Provider Manual

Highmark Blue Cross Blue Shield of Western New York
Medicaid Managed Care and Child Health Plus

HIGHMARK WESTERN NEW YORK

NYHM-CD-PM-070376 January 2025

Please note: Material in this provider manual is subject to change. Please go to **providerpublic.mybcbswny.com** for the most up-to-date information.

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1 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 healthcare practitioners in the state of New York.

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

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 **1-866-231-0847 (TTY 711)** 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.

Highmark BCBS complies with all New York State (NYS) Medicaid and federal guidelines and incorporates them into our policies and procedures. As such, we require providers rendering care to our members to adhere to these guidelines, policies and procedures.

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 **1-866-231-0847 (TTY 711)** to receive a new one.

2 OVERVIEW

Who is Highmark BCBS?

Highmark Blue Cross Blue Shield (Highmark BCBS) is a trade name of Highmark Western and Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield 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.

Medicaid Managed Care (MMC), Child Health Plus (CHPlus) and Health and Recovery Plan (HARP),the government-sponsored health insurance programs, provide services to eligible members in Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, 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 healthcare to the communities we serve.

Mission

Our mission is to operate a community-focused managed care company with an emphasis on the public sector healthcare market. We will coordinate members' physical and behavioral healthcare, 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 healthcare 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 healthcare
- Foster quality improvement mechanisms that actively involve providers in re-engineering healthcare delivery
- Encourage a customer service orientation with regular measurement of member and provider satisfaction

Summary

Escalating healthcare 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 healthcare.

3 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:	**1-866-231-0847 (TTY 711)**
Provider Services fax:	**1-800-964-3627**
TTY Line:	**711**
Automated Provider Inquiry Line for Member Eligibility:	**1-866-231-0847 (TTY 711)**
Electronic Data Interchange (EDI):	**1-800-282-4548**
24/7 NurseLine:	**1-866-231-0847 (TTY 711)**
Member Services:	**1-866-231-0847 (TTY 711)**
Pharmacy Member Services For CHPlus Only:	**1-833-232-1713**
Pharmacy Member Services For NY Medicaid and HARP through NYRx:	**1-800-541-2831**
Appeals Inquiry:	**1-866-231-0847 (TTY 711)**

Other Contact Information

Vision services

- Member Services: **1-866-231-0847 (TTY 711)**
- Provider Services: **1-866-231-0847 (TTY 711)**
- Website: **providerpublic.mybcbswny.com**

Liberty Dental (dental services):

- Members: **1-833 276 0846**
- Providers: **1-888-352-7924**
- Website: **libertydentalplan.com/bcbswny**

Carelon Medical Benefits Management (precertification for cardiology, radiology, radiation oncology, musculoskeletal programs):

- Providers: **1-855-574-6483.** The call center will be open to take calls 8 a.m. – 8 p.m. ET.
- Web portal: **providerportal.com**

Carelon Medical Benefits Management (precertification for physical, occupational and speech therapy):

- Providers: **1-855-574-6483.** The call center will be open to take calls 8 a.m. – 8 p.m. ET.
- Web portal: **providerportal.com**

CarelonRx:

- Mail order (Child Health Plus only): **1-833-396-0309** Fax number: **1-833-389-4172**

Medical Answering Services, LLC (MAS) nonemergent transportation:

- Allegany County: **1-866-932-7740**
- Cattaraugus County: **1-866-932-7740**
- Chautauqua County: **1-866-932-7740**
- Erie County: **1-866-932-7740**
- Genesee County: **1-866-932-7740**

- Niagara County: **1-866-932-7740**
- Orleans County: **1-866-932-7740**
- Wyoming County: **1-866-932-7740**
- Website: **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 **providerpublic.mybcbswny.com** 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.

Provided below is additional information to assist you in your day-to-day interaction with us.

Member Eligibility	• Contact the Provider Inquiry line at **1-866-231-0847 (TTY 711)** or online: **providerpublic.mybcbswny.com** and navigate to the Availity link
Physical Health Notification/Precertification	May be telephoned, submitted online or faxed to Highmark BCBS: • Telephone: **1-866-231-0847 (TTY 711)** • Fax: **1-800-964-3627** • Online: **providerpublic.mybcbswny.com** Data required for complete notification/precertification: • Member ID number • Legible name of referring provider • Legible name of individual referred to provider • Number of visits/services • Date(s) of service • Diagnosis • 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:
	• Electronic Availity claims payer IDs
	  ○ Availity: 00246
	• Via mail:
	  Claims
	  P.O. Box 61010
	  Virginia Beach, VA 23466-1010
	• Timely filing is within 120 days from the date of service, or per the terms of the provider agreement.

	• Corrected claims must be submitted within 90 days from the date of Explanation of Payment (EOP). • 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 **1-866-231-0847 (TTY 711)**.
Medical Appeal Information	• Medical appeals must be filed within 60 calendar days of the date of the notice of action. • Request an appeal using Interactive Care Reviewer (ICR) accessed through Availity Essentials. Use this digital authorization application for any eligible denied authorization affiliated with your tax id/organization at **https://Availity.com** • To request an appeal through ICR you need to have the Authorization Referral Request role assignment on Availity. Your organization's Availity administrator can give you access to this role. • The application allows you to upload supporting documentation. You will receive acknowledgement of your submission, along with an appeal case ID. • To be eligible the case must be in a denied status. You can also request a clinical appeal through ICR for cases submitted by phone and fax. • File a standard medical appeal at: 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: Online (for reconsiderations and claim payment appeals): Use the secure provider Availity Appeal application at **https://Availity.com**. Through Availity, you can upload supporting documentation and receive immediate acknowledgement of your submission. For Appeals, your Availity Essentials user account will need the Claim Status role. To Send Attachments from Claim Status, you'll need the Medical Attachments role. Locate the claim you want to dispute on Availity using Claim Status from the Claims & Payments menu. If available, select Dispute Claim to initiate the dispute. Go to Request to navigate directly to the

	initiated dispute in the appeals dashboard add the documentation and submit. • Providers who have questions about Availity registration or as they begin to use the new functionality should contact Availity Client Services at **1-800-282-4548**. • Via mail: Payment Appeals Team P.O. Box 62429 Virginia Beach, VA 23466-2429
Provider Grievances	• Provider grievances should be submitted to: Provider Relations – Central Intake Unit Provider Appeals P.O. Box 61599 Virginia Beach, VA 23466-1599
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@wellpoint.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 **1-866-231-0847 (TTY 711)**.
Provider Service Representatives	For more information, contact Provider Services at **1-866-231-0847 (TTY 711)**.
Pharmacy	**1-866-231-0847 (TTY 711)** for CHPlus only **1-877-309-9493** for Medicaid and HARP prior authorization (through NYRx program)
Foster Care Liaison	**1-866-231-0847 (TTY 711)**
24/7 NurseLine	**1-866-231-0847 (TTY 711)**
New York State Department of Health	**1-800-206-8125**
Behavioral Health Precertification	Submit electronically using our preferred method via **https://Availity.com** or **1-866-231-0847 (TTY 711)**
New Baby, New Life program	**1-866-231-0847 (TTY 711)**
Plan Compliance Officer	**1-757-473-2737, ext. 31028**
Report fraud	**1-877-725-2702**
Condition Care/ (CNDC)	**1-888-830-4300**
WIC program	**health.state.ny.us/prevention/nutrition/wic**

Clinical Practice Guidelines	**1-866-231-0847 (TTY 711)**
Domestic Violence Coordinator	**1-866-231-0847 (TTY 711)**

4 PRIMARY CARE PROVIDERS

Primary Care Providers

The PCP is a provider who serves as the entry point into the healthcare 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 healthcare 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 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; or in an Article 29i licensed Voluntary Foster Care Agency (VFCA).

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 thirty (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
- VFCAs
- 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 healthcare 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 **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: **1-800-368-1019** (**TTY/TTD: 1-800-537-7697**)

Complaint forms are available at **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: Member Complaint and Appeals Department, P.O. Box 62429, Virginia Beach, VA 23466-2429
- Phone: **1-866-231-0847 (TTY 711)** (**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 under the age of 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.

The Health and Recovery Plan (HARP) is an enhanced benefit package for members with complex behavioral health needs. It is made up of physical health, behavioral health, pharmacy, and waiver services. HARP is for adults (aged 21 and older) who have certain health conditions. These conditions are set by the state. HARP helps members get the care they need while keeping them in their homes and communities.

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 **1-866-231-0847 (TTY 711)** 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 healthcare plan. If the newborn is not identified as SSI or SSI-related and therefore excluded from a healthcare 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 **providerpublic.mybcbswny.com** or through **https://Availity.com**. (Select Payer Spaces > Applications > Provider Online Reporting)

To request a hard copy of your panel listing be mailed to you, call Provider Services at **1-866-231-0847.**

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:

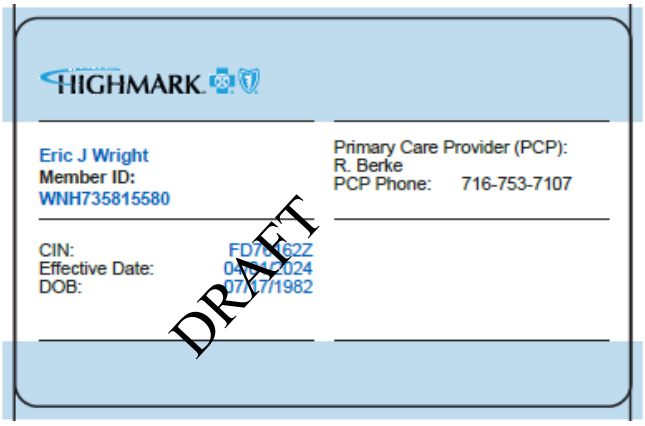
- The member's ID number
- The member's name (first name, last name and middle initial)
- The member's date of birth
- The member's enrollment effective date
- Toll-free phone numbers for information and/or authorizations
- Toll-free 24/7 NurseLine, available 24 hours a day, 7 days a week
- Descriptions of procedures to be followed for emergency or special services
- Highmark BCBS address and telephone number
- PCP name and telephone number

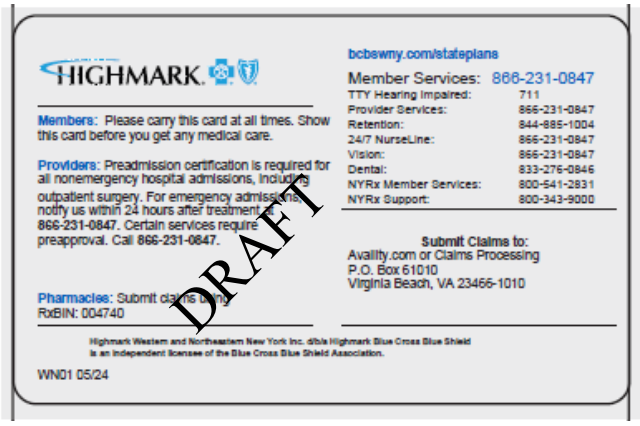
Our members also have access to:

- 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 not 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, with member's written consent, 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 at any time. Verbal complaints should be made by contacting us at **1-866-231-0847 (TTY 711)** 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 healthcare 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:** 72 hours from receipt of all necessary information for urgent, preservice, and concurrent services.
- **Standard:** 30 calendar days from receipt of the complaint.

The member or someone on behalf of the member, with the member's written consent, has the right to file a complaint at any time with the NYSDOH at **1-800-206-8125**.

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 sixty (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 fifteen (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 who are of the same or similar specialty within Highmark BCBS than the person who made the complaint determination and not a subordinate of the original practitioner. Complaint appeal determinations with a clinical basis must be made by personnel qualified to review the appeal, including licensed, certified or registered healthcare professionals who did not make the initial determination, at least one of whom must be a clinical peer reviewer.

The complaint appeal must be resolved, and the notice provided to the member as expeditiously as the member's condition requires and within State established time frames that may not exceed the following time frames:

- Standard Complaint Appeals: Within thirty (30) calendar days of receipt of the appeal request.
- Expedited Complaint Appeals: Within two business days after all info is received, but not greater than seventy-two (72) hours of receipt of the appeal request.

For expedited complaint appeals, the complaint appeal decision is reached within two business days, but not greater than 72 hours 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 complaint appeals.

Documentation of Complaints and Complaint Appeals

We will maintain a file on each complaint and associated complaint 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 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

5 HIGHMARK BCBS HEALTHCARE 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, Health and Recovery Plan,(HARP) 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 and or the 29-I foster care agency 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 means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain that a prudent layperson,

possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

a) Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
b) Serious impairment to such person's bodily functions;
c) Serious dysfunction of any bodily organ or part of such person; or
d) Serious disfigurement of such person.

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 healthcare agency in the member's home and include therapeutic and preventive nursing, home health aides, medical supplies, equipment and appliances, rehabilitative therapies (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 Healthcare Benefits

Benefits are limited to 40 home healthcare visits per calendar year for services provided by a certified home healthcare 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), HARP, 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

Covered Benefits for Children

The table below outlines the changes to covered benefits for all members under 21 years of age. Future benefit carve-ins are identified below. More specific information related to each service is outlined below the table.

Service	Current Delivery System	Medicaid Managed Care Organization and CHPlus Benefit Package
Assertive Community Treatment (minimum age is 18 for medical necessity for this adult-oriented service);	Current benefit	Current benefit MMC CHPlus eff 1/1/2023

Service	Current Delivery System	Medicaid Managed Care Organization and CHPlus Benefit Package
Young Adult Act (ages 18-25) and Youth Act.		
Caregiver/Family Support and Services (HCBS)	Current benefit	Current benefit MMC CHPlus eff 1/1/2024
Community First Choice Option (CFCO) state plan services for children meeting eligibility criteria	FFS	TBD
Children's crisis intervention	Current benefit	Current benefit MMC CHPlus eff 1/1/2023
Children's day treatment	FFS	TBD
Comprehensive psychiatric emergency program (CPEP) including extended observation bed	Current benefit	Current benefit
Community Habilitation (HCBS)	Current benefit	Current benefit MMC CHPlus eff 1/1/2024
Community Self Advocacy Training (HCBS)	Current benefit	Current benefit MMC CHPlus eff 1/1/2024
Continuing day treatment (minimum age is 18 for medical necessity for this adult-oriented service)	Current benefit	Current benefit
Community psychiatric treatment and supports	Current benefit	Current benefit MMC CHPlus eff 1/1/2023
Crisis intervention demonstration service	MMC demonstration benefit for all ages	Current MMC demonstration benefit for all ages
Day Habilitation (HCBS)	Current benefit	Current benefit MMC CHPlus eff 1/1/2024
Family peer support services	Current benefit	Current benefit MMC CHPlus eff 1/1/2023
Health Home care management	Current benefit	Current benefit MMC
Inpatient psychiatric services	Current benefit	Current benefit
Intensive psychiatric rehabilitation treatment (IPRT)	Current benefit	Current benefit

Service	Current Delivery System	Medicaid Managed Care Organization and CHPlus Benefit Package
Licensed behavioral health practitioner service	MMC demonstration benefit for all ages	Current MMC demonstration benefit for all ages
Licensed outpatient clinic services	Current benefit	Current benefit
Medically managed detoxification (hospital-based)	Current benefit	Current benefit
Medically supervised inpatient detoxification	Current benefit	Current benefit
Medically supervised outpatient withdrawal	Current benefit	Current benefit
Mobile Crisis	Current benefit	Current benefit MMC CHPlus eff 1/1/2023
Office of Addiction Services and Supports (OASAS) inpatient rehabilitation services	Current benefit	Current benefit
OASAS opioid treatment program (OTP) services	Current benefit	Current benefit
OASAS outpatient and residential addiction services	MMC Demonstration benefit for all ages	Current MMC Demonstration benefit for all ages
OASAS outpatient rehabilitation programs	Current benefit	Current benefit
OASAS outpatient services	Current benefit	Current benefit
Outpatient mental health (OMH) state-operated inpatient	FFS	TBD
Other licensed practitioner (OLP)	Current benefit	Current benefit MMC CHPlus eff 1/1/2023
Palliative Care (HCBS) – Massage, Bereavement, Expressive, Pain and Symptom	Current benefit	Current benefit MMC CHPlus eff 1/1/2024
Partial hospitalization	Current benefit	Current benefit
Prevocational Services (HCBS)	Current benefit	Current benefit MMC CHPlus eff 1/1/2024
Personalized recovery-oriented services (minimum age is 18 for medical	Current benefit	Current benefit MMC

Service	Current Delivery System	Medicaid Managed Care Organization and CHPlus Benefit Package
necessity for this adult oriented service)		
Psychosocial rehabilitation (PSR)	Current benefit	Current benefit MMC CHPlus eff 1/1/2023
Rehabilitation services for residents of community residences	FFS	TBD
Residential rehabilitation services for youth (RRSY)	FFS	CHPlus eff 1/1/2023
Residential supports and services (new early and periodic screening, diagnostic and treatment EPSDT prevention, formerly known as foster care Medicaid per diem)	Office of Children and Family Services (OCFS) foster care	Current benefit MMC CHPlus eff 1/1/2023
Residential treatment facility (RTF)	FFS	TBD
Respite Services (HCBS)	Current benefit	Current benefit MMC CHPlus eff 1/1/2024
Supported Employment (HCBS)	Current benefit	Current benefit MMC CHPlus eff 1/1/2024
School-based Health	FFS	TBD
Teaching family home	FFS	TBD
Youth peer support and training	Current benefit	Current benefit MMC CHPlus eff 1/1/2023

Additional Considerations for Children Receiving Home and Community-Based Services (HCBS) and Receiving Residential Support Services

Highmark BCBS is responsible for providing all Benefit Package services to enrolled children/youth placed in foster care, promoting continuity of care, and ensuring healthcare services are delivered in a trauma-informed manner and consistent with standards of care recommended for children in foster care. Children/youth often enter foster care without having had access to traditional preventive healthcare services. As a result, children/youth in foster care require an increase in the frequency of their health monitoring.

Highmark BCBS covers the following Residential Supports and Services for enrollees who are eligible to be served by a 29-I Health Facility, in accordance with the 29-I Billing Guidance:

1. Core Limited Health-Related Services (CLHRS) on a per diem basis, inclusive of:
    a. Nursing Services

b. Skill Building Licensed Behavioral Health Practitioner (LBHP)
c. Medicaid Treatment Planning and Discharge Planning
d. Clinical Consultation/Supervision Services
e. VFCA Managed Care Liaison/Administration

2. Medically necessary Other Limited Health-Related Services (OLHRS) that the 29-I Health Facility is authorized by the State to provide may include:

a. Children and Family Treatment Supports and Services (CFTSS)
   i. Other Licensed Practitioners (OLP)
   ii. Community Psychiatric Supports and Treatment (CPST)
   iii. Psychosocial Rehabilitation (PSR)
   iv. Family Peer Supports and Services (FPSS)
   v. Youth Peer Support and Training (YPST)
   vi. Crisis Intervention (CI)

b. Children's Waiver HCBS
   i. Caregiver Family Supports and Services
   ii. Community Advocacy and Support
   iii. Respite (Planned and Crisis)
   iv. Prevocational Services
   v. Supported Employment
   vi. Day Habilitation
   vii. Community Habilitation
   viii. Palliative Care: Bereavement Therapy
   ix. Palliative Care: Expressive Therapy
   x. Palliative Care: Massage Therapy
   xi. Palliative Care: Pain and Symptom Management
   xii. Environmental Modifications
   xiii. Vehicle Modifications
   xiv. Adaptive and Assistive Equipment
   xv. Non-Medical Transportation

c. Medicaid State Plan services
   i. Screening, diagnosis and treatment services related to physical health, including but not limited to:
      - Ongoing treatment of chronic conditions as specified in treatment plans
      - Diagnosis and treatment related to episodic care for minor ailments, illness or injuries, including sick visits
      - Primary pediatric/adolescent care
      - Immunizations in accordance with NYS or NYC recommended childhood immunization schedule
      - Reproductive healthcare

   ii. Screening, diagnosis and treatment services related to developmental and behavioral health. This includes the following:
      - Psychiatric consultation, assessment, and treatment
      - Psychotropic medication treatment
      - Developmental screening, testing, and treatment
      - Psychological screening, testing and treatment

- Smoking/tobacco cessation treatment
- Alcohol and/or drug screening and intervention
- Laboratory tests

For children transitioning from a 1915(c) waiver program, Highmark BCBS will continue to authorize covered HCBS and LTSS in accordance with the most recent plan of care for at least 180 days following the date of transition of children's specialty services newly carved into managed care. Service frequency, scope, level, quantity and existing providers at the time of the transition will remain unchanged (unless such changes are requested by the enrollee or the provider refuses to work with Highmark BCBS) for no less than 180 days during which time a new plan of care is developed.

Note: During the initial 180-day transition, Highmark BCBS will authorize any children's specialty services newly carved into managed care added to the plan of care under a person-centered process without conducting utilization review.

For 24 months from the date of transition of the children's specialty services carve-in, for FFS children in receipt of HCBS at the time of enrollment, Highmark BCBS will continue to authorize covered HCBS and LTSS in accordance with the most recent plan of care for at least 180 days following the effective date of enrollment. Service frequency, scope, level, quantity and existing providers at the time of enrollment will remain unchanged (unless such changes are requested by the member or the provider refuses to work with Highmark BCBS) for no less than 180 days during which time a new plan of care is developed.

To facilitate a smooth transition of HCBS and LTSS authorizations for children in receipt of HCBS, Highmark BCBS accepts plans of care for a child in the care of a local department of social services (LDSS)/licensed Voluntary Foster Care Agencies (VFCA), and LDSS/VFCA confirms the MCO selection process has been completed.

Highmark BCBS will continue to accept plans of care for children in receipt of HCBS in advance of the effective date of enrollment when Highmark BCBS is notified by another MCO, a Health Home care manager or the independent entity that there is consent to share the plan of care with us, and the family demonstrates the MCO selection process has been completed. For a child in the care of a LDSS/licensed VFCA, we'll continue to accept plans of care in advance of the effective date of enrollment if the LDSS/VFCA confirms the MCO selection process has been completed.

Mental Health: Medicaid Managed Care, HARP **& CHPlus 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 behavioral health treatment services are expected to be person-centered, strength-based and recovery-focused.

All members may self-refer for behavioral health and substance use services. Behavioral health services visits are coordinated by calling **1-866-231-0847 (TTY 711)**. 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 **1-866-231-0847 (TTY 711)**.

SUD Crisis Services

Crisis services provide a variety of treatment options designed to provide immediate care for people who are intoxicated or incapacitated by their use of alcohol or other substances. The primary goal of these services is to manage withdrawals from substances, as well as medical and psychiatric complications during withdrawals. Crisis services include detox services and are also designed to facilitate connections to continued care.

Detoxification: Medicaid Managed Care, HARP & CHPlus

Medically Managed withdrawal Management and Medically Supervised Withdrawal Management (inpatient and outpatient).

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.

Medically supervised withdrawal is covered on an inpatient and outpatient basis.

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.

Inpatient Chemical Dependency: Medicaid Managed Care, HARP & CHPlus

Inpatient Rehabilitation

Inpatient programs provide a safe and supportive setting for the evaluation, treatment, and rehabilitation of people with substance use disorders. These facilities offer 24-hour, 7-day a-week care that is supervised at all times by a medical professional. Inpatient services include intensive management of symptoms related to addiction and monitoring of the physical and mental complication resulting from substance use.

Substance use disorder 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 Addiction Services and Supports 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.

Outpatient Chemical Dependency Services: Medicaid Managed Care, HARP & CHPlus

Outpatient facilities provide clinical services for people with an addiction to substances and their families who have been impacted by their addiction. Outpatient services may be delivered at different levels of intensity according to the needs of the patient. These include counseling, education, and connections to community services. Medically supervised ambulatory chemical dependence outpatient clinics programs, as well as medically supervised chemical dependence outpatient rehabilitation programs, are covered along with intensive outpatient, and Medication Assisted Treatment services.

Opioid Treatment: Medicaid Managed Care & HARP

Opioid Treatment Centers (OTP) are OASAS-certified sites where medication to treat opioid dependency is administered. These medications can include methadone, buprenorphine, and suboxone. In addition to medications, these facilities also offer counseling and educational services. In most cases, patients receiving services at an OTP clinic are provided treatment over a lifetime, similar to management of chronic physical ailments.

Residential Services: Medicaid Managed Care & HARP

Residential services are designed for people who are in need of support in their recovery, and may not be able to participate in treatment without a 24-hour residential setting. Residential services are designed to develop or maintain recovery through a structured, substance-free setting, and can include group support, skills development related to independent living, and other services designed to promote recovery.

Stabilization, Rehabilitation and Reintegration 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: Medicaid Managed Care, HARP & CHPlus

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

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 healthcare 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.

Mobile Crisis Services: Medicaid Managed Care, HARP & CHPlus

Telephonic Crisis Triage and Response

Upon contact by the individual or referent, a provider will answer the call to determine the appropriate service response to the crisis. Referents may include families, providers, crisis hotlines, **911** operators, law enforcement or other sources, depending on what resources are available. Telephonic crisis triage and response coverage must be available 24 hours a day, 7 days a week and 365 days a year. A provider can only bill for telephonic crisis triage and response if they provide this service to an individual enrolled in Medicaid Managed Care or a collateral.

Mobile Crisis Response

Mobile crisis teams are dispatched to an individual's home or any community setting where a crisis may be occurring, to provide brief intervention and facilitate access to other crisis/behavioral health services. They provide appropriate care and support while avoiding unnecessary law enforcement involvement, emergency department use and hospitalization. However, mobile crisis response may include co-response with local law-enforcement, if possible and appropriate.

Mobile and Telephonic Follow-Up Services

Mobile Crisis service providers may bill MMCOs for mobile and telephonic follow-up services provided to a member of a qualifying crisis service. Follow-up services are eligible for reimbursement if provided within 14 days of the qualifying crisis episode. Follow-up services may be delivered face-to-face or through telephonic contact.

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 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 outpatient substance use disorder (SUD) services
    - For opioid treatment (methadone maintenance), only notification is required.

Continued Day Treatment: Medicaid Managed Care & HARP

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: Medicaid Managed Care, HARP & CHPlus

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): Medicaid Managed Care & HARP

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: Medicaid Managed Care, HARP & CHPlus

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.

