities, lab tests may be referred to one of the Highmark BCBS preferred lab vendors. • See the provider referral directory for a complete listing of participating vendors.

Service	Requirement	Comments
Medical Supplies		• Consumable medical supplies and equipment are items other than drugs, prosthetic or orthotic appliances or DME that have been ordered by a qualified practitioner in the treatment of a specific medical condition and are: consumable, nonreusable, disposable or for a specific rather than incidental purpose and generally have no salvageable value. Disposable medical supplies are disposed of after use by a single individual. • **Medicaid Managed Care members**: Supplies do not require precertification and are covered and billable under medical benefits similar to DME. Some medical supplies, such as insulin syringes, are covered under pharmacy. Visit our website for code-specific information. • Medical supplies used during home care services are covered as part of the home care service rate. A list of these supplies can be found in the Medicaid Management Information Systems (MMIS) Home Health Services provider manual. • **CHPlus members:** Medical supplies are not covered with the exception of diabetic supplies and medical supplies that are routinely furnished as part of a clinic or office visit, which is covered by Highmark BCBS. Medical supplies used during home care services are covered as part of the home care service rate. A list of these supplies can be found in the MMIS Home Health Services provider manual.
Neurology	No precertification required for network provider for E&M and testing	Precertification is required for neurosurgery, spinal fusion and artificial intervertebral disc surgery. See the Diagnostic Testing section of this grid.
Observation		Observation services are covered for patients who are seen, evaluated and admitted to an observational unit. Precertification is not required for participating facilities.
Obstetrical Care		• No precertification is required for coverage of obstetrical (OB) services, including obstetrical visits, diagnostic tests and laboratory services when performed by a participating provider. • Notification to Highmark BCBS is required at the first prenatal visit.

Service	Requirement	Comments
		• No precertification is required for coverage of labor and delivery and for circumcision for newborns up to 12 weeks of age. • Notification of delivery is required within 24 hours with newborn information. OB case management programs are available. See the Diagnostic Testing section of this grid. • One sonogram is covered per pregnancy; additional sonograms are covered with submission of supportive applicable diagnosis codes.
Ophthalmology	No precertification required for E&M, testing and procedures	• Precertification is required for repair of eyelid defects. Services considered cosmetic in nature are not covered. See the Diagnostic Testing section of this grid. • See the Vision Services section of this grid. • **Medicaid Managed Care members:** Members may self-refer to Article 28 clinics affiliated with the College of Optometry of the State University of New York to obtain covered optometry services.
Oral Maxillofacial	Precertification	See the Plastic/Cosmetic/Reconstructive Surgery section of this grid.
Orthodontic Care	Precertification	• **Medicaid Managed Care members:** Covered for children up to age 21 who have severe problems with teeth that causes difficulty chewing foods such as severely crooked teeth, cleft palette or cleft lip. Providers may call Healthplex at **888-468-2183**. • **CHPlus members:** Not covered
Orthotics and Prosthetics/ Orthopedic Footwear	Precertification	• Orthotic devices are those devices used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body. Prosthetic appliances are those appliances and devices ordered by a qualified practitioner that replace any missing part of the body. • Precertification is required for certain orthotic devices. For code-specific precertification requirement for DME, please refer to our website; go to the Quick Tools menu and click on Precertification Lookup. • **Medicaid Managed Care members**: Orthotics and prosthetics are subject to Medicaid coverage and limits. Coverage for orthopedic footwear only for children under 21 years of age that require orthopedic footwear, shoes attached to a lower-limb orthotic brace or as a component of a comprehensive diabetic treatment plan to treat amputation, ulcerations, pre-ulcerative calluses,

Service	Requirement	Comments
		peripheral neuropathy with evidence of callus formation, foot deformities or poor circulation. • **CHPlus members**: Orthotic devices prescribed solely for use during sports are not covered. There is no coverage for cranial prosthesis (for example, wigs) and dental prosthesis, except those made necessary due to accidental injury to sound, natural teeth and provided within 12 months of the accident, and except for dental prosthesis needed in treatment of congenital abnormality or as part of reconstructive surgery.
Otolaryngology (ENT) Services	No precertification for network provider for E&M, testing and procedures	Precertification required for tonsillectomy and/or adenoidectomy, nasal/sinus surgery, cochlear implant surgery and services. See the Diagnostic Testing section of this grid.
Out-of-Area/ Out-of-Network Care	Precertification	• Precertification is required with the exception of emergency care (including self-referral). • Out-of-area care is only covered for emergent services; elective services are not covered. • Out-of-network care is only covered in instances of continuity of care for new enrollees, instances where the provider leaves the network or if an in-network provider is not available to perform the service. • **CHPlus members**: This is not a covered benefit except for emergency services.
Outpatient/ Ambulatory Procedure/ Surgery	Precertification	• Precertification requirements are based on the services rendered. Please visit our website for code-specific requirements. • **Medicaid Managed Care members:** Knee arthroscopy when the primary diagnosis is osteoarthritis of the knee (without mechanical derangement of the knee) is not covered.
Pain Management	Precertification	• Precertification is required for all services and procedures. Contact OrthoNet for authorization of all pain management services related to spinal procedures at: **855-596-7618**. • **Medicaid Managed Care members:** Prolotherapy, intradiscal steroid injections, facet joint steroid injections, systemic corticosteroids and traction (continuous or intermittent) for lower back pain are not covered.
Pharmacy		The pharmacy benefit covers medically necessary prescription and over-the-counter (OTC) drugs prescribed

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<tr><th>Service</th><th>Requirement</th><th>Comments</th></tr>
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by a licensed provider. Exceptions and restrictions exist as the benefit is provided under a closed formulary/Preferred Drug List (PDL).

Please refer to the appropriate PDL and/or the Medicaid Medication Formulary for the preferred products within therapeutic categories as well as requirements around generics, prior authorization (PA), step therapy, quantity edits and the PA process.

Note: Be sure to check the back of the member’s ID card for applicable pharmacy information. The PDL and formulary are housed on our provider self-service site.

Prescription and OTC drugs are covered for Medicaid Managed Care and CHPlus members.
Enteral formula is covered under the DME benefit. See the DME section.
Medicaid Managed Care and CHPlus members: Growth hormone injections solely for Idiopathic Short Stature (ISS) in children are not covered.
PA is required for all nonformulary drugs and other certain medications.

Many self-injectable medications, self-administered oral specialty medications and office-administered specialty medications are available through Accredo or pharmacies in our specialty network and require PA.
To determine if a medical injectable requires precertification, please go to the Quick Tools section of our website and click on Precertification Lookup. For a complete list of covered injectables, please visit the Pharmacy section of our website.
Important phone numbers are below.

<table>
<tr><th>If you need to:</th><th>Call:</th></tr>
<tr><td>Initiate a PA request for:
• All Highmark BCBS members
• Medical injectables covered under the medical benefit for all members</td><td>Highmark BCBS Provider Services Prior Authorization:
866-231-0847</td></tr>
<tr><td>Schedule delivery once you receive a
PA approval notice for Highmark BCBS members</td><td>Accredo:
800-803-2523</td></tr>
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Service	Requirement	Comments
Physiatry	Precertification	Precertification is required for coverage of all services and procedures related to pain management.
Physical Medicine and Rehabilitation	Precertification	Precertification is required for coverage of all services and procedures related to pain management.
Plastic/Cosmetic/Reconstructive Surgery (including Oral Maxillofacial Services)		• No precertification is required for coverage of E&M codes. • All other services require precertification. Services considered cosmetic in nature are not covered. Services related to previous cosmetic procedures are not covered (for example, scar revision, keloid removal resulting from pierced ears). Reduction mammoplasty requires the medical director's review. • No precertification is required for coverage of oral maxillofacial E&M services. • Precertification is required for coverage of trauma to the teeth and oral maxillofacial medical and surgical conditions, including TMJ.
Podiatry		• No precertification for coverage of E&M, testing and procedures when provided by a participating podiatrist. • **Medicaid Managed Care members**: Services provided by a podiatrist for persons under age 21 and adults with diabetes must be covered upon referral of a physician, registered physician assistant, certified nurse practitioner or licensed midwife.
Radiation Therapy		• No precertification is required for coverage of radiation therapy procedures when performed in the following outpatient settings by a participating facility or provider: office, outpatient hospital and ambulatory surgery center.
Radiology Services		See the Diagnostic Testing section of this grid.
Rehabilitation Therapy (Short Term): OT, PT, RT and ST	Precertification	• Precertification is required for outpatient therapy services after the initial consultation. Providers should contact OrthoNet at: **855-596-7618**. Members needing therapy to learn or participate in a school setting should be evaluated for school-based therapy. Other therapy services for rehabilitative care will be covered as medically necessary. • **Medicaid Managed Care members:** Outpatient visits for physical, occupational and speech therapy are limited to 20 visits per visit type per calendar year. Limits