Personalized Recovery-Oriented Services (PROS): Medicaid Managed Care & HARP

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: Medicaid Managed Care, HARP & CHPlus

ACT and Youth 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: Medicaid Managed Care, HARP & CHPlus

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: Medicaid Managed Care & HARP

Health Home care managers provide comprehensive, integrated medical and behavioral healthcare management to Medicaid-enrolled adults and children with chronic conditions to ensure access to appropriate services, improve health outcomes, prevent hospitalizations and emergency room visits, and avoid unnecessary care. HHCM services are 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: Medicaid Managed Care, HARP & CHPlus

SUD Services

Include participant-centered inpatient and residential 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: Medicaid Managed Care, HARP & CHPlus

- **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 Addiction Services and Supports (OASAS).

Rehabilitation Services for Residential SUD Treatment Supports (OASAS Service): Medicaid Managed Care & HARP

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 cooccurring 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.

Gambling Disorder Treatment Medicaid Managed Care & HARP

Provided by Office of Addiction Services and Supports (OASAS) certified programs is a covered service. Members can get Gambling Disorder Treatment: face-to-face; or through telehealth. If a member needs Gambling Disorder Treatment, she/he can get the service from an OASAS outpatient program or if necessary, an OASAS inpatient or residential program. The member does not need a referral from her/his primary care provider (PCP) to get these services.

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: Medicaid Managed Care, HARP & CHPlus

- **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.
- **Community Psychiatric Support and Treatment (CPST):** CPST includes time-limited goal-directed supports and solution-focused interventions intended to achieve identified person-centered goals or objectives as set forth in the individual's Plan of Care and CPST Individual Recovery Plan.
- **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.

Nonmedical Transportation

Nonmedical transportation services are necessary, as specified by the service plan, to enable participants to gain access to authorized home- and community-based services that enable them to integrate more fully into the community and ensure the health, welfare and safety of the participant.
This service will be provided to meet the participant's needs as determined by an assessment performed in accordance with NYSDOH requirements and as outlined in the participant's service plan.

Children's Crisis Intervention

Refers to services provided to children/youth who are identified as experiencing an acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involve to effectively resolve it. The services are designed to interrupt and/or ameliorate the crisis experience; include an assessment that is culturally and linguistically sensitive; result in immediate crisis resolution and de-escalation; and the development of a crisis plan. The goals are engagement, symptom reduction, stabilization, and restoring individuals to a previous level of functioning or developing the coping mechanisms to minimize or prevent the crisis in the future. The service is recommended by a licensed medical or behavioral health practitioner. All

activities must occur within the context of a potential or actual behavioral health crisis. Services are delivered in a trauma-informed, culturally and linguistically competent manner.

Children's Community Psychiatric Supports and Treatment (CPST)

CPST services are goal-directed supports and solution-focused interventions intended to address challenges associated with a behavioral health need and to achieve identified goals or objectives as set forth in a child's treatment plan. This includes the implementation of interventions using evidence-based techniques drawn from cognitive-behavioral therapy and/or other evidence-based psychotherapeutic interventions. CPST refers to community-based services provided to children and families who may have difficulty engaging in formal office settings but can benefit from community based rehabilitative services. The service may include rehabilitative psychoeducation, intensive interventions, strength-based treatment planning, rehabilitative supports, crisis avoidance and/or intermediate term crisis management. The service is recommended by a licensed medical or behavioral health practitioner. Services are delivered in a trauma informed, culturally and linguistically competent manner.

Children's Family Peer Support Services (FPSS)

Family Peer Support Services are an array of formal and informal activities and supports provided to families caring for/raising a child who is experiencing social, emotional, medical, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community. FPSS provide a structured, strength-based relationship between a family peer advocate and the parent/family member/caregiver for the benefit of the child/youth. The service may include transition support, self-advocacy, parent skill development, and/or community connections and natural supports. The service is recommended by a licensed medical or behavioral health practitioner. Services are delivered in a trauma-informed, culturally and linguistically competent manner.

Children's Other Licensed Practitioner (OLP)

A nonphysician licensed behavioral health practitioner who is available to provide interventions using evidence-based techniques drawn from cognitive-behavioral therapy and/or other evidence-based psychotherapeutic interventions approved by New York state. OLP does not require a diagnosis and can be provided by a recommending licensed practitioner without diagnosis. This service allows for the delivery of services in the community in order to effectively engage children and youth. Activities include recommending treatment that also considers trauma-informed, cultural variables and nuances; and individual, family and/or group outpatient psychotherapy and behavioral health assessment, evaluation and testing. Services should be offered in the setting best suited for desired outcomes including home, or other community-based setting in compliance with state practice law (including telemedicine). Services are delivered in a trauma-informed, culturally and linguistically competent manner.

Children's Psychosocial Rehabilitation (PSR)

Children's psychosocial rehabilitation services are designed to restore, rehabilitate, and support a child's/youth's developmentally appropriate functioning as necessary for the integration of the child/youth as an active and production member of their family and community with the goal of achieving minimal ongoing professional intervention. Services assist with implementing interventions on a treatment plan to compensate for, or eliminate, functional deficits and interpersonal and/or behavioral health barriers associated with a child/youth's behavioral health needs. Activities are hands on and task-oriented, intended to achieve the identified goals or objectives as set forth in the child/youth's individualized treatment plan. PSR services are to be recommended by a licensed practitioner and a part

of a treatment plan. Services are delivered in a trauma-informed, culturally and linguistically competent manner.

Children's Youth Peer Support and Training

Children's youth peer support and training s**ervices** are formal and informal services and supports provided to youth who are experiencing social, medical, emotional, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community centered services. These services provide the training and support necessary to ensure engagement and active participation of the youth in the treatment planning process and with the ongoing implementation and reinforcement of skills. Services are delivered in a trauma-informed, culturally and linguistically competent manner.

Community First Choice Option (CFCO)

TBD, the following CFCO services will be available:

- Assistive Technology
- Community Transitional Services
- Environmental Modification
- Home Delivered Meals
- Moving Assistance
- Skill Acquisition Maintenance and Enhancement/Community Habilitation
- Vehicle Modification

An individual eligible to receive CFCO services must:

1. Be Medicaid eligible for community coverage with community-based long term care (with our without a spend down) or be Medicaid eligible for coverage for all care and services;
2. Have an assessed institutional level of care; and
3. Reside in his/her own home, or the home of a family member.

Eye Care and Low-Vision Services

For a list of providers, please contact **1-866-231-0847 (TTY 711)** or visit **providerpublic.mybcbswny.com**. 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. Due to the NYS Pharmacy Benefit Transition, as of 4/1/2023 hearing aid batteries when provided by DME providers are covered under NYRx.

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, hearing aid batteries, 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.
- Unlisted (‘dump’) codes require an invoice be submitted with the claim and reimbursement is based upon the Wellpoint IPA fee schedule.
- 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 (CHPlus only)
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.

Due to the NYS Pharmacy Benefit Transition, as of 4/1/2023 enteral and parenteral nutrition for Medicaid Managed Care members when provided by DME providers are covered under NYRx.

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 — Liberty Dental

Dental care for members will be handled through Liberty Dental. Liberty Dental 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 Liberty Dental. Upon completion of treatment, all facility and anesthesia charges must be billed separately to us. For benefit information, contact the Liberty Dental Provider Hotline at **1-888-352-7924**.

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. 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 the MAS website at **medanswering.com**. For county-specific information, call **1-866-932-7740**:

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

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

Pharmacy Services

Beginning April 1, 2023, the pharmacy benefit for Medicaid Managed Care Members (TANF, SSI, HARP) will be managed by the NYRx Medicaid Pharmacy Program.

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 medications require prior authorization. Our members have access to most national pharmacy chains and many independent retail pharmacies. Our pharmacy network consists of pharmacies in Allegany, Cattaraugus, Chautauqua, Erie, Orleans, Genesee, Niagara and Wyoming counties. It includes CVS Pharmacy, Rite Aid Pharmacy, Tops Pharmacy, Wegmans Pharmacy, and national chains and independent retailers throughout the state.

All members must use a Highmark BCBS network pharmacy when filling prescriptions in order for benefits to be covered. Members can locate a network pharmacy by logging into the member portal.

Copays

Copays do not apply for CHPlus members.
Medicaid Managed Care members follow NYRx copay requirements as of 4/1/2023.

Monthly Limits (CHPlus only)

Most prescriptions are limited to a maximum 30-day supply per fill.

Covered Drugs (CHPlus only)

Our CHPlus 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 healthcare 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 CHPlus *PDL* is posted on our provider self-service site. For a hard copy, contact the Pharmacy department at 1-**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 CHPlus *PDL*
- Any other drug listed on the Highmark BCBS CHPlus *PDL* which, under applicable state law, may only be dispensed upon the written prescription of a physician or other lawful prescriber

Over-the-Counter (OTC) Drugs

We have an OTC medication benefit. Our members may obtain a prescription for OTC or non-legend drugs. The following are examples of OTC medication classes covered. Please refer to our Child Health Plus *PDL* for a list of covered items. The list is subject to change.

- Analgesics/antipyretics
- Antacids
- Antibacterials, topical
- Antidiarrheals
- Antiemetics
- Antifungals
- Antihistamines
- Contraceptives
- Cough and cold preparations
- Decongestants
- Diabetic supplies, needles, and syringes
- Laxatives
- Non-steroidal anti-inflammatory agents
- Pediculocides
- Prenatal vitamins
- Respiratory agents (including spacing devices)
- Topical anti-inflammatories
- Topical pain medication

Branded versus Generic Drugs

Our pharmacy program is a mandatory generic program for brand products where there is a generic equivalent. Brand name medications, if medically necessary, can be requested through the PA process. Select narrow therapeutic index medications are excluded from the mandatory generic program.

Contraceptives
The pharmacy benefit covers prescription and OTC contraceptives. The member may receive up to a 12-month supply in a single fill for maintenance contraceptives. Intrauterine devices are covered under medical benefits and not covered as pharmacy claims.

Infertility Drugs
Infertility drugs are not a covered benefit for CHPlus.

Prior Authorization for Pharmacy Benefit Drugs

We strongly encourage you to write prescriptions for preferred products as listed on the appropriate CHPlus *PDL*. If, for medical reasons, a member cannot use a preferred product, you're required to contact Pharmacy Services to obtain prior authorization (PA). Please note that certain drugs on the *PDL* may be subject to PA.

PA for CHPlus members only may be requested by submitting an electronic PA through **covermymeds.com**.

PA for CHPlus members only may be requested by calling Provider Services at **1-866-231-0847 (TTY 711)**. 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.

For Medicaid and HARP PA's, please call NYRx at **1-877-309-9493**.
A *Prior Authorization Form* can also be found at **newyork.fhsc.com/providers/pa_forms.asp**.

PA review time frames

PA requests for CHPlus are reviewed and notification of a decision is made within 24 hours of receipt of a completed request through both verbal and written correspondence.

To ensure timely processing of requests, all relevant clinical information and previous drug history must be included and/or provided with the request.

Emergency supply

Highmark BCBS network pharmacies may provide a 72-hour emergency supply of medication to members who have an immediate need to start a medication that is being reviewed for coverage through the PA process. The network pharmacy may enter the designated override code CarelonRx provides and submits a claim for the 72-hour supply of medication. You don't need to call to request the emergency supply. Exclusions may apply.

Excluded Drugs

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

- Anti-wrinkle agents (for example, Renova)
- Compound bulk powder
- Drugs used for cosmetic reasons or hair growth
- Drugs used for experimental or investigational indication
- Growth hormones used for idiopathic short stature (ISS)
- Infertility medications — except bromocriptine, clomiphene, letrozole, tamoxifen
- Non-CMS rebatable drugs

- DESI 5 or 6 drugs
- Sexual dysfunction drugs (for example, Viagra and Intrarosa)
- Weight-loss drugs

Drugs not covered by pharmacy benefit but available under the medical benefit:
- Enteral formula
- Gene therapy
- Hemophiliacs
- Implantable drugs and devices (for example, Mirena, Paragard)

Hyaluronic drugs are not covered by pharmacy or medical benefit for any indication (for example):
- J7321 — Hyalgan or Supartz
- J7323 — Euflexxa
- J7324 — Orthovisc
- J7325 — Synvisc or Synvisc-one
- J7326 — Gel-One

Specialty Medications

Specialty medications are high-cost injectable drugs that generally require close supervision and monitoring of the drug therapy. These drugs often require special handling, such as temperature-controlled packaging and overnight delivery and are often unavailable at retail pharmacy stores.
Please refer to the Specialty Drugs on our website for additional information.

Specialty Drug Program (for CHPlus Only)

Specialty pharmacies are different. A specialty pharmacy does more than just fill prescriptions. These pharmacies serve members with complex or chronic conditions. Specialty medications are used to treat these conditions and often require special storage or extra support. Specialty pharmacies have highly trained pharmacists and nurses to provide personal care and guidance to help your member manage their condition.

If your member has a specialty condition, they have the option to use CarelonRx Specialty Pharmacy for their specialty medications. These medications are delivered to their home or shipped to a local pharmacy for pickup.

With CarelonRx Specialty Pharmacy, members get:
- Free shipping with confidential, on-time delivery
- 24/7 access to trained professionals
- Individualized care

To schedule delivery for specialty medications, you can contact CarelonRx at **1-833-255-0646.**

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

Prescribers can send electronic prescriptions to CarelonRx Specialty Pharmacy and may also be required to fill out a specialty pharmacy form in addition to calling or faxing in a valid New York State prescription to the pharmacy that the member has 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 **providerpublic.mybcbswny.com.**

Prenatal Vitamins
Highmark BCBS's CHPlus formulary contains an extensive list of prenatal vitamins, including Atabex, Nestab tablet, Obtrex tablet, One-A-Day Women's Prenatal, Right Step Prenatal, Theranatal Core Nutrition, and many other OTC formulations.

Intrauterine Devices
Please use the options below to receive long-acting reversible contraceptives for administration at your office. These devices can only be obtained under the medical benefit using the below instructions. As always, you have the buy and bill option under a member's medical benefit.

For Kyleena, Mirena, Liletta, and Skyla: If you choose CVS/Caremark Specialty Pharmacy under the medical benefit, they are available to assist you Monday through Friday from 7:30 a.m. to 7:30 p.m. ET and can accept the prescription using a method convenient for you. The prescription can be given to a CVS Specialty pharmacist over the phone by providing the patient's name and insurance information at **1-877-254-0015**. The prescription or the completed manufacturer form can also be faxed to **1-866-336-8479**. The buy and bill option under the member's medical benefit is also an option.

For Nexplanon: You must first follow the manufacturer's instructions by calling **1-844-NEX4321** (**1-844-639-4321**) Monday through Friday from 8 a.m. to 8 p.m. ET. After this, you have the option of CVS/Caremark Specialty Pharmacy or buy and bill, both under the medical benefit.

For Paragard: Use the buy and bill option. Call Paragard Access Solutions at **1-877-PARAGARD** (**1-877-727-2427**). They are available Monday through Friday from 8:30 a.m. to 8 p.m. ET. Use the Paragard Direct option for providers.

Opioids
Per New York state regulations, prescriber may not initially prescribe more than a 7-day supply of an opioid medication for acute pain. This rule does not include prescribing for chronic pain, pain being treated as a part of cancer care, hospice or other end-of-life care, or palliative care. Upon any subsequent consultations for the same pain, the practitioner may issue, in accordance with existing rules and regulations, any appropriate renewal, refill, or new prescription for an opioid.

Highmark BCBS limits coverage of initial prescription of short-acting opioids to 7-day supply, and subsequent prescriptions to 7-day supply for up to a total of 14-day supply in 30 days. Prescriptions for long-acting opioids require prior authorization regardless of day supply. Exceptions are given to patients being treated for cancer, in hospice or palliative care.

Members will be limited to four prescriptions for Opioids in a rolling 30 calendar day period. Prior Authorization maybe required for these patients to fill more than four opioid prescriptions in a 30-day period if system configuration does not allow their claims to bypass. Exceptions are given to patients being treated for cancer, sickle cell anemia and long term care pharmacy claims.

Smoking Cessation Products
Some smoking cessation products are covered without prior authorization or course limitation. However, quantity limit, refill-too-soon edit, and age limit (if applicable) still apply.

Split Fill Program
The split fill program is designed to prevent wasted prescription drugs if the treatment plan changes. The prescription drugs included under this program have been identified as requiring more frequent follow up to monitor response to treatment and reactions.

The initial and/or the second prescription are limited to a 15-day supply. The therapeutic classes included in this program are (list is subject to change):

- Anti-neoplastic agents
- Hepatitis B agents
- Certain antipsychotics

The initial and/or the second prescription are limited to a small-sized tube. The therapeutic class included in this program is (list is subject to change):
Topical acne treatment

Vaccines
Coverage for children through 18 years of age continues to be provided through the Vaccine for Children (VFC) program. Participating pharmacies in the VFC program can now submit claims for the administration fee of the flu vaccine through the health plan. The cost of the flu vaccine is covered by the VFC program; however, administration fees can be reimbursed by the health plan when submitted thru the ingredient cost field.

Highmark BCBS covers certain pharmacy vaccines for Child Health Plus members under Pharmacy Benefit. These vaccines include:

- Flu (Two years of age and older)
- Pneumococcal
- Covid 19

Medical Injectables (Physician Administered Drugs)

For Medicaid, HARP and CHPlus certain medical injectables obtained directly by a medical provider or infusion pharmacy, and administered in a medical setting may require pre-certification. To determine whether the medical injectable you are prescribing requires pre-certification, please refer to the Prior Authorization Lookup tool at **providerpublic.mybcbswny.com/western-new-york-provider/resources/precertification-requirements/precertification-lookup**.

PA may be requested by submitting an electronic PA through Availity.

PA may also be submitted by calling Provider Services at **1-866-231-0847 (TTY 711)**. 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 in accordance to certain established medical criteria.

A Prior Authorization form for WNY members can also be found on our website at providerpublic.myBCBS.com/western-new-york-provider/resources/forms and can be submitted by fax. Be prepared to submit relevant clinical information regarding the member's need for a nonpreferred product or a medication requiring PA along with the fax form.

Pharmacy Clinical Programs

To help our providers deliver high-quality and comprehensive care, Highmark BCBS may offer information and recommendations as part of the many tools providers use to determine a treatment plan. The information is either mailed or faxed to our providers. Programs include topics on:

- HEDIS®/Quality Assurance Reporting Requirements (QARR) measures
- Controlled substance utilization monitoring
- Asthma management
- Diabetes management
- Depression/Psychosis management
- Polypharmacy

HEDIS®/QARR is a registered trademark of the National Committee for Quality Assurance (NCQA).

Certain programs may request response from our providers. If you have any questions regarding the letter/fax you received, please contact the phone number listed on the letter/fax.

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

Vaccines for Children Program

The New York State Department of Health requires physicians and other providers to obtain all vaccines for their Child Health Plus patients through the Vaccines for Children (VFC) program. Providers who are not enrolled in VFC must enroll in order to receive vaccines. Providers who do not participate in the VFC program will not receive free vaccines, nor will they receive payment from Highmark BCBS for the cost of the vaccine. Highmark BCBS Child Health Plus members cannot be billed for vaccine costs.

For information about VFC enrollment in WNY, contact the VFC program at **1-212-447-8175**, Monday through Friday from 9 a.m. to 5 p.m. For information about VFC enrollment in all other locations, contact the New York State VFC program at **1-800-KID SHOTS** (**1-800-543-7468**), Monday through Friday from 9 a.m. to 5 p.m. More information on VFC can also be found at: **health.ny.gov/prevention/immunization/vaccines_for_children.**

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 therapy for MMC and Highmark BCBS members are limited to 40 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.

Coverage of outpatient, occupational and speech therapies for MMC 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 healthcare 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 healthcare 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 **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 CHPlus 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)

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 members and their newborns. We use several resources to identify pregnancies as early as possible. Sources of identification include, state enrollment files, claims data, and hospital census reports as well as provider and member 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. They may also collaborate with community partners to facilitate connecting members to local and national agencies who can assist with services and support.

When it comes to pregnancy, we are committed to healthy outcomes for our members and their babies. That is why we encourage all our pregnant and postpartum members to take part in our New Baby, New Life program, a comprehensive program which offers:

- Individualized, one-on-one case management support for pregnant members at the highest risk
- Care coordination for those who may need a little extra support
- Digital perinatal educational tools
- Information on community resources
- Incentives 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, perinatal members have access to a digital perinatal offering. This digital offering is available by smartphone app and provides pregnant and postpartum members with timely, proactive, and culturally appropriate education. Once members are identified as being pregnant, they will receive an invitation to access this program by downloading the app. After the app is installed and the member registers, they are asked to complete a pregnancy screener. The answers provided in the screener allows us to assess their pregnancy risk.

After risk assessment is complete, the app delivers gestational-age appropriate education directly to the member. This digital offering does not replace the high-touch, individual case management approach for our highest risk pregnant members; however, it does serve as a supplementary tool to extend our health education outreach. The goal of the expanded outreach is to ensure maternity education is available to all perinatal members and help Blue Cross Blue Shield to identify members who experience a change in risk acuity throughout the perinatal period.

We require notification of pregnancy at the first prenatal visit and notification of delivery following birth. You may choose to complete the notification of pregnancy and delivery in Availity or fax the forms to Blue Cross Blue Shield at **1-800-964-3627**.

We encourage healthcare providers to share information about the New Baby, New Life program and the digital perinatal apps offered at Blue Cross Blue Shield with members. Members may access information about the products that are available by visiting the Blue Cross Blue Shield member website.

For more information about the New Baby, New Life program or the digital app, reach out to your OB Practice Consultant or Provider Services at **1-866-231-0847** (**TTY 711**), or refer to our website at **providerpublic.mybcbswny.com/western-new-york-provider/patient-care/maternal-child-services**.

If you have a member in your care that would benefit from case management, please call us at **1-866-231-0847 (TTY 711)**. Members can also call our 24-hour Nurse Helpline at **1-866-231-0847 (TTY 711)**, available 24 hours a day, 7 days a week.

Neonatal Intensive Care Unit (NICU) Care Management

If a baby is born premature or with a serious health condition, they may be admitted to the NICU. We believe the more parents know, the better they will be able to care for their infant. To support them, we have a NICU Care Management program.

We extend our support by helping parents to prepare themselves and their homes for when baby is released from the hospital. After baby is home, our case managers continue to provide education and assistance in improving baby's health, preventing unnecessary hospital readmissions, and guiding parents to community resources if needed.

The NICU can be a stressful place, bringing unique challenges and concerns that parents may have never imagined. The anxiety and stress related to having a baby in the NICU can potentially lead to symptoms of post-traumatic stress disorder (PTSD) in parents and caregivers. To reduce the impact of PTSD among our members, we assist by:

- Helping parents engage with hospital-based support programs
- Facilitating parent screenings for potential PTSD
- Connecting parents with behavioral health program resources and community support as needed
- Actively asking for their feedback on the provided resources and how an increased awareness of PTSD has helped

For more information about our NICU Care Management program, reach out to Provider Services at **1-866-231-0847** (**TTY 711**), or refer to our website at **providerpublic.mybcbswny.com/western-new-york-provider/patient-care/maternal-child-services**.

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) - as of 4/1/2023, this restriction will be handled by the State Restricted Recipient Program due to the Pharmacy Benefit Transition.
- 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 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, gender, gender identity, race, color, religion, national origin, age, marital status or sexual orientation. If you have any questions or concerns about this right, call **1-866-231-0847 (TTY 711)** or visit **providerpublic.mybcbswny.com**.
- Be told where, when and how to get the services they need from Highmark BCBS.
- Be told by their PCP or another practitioner 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 or another practitioner 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 healthcare provider, a health plan, employer or a healthcare clearinghouse.
        - Has to do with physical or mental health condition, providing healthcare to a member, or paying for providing healthcare to a member.
- Use the Highmark BCBS complaint and appeal system to settle any complaints or appeals 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, or about the organization or the care it provides.
- 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 healthcare 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 healthcare with their healthcare 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 healthcare 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 **1-866-231-0847 (TTY 711)**.
- Call our Member Services department toll free at **1-866-231-0847 (TTY 711)** 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 **1-866-231-0847 (TTY 711)**.
- 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 healthcare 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 or other practitioners to guard and improve their health.
- Give Highmark BCBS, their PCPs or other practitioners the information they need to take care of their medical needs.
- Listen to advice from practitioners and ask questions when they are in doubt.
- Know and get involved in their healthcare; members should talk with their PCPs or other practitioners about recommended treatment and follow the plans and instructions for care agreed upon, to the best of their ability.
- 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 or other practitioners if they do not get better.
- Ask for a second opinion.
- Treat healthcare staff with the same respect the member expects.
- Tell Highmark BCBS if they have problems with any healthcare 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.

6 BEHAVIORAL HEALTH SERVICES

Overview

The Highmark BCBS Behavioral Health program was created to manage the needs of members seeking treatment for substance use and mental health problems. The program promotes the mental health, resilience and wellbeing of our members who are in treatment for mental and substance use disorders, provides support to those who experience and/or are in recovery from these conditions along with their families and communities. Highmark BCBS understands that a member's physical health needs may be impacted by an individual's behavioral health and the prevention, early detection, and treatment of behavioral health conditions can lead to improved physical and community health.

Highmark BCBS complies with state Medicaid guidance including managed care policy documents, relevant performance improvement specification documents or manuals, and policies governing prior authorization, concurrent or retrospective review. Specifically, we incorporate the following resources into our policies and procedures:

- Office of Mental Health's *Clinic Standards of Care* (**NYS Bureau of Inspection and Certification MHOTRS Program Standards of Care Anchor Element July 2023**)
- Office of Mental Health's Best Practices Manual (**omh.ny.gov/omhweb/bho/docs/best-practices-manual-utilization-review-adult-and-child-mh-services.pdf**)
- Office of Addiction Services and Supports' guidance (**https://oasas.ny.gov/about**)
- Office of Health Insurance Programs' *Policy and Proposed Changes to Transition Children in Direct Placement Foster Care into Medicaid Managed Care,* April 2013 (**health.ny.gov/health_care/medicaid/redesign/docs/policy_and_proposed_changes_fc.pdf**)
- *OCFS Working Together: Health Services for Children/Youth in Foster Care Manual* (**ocfs.ny.gov/main/sppd/health_services/manual.asp**)
- Office of Health Insurance Programs' *Principles for Medically Fragile Children,* July 2014
- Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract, as amended March 1, 2019.
- OPWDD HCBS waiver and other services available to persons with developmental disabilities (**opwdd.ny.gov)**

Each member's treatment should be individualized/person-centered and focused on improving the member's overall well-being. Providers should deliver care in a manner which adheres to recovery-oriented principles.

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) 3.0 assessment tool for level of care determination or Office of Addiction Services and Supports (OASAS) For all mental health services, Highmark BCBS and InterQual Care Guidelines medical necessity criteria will be used to assess medical necessity. For all addiction services, state approved LOCADTR 3.0 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.

Highmark BCBS promotes behavioral health/medical integration for children, including at-risk populations as defined by the state.

- Providers can access Provider Services for information related to referral and linkage support for child and adolescent patients.
- The Health Home or Highmark BCBS will coordinate access to rapid consultation from child and adolescent psychiatrists. Staff will assist in reviewing urgent medical need and make necessary linkages to behavioral health providers to best serve the child/family need.

Behavioral healthcare 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. In addition, Highmark BCBS will educate providers regarding the plan support for provider access to 1) rapid consultations from child and adolescent psychiatrists and 2) referral and linkage support for child and adolescent patients. Training will be part of the initial orientation and ongoing trainings for providers.

Meeting the Needs of Children and Youth Members

Highmark BCBS ensures participating providers have expertise in caring for medically fragile children (including children with co-occurring developmental disabilities) so they receive services from appropriate providers. We expanded our current provider training curriculum to reflect the expanded children's benefit and populations. Highmark BCBS has initial training available of newly contracted providers or provider groups within 30 calendar days of participating status date or contract effective date, whichever is later. This includes all new plan providers who join the network and work with the expanded children benefit and populations, including OMH licensed, OASAS certified and VFCA 29-I

licensed. We also conduct ongoing training as deemed necessary to ensure compliance with NYS regulations and in trainings that promote member wellness and recovery. Trainings will be offered in person, via WebEx or online (website or other online options). These trainings will be offered at a date and time convenient to the provider.

Highmark BCBS will communicate sessions offered to all providers via mailings and/or provider website postings and will be updated regularly.

Participating providers should refer to appropriate, in-network community and facility providers to meet the needs of the child or seek authorization from Highmark BCBS for out-of-network providers when participating providers can't meet the child's needs. Highmark BCBS authorizes these services in accordance with established time frames in the *Medicaid Managed Care Model Contract* and Office of Health Insurance Program's *Principles for Medically Fragile Children* (under EPSDT, HCBS, and CFCO rules) as well as with consideration for extended discharge planning.

Highmark BCBS works to comprehensively meet the needs of children and youth under 21 years of age with behavioral health and HCBS. This includes addressing the needs of medically fragile children, children with behavioral health diagnosis(es) and children in foster care with developmental disabilities.

Special Considerations for Transitioning Services from Medicaid FFS to MMC for HCBS eligible children

Children who are already enrolled in Medicaid, who are believed to be HCBS eligible and/or in need of HCBS, will be referred to a Health Home. Health Home care managers will work with the child, family and providers to determine HCBS eligibility. The level of care determination is comprised of meeting three factors: target population, risk factors and functional criteria as outlined in the state requirements for the children's 1115 waiver demonstration.

Provider Reimbursements

Highmark BCBS will reimburse at least the Medicaid FFS fee schedule for 24 months or as long as New York state mandates (whichever is longer) for the following services/providers:

1. New state plan services including OLP; crisis intervention; CPST; PSR; family peer support services and youth peer support and training; and preventive residential supports.
2. OASAS clinics (Article 32 certified programs)
3. All OMH licensed ambulatory programs (Article 31 licensed programs)
4. Children's Home and community-based services (HCBS)

Highmark BCBS will execute single case agreements with nonparticipating providers to meet clinical needs of children when in-network services are not available. Highmark BCBS will reimburse the Medicaid FFS fee schedule for 24 months for all single-case agreements.

Highmark BCBS will contract with OASAS residential programs and pay their allied clinical service providers on a single case or contracted basis for members who are placed in an OASAS certified residential program to ensure access to and continuity of care for patients placed outside of the Highmark BCBS service area.

State Plan Service and Aligned Children's Home and Community-based Services Eligibility

The State Plan Service and Home and Community-Based Services (HCBS) waiver is a federally approved initiative permitting the state of New York to make certain services available under Medicaid, not typically included in the Medicaid state plan for a targeted group of individuals with specific health needs and who meet specific eligibility criteria. HCBS will be managed in compliance with CMS HCBS Final Rule and any applicable state guidance.

HCBS are designed to allow children/youth to participate in a vast array of habilitative services by granting access to a series of Medicaid funded services. New York has affirmed its commitment to serving individuals in the least restrictive environment by providing services and supports to children and their families to enable them to remain at home and in the community. HCBS are designed for people who (but for these services) require the level of care provided in a more restrictive environment such as in a long-term care facility or psychiatric inpatient care and for those at risk of elevating to that level of care.

The state plan services will provide services that focus on:

- Prevention and wellness
- Improving integration of behavioral health and health-focused services earlier in a child's life
- Allowing interventions to be delivered in natural community-based settings where children and their families live
- Making available lower intensity services for children that present the need for more restrictive settings and higher intensity services.

The state plan services are rehabilitative services under the EPSDT benefit and available to children/youth under the age of 21 who are Medicaid eligible, that meet medical necessity. These services known as Children and Family Treatment and Support Services (CFTSS) can be delivered in the community where the child/youth lives, attends school, and/or engages in services. These services include: other licensed professional (OLP), crisis intervention, community psychiatric supports and treatment (CPST), psychosocial rehabilitation services, family peer support services, youth peer advocacy and training.

Who May Provide Care?

An incorporated, not-for-profit agency or governmental entity may apply to be a provider of CFTSS services. A certification process exists for both licensed and unlicensed OASAS or OMH providers. Providers must apply for designation and, if necessary, apply for OMH license and OASAS certification.

Interested agencies currently OMH licensed and OASAS certified should sign the *Attestation for Currently Certified OASAS Providers and Currently Licensed OMH Providers Form*

The Department of Health website
health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/proposed_spa.htm

- Contains information regarding the CFTSS including webinars, trainings and timelines, the CFTSS manual and HCBS service definitions and criteria.

The Department of Health website **health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/1115_waiver_amend.htm** contains information regarding HCBS; Children's 1115 Waiver Amendment and HCBS manual and rates.

Children's HCBS Care Process

The plan collaborates with Health Homes, medical providers and behavioral health providers to ensure children are appropriately reviewed for eligibility of HCBS services; a plan of care is developed with the child and family; appropriate referrals to service providers are made; services are provided and the level of care for the child is met.

The HCBS care process involves the following steps:

- The individual is determined to be eligible or reassessed annually for HCBS services.
- A plan of care is developed with the child and the family that meets the specific needs of the member whether the child is developmentally disabled, medically fragile or with specific behavioral health needs.
- Referrals are made to HCBS providers. These providers are certified by the state and are also contracted with the plan's network.
- The child will access the services and the service provider will ensure the child's level of care is assessed and communicated to the plan.
- The plan will perform ongoing monitoring of the child's plan of care to ensure that services are being accessed and that that the child is progressing with the plan of care goals.

Description of referral process for Children's HCBS and HCBS eligibility assessment

There are potentially three points of referral for a child into HCBS services who are currently not engaged with HCBS services:

- Community/medical providers — may identify in collaboration with the family that the child could benefit from the HCBS array of services. These providers may include the child's PCP, specialist, community supports and government agencies (for example, foster care; OPWDD).
- Health Homes — a child may already be enrolled with a Health Home, but not currently engaged with HCBS services. A Health Home may, through review of the child's care plan, identify that the child may benefit from specific HCBS services.
- The Health Plan identifies children who could potentially be eligible for services through plan claims' data. These children are referred to a Health Home who then reaches out to the family regarding the HCBS services and their benefit to the child.

The referral to HCBS services may be submitted online using one of the available Health Home portals. The referral form is accepted by the Health Home who completes the initial eligibility assessment for the level of care and level of need of the child.

Both level of care and level of need determinations involve/require the completion of a common assessment tool, the CANS-NY (except for LOC DD). The results of a comprehensive CANS-NY will play a role in determining functional deficits and identifying risk factors for the child.

The target criteria, risk factors and functional limits are to be documented in the Uniform Assessment System.

Once determined to be eligible, the child is referred to an in-network HCBS service provider who meets with the child/family to begin the service delivery process. The HCBS provider will complete an intake/assessment regarding their particular service area to determine frequency, scope, and duration in conjunction with the family/child. The HCBS provider will coordinate with the Health Home care manager or independent entity to provide them with these details to inform and update the plan of care. The child will access the services and the HCBS service provider will ensure the child's level of care is assessed and communicated to the plan.

Plan of care by Health Home care managers
For children enrolled in an MMCP, within 30 calendar days from the completion and signed (initial) plan of care (POC), the HHCM must send the POC to the MMCP with whatever information is available at that time.

If the POC that is sent to the MMCP is an HCBS only POC, then when the HHCM develops a comprehensive POC that complies with Health Home Serving Children standards (within 60 days of Health Home enrollment), the POC must be resent to the MMCP.

- If the F/S/D has not been reported from each of the providers or services, then the POC must still be updated and sent to the MMCP within the 30-calendar day time frame.
    - Once the remaining providers and or services have been reported with F/S/D, then the POC will be updated again with the new information within 10 business days of being notified by the HCBS provider of the F/S/D on the Children's HCBS Authorization and Care Manager Notification Form and the updated POC is shared with the MMCP.
    - If a new need and or service is identified by the HHCM, child/family, involved providers, etc., then the above outlined steps would be followed and the HHCM sends the updated POC to the MMCP within 30 calendar days of the revision.

Note: If the member is in urgent need of services and/or will go over the initial 60 days/96 units/24 hours prior to the POC being sent to the MMCP, once the MMCP received the Children's HCBS Authorization and Care Manager Notification Form the MMCP will contact the HHCMA/HHCM to verify the POC.

Plan of care by C-YES:
C-YES must develop an HCBS POC using information from the HCBS/LOC Eligibility Determination, and a person-centered discussion that identifies personal goals and how specific HCBS may support the child in achieving those goals.

- For children who are enrolled in an MMCP and not in a Health Home: C-YES must send the HCBS POC to the MMCP within 15 calendars days of its development with whatever information is available at that time. The MMCP is required to update the HCBS POC with the child/family using the information provided by the HCBS providers from the Children's HCBS Authorization and Care Manager Notification Form and related service authorization determinations. The MMCP will meet with the child and family as needed to maintain the POC with person-centered service planning and care management for children with special needs as per the Model Contract.

C-YES will determine annual HCBS/LOC Eligibility and conduct an annual review and will coordinate with the MMCP to update the HCBS POC, with signatures based upon the HCBS/LOC reassessment.

The plan will be prompted to automatically authorize HCBS upon notification by the HCBS provider that the child has engaged in care. It is required that the Health Home care manager submits a plan of care listing the specific HCBS prior to the date of the first HCBS appointment — this serves as notice to the plan and will permit initial authorization of the service.

The initial authorization will be effective for 60 days from the date of initial receipt. The automatic authorization permits by service and includes 96 units or a total of 24 hours of service, not to exceed 60 calendar-day duration. Highmark BCBS will require concurrent review if the HCBS exceeds 60 days/96 units/24 hours of service (whichever is first). The HCBS provider will submit the *Authorization Form* to Highmark BCBS to request additional service prior to the end of the initial authorization period. The request must include the recommended scope, frequency and duration of the service. To avoid disruption in service, the HCBS provider is encouraged to submit this request as soon as it is apparent that the service will exceed the limit. Requests submitted less than 14 days before expiration of service may not be authorized before runout. Highmark BCBS will review the request and issue a concurrent review determination within the authorization request time frames described in the *Medicaid Managed Care Model Contract*. Highmark BCBS may request additional information related to the service authorization request from the HCBS provider to ensure that the service is appropriate and meets the needs of the child.

Highmark BCBS will notify the child, parent, guardian, and legally authorized representative, HCBS provider and the Health Home care manager of the service authorized and time frame of authorization.

The plan will perform ongoing monitoring of the child's plan of care to ensure that services are being accessed and that that the child is progressing with the plan of care goals.
Plan will ensure the following:

- Children who are eligible for HCBS have care management and a care plan for their HCBS services.
- Health Home care managers develop a single Health Home comprehensive plan of care that includes all services the member needs (health, behavioral health, community and social supports, specialty services, etc.).

Targeted Population for HCBS

To access HCBS, a child must be determined eligible based on meeting target and risk factors in addition to functional deficits measured by the CANS-NY assessment.
Children and youth seeking HCBS must be under 21 years old and eligible for Medicaid.
HCBS eligibility is comprised of three components: 1) target criteria, 2) risk factors and 3) functional criteria.

There are 2 HCBS eligibility groups:
1. Level of care: children that meet institutional placement and
2. Level of need: children who are at risk of institutional placement.

The services are accessible to the child once a provisional Plan of Care (POC) is in place. The Plan will ensure that the POC was developed in a person-centered manner, compliant with federal regulations and state guidance, and meets individual needs.

Both level of care and level of need determinations involve/require the completion of a common assessment tool, the CANS-NY (except for LOC DD).

The results of a comprehensive CANS-NY will play a role in determining functional deficits and identifying risk factors.

Whether a child meets the level of care or the level of need criteria, eligible children, youth and their families will have access to the same array of HCBS services which will be provided in a person-centered manner.

Providers of HCBS and the new state plan services must also be enrolled in the Medicaid program for billing and reimbursement purposes.

Targeted Population for CFTSS Services

The new state plan services are rehabilitative services under the EPSDT benefit and available to children/youth under the age of 21 who are Medicaid eligible, that meet medical necessity. The medical necessity criteria are specific to each SPA service.

Plan will adopt state guidelines for member eligibility and medical necessity. The state guidelines are available at **health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/proposed_spa.htm**.

Office of Persons with Developmental Disabilities

The Office of Persons with Developmental Disabilities (OPWDD) Home- and Community-Based Services (HCBS) waiver is a federally approved initiative permitting the state of New York to make certain services available under Medicaid not typically included in the Medicaid state plan for a targeted group of individuals with developmental disabilities and who meet specific eligibility criteria.

The waiver is intended to decrease the risk of institutionalization by providing personalized services in the community. These services are based on the needs, preferences and personal goals of the consumer.

Waiver-funded services emphasize individualized services, community inclusion, independence and productivity. The OPWDD HCBS waiver was designed to reduce costs while increasing choice and flexibility in service.

Who May Provide Care?

An incorporated, not-for-profit agency or governmental entity may apply to be a provider of waiver services. Individuals interested in becoming an authorized provider must obtain not-for-profit status. Evidence of article of incorporation noting the practitioner will provide services to persons with developmental disabilities will be required.

Interested agencies should contact the OPWDD Developmental Disabilities Services Office (DDSO) in their county.

Targeted Population

To be eligible to participate in the OPWDD HCBS waiver, an individual must:

- Be diagnosed with a developmental disability.
- Be eligible for intermediate care facility (ICF)/mental retardation (MR) level of care.
- Be eligible for Medicaid.

- Choose HCBS waiver services over institutional care.

An individual with a developmental disability and residing in New York can request enrollment in the HCBS waiver by contacting their county's DDSO.

Providers of waiver services must also be enrolled in the Medicaid program for billing and reimbursement purposes.

For additional information regarding the OPWDD HCBS waiver and other services available to persons with developmental disabilities, visit the OPWDD website at **opwdd.ny.gov**.

For a listing of DDSOs, visit **opwdd.ny.gov**.

Children Placed in Foster Care and Article 29-I Health Facilities

Children/youth placed in foster care, including those in direct placement foster care and placement in the care of VFCAs statewide, are mandatorily enrolled in Medicaid managed care (MMC) unless the child/youth is otherwise exempt or excluded from enrollment. Exemptions and exclusions from MMC enrollment are included in the 1115 Medicaid Redesign Team Waiver Special Terms and Conditions at **health.ny.gov/health_care/medicaid/redesign/medicaid_waiver_1115.htm**. Children enrolled in CHPlus who enter into foster care will be transitioned to MMC; however, undocumented immigrant children placed in foster care are only eligible to enroll in CHPlus.

Who May Provide Care?

In alignment with the MMC/CHPlus enrollment of the foster care population in the care of VFCAs, VFCAs may opt to become a licensed healthcare facility provider through New York State Public Health Law (PHL) Article 29-I, which provides for the provision of Core Limited Health-Related Services (CLHRS) and Other Limited Health-Related Services (OLHRS), and enter into an Highmark BCBS agreement for the provision of these services to eligible enrolled children/youth. On January 1, 2023, CLHRS and OLHRS are included in the CHPlus Benefit Package.

Not all VFCAs have elected to become Article 29-I providers; VFCAs who opt out of Article 29-I licensure are not authorized to provide health services and will not be reimbursed for Article 29-I health services.

Highmark BCBS is responsible for providing all Benefit Package services to enrolled children/youth placed in foster care, promoting continuity of care, and ensuring healthcare services are delivered in a trauma-informed manner and consistent with standards of care recommended for children in foster care. Children/youth often enter foster care without having had access to traditional preventive healthcare services. As a result, children/youth in foster care require an increase in the frequency of their health monitoring.

Highmark Blue Cross BlueShield covers the following Residential Supports and Services for enrollees who are eligible to be served by a 29-I Health Facility, in accordance with the 29-I Billing Guidance:

1. Core Limited Health-Related Services (CLHRS) on a per diem basis, inclusive of:
    a. Nursing Services
    b. Skill Building Licensed Behavioral Health Practitioner (LBHP)
    c. Medicaid Treatment Planning and Discharge Planning
    d. Clinical Consultation/Supervision Services

e. VFCA Managed Care Liaison/Administration

2. Medically necessary Other Limited Health-Related Services (OLHRS) that the 29-I Health Facility is authorized by the State to provide may include:

a. Children and Family Treatment Supports and Services (CFTSS)
   i. Other Licensed Practitioners (OLP)
   ii. Community Psychiatric Supports and Treatment (CPST)
   iii. Psychosocial Rehabilitation (PSR)
   iv. Family Peer Supports and Services (FPSS)
   v. Youth Peer Support and Training (YPST)
   vi. Crisis Intervention (CI)

b. Children's Waiver HCBS
   i. Caregiver Family Supports and Services
   ii. Community Advocacy and Support
   iii. Respite (Planned and Crisis)
   iv. Prevocational Services
   v. Supported Employment
   vi. Day Habilitation
   vii. Community Habilitation
   viii. Palliative Care: Bereavement Therapy
   ix. Palliative Care: Expressive Therapy
   x. Palliative Care: Massage Therapy
   xi. Palliative Care: Pain and Symptom Management
   xii. Environmental Modifications
   xiii. Vehicle Modifications
   xiv. Adaptive and Assistive Equipment
   xv. Non-Medical Transportation

c. Medicaid State Plan services
   i. Screening, diagnosis and treatment services related to physical health, including but not limited to:
      - Ongoing treatment of chronic conditions as specified in treatment plans
      - Diagnosis and treatment related to episodic care for minor ailments, illness or injuries, including sick visits
      - Primary pediatric/adolescent care
      - Immunizations in accordance with NYS or NYC recommended childhood immunization schedule
      - Reproductive healthcare
   ii. Screening, diagnosis and treatment services related to developmental and behavioral health. This includes the following:
      - Psychiatric consultation, assessment, and treatment
      - Psychotropic medication treatment
      - Developmental screening, testing, and treatment
      - Psychological screening, testing and treatment
      - Smoking/tobacco cessation treatment
      - Alcohol and/or drug screening and intervention

- Laboratory tests

OLHRS do not include the following services:

i. surgical services
ii. dental services
iii. orthodontic care
iv. general hospital services including emergency care
v. birth center services
vi. emergency intervention for major trauma
vii. treatment of life-threatening or potentially disabling conditions
viii. nursing services, skill building activities (provided by LBHPs as described in the Article 29-I VFCA Health Facilities License Guidelines and any subsequent updates), and Medicaid treatment planning and discharge planning, including medical escorts and any clinical consultation and supervision and tasks associated with the 29-I MMCP Liaison/Administrator in 29-I Health Facilities. These services are included in the Preventive or Rehabilitative Residential supports of the mandatory CLHRS.

Essential Community Providers

1. Essential Community Providers are providers with expertise in serving children/youth placed in foster care.
2. 29-I Health Facilities will make reasonable effort to notify the State of Essential Community Providers commonly accessed by children/youth placed with the 29-I Health Facility.
3. For children/youth in their care, 29-I Health Facilities will make reasonable effort to refer to or arrange for access to Essential Community Providers that are participating with Highmark BCBS. If known in advance and services are not urgently needed, the 29-I Health Facilities will notify Highmark BCBS that an enrolled child/youth is in need of services from an out-of-network Essential Community Provider.
4. Highmark BCBS will reimburse Essential Community Providers for covered Benefit Package services in accordance with Provider Agreement provided to our members placed in foster care or in the care of a 29-I Healthcare Facility.
5. Highmark BCBS will support and facilitate ongoing access to these Essential Community Providers by:
    a. Offering contracts to identified Essential Community Providers, where such provider is enrolled in the Medicaid program, or otherwise facilitating access to such providers through out of network arrangements, where agreed to by the provider.
    b. Responding promptly to the 29-I Health Facility's notification that a member requires services from an Essential Community Provider to arrange any necessary authorization or agreements for the member to access medically necessary covered services.

Targeted Population

A. Children/youth placed in foster care, including those in direct placement foster care and placement in the care of VFCAs statewide, are mandatorily enrolled in MMC unless the

child/youth is otherwise exempt or excluded from enrollment. Children enrolled in CHPlus who enter into foster care will be transitioned to MMC; however, undocumented immigrant children placed in foster care are only eligible to enroll in CHPlus.

B. Effective upon licensure by the State, 29-I Health Facilities will provide CLHRS and OLHRS to children/youth as described in the Article 29-I VFCA Health Facilities License Guidelines and the 29-I Billing Guidance. Child/youth populations served by 29-I Health Facilities and covered by Highmark BCBS for CLHRS and/or OLHRS are described and defined in the 29-I Billing Guidance, including:
   1. Children/youth placed in foster care;
   2. Babies residing with their parent who are placed in a 29-I Health Facility and in foster care (8D Babies);
   3. Children/youth placed in a 29-I Health Facility by Committee on Special Education (CSE);
   4. Pre-dispositional placed youth; and
   5. Children/youth and adults who are discharged from a 29-I Health Facility

For additional State Guidance regarding the transition of youth and children in foster care, see the Guidance Document Transition of Children Placed in Foster Care and NYS Public Health Law Article 29-I Health Facility Services into Medicaid Managed Care by the NYS Department of Health and the Office of Children and Family Services Version 1.0 published January 6, 2021.

Care Coordination Considerations – Foster Care Liaison

A. LDSS Foster Care Coordinator
   1. The LDSS will designate a Foster Care Coordinator to be the 29-I Health Facility and Highmark BCBS contact for general issues and specific foster care cases.
   2. The LDSS will notify the Highmark BCBS Foster Care Liaison within 5 business days, either electronically or in writing using the Transmittal Form of members entering, a change in placement or discharging foster care.
   3. The LDSS will ensure that court ordered services, including medical evaluations and healthcare services, are communicated to the 29-I Health Facility and Highmark BCBS Foster Care Liaison.
   4. The LDSS will report to the Highmark BCBS Foster Care Liaison any changes in status that affect care and services for the member, including, but not limited to the need for additional assessment(s); change in status resulting from diagnostic assessments; need for a change in primary care provider or care management agency; enrollee's placement with a 29-I Health Facility; and new foster care placement address.
   5. Upon notification by Highmark BCBS of any changes in a member's status, the LDSS must take appropriate action, including necessary follow-up for the member's care and updating case information in the system.
   6. The LDSS may delegate the responsibilities to the 29-I Health Facility with which the child/youth is placed. The LDSS will inform Highmark BCBS what responsibilities are delegated to the 29-I Health Facility.

B. 29-I Health Facility Foster Care Liaison

   1. In accordance with the Article 29-I Health Facilities License Guidelines (available at

health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/final_draft_vfca_health_facilities_license_guidelines.pdf)

2. the 29-I Health Facility will designate a Foster Care Liaison) that will coordinate with the Highmark BCBS's Foster Care Liaison and the LDSS. When a member is placed in the care of a 29-I Health Facility, the 29-I Foster Care Liaison will:

a. Carry out responsibilities delegated to the 29-I Health Facility by the LDSS for MMC.

b. Be the primary contact person for Highmark BCBS to assist with ensuring coverage and access to care for the child/youth in the care of the 29-I Health Facility, including but not limited to:

i. Informing Highmark BCBS of and coordinating access to immediately needed services;

ii. Referring children/youth for needed services and assisting in provider selection;

iii. Coordinating with healthcare providers, including school and community-based services;

iv. Sharing of plans of care and communicating significant changes in the child/youth's health or functioning, need for additional required/recommended assessments;

v. Assisting with court ordered services and fair hearings;

vi. Discharge planning;

vii. Notifying Highmark BCBS of changes in residential status or foster care placement, absence from the 29-I Health Facility, or other insurance coverage;

viii. Maintaining eligibility for public or private health insurance and coordinating benefits;

ix. Assisting with consent and/or confidentiality issues.

x. The 29-I Health Facility will notify the Highmark BCBS Foster Care Liaison within 5 business days, either electronically or in writing using the Transmittal Form of members entering, a change in placement or discharging foster care.

xi. The 29-I Foster Care Liaison will oversee all business functions and interact with clinical and billing staff within the agency

xii. The 29-I Health Facility will establish appropriate mechanisms for exchanging information with Highmark BCBS, including but not limited to receipt of member notices, welcome letters/ temporary identification, and Highmark BCBS identification cards.

C. Highmark BCBS Foster Care Liaison

1. Highmark BCBS will designate a Foster Care Liaison to be readily available to the LDSS and 29-I Health Facility during regular business hours to address any issues for managed care enrollees in foster care. Highmark BCBS shall identify a backup contact when the MMC Foster Care Liaison is not available.

2. Highmark BCBS is responsible for ensuring there is a high-touch coordination approach with OCFS, LDSS, and the 29-I Health Facility for all enrolled children/youth in foster care and/or placed with a 29-I Health Facility. The Highmark BCBS Foster Care Liaison shall be the direct Highmark BCBS contact for care coordinators and service providers.

3. The Highmark BCBS Foster Care Liaison is responsible for monitoring access to care for enrolled children/youth in foster care and/or placed with a 29-I Health Facility. The Highmark BCBS Foster Care Liaison will have the authority to and will assist with enrollment, disenrollment, and access to care issues (including facilitation of single case agreements when a child/youth is placed outside of the Highmark BCBS's service area).