Service	Requirement	Comments
		do not apply for children under age 21, members with developmental disabilities and those with brain injuries. • **CHPlus members:** There are no limits for CHPlus members. Visits are based on medical necessity. PT, OT and ST for children diagnosed with autism spectrum disorder are also covered when such treatment is deemed habilitative or nonrestorative. • All therapy services are subject to retrospective utilization review.
Referral		• A referral is required for all specialty visits. The referral should be obtained from the member's PCP. There is no specific Highmark BCBS referral form. Referrals can be given on prescription or stationery. • No precertification is required for in-network referral. • All out-of-network referrals require precertification.
Skilled Nursing Facility	Precertification	Precertification is required for coverage of all services.
Smoking Cessation Counseling		• No precertification or notification is required. Smoking cessation counseling must be provided by a physician, registered physician's assistant, registered nurse practitioner or licensed midwife during a medical visit (no group sessions). • All Medicaid Managed Care members are allowed up to eight counseling sessions within a continuous 12-month period. Use diagnosis codes 99406 and 99407.
Specialty Referral		• A referral is required for all specialty visits. The referral should be obtained from the member's PCP. There is no specific Highmark BCBS referral form. Referrals can be given on prescription or stationery. • There is no precertification required for in-network referral. • All out-of-network referrals require precertification.
Sterilization		• Sterilization services are a covered benefit for members age 21 and older. • No precertification or notification is required for coverage of sterilization procedures, including tubal ligation and vasectomy. • **A sterilization consent form is required for claims submission.** For hysterectomies, use form 3133. For sterilizations, use form 3134. • Reversal of sterilization is not a covered benefit.
Transportation		• No precertification or notification is required except for planned air transportation (airplane). To arrange

Service	Requirement	Comments
(Nonemergent)		transportation, contact Medical Answering Services, LLC (MAS) (see the Quick Reference Information section for the correct phone numbers). • **CHPlus members**: This is not a covered benefit.
Urgent Care Center		No notification or precertification is required for a participating facility.
Vision Services — Medicaid Managed Care and CHPlus		• Members and providers may contact **866-231-0847**. • **Medicaid Managed Care**: Members are allowed to self-refer to any participating provider of vision services (optometrist or ophthalmologist) for refractive vision services once every two years unless otherwise justified as medically necessary or unless eyeglasses are lost, damaged or destroyed. Eyeglasses and examinations are limited to once every 24 months unless otherwise justified as medically necessary. Contact lenses are covered once every 24 months only when medically necessary. Members diagnosed with diabetes are eligible for an annual dilated eye (retinal) examination. • **CHPlus members**: Vision examinations performed by a physician or optometrist for the purpose of determining the need for corrective lenses and, if needed, to provide a prescription are covered. Vision examinations and eyeglasses are covered every 12-month period. • Members are financially responsible for upgrades of frames and/or lenses that are not medically necessary (for example, personal preference upgrades).
Well-Woman Exam	Self-referral	Two well-woman exams are covered per calendar year when performed by a PCP or an in-network GYN. Exam includes routine lab work, STD screening, Pap smear and mammogram (age 35 or older).
Revenue Codes		Precertification or notification is required for services billed by facilities with revenue codes for inpatient, OB, home health care, hospice, MRI, high-dollar injectables, chemotherapeutic agents, pain management and rehabilitation (physical/occupational/respiratory therapy), and rehabilitation short-term (speech therapy) require precertification or notification. For a list of the specific revenue codes requiring precertification, please refer to our website.

For services that require precertification, we use McKesson InterQual Criteria to determine medical necessity for inpatient services and Highmark BSBC medical policies and clinical UM guidelines for outpatient services.

We're staffed with clinical professionals who coordinate services provided to members and are available 24 hours a day, 7 days a week to accept precertification requests. When we receive your request for medical services via fax, the precertification assistant will verify eligibility and benefits, which will then be forwarded to the nurse reviewer.

The nurse will review the request and the supporting medical documentation to determine the medical appropriateness of diagnostic and therapeutic procedures. When appropriate, the nurse will assist you in identifying alternatives for health care delivery as supported by the medical director.

When the clinical information received meets medical necessity criteria, a Highmark BCBS reference number will be issued to you.

If the request is urgent (that is, an expedited service), the decision will be made within 24 hours.

If the precertification documentation is incomplete or inadequate, the nurse will not approve coverage of the request but will instead ask you to submit the additional necessary documentation.

If the medical director denies the request for coverage, the appropriate notice of proposed action will be mailed to the requesting provider, the member's primary physician, the facility and the member.

Inpatient Reviews

Inpatient Admission Reviews

All inpatient hospital admissions, including urgent and emergent admissions, will be reviewed within one business day. A Highmark BCBS Utilization Review (UR) clinician determines the member's medical status through communication with the hospital's UR department. Appropriateness of stay is documented, and the concurrent review is initiated. Cases may be referred to the medical director, who renders a decision regarding the coverage of hospitalization. Diagnoses meeting specific criteria are referred to the medical director for possible coordination by the care management program.

Inpatient Concurrent Review

Each network hospital will have an assigned Utilization Management (UM) clinician. Each UM clinician will conduct a concurrent review of the hospital medical record via fax, phone or electronic medical record (EMR) to determine the precertification of coverage for a continued stay.

When one of our UM clinicians reviews the hospital's medical record, he or she will conduct continued stay reviews and review discharge plans.

When the clinical information received meets medical necessity criteria, approved days and bed-level coverage will be communicated to the hospital for the continued stay.

Our UM clinicians will help coordinate discharge planning needs with the hospital utilizations review staff and attending physician. The attending physician is expected to coordinate with the member's PCP regarding follow-up care after discharge. The PCP is responsible for contacting the member to schedule all necessary follow-up care. In the case of a behavioral health discharge, the attending physician is responsible for ensuring the consumer has secured an appointment for a follow-up visit with a behavioral health provider to occur within seven calendar days of discharge.

We will authorize covered length of stay based on the clinical information that supports the continued stay. Length of stay authorizations for confinements are based on the severity of the illness and subsequent course of treatment or if it is predetermined by state law. Exceptions are made by the medical director.

If, based upon appropriate criteria and after attempts to speak to the attending physician, the medical director denies coverage for an inpatient stay request, the appropriate notice of action will be mailed to the hospital, the attending provider and the member.

Discharge Planning
Discharge planning is designed to assist you in the coordination of the member discharge when acute care (hospitalization) is no longer necessary.

When long-term care is necessary, we work with you to plan the member's discharge to an appropriate setting for extended services. These services can often be delivered in a nonhospital facility such as a:

- Hospice facility
- Convalescent facility
- Home health care program (for example, home IV antibiotics)

When you identify medically necessary and appropriate services for the member, we will assist you and the discharge planner in providing a timely and effective transfer to the next appropriate level of care.

Discharge plan authorizations follow InterQual criteria guidelines. Authorizations include but are not limited to, transportation, home health, DME, pharmacy, follow-up visits to practitioners or outpatient procedures.

Confidentiality of Information
Utilization management, case management, disease management, discharge planning, quality management and claims payment activities are designed to ensure patient-specific information, particularly protected health information obtained during review. Information is kept confidential in accordance with applicable laws, including HIPAA, and is used for the purposes defined above. Information is shared only with entities who have the authority to receive such information and only with those individuals who need access to such information in order to conduct utilization management and related processes.

Emergency Services
We provide 24/7 NurseLine service with clinical staff to provide triage advice, referral and, if necessary, to make arrangements for treatment of the member. The staff has access to qualified behavioral health professionals to assess behavioral health emergencies.

We do not discourage members from using the 911 emergency system or deny access to emergency services. Emergency services are provided to members without requiring precertification. Emergency services coverage includes services needed to evaluate or stabilize an emergency medical condition. Criteria used to define an emergency medical condition are consistent with the prudent layperson standard and comply with federal and state requirements.

An emergency medical condition is defined as a physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) 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 the following:

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

Emergency response is coordinated with community services, including the police, fire and EMS departments, juvenile probation, the judicial system, child protective services, chemical dependency, emergency services and local mental health authorities, if applicable.