4. The Highmark BCBS Foster Care Liaison is responsible for ensuring immediate issuance of a Welcome Letter, other temporary identification showing the effective date of enrollment, and/or a replacement insurance identification card/temporary identification as necessary to ensure the enrollee's access to needed care.

5. Highmark BCBS shall develop and implement a system of communication and notification with the LDSS/29-I Health Facility that includes:
    a. A mechanism (for example, fax, secure email or IT solution as agreed upon by the OCFS/LDSS/29-I Health Facility) implemented through the Foster Care Liaison for receiving information including, but not limited to:
        - Changes in placement or address for children/youth in foster care; and/or
        - Changes in health status or provider for children/youth in foster care.
    b. A mechanism for the Foster Care Liaison to notify the LDSS/29-I Health Facility of any health or other concerns related to children/youth in foster care.
    c. Use of the State's Transmittal Form for communicating between the LDSS Case Worker, the 29-I Foster Care Liaison and the Highmark BCBS Foster Care Liaison.

For additional State Guidance regarding required assessments, access to care, authorization and notification of services, network and contracting requirements, complaints and appeals and the Transmittal Form and Instructions see the Guidance Document Transition of Children Placed in Foster Care and NYS Public Health Law Article 29-I Health Facility Services into Medicaid Managed Care by the NYS Department of Health and the Office of Children and Family Services Version 1.0 published January 6, 2021.

Service Utilization Review of Children's HCBS and CFTSS Services

The plan will review service utilization to ensure compliance with the approved plan of care. The plan will develop reports with the goal of identifying service patterns which are inconsistent with the plan of care. Report results will be reviewed with applicable parties (for example, behavioral health provider, Health Home and plan staff) to ensure that services are delivered per the plan of care and to discuss circumstances surrounding variations in care.

Home and Community-based Services for Adults Enrolled in the Health and Recovery Plan (HARP)

HCBS were established to improve behavioral healthcare delivery to individuals who were at risk of placement into hospitals, nursing homes or other institutions. Recipients had to be evaluated and assessed to meet an institutional level of care (in other words, they could be admitted to an institution if not for the availability of an HCBS waiver program). HCBS are designed to allow individuals to gain the motivation, functional skills, and personal improvement to be fully integrated into communities. A person served in a HCBS waiver must be assessed using a validated comprehensive assessment tool to determine their treatment, rehabilitation, and support needs. A comprehensive, person-centered plan of care is then developed, and the person is then connected to appropriate services. The care plan must be developed in

a conflict free manner, meaning the person conducting the assessment and developing the plan of care cannot direct referrals for service only to their agency or network.

The Health and Recovery Plan is a recovery model of care that emphasizes and supports a person's potential for recovery by optimizing quality of life and reducing symptoms of mental illness and substance use disorders through empowerment, choice, treatment, educational, employment, housing, and health and well-being goals. Recovery is generally seen in this approach as a personal journey rather than a set outcome, and one that may involve developing hope, a secure base and sense of self, supportive relationships, self-direction, social inclusion, and coping skills.

Adult HCBS provide opportunities for adult Medicaid beneficiaries with mental illness and/or substance use disorders to receive services in their own home or community. HCBS creates an environment where our health plan, service providers, members, families, and government partner help members prevent and manage chronic health conditions and recover from serious mental illness and substance use disorders.

The partnership will be based on these core principles:
Person-Centered Care: Services should reflect an individual’s goals and emphasize shared decision-making approaches that empower members, provide choice, and minimize stigma. Services should be designed to optimally treat illness and emphasize wellness and attention to the persons overall wellbeing and full community inclusion.

Recovery-Oriented: Services should be provided based on the principle that all individuals have the capacity to recover from mental illness and/or substance use disorders. Specifically, services should support the acquisition of living, employment, and social skills and be offered in home and community-based settings that promote hope and encourage each person to establish an individual path towards recovery.

Integrated: Services should address both physical and behavioral health needs of individuals. Care coordination activities should be the foundation for care plans, along with efforts to foster individual responsibility for health awareness.

Data-Driven: Providers should use data to define outcomes, monitor performance, and promote health and well-being. Performance metrics should reflect a broad range of health and recovery indicators beyond those related to acute care.

Evidence-Based: Services should utilize evidence-based practices where appropriate and provide or enable continuing education activities to promote uptake of these practices.
Trauma-Informed: Trauma-informed services are based on an understanding of the vulnerabilities or triggers experienced by trauma survivors that may be exacerbated through traditional service delivery approaches so that these services and programs can be more supportive and avoid re-traumatization. All programs should engage all individuals with the assumption that trauma has occurred within their lives.
Peer-Supported: Peers will play an integral role in the delivery of services and the promotion of recovery principles.

Culturally Competent: Culturally competent services that contain a wide range of expertise in treating and assisting people with Serious Mental Illness (SMI) and substance use disorder (SUD) in a manner responsive to cultural diversity.

Flexible and Mobile: Services should adapt to the specific and changing needs of each individual, using off-site community service delivery approaches along with therapeutic methods and recovery approaches which best suit each individual's needs. BH HCBS, where indicated, may be provided in home or off-site, including appropriate community settings such as where an individual works, attends school or socializes.

Inclusive of Social Network: The individual, and when appropriate, family members and other key members of the individual's social network are always invited to initial meetings, or any necessary meetings thereafter to mobilize support.

Coordination and Collaboration: These characteristics should guide all aspects of treatment and rehabilitation to support effective partnerships among the individual, family and other key natural supports and service providers.

Adult HCBS include the following:

- Habilitation
- Pre-vocational services
- Transitional Employment
- Intensive Supported Employment
- Ongoing Supported Employment

Effective February 1, 2022, four Adult Behavioral Health Home and Community Based Services changed to Community Oriented Recovery and Empowerment (CORE) Services.

CORE services are available to adults (age 21 years and above) who qualify for HARP with a recommendation from a Licensed Practitioner of the Healing Arts (LPHA) which could be a qualified medical or behavioral health provider.

CORE Services include:

- Psychosocial Rehabilitation (PSR): This service helps members with life skills, finding or keeping a job; starting or returning to school; and using community resources.
- Community Psychiatric Support and Treatment (CPST). This service helps members manage symptoms through counseling and clinical treatment.
- Empowerment Services - Peer Supports. This service helps the member connect to peer specialists who will provide support and assistance.
- Family Support and Training (FST). This service gives the member's family and friends the information and skills to help and support the member.

In addition to the above services, Short-term Crisis Respite and Intensive Crisis Respite are now called Crisis Intervention Services and are available to the member.

The NYS OMH has outlined specific requirements for providers to become designated to provide CORE services. The specific criteria can be found on the OMH website at **omh.ny.gov/omhweb/bho/core/providers**.

Adult HCBS Eligibility and Enrollment

HARP enrollment is open to Medicaid beneficiaries aged 21 and older with serious mental illness and/or substance use disorders. HARP-eligible members are identified by NYS based on previous utilization of

certain kinds of Medicaid mental health and substance use services. A detailed workflow of the Adult BH HCBS eligibility and referral process can be found on the Department of Health website: **health.ny.gov/health_care/medicaid/program/medicaid_health_homes/workflow_guidance.htm.**

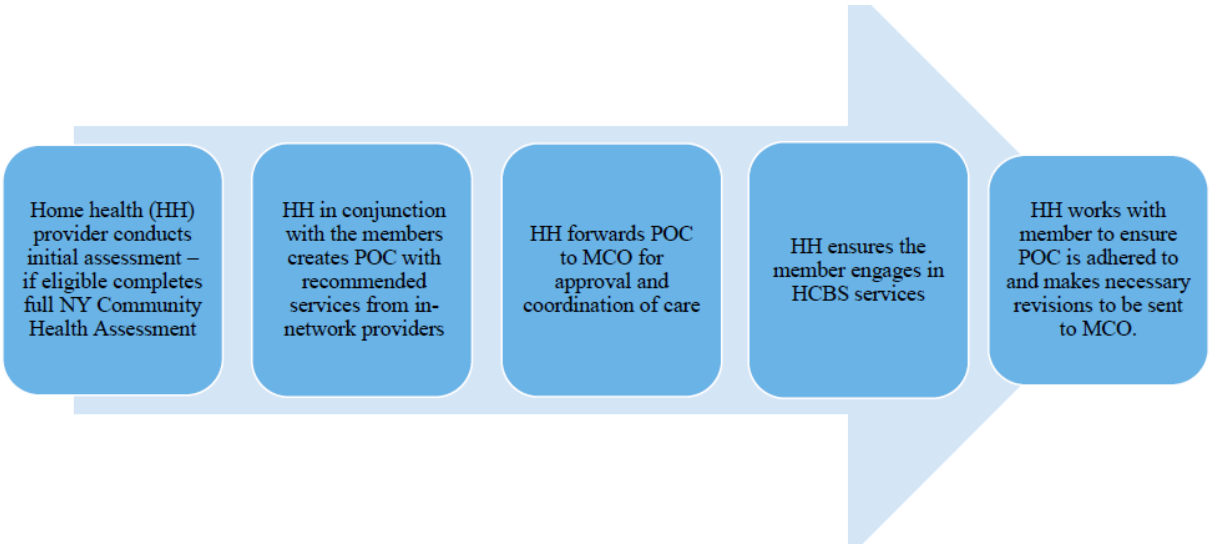
Individuals identified as HARP eligible must be offered care management through State-designated Health Homes. HARP eligible members are identified by the State on an ongoing basis and shared with the HARPs, which make assignments to Health Homes. As part of providing care coordination for an individual enrolled in a HARP or HIV SNP, the care manager will ensure the individual is informed of the BH HCBS benefits available to them, have a person-centered discussion with the individual about their recovery goal(s), and how BH HCBS may help achieve their goals. HARP members who are interested in BH HCBS will be individually assessed in a conflict free manner for BH HCBS eligibility using the NYS Eligibility Assessment (EA), and if eligible, eligibility is determined for Tier 1 or Tier 2 BH HCBS. Tier 1 BH HCBS includes employment and education support. Tier 2 includes Tier 1 services and Habilitation. Non-Medical Transportation services are available for eligible individuals under either Tier 1 or Tier 2. If BH HCBS eligibility is determined based on the completed NYS EA, a Plan of Care will be developed. The Health Home Care Manager or Recovery Coordinator will work in collaboration with the individual and identify the BH HCBS that will be included in the Plan of Care. If BH HCBS eligibility is NOT determined based on the NYS EA, the Plan of Care cannot include BH HCBS. If an individual does not want BH HCBS, the Health Home Care Manager should note this and not conduct the EA.

Re-assessment for BH HCBS eligibility will be conducted on an annual basis, or after a significant change in the member's condition such as an inpatient admission or a loss of housing. Health Homes will provide care management and will conduct assessments and develop Plans of Care for individuals for BH HCBS. If a member chooses not to enroll in a Health Home, the assessment will be completed by State Designated Agency and care management will be provided by the Health Plan. Designated provider agencies will deliver the BH HCBS as described in the benefit section of the HCBS manual: **omh.ny.gov/omhweb/bho/docs/hcbs-manual.pdf**.

Health Home core services include:

- Comprehensive care management
- Connecting to healthcare providers
- Care coordination and health promotion
- Comprehensive transitional care
- Referral to a community and social support services
- Client and family supports
- Help with housing

The Health Home works collaboratively with the member, the Plan and service providers as part of the HCBS workflow as illustrated below:



State Designated Entities (SDE)

Members may choose not to enroll in a Health Home. For those individuals, the most effective education and engagement into Adult HCBS services may occur through existing therapeutic or supportive working relationships. These providers are often best positioned to help the member understand the benefit of HCBS and Health Home, identify recovery goals, and link directly to services. These SDEs (Recovery Coordination Agencies) are agencies or community-based organizations that are state-designated Health Homes or affiliated with a Health Home and who have qualified staff (Recover Coordinators) to conduct assessments, develop Plans of Care, and conduct care management services.

RCAs must also comply with CMS conflict-free case management rules (42 CFR Part 441.301). The RCAs will:

- Educate members about the benefits of Health Homes
- Receive referrals directly from the Plan
- Conduct the NYS Eligibility Assessment for Adult HCBS
- Engage in person-centered HCBS Plan of Care discussions with the member
- Request a Level of Determination from the Plan
- Offer a choice of Adult HCBS providers
- Initiate referrals to the HCBS providers
- Develop an integrated Plan of Care
- Conduct annual re-assessments

Plan of Care and Service Delivery

Based on an independent assessment of functioning and informed by the individual, the written Plan of Care must meet the following requirements:

- The Plan of Care must include services chosen by the individual to support independent community living in the setting of his or her own choice and must support integration in the community, including opportunities to seek employment, engage in community life, control personal resources, and to receive services within the community.
- Settings where the BH HCBS are provided must be selected from among options by the individual, optimize autonomy and independence in making live choices, and ensure an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- Include the individual's strengths, capacities, and preferences.

- Include the necessary information and support to the individual to ensure that they can direct their planning process as much as possible.
- Be developed to include clinical and support needs that are indicated by the independent functional assessment.
- Be comprised of goals and desired outcomes that are chosen by the individual.
- Take into consideration the culture of the person served.
- Promote the health and welfare of those receiving services.
- Include services and supports (paid by Medicaid, natural supports, and other community supports) that will enable the individual to meet the goals and outcomes identified in the Plan of Care.
- Include frequency, duration, and scope of BH HCBS identified in the Plan of Care.
- Identification of risk factors and barriers with strategies to overcome them, including individualized back-up plans.
- Be written in a way that is clearly understandable by the individual.
- Include the individual and the entity that is responsible for the oversight of the Plan of Care implementation, review of progress and need for modifications if desired outcomes are not being met or the individual's needs change.
- Include individual attestation of choice of providers.
- Include an informed consent of the individual in writing along with signatures of all individuals responsible for the plan implementation.
- Be sent to all of the individuals and others involved in implementing and monitoring the Plan of Care,
- The Plan of Care should not include services that are duplicative, unnecessary, or inappropriate.
- Be timely and occur at least annually at times and locations of the individual's convenience.
- Provide a method for the individual to request updates to their Plan.

HCBS Service Types — For a complete description of the HCBS definitions and detail regarding service components, modalities, settings, admissions/eligibility criteria, limitations/exclusions, certification/provider qualifications and staffing ratios/case limits refer to the OMH HCBS Provider Manual located on the OMH website at **omh.ny.gov/omhweb/bho/docs/hcbs-manual.pdf**.

Adult HCBS Providers — The NYS OMH has outlined specific requirements for providers to become designated to provide HCBS services. The specific criteria can be found on the OMH web site at **omh.ny.gov/omhweb/bho**.

Adult HCBS Providers who have contracted with the Plan can be found by searching our on-line Provider Directory at **providerpublic.mybcbswny.com/western-new-york-provider/resources/referrals**.

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 or notification after January 1, 2017:

- All inpatient mental health services notification is required within 48 hours**
- All inpatient rehabilitation SUD notification is required within 48 hours*
- All residential SUD services notification is required within 48 hours*

- Partial hospitalization
- Intensive outpatient treatment
- Psychological and neuropsychological testing
- Intensive psychiatric rehabilitation
- Some rehabilitation services
- Some outpatient services
- Applied behavior analysis (ABA) services
- Medically managed detoxification (hospital based). treatment notification is required within 48 hours *

The quickest, most efficient way to request prior authorization is via Availity Essentials the secure multi-payer platform at **https://Availity.com**. The digital authorization application offers a streamlined and efficient experience for providers requesting inpatient and outpatient behavioral health services for Highmark members. Providers can also use this tool to inquire about previously submitted requests regardless of how they were submitted (phone, fax, or other online tool):

- **Initiate preauthorization requests online**, eliminating the need to fax. The authorization application allows detailed text, photo images and attachments to be submitted along with your request.
- **Review** requests previously submitted via phone, fax, or other online tool.
- **Instant accessibility** from almost anywhere, including after business hours.
- **Utilize the dashboard** to provide a complete view of all utilization management requests with real-time status updates.
- **Real-time results** for some common procedures.
- **Access** the authorization application from Availity's homepage. Select Patient Registration then choose *Authorizations and Referrals*.

For an optimal experience with the authorization application, use a browser that supports 128-bit encryption. This includes Internet Explorer 11, Chrome, Firefox or Microsoft Edge.

The website will be updated as additional functionality and lines of business are added throughout the year.

* As of January 2017, New York state regulations states that plans cannot review for medical necessity for up to 28 days when an in-network provider notifies the plan of the admission within 48 hours of the admission and sends over the LOCADTR and the initial treatment plan. This is not applicable if the provider does not notify and send the needed information within 48 hours of the admission or if the provider is out-of-network.

**Highmark BCBS follows the New York State Office of Mental Health Best Practices Manual for Utilization Review for Adult and Child Mental Health Services which outlines the best practice approaches to utilization review in a manner that is aligned with the Guiding Principles as well as state and federal laws related to utilization review and behavioral health parity. As of September 1, 2022 providers should notify the plan of all in-network and out-of-network admissions to inpatient and partial hospital programs, even if specific triggers are not met. Note: Utilization review is prohibited for the first 30 days of admission to an in-network, in-state hospital licensed by the Office of Mental Health for inpatient psychiatric hospital services or partial hospitalization services unless certain trigger criteria are met. Providers must provide such notification and the initial treatment plan within two business days of

the admission. Such services may be reviewed by a utilization review agent retrospectively once the episode of care is complete.

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:

- Emergency room (ER) services, crisis services and a comprehensive psychiatric emergency program including extended observation beds which do not require authorization
    - 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

Behavioral Health Prior Authorization/Medical Necessity (MN)

Benefit	Medicaid Managed Care (MMC) and Medicaid Supplemental Security Income (SSI)	Health and Recovery Plan (HARP)	Child Health Plus (CHPlus)
Outpatient mental health (OPMH)	Covered: No authorization required for par provider.	Covered: No authorization required for par provider.	Covered: No authorization required for par provider.
Harm reduction services	Covered: No authorization required for par provider.	Covered: No authorization required for par provider.	Not covered
Child and family treatment support services (CFTSS) — family peer support, community psychiatric and supports treatment (CPST), other licensed practitioner (OLP), psychosocial rehabilitation (PSR)Youth Peer Services; Crisis intervention services	Covered: No authorization required for par provider.	Not covered	Covered: No authorization required for par provider effective 1/1/2023

Benefit	Medicaid Managed Care (MMC) and Medicaid Supplemental Security Income (SSI)	Health and Recovery Plan (HARP)	Child Health Plus (CHPlus)
Children's home- and community-based services (HCBS)	Covered: Must be authorized, based on Plan of Care review.	Not covered	Not covered
Children/Youth in VCFA – Core limited health services; required assessments	Covered: No authorization required for par provider. Notification is requested	Not covered	Covered effective 1/1/23: No authorization required for par provider. Notification is requested
Psych testing	Covered: Must be authorized, based on MNC.	Covered: Must be authorized, based on MNC.	Covered: Must be authorized, based on MNC.
Applied behavior analysis (ABA) services	Covered effective 1/1/2023: requires authorization	Covered: Requires authorization	Covered: Requires authorization.
Transcranial magnetic stimulation (TMS) services	Covered: No authorization required for par provider	Covered: No authorization required for par provider.	Not Covered.
Outpatient (OP) substance use services	Covered: No authorization required for participating providers.	Covered: No authorization required for participating providers.	Covered: No authorization required for participating providers.
OP ambulatory detox	Covered: No preauthorization for par providers.	Covered: No preauthorization for par providers.	Covered: No preauthorization for par providers.
Opioid Treatment program (previously known as Methadone Maintenance)	Covered: Office of Alcoholism and Substance Abuse Services (OASAS)-licensed facility — No authorization required for par providers.	Covered: OASAS-licensed facility — No authorization required for par providers.	Not covered
Inpatient (IP) psychiatric	Covered: Notification required within 2 business days. MNC review conducted for patients who meet trigger criteria.	Covered: Notification required within 2 business days. MN C review conducted	Covered: Notification required within 2 business days. Review conducted for patients who meet trigger criteria.

Benefit	Medicaid Managed Care (MMC) and Medicaid Supplemental Security Income (SSI)	Health and Recovery Plan (HARP)	Child Health Plus (CHPlus)
		for patients who meet trigger criteria.	
IP detox	Covered: INN providers should notify within 48 hours with the required clinical. If notified, MNC review is prohibited for 28 days. OON require authorization and concurrent review and INN who do not notify require authorization and concurrent review.	Covered: INN providers should notify within 48 hours with the required clinical. If notified, MNC review is prohibited for 28 days. OON require authorization and concurrent review and INN who do not notify require authorization and concurrent review.	Covered: INN providers should notify within 48 hours with the required clinical. If notified, MNC review is prohibited for 28 days. OON require authorization and concurrent review and INN who do not notify require authorization and concurrent review.
IP substance use disorder (SUD) rehabilitation	Covered: INN providers should notify within 48 hours with the required clinical. If notified, MNC review is prohibited for 28 days. OON require authorization and concurrent review and INN who do not notify require authorization and concurrent review.	Covered: INN providers should notify within 48 hours with the required clinical. If notified, MNC review is prohibited for 28 days. OON require authorization and concurrent review and INN who do not notify require authorization and concurrent review.	Covered: INN providers should notify within 48 hours with the required clinical. If notified, MNC review is prohibited for 28 days. OON require authorization and concurrent review and INN who do not notify require authorization and concurrent review.
Electroconvulsive therapy (ECT)	Covered: Based on MN. Requires authorization and concurrent review.	Covered: Based on MN. Requires authorization and concurrent review.	Covered: Based on MN. Requires authorization and concurrent review.
Psychiatric Partial Hospitalization Program (PHP)	Covered: Notification required within 2 business days. Review conducted for patients who meet trigger criteria.	Covered: Notification required within 2 business days. Review conducted for patients who meet trigger criteria.	Covered: Notification required within 2 business days. Review conducted for patients who meet trigger criteria.

Benefit	Medicaid Managed Care (MMC) and Medicaid Supplemental Security Income (SSI)	Health and Recovery Plan (HARP)	Child Health Plus (CHPlus)
Mental health and substance use intensive outpatient (IOP)	Covered: Notification required within 2 business days. Review conducted for patients who meet trigger criteria.	Covered: Notification required within 2 business days. Review conducted for patients who meet trigger criteria.	Covered: Notification required within 2 business days. Review conducted for patients who meet trigger criteria.
Intensive psychiatric rehabilitation treatment (IPRT)	Covered: Requires authorization.	Covered: Requires authorization.	Not covered
Continuing Day treatment	Covered: No authorization required.	Covered: No authorization required	Not covered
Assertive community treatment (ACT)	Covered: No authorization required	Covered: No authorization required	Covered No authorization required
Personalized recovery oriented services (PROS)	Covered: No authorization required	Covered: No authorization required	Not covered
SUD OP rehab services	Covered: No authorization required	Covered: No authorization required	Not covered
Health Home care coordination and management	Covered: No authorization required.	Covered: No authorization required.	Not covered
Emergency room (ER)	Covered: No authorization required.	Covered: No authorization required.	Covered: No authorization required.
Screening, brief intervention and referral to treatment for chemical dependence (SBIRT)	Covered: No authorization required.	Covered: No authorization required.	Covered: No authorization required.
Comprehensive Psychiatric Emergency Program (CPEP) (services need to be billed as CPEP)	Covered: No authorization required.	Covered: No authorization required.	Covered: No authorization required.
Mobile crisis services	Covered: No authorization required.	Covered: No authorization required.	Covered effective 1/1/23: No authorization required.

Benefit	Medicaid Managed Care (MMC) and Medicaid Supplemental Security Income (SSI)	Health and Recovery Plan (HARP)	Child Health Plus (CHPlus)
Residential eating disorder	Not covered	Not covered	Not covered
Adult Home and Community Based Services - HCBS	Not covered	Covered: Must be authorized, based on Plan of Care review	Not covered
Adult CORE services	Not covered	Covered. No authorization required	Not covered
Residential rehabilitation services Part 820 for SUD including stabilization, rehabilitation and reintegration.	Covered: INN providers should notify within 48 hours with the required clinical. If notified, MNC review is prohibited for 28 days. OON require authorization and concurrent review and INN who do not notify require authorization and concurrent review.	Covered: INN providers should notify within 48 hours with the required clinical. If notified, MNC review is prohibited for 28 days. OON require authorization and concurrent review and INN who do not notify require authorization and concurrent review.	Not covered

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

Service	**Prior authorization/notification required?**	**Concurrent review authorization**	**Additional guidance**
Outpatient mental health office and clinic services including: initial assessment; psychosocial assessment; and individual, family/collateral and group psychotherapy	No	No	

Service	Prior authorization/notification required?	Concurrent review authorization	Additional guidance
Outpatient mental health office and clinic services: psychiatric assessment; medication treatment	No	No	
Outpatient mental health office and clinic services: off-site clinic services	No	No	The New York State Office of Mental Health (OMH) newly released Part 599 regulations bringing OMH Article 31 Clinic services under the Medicaid State Plan Rehab Option as Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS). This shift will add flexibility for billing and waiver processes and include an allowance for offsite service provision for all populations served within MHOTRS.
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	No	No	
PROS active rehabilitation	No	No	
Mental health continuing day treatment (CDT)	No	No	
Mental health intensive outpatient (*Note: not state plan*)	Notification required within 2 business days	Notification required within 2 business days	
Mental health partial hospitalization	Notification required within 2 business days	Notification required within 2 business days	
Assertive community treatment (ACT)	No	No	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	No	See OASAS guidance regarding use of LOCADTR tool to inform level of care determinations.

Service	Prior authorization/notification required?	Concurrent review authorization	Additional guidance
			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	Yes	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	No	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.
Children's crisis intervention	No	No	
Children's day treatment	Yes	Yes	
Community psychiatric supports and treatment	No	No	
Family peer support services	No	No	
Youth peer support	No	No	

Service	Prior authorization/notification required?	Concurrent review authorization	Additional guidance
Children's Home- and Community-Based Services	Yes	Yes	Must be authorized, based on care plan review. Requires HCBS referral form.
Health Home care management	No	No	
Psychosocial rehabilitation for children	No	No	
Other licensed practitioner for children (OLP)	No	No	
Mobile crisis	No	No	

Emergency Pharmacy Protocols (CHP Only)

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.