When a member seeks emergency services at a hospital, the determination as to whether the need for those services exists will be made for purposes of treatment by a physician licensed to practice medicine or, to the extent permitted by applicable law, by other appropriately licensed personnel under the supervision of or in collaboration with a physician licensed to practice medicine. The physician or other appropriate personnel will indicate in the member's chart the results of the emergency medical screening examination. We will compensate the provider for screening, evaluation and examination that is reasonable and calculated and assist the provider with determining whether or not the patient's condition is an emergency medical condition.

If there is concern surrounding the transfer of a patient (for example, whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an unstable transfer outweigh the risks), the judgment of the attending physician(s) caring for the member at the treating facility prevails and is binding on Highmark BCBS. If the emergency department is unable to stabilize and release the member, we will assist in coordination of the inpatient admission, regardless of whether the hospital is network or non-network. All transfers from non-network to network facilities are to be conducted only after the member is medically stable and the facility is capable of rendering the required level of care.

If the member is admitted, the facility is required to notify us. Upon notification, our concurrent review nurse will implement the concurrent review process to ensure coordination of care.

Urgent Care

We require our members to contact their PCPs in situations where urgent, unscheduled care is necessary. Precertification with us is not required for a member to access a participating urgent care center.

QUALITY MANAGEMENT

Overview

We maintain a comprehensive Quality Management program to objectively monitor and systematically evaluate the care and service provided to members. The scope and content of the program reflects the demographic and epidemiological needs of the population served. Members and providers have opportunities to make recommendations for areas of improvement. The Quality Management program goals and outcomes are available to providers and members upon request. To request a copy of our Quality Management program evaluation, please call the New York State Quality Management (QM) department at **866-231-0847**.

The initial program development was based on a review of the needs of the population served. Systematic re-evaluation of the needs of the plan's specific population occurs on an annual basis. This includes not only age/sex distribution but also a review of utilization data — inpatient, emergent/urgent care and office visits by type, cost and volume. This information is used to define areas that are high volume or that are problem prone. Studies are planned across the continuum of care and service, with ongoing proactive evaluation and refinement of the program.

Use of Performance Data

Practitioners and providers must allow Highmark BCBS to use performance data in cooperation with our quality improvement program and activities. Practitioner/provider performance data refers to compliance rates, reports and other information related to the appropriateness, cost, efficiency and/or quality of care delivered by an individual health care practitioner (such as a physician) or a health care organization (such as a hospital). Common examples of performance data include the HEDIS® quality of care measures maintained by the National Committee for Quality Assurance (NCQA) and the comprehensive set of measures maintained by the National Quality Forum (NQF).

Quality of Care

All physicians, advanced registered nurse practitioners and physician assistants are evaluated for compliance with pre-established standards as described in our credentialing program.

Review standards are based on medical community standards, external regulatory and accrediting agencies' requirements and contractual compliance.

Reviews are accomplished by Quality Management (QM) coordinators and associate professionals who strive to develop relationships with providers and hospitals that will positively impact the quality of care and services provided to our members. Results are then submitted to our QM department and incorporated into a profile.

Our quality program includes review of quality of care issues identified for all care settings. QM staff use member complaints, reported adverse events and other information to evaluate the quality of service and care provided to our members.

Communicable Disease Reporting
The NYS and NYC Departments of Health require the reporting of all cases of communicable diseases. We will assist in this process by notifying PCPs when there has been a report of a potential communicable disease to us through our claim system. The diagnosis will be clarified, and for those members with a confirmed diagnosis of tuberculosis, sexually transmitted disease, hepatitis or HIV, we will help the PCP with case management services if necessary.

Accreditation
Accreditation is a process for an impartial organization to review a company's operations and ensure it is conducting business consistent with national standards. It also supports continuous improvement, guiding the plan to measure, analyze, report and improve the quality of services provided to members.

National evaluations of health plan performance and customer satisfaction are driven by the NCQA and used in the accreditation process. Two of the most important measures of performance and member satisfaction are HEDIS and CAHPS. HEDIS is a set of standardized performance measures used to compare the performance of managed care plans and measures for physicians based on value rather than cost. More than 90% of America's health plans use HEDIS and report rates annually. The CAHPS survey is a member satisfaction survey administered annually to a random sample of Highmark BCBS members.

Our plan scores are compared to other health plans' scores on specific measures for benchmarking purposes. Accreditation results are displayed on public websites to assist employers and individual consumers in making informed decisions about their health plan options. Highmark BCBS is currently accredited by the NCQA.

CAHPS Member Satisfaction Survey
In an effort to better serve our members, we conduct the CAHPS member satisfaction survey each year. The CAHPS survey asks our members to rate their experiences with their doctors and/or specialists and health plans throughout the previous six months. More specifically, the survey asks if we provide good access to care, how quickly members were able to get appointments with providers and specialists, and if members feel they are getting the care they need. You play a critical role in the CAHPS survey — we count on you to help us improve health care quality. We report the results of the survey on a yearly basis, as well as some of the activities and initiatives that have been implemented to improve our performance and member satisfaction with our plan. To request a copy of the member satisfaction survey results, call the New York State (NYS) QM department at **866-231-0847**.

Quality Assurance Reporting Requirements
The Quality Assurance Reporting Requirements (QARR) program applies to Child Health Plus and Medicaid Managed Care.

QARR is a program overseen by the NYSDOH that monitors health plan quality in NYS. The program consists of a series of age-specific and/or health-specific measures designed to examine managed care plan performance in several key areas. QARR data is collected

through encounter (claims) data from inpatient or outpatient visits, pharmacy data, laboratory claims or from the member's medical record. The DOH uses QARR data to work with plans and providers to enhance the health care outcomes of managed care members through performance feedback, quality improvement programs, technical assistance and highlighting of best practices. All Medicaid health plans in NYS are required to submit QARR data.

Examples of measures reported for QARR include:

- Well-child visits: 15 months, 3 to 6 years and 12 to 21 years
- Child/adult access to care
- Immunizations completed by age 2
- Lead testing prior to the age of 25 months
- Timeliness and frequency of prenatal care and timeliness of postpartum care
- Comprehensive diabetes care
- Screening of adolescents for alcohol/substance abuse and tobacco use
- Breast cancer screening
- Cervical cancer screening
- Appropriate treatment of asthma
- HIV/AIDS comprehensive care

Our internal claims system will collect pertinent QARR information as it is received. The balance of information will be extracted from member medical records, as necessary. Health care professionals from our Quality Management department will contact your office or facility to gain access to the medical records needed to collect the required information. All efforts will be made not to inconvenience you or your staff in the process. It is important to remember that the more information that can be extracted from claims data, the less likely a medical record review will be necessary.

Provider Profiling

The Quality Management department uses provider-profiling methodology, rationale and processes for classifying physician performance. The method applies to the following key measures: access and availability to care, member complaints, ER utilization and PCP turnover rates.

The principal features of the methodology ensure:

- Clearly defined goals and objectives for the profiling activity have been developed, including the communication of a profiling summary to providers and the provision of provider/office manager education, based on findings and corrective action plans with time tables and measurable benchmarks of success, as indicated.
- Descriptions and rationale for each measure have been developed, and supporting clinical documentation is included, when appropriate.
- The measures selected for the profile meet criteria for valid and reliable measurement and when analyzed as a whole, will be used as a tool to target opportunities for improvement. Additionally, a summary of these results will be shared with the involved physicians to promote continuous quality improvement activities.

- Quality profiles examine a broad range of practice measures and have some adjustments for risk, and similar cohorts are analyzed across practices to fairly compare each provider.
- Profiles include data from multiple sources, including claims, QARR, medical record review data, utilization management and pharmacy data, member satisfaction surveys, enrollment and PCP assignment data, member complaints and provider-supplied information, such as office hours, walk-in policies, etc.

Measure Selection Criteria
The measures selected for the physician quality profile met the following criteria:

- The definition of the measure has been consistent over one year, meaning that the measurement methodology has not changed appreciably.
- Data has been reported in the measurement area for a minimum of one year.
- The measure is readily understood and its validity accepted.
- The data for the measure are available and meet accepted standards for completeness.
- The size of the population for selecting a measure is adequate. A panel size limit (completed only for panels of 100 or more) has been selected. In relation to QARR scores when reviewed by an individual provider, the population will often be too small to provide a statistically significant result but will nonetheless be reviewed as one measure of the provision of services.

Description and Definition of the Measures
QARR Indicator: A summary of applicable QARR measurement scores. The report details the population reviewed for each measure and the pass/fail experience of each member enrolled in the plan for at least one year. QARR scores for each group practice, individual PCP and/or IPA are reported with the associated Highmark BCBS average as an indication of PCP performance in relation to one's peer group. This data is presented in its raw form, with no interpretation or comparative narration provided.

The following QARR measures are some of the components of this indicator:

- Adult access to primary care
- Child access to primary care
- Cervical cancer screening
- Breast cancer screening
- Immunizations
- Lead screening
- Well care

Physician Indices (Utilization Metrics): Includes the utilization experience of members as both a volume statistic and proportion of total panel membership. It includes provider visits as well as emergency room, inpatient and nonparticipating provider/facility utilization.

Utilization:

- The proportion of members with a PCP visit during the year
- The proportion of members with an ER visit during the year

- The proportion of members with a well-care visit during the year
- The proportion of members with a visit to a nonparticipating provider/facility during the year
- The proportion of members admitted with conditions that are considered avoidable when managed effectively in an outpatient setting

Member Complaints: Reviewed by providers; complaint categories determined to be provider-related are reviewed for volume, severity and substantiation. Those related to access and availability, quality of care/treatment, physician office environment, reimbursement/billing disputes or communication with PCP and/or office staff will be reviewed for the previous 12 months and reported as a raw score of complaints assigned to the PCP, as well as a ratio of complaints per 100 members for comparative purposes.

The following NYS reportable complaint categories will be reviewed for this purpose:

- Appointment availability
- Excessive wait time at provider's office
- Denial of clinical treatment
- Dissatisfaction with quality of care
- Dissatisfaction with provider services (nonmedical)
- Dissatisfaction with obtaining provider services after hours
- Difficulty obtaining referrals
- Communication/physical barriers
- Reimbursement/billing issues

Complaints will be identified as total complaints lodged and total substantiated complaints.

Outcomes: All indices included in our provider-profiling summary will be presented in a standardized reporting format accessible to you upon request. Formal assessment of provider performance will be evaluated on a periodic basis using the previously stated criteria and an appropriate group of health care professionals using similar treatment modalities and serving a comparable patient population. The resulting report will be reviewed by the provider-profiling oversight committee, who will schedule onsite appointments with PCPs to present results and afford PCPs the opportunity to engage in dialogue regarding the report findings, discuss the unique nature of their practices and work cooperatively and collaboratively with the plan to assess opportunities to improve performance and/or identify practice areas that are working well. We reserve the right to use data about provider performance for business purposes.

Public Health Issues

We work with the NYC and NYS Departments of Health to identify, track and, when possible, address any public health issues that may arise in our member population. Some areas of focus are communicable disease reporting, lead testing and reporting, accessing and reporting to the City Immunization Registry (CIR), and child abuse and domestic violence identification and follow-up.

Domestic Violence

You're expected to screen for cases of domestic violence as part of routine assessments and provide members with appropriate referrals when indicated. Questions regarding domestic violence should be referred to the Associate Vice President of Behavioral Health or the Domestic Violence Coordinator at **866-231-0847**. In addition, you may contact the NYS Domestic Violence Hotline at **800-942-6906**.

HIV Testing

New York requires that HIV testing is offered to all individuals between the ages of 13 and 64 receiving hospital or primary care services and diagnosis and treatment services; services include pre- and post-counseling and coordination for medical care for individuals confirmed as positive. Facilities can create their own consent form as long as the language is consistent with standardized, DOH-created model forms. Consent may be part of a general consent to medical care, though specific opt-out language for HIV testing must be included. Consent for rapid HIV testing can be oral (except in correctional facilities) and noted in the medical record. Additional information regarding HIV testing laws can be found at **www.health.ny.gov/diseases/aids/testing/law/faqs.htm**.

Credentialing

Credentialing is an industry-standard, systemic approach to the collection and verification of an applicant's professional qualifications. This approach includes a review of relevant training, licensure, certification and/or registration to practice in a health care field and academic background. The credentialing process evaluates the information gathered and verified and includes an assessment of whether the applicant meets certain criteria relating to professional competence and conduct. We use current NCQA standards and guidelines for the accreditation of managed care organizations (MCOs), as well as state-specific requirements for the credentialing and recredentialing of licensed independent providers and organizational providers with whom we contract. This process is completed before a practitioner or provider is accepted for participation in our network.

Credentialing Requirements

To become a participating Highmark BCBS provider, you must hold a current, unrestricted license issued by the state. You must also comply with our credentialing criteria and submit all additionally requested information. A complete *Credentialing Application* (for practitioners) or a Highmark BCBS *Ancillary/Facility Application*, plus all required attachments, must be submitted to initiate the process. We're one of over 600 participating health plans, hospitals and health care organizations that currently utilize the Council for Affordable Quality Healthcare (CAQH) Universal Provider Data Source (UPD) for gathering credentialing data for physicians and other health care professionals. Under this program, you can use a standard application (state-mandated applications are included in the UPD) and a common database to submit an electronic application.

Each provider, applicable ancillary/facility and hospital shall remain in full compliance with our credentialing criteria, as set forth in our credentialing policies and procedures and all applicable laws and regulations. Each provider, applicable ancillary/facility and hospital will complete the application form upon request and must comply with other such credentialing criteria as we've established. Copies of our application procedures and qualification requirements are available upon request.

The New York Public Health Law Section 4406-d requires provisional credentialing for newly licensed health care professionals relocating to New York state who have not previously practiced in this state. If a health care professional joins a group practice (all of whom are participating with the plan), provisional credentialing applies if the plan does not approve or deny the application within 90 days of its completion. A provisionally credentialed physician/health care professional may not be designated as a member's PCP until full credentialing is completed. Network participation for a provisionally credentialed health care professional begins on the day following the 90 days after receipt of the completed application and lasts until the final credential determination. The group practice agrees that, should the applicant be denied, the physician or group shall refund any payments made by the plan for in-network services exceeding any out-of-network benefits payable under the enrollee's contract; and the group shall not pursue reimbursement from the enrollee except for applicable copays or coinsurance. Prompt pay interest and penalties shall not be assessed to denials of claims during the provisional credentialing period. We shall not deny, after appeal, a claim for services provided by a provisionally credentialed physician solely on the grounds that it is untimely.

Credentialing Procedures

We're committed to operating an effective, high-quality credentialing program. We credential the following provider types:

- Medical doctors
- Doctors of osteopathy
- Doctors of dental surgery
- Doctors of dental medicine
- Doctors of podiatric medicine
- Doctors of chiropractic
- Physician assistants
- Optometrists
- Dentists
- Nurse practitioners
- Certified nurse midwives
- Licensed professional counselors/social workers
- Psychologists
- Physical/occupational therapists
- Speech/language therapists
- Organizational providers (for example, hospitals, free-standing facilities and ancillary services providers)

During recredentialing, each provider must show evidence of satisfying these policy requirements and must have satisfactory results relative to our measures of quality of health care and service. Failure to comply timely with the recredentialing process may result in termination from the provider network. Providers who have a break in service for a period lasting longer than 30 days must undergo initial credentialing.

We have an established credentialing committee and a quality advisory committee who formally determine credentialing decisions. The credentialing committee will make decisions regarding participation of initial applicants and their continued participation at the time of recredentialing. The oversight rests with the medical advisory committee.

Our credentialing policy is revised periodically based on input from several sources, including but not limited to:

- The credentialing committees
- The health plan medical director
- Our Chief Medical Officer
- State and federal requirements
- Accreditation requirements

The policy will be reviewed and approved as needed, but at a minimum annually.

The provider application contains your actual signature that serves as an attestation of the credentials summarized on and included with the application. Your signature also serves as a release of information to verify credentials externally. We're responsible for externally verifying specific items attested to on the application. Any discrepancies between information included with the application and information we obtain during the external verification process will be investigated and documented and may be grounds for refusal of acceptance into the network or termination of an existing provider relationship. The signed agreement documents compliance with our managed care policies and procedures.

You have the right to inquire about the status of your application. You may do so by calling Provider Services, contacting your Provider Relations representative, or submitting your request in writing.

As an applicant for participation with us, you have the right to review information obtained from primary verification sources during the credentialing process unless prohibited by federal, state or local law. Upon notification from us, you have the right to explain information obtained that may vary substantially from that provided and to correct any erroneous information submitted by another party. You must submit a written explanation or appear before the credentialing committee if deemed necessary.

Currently, the following verifications are completed, as applicable prior to final submission of a practitioner file to the health plan medical director or credentialing committee. To the extent allowed under applicable law or state agency requirements, per NCQA Standards and Guidelines, the medical director has authority to approve clean files without input from the credentialing committee. All files not designated as meeting the organization's established

criteria will be presented to the credentialing committee for review and decision regarding participation.

In addition to the submission of an application and the execution of a Participating Provider Agreement, the following items must be reviewed and approved by the credentialing committee or the medical director.