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. Healthcare 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
Care for non-life-threatening emergency	Within 6 hours
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
Initial visit for routine care	Within 10 business days

Appointment type	Appointment standard
Follow up for routine care	Within 10 business days
Routine nonurgent, preventive appointments	Within fifteen days 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
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 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.)

Providers are required to adhere to the following access standards for members under 21 years of age:

Service type	Emergency	Urgent	Nonurgent	Follow-up to emergency or hospital discharge	Follow-up to residential services, detention discharge or discharge from justice system placement
Mental health outpatient clinic		Within 24 hours	Within one week	Within five business days of request	Within five business days of request
IPRT			Two to four	Within 24 hours	
Partial hospitalization				Within five business days of request	
Inpatient Psychiatric Services	Upon presentation				
CPEP	Upon presentation				
OASAS Outpatient Clinic		Within 24 hours	Within one week of request	Within five business days of request	Within five business days of request
Detoxification	Upon presentation				
SUD Inpatient Rehab	Upon presentation	Within 24 hours			
OASAS opioid treatment program (OTP) services		Within 24 hours	Within one week of request	Within five business days of request	Within five business days of request
Crisis intervention	Within 1 hour			Within 24 hours of mobile crisis intervention response	
CPST		Within 24 hours (for intensive in home	Within one week of request	Within 72 hours of discharge	Within 72 hours

Service type	Emergency	Urgent	Nonurgent	Follow-up to emergency or hospital discharge	Follow-up to residential services, detention discharge or discharge from justice system placement
		and crisis response services under definition)			
OLP		Within 24 hours of request	Within one week of request	Within 72 hours of request	Within 72 hours of request
Family peer support services		Within 24 hours of request	Within one week of request	Within 72 hours of request	Within 72 hours of request
Youth peer support and training			Within one week of request	Within 72 hours of request	Within 72 hours of request
PSR		Within 72 hours of request	Within five business days of request	Within 72 hours of request	Within 72 hours of request
Caregiver/ family supports and services			Within five business days of request	Within five business days of request	Within five business days of request
Crisis respite	Within 24 hours of request	Within 24 hours of request		Within 24 hours of request	
Planned respite			Within one week of request	Within one week of request	
Prevocational services			Within two weeks of request		Within two weeks of request
Supported employment			Within two weeks of request		Within two weeks of request
Community self-advocacy training and support			Within five business days of request		Within five business days of request

Service type	Emergency	Urgent	Nonurgent	Follow-up to emergency or hospital discharge	Follow-up to residential services, detention discharge or discharge from justice system placement
Habilitation			Within two weeks of request		
Adaptive and assistive equipment		Within 24 hours of request	Within two weeks of request	Within 24 hours of request	Within 24 hours of request
Accessibility modifications		Within 24 hours of request	Within two weeks of request	Within 24 hours of request	Within 24 hours of request
Palliative care			Within two weeks of request	Within 24 hours of request	

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

Providers must have policies and procedures addressing enrollees who present for unscheduled, nonurgent care with the aim of promoting enrollee access to appropriate care.

Behavioral Health Case Management

Highmark BCBS offers case management services. Providers can refer members who may benefit from case management to Highmark BCBS by emailing WNYBehavioralHealthTeam@wellpoint.com. 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 not enrolled in a Health Home, the plan will refer 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 support. 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 expects behavioral health providers to be able to see members even if there is no scheduled appointment to assess whether the member needs urgent care and/or triage.

HCBS providers are expected to monitor the hours of service used by the member to make sure services provided do not exceed benefit limits.

Members in Foster Care

Initial Health Assessments

A series of assessments provide a complete picture of the foster care child's health needs and is the basis for developing a comprehensive plan of care. Initial health activities include all of the following:

- An immediate screening of the child's medical condition including assessment for child abuse/neglect
- A comprehensive health evaluation that includes all EPSDT elements as required by the state Medicaid program; specifically for children in foster care, EPSDT screenings must be completed within 30 days of entering care in conjunction with the comprehensive health evaluation. The EPSDT screening must include federally mandated aspects related to the following:
    - A comprehensive health and developmental history including a physical exam, immunizations, laboratory tests (including lead toxicity screening) and health education
    - Hearing
    - Dental (including ongoing preventive and restorative care)
    - Mental health/substance use disorder
    - Vision
    - Follow-up health evaluation and treatments that incorporate information from the five initial assessments
    - Ongoing efforts to obtain the child's existing medical records and document medical activities

Highmark BCBS will ensure there is sufficient network capacity to complete the required foster care initial health assessments within the time frames listed in the following table:

Time frame	Activity	Mandated activity	Mandated time frame	Who performs
24 hours	Initial screening/ screening for abuse/ neglect	X	X	Health practitioner (preferred) or child welfare caseworker/health staff
5 days	Initial determination of capacity to consent for HIV risk assessment and testing	X	X	Child welfare caseworker or designated staff
5 days	Initial HIV risk assessment for child without capacity to consent	X	X	Child welfare caseworker or designated staff
10 days	Request consent for release of	X	X	Child welfare caseworker or health staff

Time frame	Activity	Mandated activity	Mandated time frame	Who performs
	medical records and treatment			
30 days	Initial medical assessment	X	X	Health practitioner
30 days	Initial dental assessment	X	X	Health practitioner
30 days	Initial mental health assessment	X		Mental health practitioner
30 days	Family planning education and counseling and follow-up healthcare for youth age 12 and older (or younger as appropriate)	X	X	Health practitioner
30 days	HIV risk assessment for child with possible capacity to consent	X	X	Child welfare caseworker or designated staff
30 days	Arrange HIV testing for child with no possibility of capacity to consent and assessed to be at risk of HIV infection	X	X	Child welfare caseworker or health staff
45 days	Initial developmental assessment	X		Health practitioner
45 days	Initial substance abuse assessment			Health practitioner
60 days	Follow-up health evaluation			Health practitioner
60 days	Arrange HIV testing for child determined in follow-up assessment to be without capacity to consent and assessed to be at risk of HIV infection	X	X	Child welfare caseworker or health staff

Time frame	Activity	Mandated activity	Mandated time frame	Who performs
60 days	Arrange HIV testing for child with capacity to consent who has agreed in writing to consent to testing	X	X	Child welfare caseworker or health staff

Relocations

If a Highmark BCBS member in foster care is placed in another county and Highmark BCBS operates in the new county, the child can transition to a new PCP and other healthcare providers without disrupting the care plan in place. If the member is placed outside Highmark BCBS's service area, Highmark BCBS will ensure access to providers with expertise in treating children involved in foster care. This ensures continuity of care and the provision of all medically necessary services.

It should be noted, per SDOH guidance:

- The MMC plan selected for enrollment or transfer must operate in the District of Fiscal Responsibility. MMC plan selection includes evaluating which plan may be in the best interest of the child/youth, and considerations such as: plan choice of child/youth and parent/guardians, where appropriate:
    - Current service needs and service provider locations
    - Identification of the child's current primary care provider (PCP)
    - Evaluation of the plans' provider network; and
    - County and other placement arrangements for the child/youth.
- Best interest refers making an informed plan enrollment decision based on the needs of the child. The LDSS and 29-I Health Facility should consider the placement and care needs of the child, how best the child may retain or gain access to care, if the child/youth is being properly assessed, and how their needs can best be met. For example: If the child is expected to be out of the county (but within NYS) for a short time, it may be more disruptive to change their MMC plan:
    - If the child is currently receiving specialty services, check if their providers are participating with a proposed MMC plan. If that provider doesn't participate in any MMC plan, the child/youth receiving care from that provider should remain in FFS

Behavioral Health Credentialing

Highmark BCBS credentials Article 29_I, OMH and OASAS licensed providers. State designation of providers will suffice for the plan's credentialing process. We will accept Article 29-I, OMH and OASAS licenses and certifications in place of any credentialing process for individual employees, subcontractors or agents of such providers with the exception of Article 29-I licensed for Primary Care Services (see credentialing process, Chapter 11 of this manual). We will not separately credential individual staff members in their capacity as employees of these programs. Highmark BCBS and the provider shall collect, and will accept, program integrity-related information as part of the licensing and certification process.

We require all Article 29-I, 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 designated Children HCBS providers:

- The plan will accept state-issued HCBS designation in place of a plan credentialing process for HCBS providers and any individual employees, subcontractors or agents.
- The plan will collect and accept program integrity related information as part of the licensing and certification process.

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. Through the health plan's Quality Management program, we support improvement strategies, monitor and evaluate quality, safety and appropriateness of medical and behavioral healthcare and services offered by the health network, and identify and act on opportunities for 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 and committees, are monitored and reported to the Medical Advisory and Quality Advisory committees. Providers, peer specialists, members, family members, youth and family peer support specialists, and child-serving providers are part of the committee. The committee members guide and provide feedback on our activities.

The Behavioral Health and HARP Quality Management Committee is accountable to and reports regularly to the Quality Advisory Committee and ultimately to the governing board. Our behavioral health/HARP medical directors and quality management director lead the committees and maintain records. Focused discussions, tracking, trending, analysis and follow up will be documented as a separate item in Behavioral Health Quality Management and HARP Committee agenda and minutes if they're related to the following:

- Physical health services for medically fragile children
- Physical health services for children with complex conditions
- Behavioral health services and HCBS for children

The committee reviews and analyzes data and information which impacts the care members receive, and recommends action plans to improve quality performance impacting members and providers. Areas include:

- Service delivery

- Program development
- System planning
- Partnerships
- The provider network
- Program quality and effectiveness

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 healthcare 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 healthcare 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.

The plan will conduct initial training of newly contracted behavioral health providers or provider groups within 30 calendar days of participating status date or contract effective date, whichever is later. This includes all new providers who join the network to support children including voluntary foster care

agencies. The material to be covered in the initial training includes subject areas covered in the provider manual and those outlined in policy Highmark BCBS provider training and follow-up.

The plan will also conduct ongoing training as deemed necessary in order to ensure compliance with New York state regulations and in trainings that promote member wellness and recovery. Trainings will be offered in person, via WebEx or online (website or other online options). These trainings will be offered at a date and time convenient to the provider.

Highmark BCBS will communicate sessions offered to all providers via mailings and/or provider website postings. Training will be offered in either large group settings, virtually via webinars or in person as scheduled.

Other trainings on the following topics will be offered by Highmark BCBS:

- Covered services for enrollees including expanded benefits for children
- Recovery principles
- Person-centered planning including plan of care development and review
- HCBS overview, eligibility assessment and services
- Treatment of medically fragile children
- Billing, coding, data interface, documentation requirements, provider profiling programs and utilization management requirements for children's services
- Cultural competency
- Federal requirements for EPSDT
- Family-driven, youth guided, person-centered treatment planning and service provision
- Therapies: Trauma-focused cognitive behavioral therapy
    - Trauma informed child-parent psychotherapy
    - Multisystemic therapy
    - Functional family therapy
    - Multi-dimensional treatment foster care
    - Dialectical behavior therapy
    - Multidimensional family therapy
    - Seven challenges
    - Adolescent community reinforcement
    - Assertive continuing care

Providers are expected to attend either an offered training or another acceptable training on these topics.

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

Highmark BCBS is 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.

Article 29-I, Children's HCBS & CFTSS Billing, Documentation and Reimbursement

Highmark BCBS will reimburse at least the Medicaid FFS fee schedule for 4-year transition period or as long as New York state mandates (whichever is longer) for the following services:

1. Core Limited Health Services
2. Other Limited Health Services
3. HCBS Services
4. CFTSS Services

Highmark BCBS will execute single case agreements with non-participating providers to meet clinical needs of members when in-network services are not available. Highmark BCBS will reimburse the Medicaid FFS fee schedule per State guidance for all single-case agreements.

Article 29-I providers will submit claims with all the required fields and the appropriate codes and other rate codes per the New York Medicaid Program, 29-I Health Facility Billing guidance found at **health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/vol_foster_trans.htm**.

The 29-I Health Facility Billing guidance applies to both MMC and CHPlus programs.

Training on Article 29-I claims submission is available to providers and additional resources are available at **Learn about Availity (mybcbswny.com)**

Children's HCBS & CFTSS providers will submit claims with all the required fields and the appropriate codes and other rate codes per the New York Medicaid Program, HCBS & CFTSS Billing guidelines are found at **Children's HCBS Billing Guidance (ny.gov)** **and** **Children and Family Treatment and Support Services (ny.gov)**.

Effective December 1, 2023, NYS is implementing a billing change that will allow claims for Children's Home and Community Based Services (HCBS) and Children and Family Treatment Support Services (CFTSS) to be paid based on the county in which services were provided, rather than a provider's corporate headquarters or central office address. This update is necessary to align with the Centers for Medicare and Medicaid Services (CMS) billing requirements, which dictate that services must be reimbursed based on the location of service delivery.

The billing requirements will apply to both Medicaid Managed Care and Child Health Plus.
The State has assigned a Federal Information Processing Standards (FIPS) code and a proxy locator code to each county in New York State. The applicable FIPS (if submitting electronically) or proxy locator (if submitting on paper) county code, indicating service location, must be included on all

Children's HCBS, and CFTSS claims submitted for dates of service on or after December 1, 2023. The county FIPS and proxy locator codes are as follows:
Link to FIPS code locator guide: **FIPS Code locator**

For Electronic Claims:

- Value code 24 and the rate code are to be entered in field 39A; the rate code is input into the amount field. Value code 85 and the FIPS code are to be entered in field 40A; the 5-digit FIPS codes is input into the amount field.

Disclaimer for Paper Claims:

- Value code 24 and the rate code are to be entered in field 39A. The rate code is input into the amount field. Value code 61 and the county locator code are to be entered in field 40A.

Claims for HCBS & CFTSS services billed without the FIPS and value code requirements will be denied for dates of service on or after 12/1/2023.
HCBS & CFTSS providers must be designated to provide services within a specific county to bill for services.

Health Home claims for Palliative Care – Counseling and Support Services, Bereavement - Assessment/Counseling and all Health Home Bereavement services must include the appropriate FIPS/County locator code.

For Telehealth services – The county code included on the claim should be the county where the member was located during the service.
Link to - **New York State Guidance**

Electronic Claims Submission

Below is the Electronic Claims Submission Payer ID:

- Availity — Claim Payer ID 00246

Electronic Data Interchange (EDI)

Availity is our exclusive partner for managing all electronic data interchange (EDI) transactions. Electronic Data Interchange (EDI), including Electronic Remittance Advices (835) allows for a faster, more efficient, and cost-effective way for providers to do business.

Use Availity for the following EDI transactions:

- Healthcare Claim: Professional (837P)
- Healthcare Claim: Institutional (837I)
- Healthcare Eligibility Benefit Inquiry and Response (270/271)
- Healthcare Services Prior Authorization (278)
- Healthcare Services Inpatient Admission and Discharge Notification (278N)
- Healthcare Claim Payment/Advice (835)
- Healthcare Claim Status Request and Response (276/277)
- Medical Attachments (275)

Availity's EDI submission Options

- EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software). To register for direct EDI transmissions, visit – **https://Availity.com** > Provider Solutions > EDI Clearinghouse.
- Use your existing vendor for your EDI transactions (work with your vendor to ensure connection to the Availity EDI Gateway)

EDI Response Reports
Claims submitted electronically will return response reports that may contain rejections. If using a Clearinghouse or Billing Vendor, please work with them to ensure you are receiving all reports. It's important to review rejections as they will not continue through the process and require correction and resubmission. For questions on electronic response reports contact your Clearinghouse or Billing Vendor or Availity at **1-800-AVAILITY** (**1-800-282-4548**).

EDI Payer ID:

- Payer ID — 00246

Note: If you use a clearinghouse, billing service or vendor, please work with them directly to determine payer ID.

Electronic Remittance Advice (835)
The 835 eliminates the need for paper remittance reconciliation.
Use Availity to register and manage ERA account changes with these three easy steps:

- Log in to Availity at **apps.https://Availity.com/availity/web/public.elegant.login**
- Select **My Providers**
- Select on **Enrollment Center** and select **Transaction Enrollment**

Note: If you use a clearinghouse or vendor, please work with them on ERA registration and receiving your ERA's.

Contact Availity

Please contact Availity Client Services with any questions at **1-800-AVAILITY (1-800-282-4548)**.

Electronic Funds Transfer (EFT)

Electronic claims payment through electronic funds transfer (EFT) is a secure and fastest way to receive payment reducing administrative processes.

Log onto the EnrollSafe enrollment hub at **enrollsafe.payeehub.org** to enroll in EFT. You will be directed through the EnrollSafe secure website to the enrollment page, where you will provide the required information to receive direct payment deposits.

If you have changes to make, use **enrollsafe.payeehub.org** to update your account.

EDI Submission for Corrected Claims

For corrected electronic claims:

Use frequency type (7) - Replacement of Prior Claim

Submit original claim number for the corrected claim

EDI segments required:
Loop 2300- CLM - Claim frequency code
Loop 2300 - REF - Original claim number

Please work with your vendor on how to submit corrected claims.

Useful EDI Documentation:

- **Availity EDI Connection Service Startup Guide** — This guide includes information to get you started with submitting Electronic Data Interchange (EDI) transactions to Availity, from registration to on-going support.
- **Availity EDI Companion Guide** — This Availity EDI Guide supplements the *HIPAA* TR3s and describes the Availity Health Information Network environment, interchange requirements, transaction responses, acknowledgements, and reporting for each of the supported transactions as related to Availity.
- **Availity Registration Page** — Availity register page for users new to Availity.

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 120 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 120 days of the date of service and submitted to the following address:

New York Claims
PO Box 61010
Virginia Beach, VA 23466-1010

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 must be 731 for initial claims or 737 for corrected claims

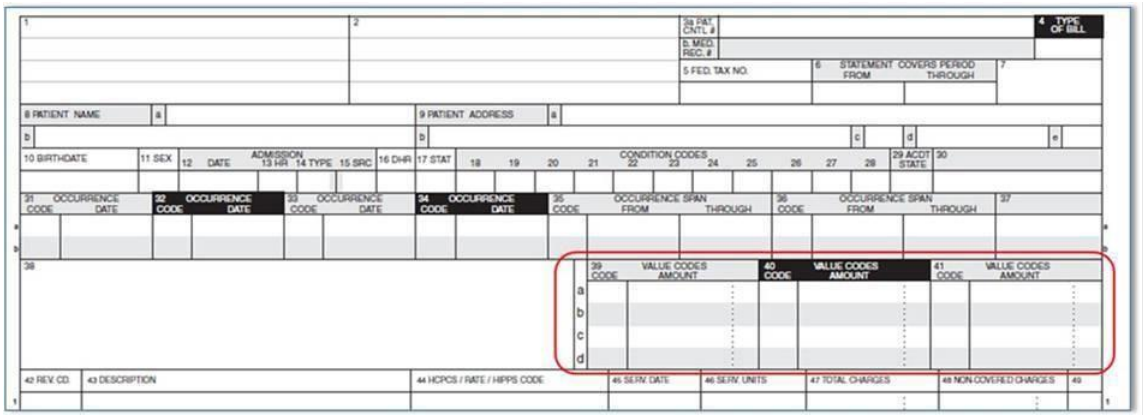
Individual/group practice claims must be submitted with the following:

- 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 followed by a ‘00’ suffix after 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 **1-866-231-0847 (TTY 711)** 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 hours a day, 7 days a week

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 board-certified in child psychiatry reviews all inpatient denials for psychiatric treatment and denials for behavioral health medications for members under 21 years of age.

- A physician certified in addiction treatment reviews all inpatient level of care/continuing stay denials for SUD treatment
- A physician reviews all denials for services for a medically fragile child, taking the needs of the family/caregiver into consideration.

Highmark BCBS will not deny coverage of an ongoing course of care unless an appropriate provider of alternate level care is approved.

HARP members follow the same complaints and grievance process as all Medicaid members within the health plan.

For additional information on the denial, grievance and appeals processes, please see Chapter 9 of this manual.

Emergency Behavioral Health Calls

When a member in crisis contacts Highmark BCBS using the toll-free number **1-866-231-0847 (TTY 711)**, 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.

Behavioral Health Resources

Reference the table below for information related to local Western New York and national resources related to behavioral health. County mental health associations offer advocacy services which are easily accessed via their website or by calling directly.

Western New York behavioral health resources		
Websites	**Links**	**Information**
Erie county mental health	**erie.gov/mentalhealth**	Community education, events, services, trainings

Western New York behavioral health resources		
Websites	**Links**	**Information**
Mental Health Advocates of Western New York	**mhawny.org/**	Programs, supports, services, screenings
Parent Network of Western New York	**parentnetworkwny.org**	A local county agency offering programs, supports, education, screenings and advocacy services for mental health issues
The Center for Parent Information and Resources	**parentcenterhub.org/mentalhealth**	Resources, webinars, parent centers
Crisis Services	**crisisservices.org**	Several phone numbers for a direct link to crisis services organizations and providers
Elmwood Wellness Center	**omh.ny.gov/omhweb/facilities/bupc**	A local wellness center that offers activities to improve fitness, general health and well-being.
Family Peer Support	**ideas4kidsmentalhealth.org/family-peer-support-workforce.html**	Resources regarding Family Peer Support
Family Peer Support	**ideas4kidsmentalhealth.org/**	Resources that promote the implementation of evidence-based practices to improve the mental health of children and their families
First Episode Psychosis (FEP)	**nimh.nih.gov/health/topics/schizophrenia/raise/fact-sheet-first-episode-psychosis.shtml**	National Institute of Mental Health mental health information fact sheet.
Foster Care Resources	**ocfs.ny.gov/portals/find-services.php**	New York State Office of Children and Family Services
Allegany County Mental Health Association	No website — call **1-585-593-1991**	A local county agency offering programs, supports, education, screenings and advocacy services for mental health issues
Cattaraugus County Mental Health Association	**mhast.org/index.html**	A local county agency offering programs, supports, education, screenings and advocacy services for mental health issues

Western New York behavioral health resources		
Websites	**Links**	**Information**
Mental Health Association of Chautauqua County	**mhachautauqua.org**	A local county agency offering programs, supports, education, screenings and advocacy services for mental health issues
Mental Health Association of Genesee and Orleans Counties	**mhago.org**	A local county agency offering programs, supports, education, screenings and advocacy services for mental health issues
Mental Health Association of Rochester/Monroe County, Inc.	**mharochester.org**	A local county agency offering programs, supports, education, screenings and advocacy services for mental health issues
Mental Health Association in Niagara County	**mhanc.com**	A local county agency offering programs, supports, education, screenings and advocacy services for mental health issues
Mental Health Association of Wyoming County	**mharochester.org/find-your-way/programs-and-services-description/**	A local county agency offering programs, supports, education, screenings and advocacy services for mental health issues
Transition Age Youth Information - New York State Office of Mental Health	**omh.ny.gov/omhweb/consumer_affairs/transition_youth/resources**	Information and resources for young people transitioning to adulthood, their families and service providers.
The Center for Practice Innovations	**practiceinnovations.org/CPI-Resources**	Consumer, family and provider portal offering education on mental health issues including transition age youth, first episode psychosis, wellness, family and community supports, peer services and other areas of information.

Western New York behavioral health resources		
Websites	**Links**	**Information**
Lead716.org	**lead716.org/**	Community organization - Lead716 is a free program aimed to provide early intervention to preschool children in WNY diagnosed with elevated lead levels in their blood.
ProjectTEACH	**projectteachny.org**	Consultations with child and adolescent psychiatrists and training on how to assess, treat and manage mental health problems.

National Behavioral Health Resources		
Websites	**Links**	**Information**
National Alliance for the Mentally Ill (NAMI)	**nami.org**	Mental health information and connect to state and local NAMI chapters
Mental Health America	**mentalhealthamerica.net**	Online resources about mental health
American Academy of Child and Adolescent Psychiatry (AACAP)	**aacap.org**	Information on child and adolescent psychiatry, parent resources
American Academy of Pediatrics (AAP)	**healthychildren.org/English/health-issues/conditions/emotional-problems/Pages/default.aspx**	Information on emotional problems in children and the role of pediatricians
Mental Help Net	**mentalhelp.net**	Information on mental health, wellness and family issues
National Mental Health Information Center	**samhsa.gov**	Mental health and substance use information and publications
National Institute of Mental Health (NIMH).	**nimh.nih.gov/health/index.shtml**	Information on mental disorders, treatment and medications
New York State Agencies		
New York State Office of Children and Family Services	**ocfs.ny.gov/**	Information about adoption, day care, child protective services, the blind and visually handicapped, foster care, adoption and services for children and families
NYS Office of Addiction Services and Supports	**oasas.ny.gov/**	Information about treatment, prevention, recovery, services, training, regulations and resources regarding substance use services.

National Behavioral Health Resources		
Websites	**Links**	**Information**
New York State Office of Mental Health	**omh.ny.gov/**	Information about treatment, prevention, recovery, services, training, regulations and resources regarding mental health services.
New York State Department of Health and Recovery Plan	**health.ny.gov/health_care/medicaid/program/medicaid_health_homes/harp_bh/**	Information for Consumers/Medicaid Recipients regarding Health and Recovery Plan
New York State Department of Health	**health.ny.gov/**	Information about health, wellness, prevention, insurance, training, regulations and resources regarding health services.
NYS Office for People with Developmental Disabilities	**opwdd.ny.gov/**	Information about supports, services, community connections, resources, regulations and guidance.
Managed Care Technical Assistance Center (MCTAC)	**omh.ny.gov/omhweb/bho/mctac.html**	MCTAC works with OMH, OASAS, and partners to offer behavioral health agencies and providers: training, consultation, educational resources and technical assistance.
New York State OMH Community Oriented Recovery and Empowerment Overview	**omh.ny.gov/omhweb/bho/core/**	Information about CORE including services, eligibility, resources & guidance, and provider application and designation

7 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 healthcare 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, healthcare 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 **1-866-231-0847** and is listed on the member's ID card. This ensures members have an additional avenue of access to healthcare 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

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 member'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 member 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, substance use disorder, asthma, diabetes) or
- One single qualifying chronic condition: (HIV/AIDS); Sickle Cell or
- Serious mental illness (adults) or
- Serious emotional disturbance or complex trauma (children) and
- A social risk factor

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
- Healthcare 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 1-**866-231-0847**.

A member or a member designee can request case management services by calling Member Services at **1-866-231-0847 (TTY 711)**.