- **Board Certification**: Verification by referencing the American Medical Association (AMA) Provider Profile, American Osteopathic Association (AOA), the American Board of Medical Specialties (ABMS), American Board of Podiatric Surgery (ABPS) and/or American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM).
- **Verification of Education and Training**: Verification by referencing board certification or the appropriate state-licensing agency in states where education is primary-source verified.
- **Verification of Work History**: You must submit a curriculum vitae documenting work history for the past five years. Any gaps in work history greater than six months must be explained in written format and brought to the attention of the medical director and credentialing committee, as applicable.
- **Hospital Affiliations and Privileges**: To the extent allowed under applicable law or state agency requirements, verification of clinical privileges in good standing at a Highmark BCBS network hospital may be accomplished by the use of an attestation signed by you. If attestation is not acceptable, hospital admitting privileges in good standing are verified for you. This information is obtained in the form of a written letter from the hospital, roster format (multiple practitioners), Internet access or by telephone contact. The date and name of the person spoken to at the hospital are documented.
- **State Licensure and Registration**: Verification of state license information to ensure you maintain a current legal license or certification to practice in the state. This information can be verified by referencing data provided to us by the state via roster, telephone or the Internet.
- **DEA Number**: Verification of the Drug Enforcement Administration (DEA) number to ensure you are currently eligible to prescribe controlled substances. This information is verified by obtaining a copy of the DEA certificate or by referencing the National Technical Information Service (NTIS) data.
- **Professional Liability Coverage**: Copy of malpractice face sheet displaying policy coverage and effective date and expiration.
- **Professional Liability Claims History**: Verification of your history of professional liability claims, if any, reviewed by the health plan credentialing committee to determine whether acceptable risk exposure exists. The review is based on information provided and attested to by you and information available from the National Practitioner’s Data Bank (NPDB). The credentialing committee’s policy is designed to give careful consideration to the medical facts of the specific cases, total number and frequency of claims in the past five years and the amounts of settlements and/or judgments.
- **Medicare and/or Medicaid Sanctions**: We verify you’re clear of any sanction, exclusion or debarring from participating in Medicare, Medicaid or any federal health care programs through accessing the Office of the Inspector General List of Excluded Individuals and Entities and the Government Service Administration Excluded Parties List System and the Office of the Medicaid Inspector General (NY OMIG).

- **Medicare**: You must not have opted out of participating in Medicare programs. We verify your absence from the Medicare Opt Out list should you apply for Medicare participation.
- **Disclosure of Ownership and Control Interest Statement**: You must submit Disclosure of Ownership and Control Interest Statement in accordance with Federal Regulations 42 C.F.R. and 455. A full and accurate disclosure of ownership and controlling interest of 5% or more.
- **Disclosures — Attestation and Release of Information**: Our Provider Application will require responses to the following:
  - Reasons for the inability to perform the essential functions of the position with or without accommodation
  - Any history or current problems with chemical dependency, alcohol or substance abuse
  - History of license revocations, suspension, voluntary relinquishment, probationary status or other licensure conditions or limitations
  - History of conviction of any criminal offense other than minor traffic violations
  - History of loss or limitation of privileges or disciplinary activity, including denial, suspension, limitation, termination or nonrenewal of professional privileges
  - History of complaints or adverse action reports filed with a local, state or national professional society or licensing board
  - History of refusal or cancellation of professional liability insurance
  - History of suspension or revocation of a DEA or CDS certificate
  - History of any Medicare/Medicaid sanctions
  - Attestation by the applicant of the correctness and completeness of the application
    - Any issue identified must be explained in writing; these explanations are presented with your application to the credentialing committee. Applicants must attest to the absence of any history involving criminal convictions in any of the programs established by Medicare and Medicaid (Titles XVIII, XIX or XX).
- **The NPDB is queried against applicants and Highmark BCBS-contracted providers**: The NPDB will provide a report for every practitioner queried. These reports are shared with the medical director and the credentialing committee for review and action as appropriate. The appropriate state-licensing agency is queried for all other providers. All sanctions are investigated and documented, including the health plan's decision to accept or deny your participation in the network.
- **Office Site Quality**: You must maintain office sites that are compliant with Americans with Disability Act. In compliance with our policy and NCQA standards, we require site visits of your office(s) based on member complaints due to quality of your office related to physical accessibility, physical appearance, adequacy of waiting and examining room space or any quality of care issue.
- **Recredentialing**: At the time of recredentialing (every three years), information for practitioners from quality improvement activities and member complaints is presented for credentialing committee review.

You are notified by telephone or in writing if any information obtained in support of the assessment or reassessment process varies substantially from the information you've submitted. You have the right to review the information submitted in support of the credentialing and recredentialing process and to correct any errors in the documentation. This will be accomplished by submission of a written explanation or by appearance before the credentialing committee, if so requested.

The decision to approve or deny initial participation will be communicated in writing within 90 days of receiving a completed application. The notification will inform you as to whether you are credentialed, whether additional time is needed or if we are at capacity to credential additional providers. If additional information is needed, we will notify you as soon as possible but no more than 90 days from the receipt of the application. To the extent allowed under applicable law or state agency requirements, per NCQA Standards and Guidelines, the medical director may render a decision regarding the approval of files meeting Highmark BCBS requirements without benefit of input from the credentialing committee. In the event your continued participation is denied, you will be notified by certified mail. If continued participation is denied, you will be allowed 30 days to appeal the decision.

Credentialing Organizational Providers
The provider application contains your actual signature that serves as an attestation that the health care facility agrees to the credentialing requirements. Providers requiring credentialing are as follows: hospitals; home health agencies; skilled nursing facilities; nursing homes; ambulatory surgery centers and behavioral health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting. The provider's signature also serves as a release of information to verify credentials externally.

Currently, the following steps are completed in addition to the application and Network Provider Agreement before approval for participation of a hospital or organizational provider.

State licensure is verified by obtaining a current copy of the state license from the organization or by contacting the state-licensing agency. Primary source verification is not required. Any restrictions to a license are investigated and documented, including the decision to accept or deny the organization's participation in the network.

We contract with facilities that meet the requirements of an unbiased and recognized authority. Hospitals (for example, acute, transitional or rehabilitation) should be accredited by The Joint Commission (TJC,) Healthcare Facilities Accreditation Program (HFAP) or the American Osteopathic Association (AOA). The Commission on Accreditation of Rehabilitation Facilities (CARF) may accredit rehabilitation facilities. Home health agencies should be accredited by TJC or the Community Health Accreditation Program (CHAP). Nursing homes should be accredited by TJC. TJC or the Accreditation Association for Ambulatory Health Care (AAAHC) should accredit ambulatory surgical centers.

If facilities, ancillaries or hospitals are not accredited, we will accept a copy of a recent state or CMS review in lieu of performing an onsite review. If accreditation or copy of a recent review is unavailable, an onsite review will be performed.

- A copy of the malpractice insurance face sheet is required. Your organization is required to maintain malpractice insurance in the amounts specified in your contract and according to our policy.
- We will track a facility/ancillary's reassessment date and reassess every 36 months as applicable. Requirement for recredentialing of organizational providers are the same for reassessment as they are for the initial assessment.

Your organization will be notified either by telephone or in writing if any information obtained in support of the assessment or reassessment process varies substantially from the information your organization has submitted.

Your organization has the right to review the information submitted in support of the assessment process and to correct any errors in the documentation. This will be accomplished by submission of a written explanation or by appearance before the credentialing committee, if so requested.

Organizational providers are recredentialed every three years unless otherwise required by state regulations.

Delegated Credentialing
Provider groups with strong credentialing programs that meet our credentialing standards may be evaluated for delegation. As part of this process, we conduct a predelegation assessment of a group's credentialing policy and program, as well as an onsite evaluation of credentialing files. A passing score is considered to be an overall average of 90% compliance. If deficiencies are identified, the group is expected to submit an acceptable corrective action plan within 30 days of receipt of the audit results. If there are serious deficiencies, we will deny the delegation or will restrict the level of delegation. We may waive the need for the predelegation onsite audit if the group's credentialing program is NCQA-certified for all credentialing and recredentialing elements. We're responsible for ongoing oversight of any delegated credentialing arrangement and will schedule appropriate reviews. The reviews are held at least annually.

Peer Review
The peer review process provides a systematic approach for monitoring the quality and appropriateness of care. Peer review responsibilities are:

- To participate in the implementation of the established peer review system
- To review and make recommendations regarding individual provider peer review cases
- To work in accordance with the executive medical director

Should investigation of a member grievance result in concern regarding a physician's compliance with community standards of care or service, all elements of peer review will be followed.