Condition Care

The Highmark BCBS Condition Care (CNDC) is based on a system of coordinated care management interventions and communications designed to assist physicians and other healthcare professionals in managing members with chronic conditions. CNDC services include a holistic, focusing on the needs of the member through telephonic and community-based resources. Motivational interviewing techniques used in conjunction with member-self empowerment. The ability to manage more than one condition to meet the changing healthcare needs of our member population. Our condition care programs include:

- Asthma
- Bipolar Disorder
- Chronic Obstructive Pulmonary Disease
- Coronary Artery Disease
- Congestive Heart Failure
- Diabetes
- HIV/AIDS
- Hypertension
- Major Depressive Disorder – Adult
- Major Depressive Disorder – Child and Adolescent
- Schizophrenia
- Substance Use Disorder

In addition to these condition-specific programs, our member-centric, holistic approach allows us to assist members with weight management and smoking cessation education.

Program features include:

- Proactive population identification processes
- Program content is based on evidence-based national practice guidelines
- Collaborative practice models to include physician and support-service providers in treatment planning
- Continuous self-management education,
- Ongoing communication with primary and ancillary providers regarding patient status
- Nine of our Condition Care programs are NCQA-accredited and incorporate outreach, education, care coordination and follow-up to improve treatment compliance and enhance self-care.

The Highmark BCBS condition care *Clinical Practice Guidelines* are located at **providerpublic.mybcbswny.com**. You can print a copy of the guidelines right from the site, or by calling Provider Services at **1-866-231-0847 (TTY 711)**.

Who is Eligible?

All Highmark BCBS members with one or more of conditions listed are eligible for CNDC services. Providers can also refer patients who can benefit from additional education and care management support. Our case managers will work collaboratively with you to obtain input in the development of care plans. Members identified for participation in any of the programs are assessed and stratified based on the severity of their conditions. Once enrolled in a program, the member is provided with continuous education on self-management concepts, which include primary prevention, coaching related healthy behaviors, and compliance/monitoring, as well as case/care management for high-risk members. Providers are given updates regarding patient status and progress.

Condition Care 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 healthcare.
- Receive courteous and respectful treatment from Highmark BCBS staff.
- Communicate complaints to Highmark BCBS.

Hours of Operation

Highmark BCBS case managers are registered nurses and are available from 8:30 a.m. to 5 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 CNDC team member at **1-888-830-4300**. Members and providers can find out more about our Condition Care programs by visiting **providerpublic.mybcbswny.com**.

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 **health.ny.gov/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.

8 PROVIDER RESPONSIBILITIES

Provider and Facility Digital Guidelines

Highmark BCBS understands that working together digitally streamlines processes and optimizes efficiency. We developed the Provider and Facility Digital Guidelines to outline our expectations and to fully inform Providers and Facilities about our digital platforms.

Highmark BCBS expects Providers and Facilities will utilize digital tools, unless otherwise prohibited by law or other legal requirements.

Digital guidelines establish the standards for using secure digital Provider platforms (websites) and applications when transacting business with Highmark BCBS. These platforms and applications are accessible to both participating and nonparticipating Providers and Facilities and encompass https://Availity.com, electronic data interchange (EDI), electronic medical records (EMR) connections and business-to-business (B2B) desktop integration.

The Digital Guidelines outline the digital/electronic platforms Highmark BCBS has available to participating and nonparticipating Providers and Facilities who serve its Members. The expectation of Highmark BCBS is based on our contractual agreement that Providers and Facilities will use these digital platforms and applications, unless otherwise mandated by law or other legal requirements.

Digital and/or electronic transaction applications are accessed through these platforms:

- Availity EDI Clearinghouse
- B2B application programming interfaces (APIs)
- EMR connections

Digital guidelines available through Availity Essentials include:

- Acceptance of digital ID cards
- Eligibility and benefit inquiry and response
- Prior authorization submissions including updates, clinical attachments, authorization status, and clinical appeals
- Claim submission, including attachments, claim status
- Remittances and payments
- Provider enrollment
- Demographic updates

Additional digital applications available to Providers and Facilities include:

- Pharmacy prior authorization drug requests
- Services through Carelon Medical Benefits Management, Inc.
- Services through Carelon Behavioral Health, Inc.

Highmark BCBS expects Providers and Facilities transacting any functions and processes above will use available digital and/or electronic self-service applications in lieu of manual channels (paper, mail, fax, call, chat, etc.). All channels are consistent with industry standards. All EDI transactions use version 5010.

Note: As a mandatory requirement, all trading partners must currently transmit directly to the Availity EDI gateway and have an active Availity Trading Partner Agreement in place. This includes providers using their practice management software & clearinghouse billing vendors.

Providers and Facilities who do not transition to digital applications may experience delays when using non-digital methods such as mail, phone, and fax for transactions that can be conducted using digital applications.

Section 1: Accepting digital ID cards

As our Members transition to digital Member ID cards, Providers and Facilities may need to implement changes in their processes to accept this new format. Highmark BCBS expects that Providers and Facilities will accept the digital version of the member identification card in lieu of a physical card when presented. If Providers and Facilities require a copy of a physical ID card, Members can email a copy of their digital card from their smartphone application, or Providers and Facilities may access it directly from Availity Essentials through the Eligibility and Benefits Inquiry application.

Section 2: Eligibility and benefits inquiry and response

Providers and Facilities should leverage these Availity Clearinghouse hosted channels for electronic eligibility and benefit inquiry and response:

- EDI transaction: X12 270/271 – eligibility inquiry and response
    - Highmark BCBS supports the industry standard X12 270/271 transaction set for eligibility and benefit inquiry and response as mandated by HIPAA.
- Availity Essentials
    - The Eligibility and Benefits Inquiry verification application allows a Provider and Facility to key an inquiry directly into an online eligibility and benefit look-up form with real-time responses.
- Provider desktop integration via B2B APIs
    - Highmark BCBS has also enabled real-time access to eligibility and benefit verification APIs that can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration opportunities.

Section 3: Prior authorization submission, attachment, status, and clinical appeals.

Providers and Facilities should leverage these channels for prior authorization submission, status inquiries and to submit electronic attachments related to prior authorization submissions:

- EDI transaction: X12 278 – prior authorization and referral:
    - Highmark BCBS supports the industry standard X12 278 transaction for prior authorization submission and status inquiry as mandated per HIPAA.

- EDI transaction: X12 275 – patient information, including HL7 payload for authorization attachments:
    - Highmark BCBS supports the industry standard X12 275 transaction for electronic transmission of supporting authorization documentation including medical records via the HL7 payload.
- Availity Essentials:
    - Authorization applications include the Availity Essentials multi-payer Authorization and Referral application for authorization submissions not accepted through Availity Essentials' multi-payer application.
        - Both applications enable prior authorization submission, authorization status inquiry and the ability to review previously submitted authorizations.
- Provider desktop integration via B2B APIs:
    - Highmark BCBS has enabled real-time access to prior authorization APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration.

Section 4: Claims: submissions, claims payment disputes, attachments, and status

Claim submissions status and claims payment disputes

Providers and Facilities should leverage these channels for electronic Claim submission, attachments (for both pre- and post-payment) and status:

- EDI transaction: X12 837 – Professional, institutional, and dental Claim submission (version 5010):
    - Highmark BCBS supports the industry standard X12 837 transactions for all fee-for-service and encounter billing as mandated per HIPAA.
    - 837 Claim batch upload through EDI allows a provider to upload a batch/file of Claims (must be in X12 837 standard format).
- EDI transaction: X12 276/277 – Claim status inquiry and response:
    - Highmark BCBS supports the industry standard X12 276/277 transaction set for Claim status inquiry and response as mandated by HIPAA.
- Availity Essentials: The Claims & Payments application enables a provider to enter a Claim directly into an online Claim form and upload supporting documentation for a defined Claim.
    - Claim Status application enables a provider to access online Claim status. Access the Claim payment dispute tool from Claim Status. Claims Status also enables online claim payment disputes in most markets and for most claims. It is the expectation of Highmark BCBS that electronic Claim payment disputes are adopted when and where it is integrated.
- Provider desktop integration via B2B APIs:
    - Highmark BCBS has also enabled real-time access to Claim Status via APIs, which can be directly integrated within participating vendor's practice management software, revenue

cycle management software and some EMR software. Contact Availity for available vendor integration.

Claim attachments

Providers and Facilities should leverage these channels for electronic Claim attachments from https://Availity.com:

- EDI transaction: X12 275 – Patient information, including HL7 payload attachment:
  - Highmark BCBS supports the industry standard X12 275 transaction for electronic transmission of supporting Claim documentation including medical records via the HL7 payload.
- Availity Essentials – Claim Status application enables a Provider or Facility to digitally submit supporting Claims documentation, including medical records, directly to the Claim.
  - Digital Request for Additional Information (Digital RFAI) – The Medical Attachments application on Availity Essentials enables the transmission of digital notifications when additional documentation including medical records are needed to process a Claim.

Section 5: Electronic remittance advice and electronic claims payment

Electronic remittance advice

Electronic remittance advice (ERA) is an electronic data interchange (EDI) transaction of the explanation of payment of your claims. Highmark BCBS supports the industry standard X12 835 transaction as mandated per HIPAA.

Providers and Facilities can register, enroll and manage ERA preference through **https://Availity.com**. Printing and mailing remittances will automatically stop thirty (30) days after the ERA enrollment date.

- Viewing an ERA on Availity Essentials is under Claims & Payments, Remittance Viewer. Features of remittance viewer, include the ability to search a two (2) year history of remittances and access the paper image.
- Viewing a portable document format (PDF) version of a remit is under Payer Spaces which provides a downloadable PDF of the remittance.

To stop receiving ERAs for your claims, contact Availity Client Services at **1-800-AVAILITY** (**282-4548**).

To re-enable receiving paper remittances, contact Provider Services.

Electronic claims payment

Electronic claims payment is a secure and fast way to receive payment, reducing administrative processes. There are several options to receive claims payments electronically.

- **Electronic Funds Transfer (EFT)**

  Electronic funds transfer (EFT) uses the automated clearinghouse (ACH) network to transmit healthcare payments from a health plan to a Provider's or Facility's bank account at no charge for the deposit. Health plans can use a Provider's or Facility's banking information only to deposit funds, not to withdraw funds. The EFT deposit is assigned a trace number (TRN) to help

match the payment to the correct 835 electronic remittance advice (ERA), a process called reassociation.

To enroll in EFT: Providers and Facilities can register, enroll, and manage account changes for EFT through EnrollSafe at **enrollsafe.payeehub.org**. EnrollSafe enrollment eliminates the need for paper registration. EFT payments are deposited faster and are generally the lowest cost payment method. For help with enrollment, use this convenient **EnrollSafe User Reference Manual**.

To disenroll from EFT: Providers and Facilities are entitled to disenroll from EFT. Disenroll from EFT payments through EnrollSafe at **enrollsafe.payeehub.org**.

- **Virtual Credit Card (VCC)**

  For Providers and Facilities who don't enroll in EFT, and in lieu of paper checks, Highmark BCBS is shifting some reimbursements to virtual credit card (VCC). VCC allow Providers and Facilities to process payments as credit card transactions. Check with your merchant processor regarding standard transaction fees that will apply.

  Note that Highmark BCBS may receive revenue for issuing a VCC.

  Opting out of virtual credit card payment. Providers and Facilities are entitled to opt out of electronic payment. To opt out of virtual credit card payment, there are two (2) options:

  - Enrolling for EFT payments automatically opts you out of virtual credit card payments. To receive EFT payments instead of virtual credit cards payments, enroll for EFT through EnrollSafe at **enrollsafe.payeehub.org**.

    OR

  - To opt out of virtual credit card payments, call **1-800-833-7130** and provide your taxpayer identification number.

- **Zelis Payment Network (ZPN) electronic payment and remittance combination**

  The Zelis Payment Network (ZPN) is an option for Providers and Facilities looking for the additional services Zelis can offer. Electronic payment (ACH or VCC) and Electronic Remittance Advice (ERA) via the Zelis portal are included together with additional services. For more information, go to **Zelis.com**. Zelis may charge fees for their services.

  Note that Highmark BCBS may receive revenue for issuing ZPN.

  ERA through Availity is not available for Providers and Facilities using ZPN.

  To disenroll from ZPN payment, there are two (2) options:

  - Enrolling for EFT payments automatically removes you from ZPN payments. To receive EFT payments instead of ZPN payments, enroll for EFT through EnrollSafe at **enrollsafe.payeehub.org**.

    OR

  - To disenroll from ZPN payments, update your Zelis registration on the Zelis provider portal or contact Zelis at **1-877-828-8770**.

Not being enrolled for EFT, VCC, or ZPN will result in paper checks being mailed.

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 healthcare. The PCP, member and member's family — together with the healthcare 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. Article 29-I Voluntary Foster Care Agencies (VFCAs), Federally qualified health centers (FQHCs) and rural health clinics (RHCs) may be included as PCPs.

The PCP shall:

- Manage the medical and healthcare needs of members, including monitoring and following up on care provided by other providers (including FFS).
- Identify specialist providers within the network for each instance when such services are determined to be necessary for the member.
- 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 healthcare 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 healthcare. 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.

Provider 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. Healthcare 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 fifteen (15) business days 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 fifteen business days
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 and the response time for a healthcare professional's call back must be specified).

Note: For appointment and availability standards for behavioral health services and for foster care assessments, refer to the Behavioral Health Services chapter.

Providers must have policies and procedures addressing enrollees who present for unscheduled, nonurgent care with the aim of promoting enrollee access to appropriate care.

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 bi-annually 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 reviews 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 provider relations staff educates providers regarding the failure. Staff attempt a second call to noncompliant providers to check for appointment timeliness following provider education. If provider continues to fail, 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.**

Minimum Office Hours

General requirements are that PCPs must practice a minimum of 16 hours a week at each primary care site. The minimum office hour's requirement may be waived under certain circumstances. A request for a waiver must be submitted by the physician to the Plan. The Plan will then submit the request to the Medical Director of the Office of Health Insurance Programs for review and approval; and the physician must be available at least eight hours/week; the physician must be practicing in the Health Provider Shortage Area (HPSA) or other similarly determined shortage area; the physician must be able to fulfill the other responsibilities of the PCP (as described in this Section); and the waiver request must demonstrate there are systems in place to guarantee continuity of care and to meet all access and availability standards (24-hour/7days per week coverage, appointment availability, etc.).

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 **1-866-231-0847 (TTY 711)**.

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 **1-866-231-0847 (TTY 711)**. 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. Retroactive PCP changes are allowed within 30 days of the PCP visit if the member was not previously seen by their PCP on record. 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 six months.

Continuity of Care (Provider Termination)

Continuity of care (provider termination) applies in its entirety to all programs, including CHPlus, HARP 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 healthcare 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 healthcare 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. Services are provided to the member at the same cost as if they received the services from an in-network provider. 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 **1-866-231-0847 (TTY 711)**. 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 healthcare 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 healthcare 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 healthcare provider must contact Highmark BCBS for a coverage determination.

If the specialist or other healthcare 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 healthcare 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.

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 specialist. When such a need is identified, the member or specialist must contact the Highmark BCBS Utilization Management department. Highmark BCBS 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 14 days of receiving the request. Based on the member's condition, the request may be expedited to three business days.

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 healthcare 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 healthcare 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 healthcare; 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

Note: For appointment and availability standards for behavioral health services, refer to the Behavioral Health Services chapter.

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 or faxing at **1-800-964-3627**. This will register the member in our New Baby, New Life℠ 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 healthcare 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. Culture, language, and health literacy are taken into account, to help ensure the understanding of

the information provided. 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 healthcare 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 healthcare 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 7 and 84 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.

Culturally and Linguistically Appropriate Services

Patient panels are increasingly diverse, and needs are becoming more complex. It is important for providers to have the knowledge, resources, and tools to offer culturally competent and linguistically appropriate care. BlueCross BlueShield wants to help, as we all work together to achieve health equity.

The U.S. Department of Health and Human Services (HHS) defines cultural competence as the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. It is a dynamic, ongoing developmental process requiring long-term commitment. The Agency for Healthcare Research and

Quality (AHRQ) Patient Safety Network explains that healthcare is defined through a cultural lens for both patients and providers. A person's cultural affiliations can influence:

- Where and how care is accessed, how symptoms are described,
- Expectations of care and treatment options,
- Adherence to care recommendations.

Providers also bring their own cultural orientations, including the culture of medicine.

Offering culturally and linguistically appropriate care incorporates a variety of skills and knowledge, including, but not limited to, the ability to:

- Recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior.
- Develop understanding of others' needs, values and preferred means of having those needs met
- Formulate culturally competent treatment plans.
- Understand how and when to use language support services, including formally trained interpreters and auxiliary aids and services, to support effective communication.
- Avoid use of family members, especially minors, to act as interpreters for limited English proficient patients.
- Understand and adhere to regulations to support the needs of diverse patients, such as the *Americans with Disabilities Act (ADA).*
- Use culturally appropriate community resources as needed to support patient needs and care.

Highmark BCBS ensures providers have access to resources to help support delivery of culturally and linguistically appropriate services. Highmark BCBS encourages providers to access and utilize **MyDiversePatients.com**.

MyDiversePatients.com: The My Diverse Patient website offers resources, information, and techniques, to help provide the individualized care every patient deserves regardless of their diverse backgrounds. The site also includes learning experiences on topics related to cultural competency and disparities that offer free Continuing Medical Education (CME) credit. Current CME offerings include:

- **Caring for Children with ADHD:** Promotes understanding of and adherence to diagnosis and treatment guidelines; use of AAP's Resource Toolkit for Clinicians; awareness of and strategies for addressing disparities.
- **My Inclusive Practice - Improving Care for LGBTQIA+ Patients:** Helps providers understand the fears and anxieties LGBTQIA+ patients often feel about seeking medical care, learn key health concerns of LGBTQIA+ patients, & develop strategies for providing effective healthcare to LGBTQIA+ patients.
- **Improving the Patient Experience:** Helps providers identify opportunities and strategies to improve patient experience during a healthcare encounter.
- **Medication Adherence:** Helps providers identify contributing factors to medication adherence disparities for diverse populations & learn techniques to improve patient-centered communication to support needs of diverse patients.
- **Moving Toward Equity in Asthma Care:** Helps providers understand issues often faced by diverse patients with asthma & develop strategies for communicating to enhance patient understanding.

- **Reducing Healthcare Stereotype Threat (HCST):** Helps providers understand HCST and the implications for diverse patients as well as the benefits of reducing HCST to both providers' patients and practices, and how to do so.

Cultural Competency Training (Cultural Competency and Patient Engagement): A training resource to increase cultural and disability competency to help effectively support the health and healthcare needs of your diverse patients.

Providers and their staff are expected to receive training to increase their knowledge in cultural competency to improve communications with patients. New York State Department of Health requires that all Medicaid providers participate in cultural competency training on an annual basis (*New York State Medicaid Managed Care Model Contract, Section 15.c)*.

Participating providers must certify, on an annual basis, that all participating providers' staff, who have regular and substantial contact with Medicaid enrollees, have completed State-approved cultural competence training curriculum, including training on the use of interpreters. The State will provide cultural competence training materials to providers upon request. Some resources provided by the State can be found at thinkculturalhealth.hhs.gov/education.

Caring for Diverse Populations Toolkit: A comprehensive resource to help providers and office staff increase effective communication by enhancing knowledge of the values, beliefs, and needs of diverse patients.

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

Highmark BCBS appreciates the shared commitment to ensuring Members receive culturally and linguistically appropriate services to support effective care and improved health outcomes.

Communication with Patients

Participating providers must abide by the following requirements applicable to communications with their patients in regards to Medicaid Managed Care (MMC) and FHPlus (Family Health Plus) products offered by the health plan and other managed care organizations (MCOs) with which participating providers may have contracts:

- Participating providers who wish to let their patients know of their affiliations with one or more MCOs must list each MCO with whom they have contracts.
- Participating providers who wish to communicate with their patients about managed care options must advise patients taking into consideration ONLY the MCO that best meets the health needs of the patients. Such advice, whether presented verbally or in writing, must be individually based and not merely a promotion of one plan over another.
- Participating providers may display Highmark BCBS outreach materials provided that appropriate material is conspicuously posted for all other MCOs with whom the participating provider has a contract.

- Upon termination of a Provider Agreement with Highmark BCBS, a provider that has contracts with other MCOs that offer MMC and FHPlus products may notify their patients of the change in status and the impact of such change on the patient.

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 healthcare 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 healthcare 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 **providerpublic.mybcbswny.com**. You can contact Provider Services at **1-866-231-0847 (TTY 711)** 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 healthcare providers about treatment choices in certain circumstances. There are two types of advance directives: 1) a durable power of attorney for healthcare, and; 2) a living will. A durable power of attorney for healthcare (durable power) allows the member to name a patient advocate to act on behalf of the member. A living will allow 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

We are committed to protecting the integrity of our healthcare program and the effectiveness of our operations by preventing, detecting and investigating fraud, waste and abuse. Combating fraud, waste and abuse begins with knowledge and awareness.

- Fraud: Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it -- or any other person. This includes any act that constitutes fraud under applicable Federal or State law.
- Waste: Includes overusing services, or other practices that, directly or indirectly, result in excessive costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- Abuse: behaviors that are inconsistent with sound financial, business and medical practices and result in unnecessary costs and payments for services that are not medically necessary or fail to meet professionally recognized standards for healthcare. This includes any member actions that result in unnecessary costs

As a recipient of funds from state and federally sponsored healthcare 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.

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.
    - 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.

Reporting Fraud, Waste or Abuse

As a Highmark BCBS provider and a participant in government-sponsored healthcare, 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 **fighthealthcarefraud.com** and select 'Report It' to access the form.
- Calling Highmark BCBS Customer Service at **1-866-231-0847 (TTY 711)**.

Any incident of fraud, waste or abuse may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped without enough information. Hence, we encourage you to give as much information as possible. We appreciate your time in referring suspected fraud, but be advised that we do not routinely update individuals who make referrals as it may potentially compromise an investigation.

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.

Importance of Detecting, Deterring and Preventing Fraud, Waste and Abuse

Healthcare fraud costs taxpayers increasingly more money every year. There are state and federal laws designed to address these crimes and impose strict penalties. Fraud, waste and abuse in the healthcare industry may be perpetuated by every party involved in the healthcare 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.

Examples of Provider Fraud, Waste and Abuse (FWA):

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Overutilization
- Misrepresentation of diagnosis or services
- Soliciting, offering or receiving kickbacks or bribes
- Unbundling – when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code
- Upcoding – when a provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

When reporting concerns involving a provider (a doctor, dentist, counselor, medical supply company, etc.) include:

- Name, address and phone number of provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility, if you have it
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

Examples of Member Fraud, Waste and Abuse

- Forging, altering or selling prescriptions
- Letting someone else use the member's ID (Identification) card
- Relocating to out-of-service Plan area and not letting us know
- Using someone else's ID card

When reporting concerns involving a member include:

- The member's name
- The member's date of birth, Member ID, or case number if you have it
- The city where the member resides
- Specific details describing the fraud, waste or abuse

Investigation Process

Our Special Investigations Unit (SIU) reviews all reports of provider and member fraud, waste and abuse for all services. If appropriate, allegations and the investigative findings are reported to all appropriate state, regulatory and/or law enforcement agencies. In addition to reporting, we may take corrective action with provider fraud, waste or abuse, which may include, but is not limited to:

- *Written warning and/or education*: We send certified letters to the Provider documenting the issues and the need for improvement. Letters may include education or requests for recoveries or may advise of further action.
- *Medical record review*: We review medical records in context to previously submitted claims and/or to substantiate allegations.
- *Prepayment Review*: A certified professional coder evaluates claims prior to payment of designated claims. This edit prevents automatic claim payment in specific situations.
- *Recoveries*: We recover overpayments directly from the provider. Failure of the provider to return the overpayment may result in reduced payment of future claims and/or further legal action.

If you are working with the SIU all checks and correspondence should be sent to:
Special Investigations Unit
740 W Peachtree Street NW
Atlanta, Georgia 30308
Attn: investigator name, #case number

Paper medical records and/or claims are a different address, which is supplied in correspondence from the SIU. If you have questions, contact your investigator. An opportunity to submit claims and/or supporting medical records electronically is an option if you register for an Availity account. Contact Availity Client Services at **1-800-AVAILITY** (**282-4548**) for more information.

About Prepayment Review

One method we use to detect FWA is through prepayment Claim review. Through a variety of means, certain Providers (Facilities or Professionals), or certain Claims submitted by Providers, may come to our attention for behavior that might be identified as unusual for coding, documentation and/or billing issues, or Claims activity that indicates the Provider is an outlier compared to his/her/its peers.

Once a Claim, or a Provider, is identified as an outlier or has otherwise come to our attention for reasons mentioned above, further review may be conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for unusual coding, documentation, and/or billing practices. If the review results in a determination the Provider's action(s) may involve FWA, unless exigent circumstances exist, the Provider is notified of their placement on prepayment review and given an opportunity to respond.

When a Provider is on prepayment review, the Provider will be required to submit medical records and any other supporting documentation with each Claim so the SIU can review the appropriateness of the services billed, including the accuracy of billing and coding, as well as the sufficiency of the medical records and supporting documentation submitted. Failure to submit medical records and supporting documentation in accordance with this requirement will result in a denial of the Claim under review. The Provider will be given the opportunity to request a discussion of his/her/its prepayment review status.

Under the prepayment review program, we may review coding, documentation, and other billing issues. In addition, one or more clinical utilization management guidelines may be used in the review of Claims submitted by the Provider, even if those guidelines are not used for all Providers delivering services to Plan Members.

The Provider will remain subject to the prepayment review process until the health plan is satisfied that all inappropriate billing, coding, or documentation activity has been corrected. If the inappropriate activity is not corrected, the Provider could face corrective measures, up to and including termination from the network at the direction of the State.

Providers are prohibited from billing a Member for services the health plan has determined are not payable as a result of the prepayment review process, whether due to FWA, any other coding or billing issue or for failure to submit medical records as set forth above. Providers whose Claims are determined to be not payable may make appropriate corrections and resubmit such Claims in accordance with the terms of their Provider Agreement, proper billing procedures and state law. Providers also may appeal such a determination in accordance with applicable grievance and appeal procedures.

Acting on Investigative Findings

If, after investigation, the SIU determines a provider appears to have committed fraud, waste, or abuse the provider:

- May be presented to the credentials committee and/or peer review committee for disciplinary action, including provider termination
- Will be referred to other authorities as applicable and/or designated by the State
- The SIU will refer all suspected criminal activity committed by a member or provider to the appropriate regulatory and law enforcement agencies.

Failure to comply with program policy or procedures, or any violation of the contract, may result in termination from our plan.

If a member appears to have committed fraud, waste or abuse or has failed to correct issues, the member may be involuntarily dis-enrolled from our healthcare plan, with state approval.

Offsets. Highmark BCBS shall be entitled to offset claims and recoup an amount equal to any overpayments ("Overpayment Amount") or improper payments made by the health plan to Provider or Facility against any payments due and payable by the health plan to Provider or Facility with respect to any Health Benefit Plan under any contract with our company regardless of the cause. Provider or Facility shall voluntarily refund the Overpayment Amount regardless of the cause, including, but not limited to, payments for Claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by the health plan that an Overpayment Amount is due from Provider or Facility, Provider or Facility must refund the Overpayment Amount within the time frame specified in letter notifying the Provider or Facility of the Overpayment Amount. If the Overpayment Amount is not received within the time frame specified in the notice letter, the health plan shall be entitled to offset the unpaid portion of the Overpayment Amount against other Claims payments due and payable by Highmark BCBS to Provider or Facility under any Health Benefit Plan in accordance with Regulatory Requirements. Should Provider or Facility disagree with any determination, Provider or Facility shall have the right to appeal such determination under [health plan brand] procedures set forth in this Provider Manual, on condition that that such appeal shall not suspend Highmark BCBS right to recoup the Overpayment Amount during the appeal process unless required by Regulatory Requirements. Highmark BCBS reserves the right to employ a third-party collection agency in the event of non-payment.

Relevant Legislation

In order to meet the requirements under the Deficit Reduction Act, you must adopt the Highmark BCBS fraud, waste and abuse policies on detecting, preventing and mitigating fraud, waste and abuse in all the federally and state funded healthcare programs in which Highmark BCBS participates. You must distribute the information 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 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 **providerpublic.mybcbswny.com**.

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 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 healthcare 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 healthcare 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.

9 MEDICAL MANAGEMENT

Medical Review Criteria

Wellpoint *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.

MCG Care Guidelines will be used for non-behavioral health emergency and concurrent inpatient reviews. Wellpoint *Clinical Utilization Management (UM) Guidelines* will be used when no specific Wellpoint *Medical Policies* exist for elective inpatient and precertification reviews. A list of the specific Wellpoint *Clinical UM Guidelines* used will be posted and maintained on the Highmark BCBS website, **bcbswny.com/content/wny/health-wellness/medical-protocols.html**, and can be obtained in hard copy by calling Provider Services at **1-866-231-0847 (TTY 711)**. 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 MCG Care Guidelines, InterQual, Wellpoint *Clinical UM Guidelines* and Wellpoint *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 under utilization, 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 **1-866-231-0847 (TTY 711)**.

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 healthcare.

Preauthorization and Notification Process

Preauthorization: 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.

The digital authorization application is the preferred method for submitting preauthorization requests. It offers a streamlined and efficient experience for providers requesting inpatient and outpatient medical or behavioral health services for our members. Additionally, providers can use this application to make inquiries on previously submitted requests, regardless of how they were sent (phone, fax, or other online tool). Capabilities and benefits of the authorization application include:

- Initiating preauthorization requests online — eliminating the need to fax. The application allows detailed text, photo images and attachments to be submitted along with your request.
- Making inquiries on previously submitted requests via phone, fax, or other online tool.
- Having instant accessibility from almost anywhere, including after business hours.
- Utilizing a dashboard that provides a complete view of all utilization management requests with real-time status updates.,
- Viewing real-time results for common procedures with immediate decisions.

You can access the authorization application from Availity's homepage. Select Patient Registration then choose **Authorizations and Referrals**. For an optimal experience, use a browser that supports 128-bit encryption. This includes Chrome, Firefox and Microsoft Edge.

The authorization application is not currently available for:

- Transplant services.
- Services administered by vendors, such as Carelon Medical Benefits Management, Inc. For these requests, follow the same preauthorization process you use today.

We'll update our website as additional functionality and lines of business are added.

HCBS Review and Criteria

Health Homes will complete assessments to assess HCBS eligibility, and are also responsible for completing a comprehensive care plan.

Health Homes and plans will work together to develop a process whereby the Health Home shares results of assessments and care plans with the plan. This can be telephonic, via fax, FTP or other methods that works for both the Health Home and the plan.

If the results of the assessment indicate the member is eligible for HCBS services, the Health Home will contact the plan, and this information will be shared with the plan. As part of the review process, the plan will discuss the assessment to ensure all data elements (health, safety, education, employment, housing, and all other related information) were reviewed and the assessment was comprehensive.

Highmark BCBS will also ensure:

- The assessment was completed by a person who meets all required qualifications.
- The initial care plan relates to the findings within the assessment.
- The care plan is person-centered and recovery-focused.

Highmark BCBS uses state-approved criteria for adult and children's HCBS services.

The dedicated HCBS case manager within the HARP or the children's team, will review the assessments and care plan and authorize the HCBS service. The HCBS care manager will be the primary contact for services requiring authorization. Ongoing concurrent review will be conducted with the in-network provider to ensure the plan of care is being followed and any barriers are being addressed. If Highmark BCBS finds deviations from the plan of care, the plan will conduct outreach to review them and discuss adjustments to either the service delivery or the plan of care.

To assess if a member is HCBS-eligible, providers should contact Highmark BCBS so necessary steps can be taken to refer to the Health Home or other approved entity, and the assessment can be completed to determine HCBS eligibility.

Health Homes/Care Management Agencies are expected to complete a care plan that incorporates the HCBS service(s) and submit it to the plan for approval.

HCBS providers are expected to contact Highmark BCBS for authorizations 1 to 5 days before the authorization is coming due. Providers can contact the plan via phone, or fax to share assessment information. Our dedicated HCBS team will review the results of the assessment and eligibility for HCBS service, functioning in an integrated utilization management and care management role. While this team authorizes services based on the HCBS criteria that are state-developed and adopted by Highmark BCBS, its role is to ensure:

- The assessments are complete and comprehensive.
- HCBS services are recovery-focused and person-centered.
- The care plans include the HCBS service(s) and all other needed services the member requests at the care plan meeting.
- There is an exchange of information between Highmark BCBS, the HCBS provider to effectively support the member.

Providers can contact the plan via phone, or fax to request authorizations for HCBS services.

Our HCBS team reviews the authorization request form and the care plan to ensure:
The HCBS service assessment ties to the goals:

- The care plan is person-centered to reflect the member's self-efficacy and personal values, choices and goals.
- The care plan is comprehensive.
- All applicable individuals, including the member, guardian(s), family member(s) and provider(s), have been consulted and agree to the type, scope and duration of the services listed within the plan.
- The care plan is inclusive of a member's strengths and barriers, includes support systems to help the member achieve their goals, and is written in a way that is understandable to the member and/or family/guardian.
- The care plan is compliant with federal regulations and state guidance.

The HCBS service is then authorized. We enter this authorization into our utilization management system, and the details of the service plan are documented in our care management system.

Additionally, all HARP members are assigned to a health plan CM. The CM will also review the members care management plan of care as well as the HCBS plan of care for similar gaps in care, duplication of services, and over or under utilization of services. This information will be communicated with the health plan HCBS Team.

Please note: HCBS are managed in compliance with the CMS HCBS Final Rule and all applicable state guidance.

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 healthcare 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 **1-866-231-0847 (TTY 711)** 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 5:30 p.m. ET. Voice messages left after business hours will be returned on the next business day.

The provider maintains the responsibility of informing member regarding the precertification or authorization of services including details of the request and outcome if confirmed by Highmark BCBS Utilization Management staff.

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 or review below 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.

Providers may call:

Liberty Dental at **1-888-352-7924** for the following:

- Utilization Review
- Provider Services
- Member Services

Carelon Medical Benefits Management at **1-855-574-6483** for the following:

- Utilization Review
- Provider Services

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 **1-866-231-0847 (TTY 711)** or faxed to **1-800-964-3627**.

Review/Determination Time frames

Time frames summarized in the paragraph section below are *Article 49 NYS* regulatory requirements. Highmark BCBS in accordance with the NYS Medicaid contract, follows the most stringent 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 **1-866-231-0847 (TTY 711)**, via fax to **1-800-964-3627** or via our website at **providerpublic.mybcbswny.com**. In the case of a standard or non-expedited request, a decision and notification will be made within three business days of receipt of the necessary information but no later than 14 calendar 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 **1-866-231-0847 (TTY 711)**
- Via fax to **1-800-964-3627**
- Via our website at **providerpublic.mybcbswny.com**

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 calendar 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 calendar days after receipt of the request 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 healthcare 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 pre-certified. A decision will be made within 24 hours of receipt of the necessary information, but no more than 30 calendar 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	***NYS Article 49 Regulatory Notification Time frame** (§ 4903 UR Determinations)
Preservice/Prospective	
Urgent	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 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	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	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 the necessary information.
Post-stabilization Care Services (Emergency Care)	
N/A	N/A

*Expedited Request

Table 2: NYS 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 the Plan/ Region		
For Medicaid Urgent Concurrent and Urgent Pre-service	If the member requests the extension, **or** The organization may extend the urgent concurrent and urgent preservice time frame once due to lack of information, for up to 14 calendar days (CD). • The time frame may be extended by up to 14 CD, but the organization must notify the member and the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.	Up to 14 calendar days
Non-urgent Pre-service	Once *	For Medicaid — up to 14 calendar days
Post-Service/ Retrospective	Once *	For Medicaid — up to 14 calendar days

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:

- 15 calendar days of a preservice request; **or**
- 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 whose credential is at least equal to that of the recommending clinician. 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 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 **1-800-206-8125** 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 healthcare 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. The reviewer will have clinical experience relevant to the adverse determination (for example, a denial of rehabilitation services will be made by a clinician with experience providing such service, or at least in consultation with such a clinician, and a denial of specialized care for a child would not be made by a geriatric specialist). To arrange such a review, providers can call **1-833-293-1659, Option 2** within seven business days of the date of the notice of action.

Appeals

A member or a member's designee has 60 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 **1-866-231-0847 (TTY 711)**, or in writing to:

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

In compliance with Federal Regulation 42 CFR 438, Highmark BCBS requires member consent for any member appeal filed by their provider. This applies to Medicaid Managed Care and Child Health Insurance Programs. For an appeal to be reviewed, it is imperative that providers supply documentation reflecting the member's written consent when filing the appeal.

Please note that this requirement does not impact the process for providers to file plan appeals or complaints on their own behalf.

As published in the March 2018 *New York State Medicaid Update*, federal regulations now require the enrollee to sign an agreement that they wish the provider to represent them during the appeal and complaint process prior to the provider filing an appeal or complaint with the health plan on the enrollee's behalf.

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 healthcare 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 72 hours after receipt of the appeal. A member may be eligible to file an external expedited appeal after the initial appeal has been denied. Expedited appeals not resolved to the satisfaction of the appealing party may file an external appeal or file a State Fair Hearing. 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 healthcare 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 Highmark BCBS contact person and phone number
- The member's coverage type
- 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 or file a State Fair Hearing
- 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.

- 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 **1-800-206-8125** and file a complaint
- 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.

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

Appeals Standard Time frames

Appeal Type	Filing an Appeal	*NYS Article 49 Regulatory Notification Time frame (§ 4903 UR Determinations)
Preservice		
Expedited (Urgent)	ASAP	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 72 hours 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	Within 60 days from the date of the notice of action	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 (2) business days of the decision.
Retrospective/post-service		
N/A	Same as standard time frame	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 including a pharmaceutical product within the meaning of PHL 4900(5)(b)(B) 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 including a pharmaceutical product within the meaning of PHL 4900(5)(b)(B) 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.

To request an external appeal, submit an attestation for an external appeal to the New York State Department of Financial Services. The attestation form is located at **dfs.ny.gov/insurance/extapp/extappqa.htm**.

The patient's physician must complete this attestation for an external appeal of a denial of services as experimental/investigational, a clinical trial, a rare disease, out of network, or for an expedited appeal.

Send the attestation form via one of the following methods:

- Mail: New York State Department of Financial Services
  99 Washington Ave., Box 177
  Albany, NY 12210
- Fax: **800-332-2729**

Note: The Department of Financial Services or the external appeal agent may need to request additional information, including the patient's medical records.

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, manage or treat conditions that cause acute suffering, endanger life, result in illness or infirmity, interfere with the capacity for normal activity, or threaten some significant handicap.
- For children and youth, services are necessary to promote normal growth and development and prevent, diagnose, treat, ameliorate or palliate the effects of a physical, mental, behavioral, genetic, or congenital condition, injury or disability
- 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 not 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 **1-800-342-3334** or fax to **1-518-473-6735**.

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 **1-866-231-0847** (**TTY 711**). 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.

10 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' healthcare needs and medical histories in conjunction with MCG Care Guidelines or InterQual criteria.

The hospital can confirm that an authorization is on file by calling **1-866-231-0847 (TTY 711)** (see Chapter 13 of this manual for instructions). If coverage of an admission has not been approved, the facility should call Highmark BCBS at **1-866-231-0847 (TTY 711)**. 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 healthcare 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 MCG or 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 **1-866-231-0847 (TTY 711)**.

Coverage of emergent admissions is authorized based on review by a concurrent review nurse. When the clinical information received meets MCG or 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

Applicable to Medicaid Managed Care and HARP

Service	Requirement	Comments

Behavioral Health/ Substance Abuse	Precertification	• Inpatient psychiatric, inpatient detoxification, inpatient substance abuse rehabilitation and ambulatory detoxification treatment require notification or 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 notification and concurrent review
		• 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:
		  o Adult HCBS services
		• No precertification required for the following:
		  o Medically supervised outpatient withdrawal – Ambulatory Detox
		  o Outpatient SUD Services (OASAS BH Solo/ group practice)
		  o Opioid treatment program / Methadone Maintenance (OTP services)
		  o Outpatient services – MH (OMH services, BH solo/group practice)
		  o Personalized Recovery Oriented Services (PROS)
		  o Transcranial Magnetic Stimulation (TMS)
		  o Comprehensive psychiatric emergency program
		  o Intensive case management/supportive case management
		  o 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.
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.

Service	Requirement	Comments
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, Liberty Dental. Dental procedures requiring anesthesia and/or planned inpatient admission or services at an outpatient ambulatory center must first be approved by Liberty Dental. 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 Liberty Dental at **1-888-352-7924** for the following:
		  o Emergency Referral Unit
		  o Provider Services Unit
		  o Provider Relations

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 Carelon Medical Benefits Management at **1-855-574-6483.**
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.

Service	Requirement	Comments
		• 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 select 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. • 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. • **Members in foster care:** See the members in Foster Care section in the Behavioral Health Services chapter for additional EPSDT considerations
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:** As of 4/1/2023, due to the NYS Pharmacy Benefit Transition, enteral and parenteral nutrition is now covered under NYRx. • **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.

Service	Requirement	Comments
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. Due to the NYS Pharmacy Benefit Transition, as of 4/1/2023 hearing aid batteries when provided by DME providers are covered under NYRx.
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 Healthcare (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. • **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:** Covered for eligible 1115 waiver children. • **CHPlus members**: Covered for eligible 1115 waiver children.
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

Service	Requirement	Comments
		• 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.
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. • Due to the NYS Pharmacy Benefit Transition, as of 4/1/2023 medical supplies provided by DME providers are covered under NYRx. • **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 Liberty Dental at **1-888-352-7924**. • **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 select 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, 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.

Service	Requirement	Comments
Out-of-Area/ Out-of-Network Care	Precertification	• Precertification is required with the exception of emergency and out-of-area urgent care services (including self-referral). • Out-of-area care is only covered for emergent and urgent care 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 Carelon Medical Benefits Management for authorization of all pain management services related to spinal procedures at: **1-855-574-6483.** • **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 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 CHPlus members. • Enteral formula is covered under the DME benefit. See the DME section. • **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 CarelonRx 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 select 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>Service</th><th>Requirement</th><th>Comments</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><th>If you need to:</th><th>Call:</th></tr>
<tr><td>Initiate a PA request for:
• All Highmark BCBS CHPlus members
• For Medicaid members NYRx
• Medical injectables covered under the medical benefit for all members</td><td>Highmark BCBS Provider Services Prior Authorization:
1-866-231-0847 (TTY 711)
1-877-309-9493 (NYRx)</td></tr>
<tr><td>Schedule delivery once you receive a PA approval notice for Highmark BCBS CHPlus members</td><td>CarelonRx:
1-833-255-0646</td></tr>
</table>
</td></tr>
<tr><td>Physiatry</td><td>Precertification</td><td>Precertification is required for coverage of all services and procedures related to pain management.</td></tr>
<tr><td>Physical Medicine and Rehabilitation</td><td>Precertification</td><td>Precertification is required for coverage of all services and procedures related to pain management.</td></tr>
<tr><td>Plastic/Cosmetic /Reconstructive Surgery (including Oral Maxillofacial Services)</td><td></td><td>• 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.</td></tr>
<tr><td>Podiatry</td><td></td><td>• 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.</td></tr>
<tr><td>Radiation Therapy</td><td></td><td>• 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.</td></tr>
<tr><td>Radiology Services</td><td></td><td>See the Diagnostic Testing section of this grid.</td></tr>
<tr><td>Rehabilitation Therapy (Short Term): OT, PT, RT and ST</td><td>Precertification</td><td>• Precertification is required for outpatient therapy services after the initial consultation. Providers should contact Carelon Medical Benefits Management at 1-855-574-6483. 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 occupational and speech therapy are limited to 20 visits per visit type per calendar year. Outpatient visits for physical therapy are limited to 40 visits per visit type per calendar year. Limits do not apply for</td></tr>
</table>

Service	Requirement	Comments
		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 CPT 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 (Nonemergent)		• No precertification or notification is required except for planned air transportation (airplane). To arrange 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/CHPlus		• Members and providers may contact **1-866-231-0847** (**TTY 711**). • **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

Service	Requirement	Comments
		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 healthcare, 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 MCG or InterQual Care Guidelines to determine medical necessity for inpatient services and Wellpoint *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 healthcare 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 MCG or 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, condition care, 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.

11 QUALITY MANAGEMENT

Overview

We operate and maintain a comprehensive Quality Management program with methods and procedures to control the utilization of services (per *Article 49* of the PHL and 42 CFR Part 456); to objectively monitor and systematically evaluate the care and service provided to adult and children/youth members. The scope and content of the program reflects the demographic and epidemiological needs of the population served; we'll amend it as needed to address the specific monitoring requirements for the benefits and services we manage and the populations we serve. Members and providers have opportunities to make recommendations for areas of improvement. The Quality Management program evaluation, including the goals and outcomes, is kept on file in written form and is available to providers and members upon request. To request a copy of our Quality Management program evaluation, please call the Quality Management (QM) department at **1-866-231-0847 (TTY 711)**.

The initial program development was based on a review of the needs of the population served to include adult and children/youths. 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 or the information needed to perform utilization — 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.

There is a comprehensive committee structure in place with oversight from our governing body. This includes but is not limited to the Quality Management Committee, Medical Operations Committee, and Credentialing Committee. Also included in the committee structure is the Children's Advisory Subcommittee which is a collaborative interdisciplinary group whose goal is to promote and support quality of care and services. The committee reviews and analyzes data and information, provides

feedback and recommends action plans to improve quality performance impacting members and providers. The committee establishes measurable objectives and assesses the evidence through quality improvement initiatives to solve problems and pursue opportunities to improve quality.

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 healthcare practitioner (such as a physician) or a healthcare organization (such as a hospital). Common examples of performance data include the HEDIS/QARR quality of care measures maintained by the National Committee for Quality Assurance (NCQA), New York Quality Assurance Reporting Requirements (QARR) 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/QARR and CAHPS. HEDIS/QARR 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/QARR 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.

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 healthcare 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 Provider Services department at **1-866-231-0847 (TTY 711)**.

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 healthcare 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
- Child/adult access to care
- Immunizations completed by age 2
- Lead testing prior to or at the age of 24 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
- Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia
- Colorectal Cancer Screening
- Diabetes Screening For People With Schizophrenia or Bipolar Disorder Using Antipsychotic Medications
- Antidepressant Medication Monitoring

- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Metabolic Monitoring for Children and Adolescents on Antipsychotics

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. Healthcare 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 timetables 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:

- Cervical cancer screening
- Breast cancer screening
- Immunizations
- Lead screening
- Well care visits for children and adolescents

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 healthcare 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 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 **New York State Immunization Information System (NYSIIS)**, 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 **1-866-231-0847 (TTY 711)**. In addition, you may contact the NYS Domestic Violence Hotline at **1-800-942-6906**.

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 **health.ny.gov/diseases/aids/testing/law/faqs.htm**.

Credentialing

Highmark BCBS's Discretion

The credentialing summary, criteria, standards, and requirements set forth herein are not intended to limit Highmark BCBS's discretion in any way to amend, change or suspend any aspect of Highmark BCBS's credentialing program ("Credentialing Program") nor is it intended to create rights on the part of practitioners or HDOs who seek to provide healthcare services to Members. Highmark BCBS further retains the right to approve, suspend, or terminate individual physicians and healthcare professionals, and sites in those instances where it has delegated credentialing decision making.

Credentialing Scope

Credentialing requirements apply to the following:

1. Practitioners who are licensed, certified or registered by the state to practice independently (without direction or supervision);

2. Practitioners who have an independent relationship with Highmark BCBS
    - An independent relationship exists when Highmark BCBS directs its Members to see a specific practitioner or group of practitioners, including all practitioners whom a Member can select as primary care practitioners; and
3. Practitioners who provide care to Members under Highmark BCBS's medical benefits.

The criteria listed above apply to practitioners in the following settings:

1. Individual or group practices;
2. Facilities;
3. Rental networks:
    - That are part of Highmark BCBS's primary Network and include Highmark BCBS Members who reside in the rental network area.
    - That are specifically for out-of-area care and Members may see only those practitioners or are given an incentive to see rental network practitioners; and
4. Telemedicine.

Highmark BCBS credentials the following licensed/state certified independent healthcare practitioners:

- Medical Doctors (MD)
- Doctors of Osteopathic Medicine (DO)
- Doctors of Podiatry
- Chiropractors
- Optometrists providing Health Services covered under the Health Benefit Plan
- Doctors of dentistry providing Health Services covered under the Health Benefit Plan including oral and maxillofacial surgeons
- Psychologists who have doctoral or master's level training
- Clinical social workers who have master's level training
- Psychiatric or behavioral health nurse practitioners who have master's level training
- Other behavioral health care specialists who provide treatment services under the Health Benefit Plan
- Telemedicine practitioners who provide treatment services under the Health Benefit Plan
- Medical therapists (for example, physical therapists, speech therapists, and occupational therapists)
- Genetic counselors
- Audiologists
- Acupuncturists (non-MD/DO)
- Nurse practitioners
- Certified nurse midwives
- Physician assistants (as required locally)
- Registered Dietitians

The following behavioral health practitioners are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing board to independently provide behavioral health services and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Certified Behavioral Analysts
- Certified Addiction Counselors
- Substance Use Disorder Practitioners

Highmark BCBS credentials the following Health Delivery Organizations (HDOs):

- Hospitals
- Home Health agencies
- Skilled Nursing Facilities (Nursing Homes)
- Ambulatory Surgical Centers
- Behavioral Health Facilities providing mental health and/or substance use disorder treatment in inpatient, residential or ambulatory settings, including:
    - Adult Family Care/Foster Care Homes
    - Ambulatory Detox
    - Community Mental Health Centers (CMHC)
    - Crisis Stabilization Units
    - Intensive Family Intervention Services
    - Intensive Outpatient – Mental Health and/or Substance Use Disorder
    - Methadone Maintenance Clinics
    - Outpatient Mental Health Clinics
    - Outpatient Substance Use Disorder Clinics
    - Partial Hospitalization – Mental Health and/or Substance Use Disorder
    - Residential Treatment Centers (RTC) – Psychiatric and/or Substance Use Disorder
- Birthing Centers
- Home Infusion Therapy when not associated with another currently credentialed HDO
- Durable Medical Equipment Providers

The following HDOs are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing agency and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Clinical laboratories (CLIA Certification of Accreditation or CLIA Certificate of Compliance)
- End Stage Renal Disease (ESRD) service providers (dialysis facilities) (CMS Certification or National Dialysis Accreditation Commission
- Portable x-ray Suppliers (CMS Certification)
- Home Infusion Therapy when associated with another currently credentialed HDO (CMS Certification)
- Hospice (CMS Certification)
- Federally Qualified Health Centers (FQHC) (CMS Certification)
- Rural Health Clinics (CMS Certification)
- Orthotics and Prosthetics Suppliers (American Board for Certification in Orthotics and Prosthetics_(ABCOP) or Board of Certification/Accreditation (BOC) or The National Examining Board of Ocularists (NEBO))

CREDENTIALS COMMITTEE

The decision to accept, retain, deny or terminate a practitioner's or HDO's participation in on one or more of Highmark BCBS's networks or plan programs is conducted by a peer review body, known as Highmark BCBS's Credentials Committee (the "CC").

The CC will meet at least once every 45 calendar days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the Vice President of Medical and Credentialing Policy, will designate a chair of the CC, as well as a vice-chair in states or regions where both Commercial and Medicaid contracts exist. In states or regions where Medicare Advantage (MA) is represented, a second vice-chair representing MA may be designated. In states or regions where an Highmark BCBS affiliated provider organization is represented, a second vice-chair representing that organization may be designated. The chair must be a state or regional lead medical director, or an Highmark BCBS medical director designee and the vice-chair must be a lead medical officer or an Highmark BCBS medical director designee, for that line of business not represented by the chair. In states or regions where only one line of business is represented, the chair of the CC will designate a vice-chair for that line of business also represented by the chair. The CC will include at least five, but no more than 10 external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine); surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one to two other types of credentialed health providers (for example, nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair's discretion. At least two of the physician committee members must be credentialed for each line of business (for example, Commercial, Medicare, and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/re-credentialing process as needed.

The CC will access various specialists for consultation, as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant's participation or terminate a practitioner from participation in one or more Networks or Plan programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are network practitioners.

During the credentialing process, all information that is obtained is confidential and not subject to review by third parties except to the extent permitted by law. Access to information will be restricted to those individuals who are deemed necessary to attain the objectives of the Credentialing Program. Specifically, information supplied by the practitioner or HDO in the application, as well as other non-publicly available information will be treated as confidential. Confidential written records regarding deficiencies found, the actions taken, and the recommended follow-up will be kept in a secure fashion. Security mechanisms include secured office facilities and locked filing cabinets, a protected computer infrastructure with password controls and systematic monitoring, and staff ethics and compliance training programs. The procedures and minutes of the CC will be open to review by state and federal regulatory agencies and accrediting bodies to the extent permitted by law.