Dissatisfaction severity codes and levels of severity are applied to quality issues. The medical director assigns a level of severity to the grievance. Peer review includes investigation of physician actions by, or at the discretion of, the medical director. The medical director takes action based on the quality issue and the level of severity, invites the cooperation of the physician and consults and informs the Medical Advisory and Peer Review committees. The

medical director informs the physician of the committee's decision, recommendations, follow-up actions and/or disciplinary actions to be taken. Outcomes are reported to the appropriate internal and external entities which include the Quality Management committee.

The peer review policy is available upon request.

Reporting Obligations

We're legally obligated to report occurrences within 30 days to the state licensure board, the National Practitioner Data Bank (NPDB), Healthcare Integrity and Protection Data Bank (HIPDB), professional associations, CMS and any other applicable state or federal authority of termination for matters involving clinical competence or professional conduct.

Additionally, we're obligated to report within days of obtaining knowledge of any information that reasonably appears to show that a health professional is guilty of professional misconduct as defined in education law.

Provider Termination

You cannot be prohibited from the following actions, nor may we terminate or refuse to renew a contract if you:

- Advocate on behalf of an enrollee.
- File a complaint against us.
- Appeal a decision we made.
- Provide information or file a report pursuant to PHL 4406-c regarding prohibitions of plans or request a hearing or review.

Appeals Process

In the event a participating provider receives notification of denial or limitation and/or restriction of credentials or termination for cause, we must provide you with a written explanation of the reason(s) for the proposed contract termination/restriction and an opportunity to appeal the decision. You have 30 days to appeal the decision in writing. A hearing may be requested if you were terminated for cause. Appeals are heard by the credentialing appeals committee, a separate credentialing peer-review body not involved in the initial decision, within 30 days of receipt of the request for a hearing. The hearing panel will be comprised of three persons appointed by the health plan. At least one person on the panel will specialize in the same discipline or same specialty as the person under review. The panel can consist of more than three members, provided the number of clinical peers constitute one-third or more of the total membership.

The provider is informed the request for appeal has been received. If an informal hearing is being offered, the time, date and location of the informal hearing is also communicated to you no less than fourteen (14) calendar days prior to the date of the informal hearing. You have the right to be represented by an attorney or other representative of your choice.

The appeals process lets you exercise your right to appear in person before the credentialing fair hearing committee or appointed hearing officer, at which time you have the right to present his or her case.

You are notified in writing of the final decision, setting forth the reasons for the decision, within 15 days of the credentialing fair hearing committee or appointed hearing officer meeting.

If the credentialing fair hearing committee or appointed hearing officer upholds a denial, the recommendation is made to initiate termination procedures for your participation with us. It is the responsibility of our duly authorized senior management to accept the committee's decision.

The final decision will be provided to you in writing, along with the specific reasons for the decision and will include one of the following:

- Reinstatement
- Provisional reinstatement with conditions we set forth
- Termination

Should the final decision result in a termination, action will be effective not less than 30 days after your receipt and not sooner than 60 days from receipt of the termination notice.

If you are terminated due to a case involving imminent harm to patient care, a determination of fraud or final disciplinary action by a state licensing board, you are not eligible for a hearing or a review.

Advance Directives

Recognizing a person's right to dignity and privacy, our members have the right to execute an advance directive, also known as a living will, to identify their wishes concerning health care services should they become incapacitated. Providers may be asked to assist members in procuring and completing the necessary forms. Advance directive documents should be on hand in the event a member requests this information. Any request should be properly noted in the medical record.

PROVIDER COMPLAINT PROCEDURES

Overview

We have a formal complaint and appeal process to handle disputes pertaining to administrative issues and nonpayment-related matters. For payment disputes, see the Provider Payment Disputes section of this manual.

You may access this process by filing a written complaint. Your complaints will be resolved fairly and consistently with our policies and covered benefits.

You aren't penalized for filing complaints. Any supporting documentation should accompany the complaint. File grievances in writing to:

Highmark Blue Cross Blue Shield
Grievance and Appeals
Provider Relations – Central Intake Unit
9 Pine St., 14th Floor
New York, NY 10005

We'll send you an acknowledgement letter within 10 business days of receipt. At no time will we cease coverage of care pending a grievance investigation.

CLAIM SUBMISSION AND ADJUDICATION PROCEDURES

Electronic Claims Submission

We encourage you to submit claims electronically through Electronic Data Interchange (EDI). Contracted providers must submit claims within 90 days from the date of service.

You may submit claims either using a clearinghouse or as a direct submitter through EDI. To become a trading partner, submit a *Trading Partner Agreement Form* and an *Electronic Data Interchange Registration Form*. An E-Solutions representative will provide outreach to assign a trading partner ID and establish connectivity with our enterprise clearinghouse.

The advantages of electronic claims submission are:

- Facilitates timely claims adjudication
- Acknowledges receipt and rejection notification of claims electronically
- Improves claims tracking
- Improves claims status reporting
- Reduces adjudication turnaround
- Eliminates paper
- Improves cost-effectiveness
- Allows for automatic adjudication of claims

The guide for EDI claims submission, including additional information related to the EDI claim process, is located on our website.

Paper Claims Submission

You also have the option of submitting paper claims. We use Optical Character Reading (OCR) technology as part of our front-end claims processing procedures. The benefits include:

- Faster turnaround times and adjudication
- Claims status availability within five days of receipt
- Immediate image retrieval by our staff for claims information, allowing more timely and accurate response to your inquiries

To use OCR technology, claims must be submitted on original red claim forms (not black and white or photocopied forms), laser printed or typed (not handwritten), and in a large, dark font. You must submit a properly completed UB-04 or CMS-1500 (08-05) within 90 days from the date of service.

CMS-1500 (08-05), UB-04 or CMS-1450 must include the following information (HIPAA compliant where applicable):

- Patient’s ID number
- Patient’s name
- Patient’s date of birth
- ICD diagnosis code/revenue codes
- Date of service
- Place of service
- Description of services rendered
- Itemized charges
- Days or units

- Provider tax ID number
- Provider name according to contract
- Highmark BCBS provider number
- NPI of billing provider when applicable
- State Medicaid ID number
- COB/other insurance information
- Authorization/precertification number
- Name of referring physician
- NPI of referring physician when applicable
- Any other state required data

We cannot accept claims with alterations to billing information. Claims that have been altered will be returned to you with an explanation of the reason for the return. We will not accept entirely handwritten claims.

Paper claims must be submitted within 90 days of the date of service and submitted to the following address:
Highmark BCBS
New York Claims
P.O. Box 62509
Virginia Beach, VA 23466-2509

International Classification of Diseases, 10th Revision (ICD-10) Description

As of October 1, 2015, ICD-10 became the code set for medical diagnoses and inpatient hospital procedures in compliance with HIPAA requirements and in accordance with the rule issued by the U.S. Department of Health and Human Services (HHS).

ICD-10 is a diagnostic and procedure coding system endorsed by the World Health Organization (WHO) in 1990. It replaces the International Classification of Diseases, 9th Revision (ICD-9) which was developed in the 1970s. Internationally, the codes are used to study health conditions and assess health management and clinical processes. In the United States, the codes are the foundation for documenting the diagnosis and associated services provided across health care settings.

Although we often use the term ICD-10 alone, there are actually two parts to ICD-10:

- Clinical modification (CM): ICD-10-CM is used for diagnosis coding
- Procedure coding system (PCS): ICD-10-PCS is used for inpatient hospital procedure coding; this is a variation from the WHO baseline and unique to the United States.

ICD-10-CM replaces the code sets ICD-9-CM, volumes one and two for diagnosis coding, and ICD-10-PCS replaces ICD-9-CM, volume three for inpatient hospital procedure coding.

Encounter Data

We maintain a system to collect member encounter data. Due to reporting needs and requirements, network providers who are reimbursed by capitation must send us encounter data for each member encounter. Encounter data can be submitted through EDI submission methods or on a CMS-1500 (08-05) claim form unless we approve other arrangements. Data will be submitted in a timely manner, but no later than 90 days from the date of service.

The encounter data will include the following:

- Member's ID number
- Member's name (first and last name)
- Member's address
- Member's date of birth
- Provider's name according to contract
- Highmark BCBS provider number
- Coordination of benefit information
- Date of encounter
- Diagnosis code
- Types of services provided (using current procedure codes and modifiers if applicable)
- Provider's tax ID number and state Medicaid ID number

Encounter data should be submitted to the following address:
Highmark BCBS
P.O. Box 62509
Virginia Beach, VA 23466-2509

HEDIS information is collected through claims and encounter data submissions. This includes but is not limited to:

- Preventive services (for example, childhood immunization, mammography, Pap smears)
- Prenatal care (for example, LBW, general first trimester care)
- Acute and chronic illness (for example, ambulatory follow-up and hospitalization for major disorders)

Compliance is monitored by our utilization and quality improvement staff, coordinated with the medical director and reported to the Quality Management committee on a quarterly basis. The PCP is monitored for compliance with utilization reporting. Lack of compliance will result in training and follow-up audits and could result in termination from the network.

Claims Adjudication

We're dedicated to providing timely adjudication of your claims for services rendered to members. All network and non-network provider claims submitted for adjudication are processed according to generally accepted claims coding and payment guidelines. These guidelines comply with industry standards as defined by the CPT and ICD manuals. Institutional claims should be submitted using EDI submission methods or a UB-04 CMS-1450, and professional services using the CMS-1500.

Use HIPAA-compliant billing codes when billing us. This applies to both electronic and paper claims. When billing codes are updated, you're required to use appropriate replacement codes for submitted claims. Highmark BCBS won't pay any claims submitted using noncompliant billing codes.

We reserve rights to use code-editing software to determine which services are considered part of, incidental to or inclusive of the primary procedure.

For claims payment to be considered, adhere to the following time limits:

- Submit claims within 90 days from the date the service is rendered; or for inpatient claims filed by a hospital, within 90 days from the date of discharge.
- In the case of other insurance, submit the claim within 90 days of receiving a response from the third-party payer.
- Claims for members whose eligibility has not been added to the state's eligibility system must be received within 90 days from the date the eligibility is added and we're notified of the eligibility/enrollment.
- Claims submitted after the 90-day filing deadline will be denied.

After filing a claim with us, review the weekly Explanation of Payment (*EOP*). If the claim does not appear on an *EOP* within 30 business days as adjudicated or you have no other written indication that the claim has been received, check the status of your claim on our website or by calling Provider Services at **866-231-0847**. If the claim is not on file with us, resubmit your claim within 90 days from the date of service. If filing electronically, check the confirmation reports that you receive from your EDI or practice management vendor for acceptance of the claim.

Clean Claims Payment

A clean claim is a request for payment for a service rendered by a provider that:

- Is submitted timely
- Is accurate
- Is submitted on a HIPAA-compliant standard claim form (CMS-1500 or CMS-1450), or successor forms thereto, or the electronic equivalent of such claim form
- Requires no further information, adjustment or alteration by the provider or by a third party in order for us to process and pay it

We adjudicate all clean electronic claims within 30 days and all clean paper claims within 45 calendar days of receipt of a clean claim. If we don't adjudicate the clean claim within the time frame specified above, we'll pay all applicable interest as required by law.

Biweekly, we produce and mail to you an *EOP*, which delineates the status of each of your claims that have been adjudicated during the previous check week cycle. Upon receipt of the requested information from you, we attempt to complete processing of the clean claims; contractually, we have 30 days for electronic claims and 45 days for paper claims.

Paper claims determined to be unclean will be returned to you along with a letter stating the reason for the rejection. Electronic claims determined to be unclean will be returned to our contracted clearinghouse that submitted the claim.

In accordance with state insurance requirements, except in a case where our obligation to pay is not reasonably clear or when there is a reasonable basis that the claim was submitted fraudulently, we'll pay the electronic claim within 30 days or paper claims within 45 days of the date of receipt. In a case where our obligation to pay a claim is not reasonably clear, we'll pay any undisputed portion of the claim and notify you in writing within the appropriate time frame above that we:

- Are not obligated to pay the claim, stating the specific reasons why we are not liable

- Need additional information to determine liability to pay the claim or make the payment

Claims Status

Log in to our website or call **866-231-0847** to check claims status.

Reimbursement Policies

Reimbursement policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Highmark BCBS benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedural Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or Revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding, billing guidelines or current reimbursement policies are not followed, Highmark BCBS may:

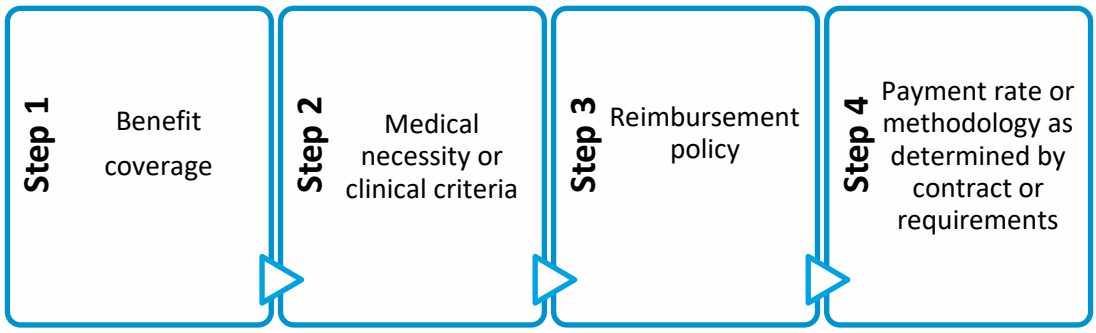
- Reject or deny the claim.
- Recover and/or recoup claim payment.

Highmark BCBS reimbursement policies are based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider or state contracts, or state, federal or CMS requirements. System logic or set up may prevent the loading of policies into the claims platforms in the same manner as described; however, Highmark BCBS strives to minimize these variations.

Highmark BCBS reserves the right to review and revise its policies periodically when necessary. When there is an update, we will publish the most current policy at **www.bcbswny.com/stateplans**.

Reimbursement Hierarchy

Claims submitted for payment must meet all aspects of criteria for reimbursement. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefit coverage, medical necessity, authorization or stipulations within a reimbursement policy. Neither payment rates nor methodology are considered to be conditions of payment.



Review Schedules and Updates
Reimbursement policies go through a review every two years for updates to state, federal or CMS contracts and/or requirements. Additionally, updates may be made at any time if we are notified of a mandate change or due to a Highmark BCBS business decision. When there is an update, we will publish the most current policy at **www.bcbswny.com/stateplans**.

Medical Coding
The Medical Coding department ensures that correct coding guidelines have been applied consistently throughout Highmark BCBS. Those guidelines include but are not limited to:

- Correct modifier use
- Analysis of codes, code definition and appropriate use
- Applying code-editing rules appropriately and within regulatory requirements
- Effective date of transaction code sets (CPT, HCPCS, ICD diagnosis/procedures, revenue codes, etc.)

Reimbursement by Code Definition
Highmark BCBS allows reimbursement for covered services based on their procedure code definition, or descriptor, as opposed to their appearance under a particular CPT category section unless otherwise noted by state, federal or CMS contracts and/or requirements. There are seven CPT sections:

- Evaluation and management
- Anesthesia
- Surgery
- Radiology (nuclear medicine and diagnostic imaging)
- Pathology and laboratory
- Medicine
- Temporary codes for emerging technology, service or procedure

Various procedure codes are located in particular CPT categories, although the procedure may not be classified within that particular category (for example, venipuncture is located in the CPT Surgical Section, although it is not a surgical procedure).

Provider Reimbursement

Electronic Funds Transfer and Electronic Remittance Advice
We offer electronic funds transfer (EFT) and electronic remittance advice (ERA). To register for ERA/EFT, please visit our website.

PCP Reimbursement
We reimburse PCPs according to their contractual arrangement.

Specialist Reimbursement
Reimbursement to network specialty care providers and network providers not serving as PCPs is based on their contractual arrangement with us.

Specialty care providers must obtain PCP approval and our approval prior to rendering or arranging any treatment that is beyond the specific treatment authorized by the PCP's referral, or beyond the scope of self-referral permitted under this program.

Specialty care provider services will be covered only when there is documentation of appropriate notification or precertification, as appropriate, and receipt of the required claims and encounter information to us.

Dual Providers
We reimburse our dual providers based on the taxonomy codes billed on each claim. The Health Care Provider Taxonomy code set allows providers to identify their specialty categories. For capitated providers, claims billed with taxonomy codes appropriate for a PCP will finalize under capitation. Claims billed with any other taxonomy codes will be reimbursed at FFS specialty rates according to providers' contractual arrangements.

Overpayment Process
Refund notifications may be identified by two entities: Highmark BCBS and its contracted vendors or the providers. Highmark BCBS researches and notifies the provider of an overpayment requesting a refund check. The provider may also identify an overpayment and proactively submit a refund check to reconcile the overpayment amount.

Once an overpayment has been identified by Highmark BCBS, Highmark BCBS will notify the provider of the overpayment. The overpayment notification will include instructions on how to refund the overpayment.

If a provider identifies an overpayment and submits a refund, a completed *Refund Notification* form specifying the reason for the return must be included. This form can be found on the provider website at **www.bcbswny.com/stateplans**. The submission of the *Refund Notification* form will allow Cost Containment to process and reconcile the overpayment in a timely manner.

The provider can also complete a *Recoupment Notification* form, which gives us the authorization to adjust claims and create claim offsets. This form can also be found on the provider website. For questions regarding the refund notification procedure, please call Provider Services at **866-231-0847** and select the appropriate prompt.

In instances where we are required to adjust previously paid claims to adhere to a new published rate, we will initiate a reconciliation of the affected claims. As such, we will determine the cumulative adjusted reimbursement amount based on the new rates. In the event the outcome of this reconciliation results in a net amount owed to us, we will commence recovery of such amounts through an offset against future claims payments. Such recoveries are not considered part of the overpayment recovery process described above or in the provider agreement.

Changes addressing the topic of overpayments have taken place with the passage of the Patient Protection and Affordable Care Act (PPACA), commonly known as the Healthcare Reform Act.

The provision directly links the retention of overpayments to false claim liability. The language of 42 U.S.C.A. § 1320a-7k makes explicit that overpayments must now be reported and returned to states or respective MCOs within 60 days of identification of the overpayment or by the date any corresponding cost report is due, whichever is later. After 60 days, the overpayment is considered a false claim, which triggers penalties under the False Claims Act, including treble damages. In order to avoid such liability, health care providers and other entities receiving reimbursement under Medicare or Medicaid should implement policies and procedures on reporting and returning overpayments that are consistent with the requirements in the PPACA.

The provision entitled “Reporting and Returning Overpayments – Deadline for Reporting and Returning Overpayments,” codified at 42 U.S.C.A. § 1320a-7k, clarifies the uncertainty left by the 2009 Fraud Enforcement and Recovery Act.

This provision of the HealthCare Reform Act applies to providers of services, suppliers, Medicaid Managed Care organizations, Medicare Advantage organizations and Medicare Prescription Drug Program sponsors. It does not apply to beneficiaries.

Provider Payment Disputes

Claims payment reconsideration process: If you do not agree with the outcome of a claim payment, and the claim payment is not a result of a medical necessity authorization decision, the provider may request an investigation, called a reconsideration, to determine and correct discovered processing errors.

Responses to itemized bill requests, submission of corrected claims and submission of coordination of benefits/third-party liability information are not considered payment disputes. These are considered correspondence and should be addressed to Claims Correspondence.

Please file payment disputes within 45 calendar days of the paid date of the *EOP*.

You may submit a reconsideration in one of three ways:

1. In writing: Submit a written reconsideration request, including all necessary supporting documentation, to:

Highmark Blue Cross Blue Shield
Payment Dispute Unit
P.O. Box 61599
Virginia Beach, VA 23466-1599

2. Verbally: Call Provider Services to request a reconsideration.
3. Online: Access and submit a reconsideration through the secure provider website.

Upon receipt of the reconsideration request, an internal review is conducted. This includes a thorough investigation by a trained claims analyst utilizing all applicable statutory, regulatory, contractual and provider subcontract provisions, Highmark BCBS policies and procedures, and all pertinent facts submitted from all parties. The results are then communicated in a determination letter to the provider within 30 calendar days of the receipt of the reconsideration.

- If the determination requires an adjustment to the claim, the investigating representative will make the adjustment.
- If the determination of the reconsideration requires additional information to resolve, the determination may be extended by 15 calendar days. A written extension letter will be sent to the provider before the expiration of the initial, 30-day determination period.
- If the determination of a claim payment appeal requires clinical expertise, it will be reviewed by the appropriate clinical Highmark BCBS staff.

The determination letter includes:

- A statement of the provider's reconsideration request.
- The reviewer’s decision, along with an explanation of the contractual and/or medical basis for the decision.
- A description of the evidence or documentation which supports the decision.

Note: If the decision results in a claim adjustment, the payment and *Explanation of Payment* will be sent separately.

Claims payment appeals: If you are dissatisfied with the outcome of a reconsideration, you may submit a formal disagreement, called a claim payment appeal. File claims payment appeals within 30 days of the outcome of the reconsideration. You may submit a claim payment appeal in one of two ways:

1. Written: Submit a written claim payment appeal, including any necessary supporting documentation, to:

Highmark Blue Cross Blue Shield
Payment Dispute Unit
P.O. Box 61599
Virginia Beach, VA 23466-1599

2. Online: Access and submit a claim payment appeal through the secure provider website.

Upon receipt of the claim payment appeal, an internal review is conducted. This includes a thorough investigation by a trained claims appeal analyst utilizing all applicable statutory, regulatory, contractual and provider subcontract provisions, Highmark BCBS policies and procedures, and all pertinent facts submitted from all parties.

The results are then communicated in a determination letter to the provider within 30 calendar days of receipt of the claim payment appeal.

- If the determination requires an adjustment to the claim, the investigating representative will make the adjustment.

- If the determination requires additional information to resolve, the determination may be extended by 15 calendar days. A written extension letter will be sent to the provider before the expiration of the initial 30-day determination period.
- If the determination of a claim payment appeal requires clinical expertise, it will be reviewed by the appropriate clinical Highmark BCBS professionals.

The determination letter includes:

- A statement of the provider's claim payment appeal.
- The reviewer's decision, along with an explanation of the contractual and/or medical basis for the decision.
- A description of the evidence or documentation which supports the decision.

Note: If the decision results in a claim adjustment, the payment and *Explanation of Payment* will be sent separately.

Coordination of Benefits

State-specific guidelines will be followed when Coordination of Benefits (COB) procedures are necessary. We agree to use covered medical and hospital services whenever available, or other public or private sources of payment for services rendered to members in our plan.

We and our providers agree the Medicaid program will be the payer of last resort when third-party resources are available to cover the costs of medical services provided to Medicaid members. When we obtain complete information regarding the responsible carrier prior to paying for a medical service, we will avoid payment by either rejecting your claim and redirecting you to bill the appropriate insurance carrier or, if we do not become aware of the resource until sometime after payment for the service was rendered, by pursuing post-payment recovery of the expenditure. You must <u>not</u> seek recovery in excess of the Medicaid payable amount.

We will avoid payment of trauma-related claims where third-party resources are identified prior to payment. Otherwise, we will investigate prospective and potential subrogation cases on behalf of the state. Paid claims are reviewed and researched post-payment to verify subrogation cases. This information is reported to the state on a regular basis for management of recoveries related to the health care expenses in these cases.

We require members to cooperate in the identification of any and all other potential sources of payment for services. In no instance will a member be held responsible for disputes over these recoveries.

Any questions or inquiries regarding paid, denied or pended claims should be directed to Provider Services at **866-231-0847**.

Billing Members

Before rendering services, always inform members that the cost of services not covered by us will be charged to the member.

If you choose to provide services we <u>do not cover</u>:

- Understand that we only reimburse for services that are medically necessary, including hospital admissions and other services

- Obtain the member's signature on the Client Acknowledgment Statement specifying that the member will be held responsible for payment of services
- Understand that you may not bill for, or take recourse against, a member for denied or reduced claims for services that are within the amount, duration and scope of benefits of the Medicaid program

Our members must not be balance-billed or billed for the amount above that which we pay for covered services.

In addition, you may not bill a member if any of the following occurs:

- Failure to timely submit a claim, including claims we don't receive
- Failure to submit a claim to us for initial processing within the 90-day filing deadline
- Failure to submit a corrected claim within the 90-day filing resubmission period
- Failure to appeal a claim within the 45-day administrative appeal period
- Failure to appeal a UR determination within 60 business days of notification of coverage denial
- Submission of an unsigned or otherwise incomplete claim
- Errors made in claims preparation, claims submission or the appeal process

Client Acknowledgment Statement

You may bill a Highmark BCBS member for a service that has been denied as not medically necessary or not a covered benefit only if both of the following conditions are met:

- The member requests the specific service or item
- You obtain and keep a written acknowledgement statement signed by you and the member stating:

"I understand that, in the opinion of (provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under Highmark BCBS as being reasonable and medically necessary for my care or that are not a covered benefit. I understand that Highmark BCBS has established the medical necessity standards for the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined to be inconsistent with the Highmark BCBS medically necessary standards for my care or not a covered benefit."

Signature: _____

Date: _____