Practitioners and HDOs are notified of their right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, Highmark BCBS's credentialing staff ("Credentialing Department") will contact the practitioner or HDO within 30 calendar days of the identification of the issue. This communication will notify the practitioner or HDO of their right to correct erroneous information or provide additional details regarding the issue and will include the process for submission of this additional information. Depending on the nature of the issue, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue, including copies of the correspondence or a detailed record of phone calls, will be documented in the practitioner's or HDO's credentials file. The practitioner or HDO will be given no less than 14 calendar days in which to provide additional information. Upon request, the practitioner or HDO will be provided with the status of their credentialing or re-credentialing application.

Highmark BCBS may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate, or conflicting credentialing information. The CC will review the information and rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.

NONDISCRIMINATION POLICY

Highmark BCBS will not discriminate against any applicant for participation in its Plan programs or provider Networks on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Highmark BCBS will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities which are provided to the Members to meet their needs and preferences, this information is not required in the credentialing and re-credentialing process. Determinations as to which practitioners and providers require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence. The CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process. Highmark BCBS will audit credentialing files annually to identify discriminatory practices, if any, in the selection of practitioners. In the event discriminatory practices are identified through an audit or through other means, Highmark BCBS will take appropriate action to track and eliminate those practices.

INITIAL CREDENTIALING

Each practitioner or HDO must complete a standard application form deemed acceptable by Highmark BCBS when applying for initial participation in one or more of Highmark BCBS's networks or plan programs. For practitioners, the Council for Affordable Quality Healthcare (CAQH) ProView system is utilized. To learn more about CAQH, visit their website at **www.CAQH.org**.

Highmark BCBS will verify those elements related to an applicants' legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the 180-calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, Highmark BCBS will review, among other things, verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

A. Practitioners

Verification Element
License to practice in the state(s) in which the practitioner will be treating Members.
Hospital admitting privileges at a TJC, DNV NIAHO, CIHQ or ACHC accredited hospital, or a Network hospital previously approved by the committee.
DEA/CDS and state-controlled substance registrations • The DEA/CDS registration must be valid in the state(s) in which practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state.
Malpractice insurance
Malpractice claims history
Board certification or highest level of medical training or education
Work history
State or Federal license sanctions or limitations
Medicare, Medicaid or FEHBP sanctions
National Practitioner Data Bank report
State Medicaid Exclusion Listing, if applicable

B. HDOs

Verification Element
Accreditation, if applicable
License to practice, if applicable
Malpractice insurance
Medicare certification, if applicable
Department of Health Survey Results or recognized accrediting organization certification
License sanctions or limitations, if applicable
Medicare, Medicaid or FEHBP sanctions

RE-CREDENTIALING

The re-credentialing process incorporates re-verification and the identification of changes in the practitioner's or HDO's licensure, sanctions, certification, health status and/or performance information

(including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner's or HDO's professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet Highmark BCBS credentialing standards ("Credentialing Standards").

All applicable practitioners and HDOs in the Network within the scope of the Credentialing Program are required to be re-credentialed every three years unless otherwise required by applicable state contract or state regulations.

HEALTH DELIVERY ORGANIZATIONS

New HDO applicants will submit a standardized application to Highmark BCBS for review. If the candidate meets Highmark BCBS screening criteria, the credentialing process will commence. To assess whether Network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and re-credentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail below, in the "Highmark BCBS Credentialing Program Standards" section, all Network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, Highmark BCBS may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or a site survey performed by a designated independent external entity within the past 36 months for that HDO.

ONGOING SANCTION MONITORING

To support certain Credentialing Standards between the re-credentialing cycles, Highmark BCBS has established an ongoing monitoring program. The Credentialing Department performs ongoing monitoring to help ensure continued compliance with Credentialing Standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the Credentialing Department will review periodic listings/reports within 30 calendar days of the time they are made available from the various sources including, but not limited to, the following:

- Office of the Inspector General ("OIG")
- Federal Medicare/Medicaid Reports
- Office of Personnel Management ("OPM")
- State licensing Boards/Agencies
- Member/Customer services departments
- Clinical Quality Management Department (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
- Other internal Highmark BCBS departments
- Any other information received from sources deemed reliable by Highmark BCBS.

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response.

APPEALS PROCESS

Highmark BCBS has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one or more of Highmark BCBS's Networks or Plan Programs. Information reviewed during this activity may indicate that the professional conduct and competence

standards are no longer being met, and Highmark BCBS may wish to terminate practitioners or HDOs. Highmark BCBS also seeks to treat network practitioners and HDOs, as well as those applying for participation, fairly and thus provides practitioners and HDOs with a process to appeal determinations terminating/denying participation in Highmark BCBS's Networks for professional conduct and competence reasons, or which would otherwise result in a report to the National Practitioner Data Bank (NPDB).

Additionally, Highmark BCBS will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It is Highmark BCBS's intent to give practitioners and HDOs the opportunity to contest a termination of the practitioner's or HDO's participation in one or more of Highmark BCBS's Networks or Plan Programs and those denials of request for initial participation which are reported to the NPDB that were based on professional conduct and competence considerations.

Immediate terminations may be imposed due to the practitioner's or HDO's license suspension, probation or revocation, if a practitioner or HDO has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs, has a criminal conviction, or Highmark BCBS's determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to Members. Participating practitioners and HDOs whose network participation has been terminated due to the practitioner's suspension or loss of licensure or due to criminal conviction are not eligible for informal review/reconsideration or formal appeal. Participating practitioners and HDOs whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for informal review/reconsideration or formal appeal.

REPORTING REQUIREMENTS

When Highmark BCBS takes a professional review action with respect to a practitioner's or HDO's participation in one or more of its Networks or Plan programs, Highmark BCBS may have an obligation to report such to the NPDB, state licensing board and legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook, the process set forth in the NPDB Guidebook will govern.

HIGHMARK BCBS CREDENTIALING PROGRAM STANDARDS

Eligibility Criteria

A. Healthcare practitioners:

Initial applicants must meet the following criteria in order to be considered for participation:

1. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP;
2. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he or she provides services to Members;
3. Possess a current, valid, and unrestricted Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substances (CDS) registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat Members. The DEA/CDS registration must be valid

in the state(s) in which the practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state; and
4. Meet the education, training and certification criteria as required by Highmark BCBS.

Initial applications should meet the following criteria in order to be considered for participation, with exceptions reviewed and approved by the CC:

1. For MDs, DOs, DPMs, and DMDs/DDSs practicing oral and maxillofacial surgery, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC), American Board of Foot and Ankle Surgery (ABFAS), American Board of Podiatric Medicine ("ABPM"), or American Board of Oral and Maxillofacial Surgery (ABOMS) in the clinical discipline for which they are applying.
2. If not certified, MDs and DOs will be granted five years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.
3. If not certified, DPMs will be granted five years after the completion of their residency to meet this requirement for the ABPM. Non-certified DPMs will be granted seven years after completion of their residency to meet this requirement for ABFAS.
4. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.

    a. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:
        i. Previous board certification (as defined by one) of the following: ABMS, AOA, RCPSC, CFPC, ABFAS, ABPM, or ABOMS) in the clinical specialty or subspecialty for which they are applying which has now expired and a minimum of 10 consecutive years of clinical practice;
        ii. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty; or
        iii. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty and a faculty appointment of assistant professor or higher at an academic medical center and teaching facility in Highmark BCBS's network and the applicant's professional activities are spent at that institution at least fifty percent (50%) of the time.

    b. Practitioners meeting one of these three alternative criteria (i., ii., iii.) will be viewed as meeting all Highmark BCBS education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to Highmark BCBS review and approval. Reports submitted by delegates to Highmark BCBS must contain sufficient documentation to support the above alternatives, as determined by Highmark BCBS.

5. For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (DNV NIAHO), Center for Improvement in Healthcare Quality (CIHQ), a Accreditation Commission

for Health Care (ACHC) accredited hospital, or a Network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may at its discretion deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Network practitioner to provide inpatient care.

6. For Genetic Counselors, the applicant must be licensed by the state to practice independently. If the state where the applicant practices does not license Genetic Counselors, the applicant must be certified by the American Board of Genetic Counseling or the American Board of Genetics and Genomics.

Criteria for Selecting Practitioners

New Applicants (Credentialing):

1. Submission of a complete application and required attachments that must not contain intentional misrepresentations or omissions.
2. Application attestation signed date within 180 calendar days of the date of submission to the CC for a vote.
3. Primary source verifications within acceptable time frames of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies.
4. No evidence of potential material omission(s) on application.
5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Members.
6. No current license action.
7. No history of licensing board action in any state.
8. No current federal sanction and no history of federal sanctions (per System for Award Management (SAM), OIG and OPM report nor on NPDB report).
9. Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat Members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who treat Members in more than one state must have a valid DEA/CDS registration for each applicable state.
10. Initial applicants who have no DEA/CDS registration will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he or she has applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:

    a. It can be verified that this application is pending.
    b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber;
    c. The applicant agrees to notify Highmark BCBS upon receipt of the required DEA/CDS registration.

d. Highmark BCBS will verify the appropriate DEA/CDS registration via standard sources.
    i. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a 90-calendar day time frame will result in termination from the Network.

Initial applicants who possess a DEA certificate in a state other than the state in which they will be seeing Highmark BCBS's Members will be notified of the need to obtain the additional DEA, unless the practitioner is delivering services in a telemedicine environment only and does not require a DEA or CDS registration in the additional location(s) where such telemedicine services may be rendered under federal or state law. If the applicant has applied for an additional DEA registration the credentialing process may proceed if all the following criteria are met:

a. It can be verified that the applicant's application is pending; and
b. The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and
c. The applicant agrees to notify Highmark BCBS upon receipt of the required DEA registration; and
d. Highmark BCBS will verify the appropriate DEA/CDS registration via standard sources; and
e. The applicant agrees that failure to provide the appropriate DEA registration within a 90-day time frame will result in termination from the network.

Practitioners who voluntarily choose to not have a DEA/CDS registration if that practitioner certifies the following:

a. controlled substances are not prescribed within his/her scope of practice; or in their professional judgement, the patients receiving their care do not require controlled substances and
b. he or she must provide documentation that an arrangement exists for an alternative provider to prescribe controlled substances should it be clinically appropriate. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber; and
c. DEA/CDS registration is or was not suspended, revoked, surrendered or encumbered for reasons other than those aforementioned.

11. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions; or for Practitioners in specialties defined as requiring hospital privileges who practice solely in the outpatient setting, there exists a defined referral arrangement with a participating Practitioner of similar specialty at a participating hospital who provides inpatient care to members requiring hospitalization.
12. No history of or current use of illegal drugs or history of or current substance use disorder.
13. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
14. No gap in work history greater than six months in the past five years; however, gaps up to 12 months related to parental leave or immigration will be acceptable and viewed as Level I. All gaps in work history exceeding six months will require additional information and review by the Credentialing Department. A verbal explanation will be accepted for gaps of six to 12 months. Gaps in excess of 12 months will require written explanations. All work history gaps exceeding six months may be presented to the geographic CC if the gap raises concerns of future substandard Professional Conduct and Competence.
15. No convictions, or pleadings of guilty or no contest to, or open indictments of, a felony or any

offense involving moral turpitude or fraud. In addition, no other criminal or civil litigation history that together with any other relevant facts, raises a reasonable suspicion of future substandard professional conduct and/or competence.

16. A minimum of the past 10 years of malpractice claims history is reviewed.
17. Meets Credentialing Standards for education/training for the specialty(ies) in which practitioner wants to be listed in Highmark BCBS's Network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs, and oral and maxillofacial surgeons;
18. No involuntary terminations from an HMO or PPO.
19. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:
    a. Investment or business interest in ancillary services, equipment or supplies;
    b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    c. Voluntary surrender of state license related to relocation or nonuse of said license;
    d. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    e. Non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    f. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window.
    g. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
    h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

    Note: the CC will individually review any practitioner that does not meet one or more of the criteria required for initial applicants.

Participation Criteria and Exceptions for Non-Physician Credentialing.

The following participation criteria and exceptions are for non-MD practitioners. It is not additional or more stringent requirements, but instead the criteria and exceptions that apply for these specific provider types to permit a review of education and training.

1. Licensed Clinical Social Workers (LCSW) or other master level social work license type:
    a. Master or doctoral degree in social work.
    b. If master's level degree does not meet criteria and practitioner obtained PhD degree as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. In addition, a doctor of social work will be viewed as acceptable.
    c. Licensure to practice independently.

2. Licensed professional counselor ("LPC"), marriage and family therapist ("MFT"), licensed mental health counselor (LMHC) or other master level license type:
    a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable

with one of the fields of study above.

b. Master or doctoral degrees in divinity, masters in biblical counseling, or other primarily theological field of study do not meet criteria as a related field of study.
c. Practitioners with PhD training as a clinical psychologist can be reviewed.
d. Practitioners with a doctoral degree in one of the fields of study will be viewed as acceptable.
e. Licensure to practice independently or in states without licensure or certification:
    i. Marriage & Family Therapists with a master's degree or higher:
        a. Certified as a full clinical member of the American Association for Marriage and Family Therapy (AAMFT), OR proof of eligibility for full clinical membership in AAMFT (documentation from AAMFT required).
    ii. Mental Health Counselors with a master's degree or higher:
        a. Provider applicant must be a Certified Clinical Mental Health Counselor (CCMHC) as determined by the Clinical Academy of the National Board of Certified Counselors (NBCC) (proof of NBCC certification required) or meet all requirements to become a CCMHC (documentation of eligibility from NBCC required).

3. Pastoral Counselors:
    a. Master's or doctoral degree in a mental health discipline.
    b. Licensed as another recognized behavioral health provider type (for example, MD/DO, PsyD, SW, RNCS, ARNP, and MFT, OR LPC) at the highest level of independent practice in the state where the practice is to occur OR must be licensed or certified as a pastoral counselor in the state where the practice is to occur.
    c. A fellow or diplomat member of the Association for Clinical Pastoral Education (ACPE) OR meet all requirements to become a fellow or diplomat member of the ACPE [documentation of eligibility of ACPE required].

4. Clinical nurse specialist/psychiatric and mental health nurse practitioner:
    a. Master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing.
    b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.
    c. Certification by the American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA) in psychiatric nursing, or the Pediatric Nursing Certification Board. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner, or Family Psychiatric and Mental Health Nurse Practitioner; and
    d. Valid, current, unrestricted DEA/CDS registration, where applicable with appropriate supervision/consultation by a Network practitioner as applicable by the state licensing board. For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members.

4. Clinical Psychologists:
    a. Valid state clinical psychologist license.
    b. Doctoral degree in clinical or counseling, psychology or other applicable field of study.
    c. Master's level therapists in good standing in the Network, who upgrade their license to

clinical psychologist as a result of further training, will be allowed to continue in the Network and will not be subject to the above education criteria.

5. Clinical Neuropsychologist:
   a. Must meet all the criteria for a clinical psychologist listed in Section 4 above and be Board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical Neuropsychology (ABCN);
   b. A practitioner credentialed by the National Register of Health Service Providers (National Register) in psychology with an area of expertise in neuropsychology may be considered; and
   c. Clinical neuropsychologists who are not board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
      i. Transcript of applicable pre-doctoral training;
      ii. Documentation of applicable formal one-year post-doctoral training (participation in CEU training alone would not be considered adequate);
      iii. Letters from supervisors in clinical neuropsychology (including number of hours per week); or
      iv. Minimum of five years' experience practicing neuropsychology at least ten hours per week.

6. Licensed Psychoanalysts:
   a. Applies only to practitioners in states that license psychoanalysts.
   b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Highmark BCBS Credentialing Policy (for example, psychiatrist, clinical psychologist, licensed clinical social worker).
   c. Practitioner must possess a valid psychoanalysis state license.
      (a) Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.
      (b) Meet examination requirements for licensure as determined by the licensing state.

7. Process, requirements and Verification – Nurse Practitioners:
   a. The nurse practitioner (NP) applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
   b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a registered nurse, and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing agency provided that that agency verifies the education or from the certification board if that board provides documentation that it performs primary verification of the professional education and training If the licensing agency or certification board does not verify highest level of education, the education will be primary source verified in accordance with policy.
   c. The license status must be that of NP as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.

d. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Highmark BCBS procedures. If there are in force adverse actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.
e. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:
    i. Certification program of the American Nurse Credentialing Center, a subsidiary of the American Nursing Association;
    ii. American Academy of Nurse Practitioners – Certification Program;
    iii. National Certification Corporation;
    iv. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (note: CPN – certified pediatric nurse is not a nurse practitioner);
    v. Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY; or
    vi. American Association of Critical Care Nurses Acute Care Nurse Practitioner Certification (ACNPC); ACNPC-AG – Adult Gerontology Acute Care. This certification must be active and primary source verified.

If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Highmark BCBS is not required. If the applicant is not certified or if his/her certification has expired, the application will be submitted for individual review.

f. If the NP has hospital privileges, he or she must have hospital privileges at a CIHQ, TJC, DNV NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the nurse practitioner will be obtained. Any adverse action against any hospital privileges will trigger a Level II review.
g. The NP applicant will undergo the standard credentialing processes outlined in Highmark BCBS's Credentialing Policies. NPs are subject to all the requirements outlined in the Credentialing Policies including (but not limited to): the requirement for Committee review of Level II files for failure to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
h. Upon completion of the credentialing process, the NP may be listed in Highmark BCBS's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
i. NPs will be clearly identified:
    i. On the credentialing file;
    ii. At presentation to the CC; and
    iii. Upon notification to network services and to the provider database.

8. Process, Requirements and Verifications – Certified Nurse Midwives:

a. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other practitioner with the exception of differing information regarding education, training and board certification.
b. The required educational/training will be at a minimum that required for licensure as a registered nurse with subsequent additional training for licensure as a Certified Nurse Midwife by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification of the education, or from the certification board if that board

provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with policy.

c. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.

d. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Highmark BCBS procedures. If there are current adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.

e. All CNM applicants will be certified by either:

iv. The National Certification Corporation for Ob/Gyn and neonatal nursing; or

v. The American Midwifery Certification Board, previously known as the American College of Nurse Midwifes.

This certification must be active and primary source verified. If the state licensing board primary source verifies one) of these certifications as a requirement for licensure, additional verification by Highmark BCBS is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic CC.

j. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, DNV NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a Level II review. In the event the CNM provides only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/Gyn.

k. The CNM applicant will undergo the standard credentialing process outlined in Highmark BCBS's Credentialing Policies. CNMs are subject to all the requirements of the Credentialing Policies including (but not limited to): the requirement for CC review for Level II applicants, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the Network.

l. Upon completion of the credentialing process, the CNM may be listed in Highmark BCBS's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.

m. CNMs will be clearly identified:

i. On the credentialing file;

ii. At presentation to the CC; and

iii. Upon notification to network services and to the provider database.

9. Process, Requirements and Verifications – Physician's Assistants (PA):

a. The PA applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.

b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.
c. The license status must be that of PA as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
d. If the PA has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Highmark BCBS procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
e. All PA applicants will be certified by the National Commission on Certification of Physician's Assistants. This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Highmark BCBS is not required. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to Credentialing Policy #8, as adopted or amended by each Highmark BCBS Health Plan and submitted for individual review by the CC.
f. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, DNV NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.
g. The PA applicant will undergo the standard credentialing process outlined in Highmark BCBS's Credentialing Policies. PAs are subject to all the requirements described in these Credentialing Policies including (but not limited to): committee review of Level II files failing to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
h. Upon completion of the credentialing process, the PA may be listed in Highmark BCBS provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
i. PA's will be clearly identified:
    iv. On the credentialing file;
    v. At presentation to the CC; and
    vi. Upon notification to network services and to the provider database.

Currently Participating Applicants (Re-credentialing)

1. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
2. Re-credentialing application signed date 180 calendar days of the date of submission to the CC for a vote;
3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or FEHBP. If, once a practitioner participates in

Highmark BCBS's Plan programs or provider Networks, federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the practitioner will become immediately ineligible for participation in the applicable government programs or provider Networks as well as Highmark BCBS's other credentialed provider Networks.

4. Current, valid, unrestricted, unencumbered, unprobated license to practice in each state in which the practitioner provides care to Members;
5. No new history of licensing board reprimand since prior credentialing review;
6. *No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per SAM, OIG and OPM Reports or on NPDB report);
7. Current DEA/CDS registration and/or state-controlled substance certification without new (since prior credentialing review) history of or current restrictions;
8. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; or for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a Network practitioner of similar specialty at a Network HDO who provides inpatient care to Members needing hospitalization;
9. No new (since previous credentialing review) history of or current use of illegal drugs or substance use disorder;
10. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
11. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
12. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
13. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
14. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:
    a. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    b. Voluntary surrender of state license related to relocation or nonuse of said license;
    c. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    d. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    e. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window;
    f. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
    g. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.
15. No quality improvement data or other performance data including complaints above the set threshold.
16. Re-credentialed at least every three years to assess the practitioner's continued compliance with Highmark BCBS standards.

*It is expected that these findings will be discovered for currently credentialed network practitioners and HDOs through ongoing sanction monitoring. Network practitioners and HDOs with such findings will be individually reviewed and considered by the CC at the time the findings are identified.

Note: the CC will individually review any credentialed Network practitioners and HDOs that do not meet one or more of the criteria for re-credentialing.

B. HDO Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, Highmark BCBS may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or site survey performed by a designated independent external entity within the past 36 months. If a HDO has satellite facilities that follow the same policy and procedures, Highmark BCBS may limit site visits to the main facility. Non-accredited HDOs are subject to individual review by the CC and will be considered for Member access need only when the CC review indicates compliance with Highmark BCBS standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care or patient safety. HDOs are re-credentialed at least every three years to assess the HDO's continued compliance with Highmark BCBS standards.

1. General Criteria for HDOs:
   a. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to Members. The license must be in good standing with no sanctions.
   b. Valid and current Medicare certification.
   c. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or the FEHBP. Note: If, once an HDO participates in Highmark BCBS's Plan programs or provider Networks, exclusion from Medicare, Medicaid or FEHBP occurs, at the time of identification, the HDO will become immediately ineligible for participation in the applicable government programs or provider Networks as well as Highmark BCBS's other credentialed provider Networks.
   d. Liability insurance acceptable to Highmark BCBS.
   e. If not appropriately accredited, HDO must submit a copy of its CMS, state site or a designated independent external entity survey for review by the CC to determine if Highmark BCBS's quality and certification criteria standards have been met.

2. Additional Participation Criteria for HDO by Provider Type:

HDO TYPE AND HIGHMARK BCBS APPROVED ACCREDITING AGENT(S)

Facility Type (Medical Care)	Acceptable Accrediting Agencies
Acute Care Hospital	CIQH, TCT, DNV NIAHO, ACHC, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, ACHC, TJC
Birthing Center	AAAHC, CABC, TJC

Home Health Care Agencies (HHA)	ACHC, CHAP, DNV NIAHO, TJC, TCT
Home Infusion Therapy (HIT)	ACHC, CHAP, TCT, TJC
Skilled Nursing Facilities/Nursing Homes	CARF, TJC
Durable Medical Equipment Suppliers	TJC, CHAP, TCT, ACHC, BOC, HQAA

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Care Hospital—Psychiatric Disorders	DNV NIAHO, ACHC, TJC, TCT
Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAHC, CARF, CHAP, COA, TJC, ACHC
Crisis Stabilization Unit	TJC
Intensive Family Intervention Services	CARF
Intensive Outpatient – Mental Health and/or Substance Use Disorder	ACHC, CARF, COA, DNV NIAHO, TJC
Outpatient Mental Health Clinic and/or Licensed Behavioral Health Clinics	CARF, CHAP, COA, ACHC, TJC
Partial Hospitalization/Day Treatment—Psychiatric Disorders and/or Substance Use Disorder	CARF, DNV NIAHO, TJC
Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Use Disorder	CARF, COA, DNV NIAHO, ACHC, TJC

Facility Type (Behavioral Health Care - Rehabilitation)	Acceptable Accrediting Agencies
Acute Inpatient Hospital – Detoxification Only Facilities	TCT, DNV NIAHO, ACHC, TJC
Behavioral Health Ambulatory Detox	CARF, TJC
Methadone Maintenance Clinic	CARF, TJC
Outpatient Substance Use Disorder Clinics	CARF, TJC, COA,

The decision to approve or deny initial participation will be communicated in writing within sixty (60) 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 sixty (60) days from the receipt of the application. 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.

Selective Contracting for Breast Cancer Surgery
In accordance with New York State Department of Health (NYS DOH) requirements for Medicaid Managed Care programs, Highmark BCBS may no longer authorize or reimburse for inpatient or outpatient mastectomy and lumpectomy procedures for its Managed Medicaid Members at hospitals and ambulatory surgery centers identified as low volume by the NYS DOH. We will provide breast cancer surgery only at hospitals and ambulatory surgery centers designated as meeting high volume thresholds as determined by the State. NYS DOH updates the list of eligible facilities annually. The list can be found at the following web site address:
health.ny.gov/health_care/medicaid/quality/surgery/cancer/breast

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.

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 healthcare 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.

12 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:

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

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.

13 CLAIM SUBMISSION AND ADJUDICATION PROCEDURES

Electronic Remittance Advice (ERA) The 835 eliminates the need for paper remittance reconciliation.

Use Availity to register and manage ERA account changes with these three easy steps:

1. Log in to Availity at **apps.https://Availity.com/availity/web/public.elegant.login**
2. Select **My Providers**
3. Select **Enrollment Center** and select **Transaction Enrollment**

Note: If you use a clearinghouse or vendor, please work with them on ERA registration and receiving your ERA's.

Electronic Data Exchange (EDI)

Highmark BCBS has a strategic relationship with Availity to serve as our Electronic Data Interchange (EDI) partner for all electronic data and transactions.

Healthcare professionals, billing services and clearinghouses who are new to the EDI space can register to exchange EDI transactions with Availity.
Your organization can submit and receive the following transactions through the Availity EDI Gateway:

- 837 Institutional Claims
- 837 Professional Claims
- 837 Dental Claims
- 835 Electronic Remittance Advice
- 276/277 Claim Status
- 270/271 Eligibility Request
- 275 Electronic Medical Attachments
- 278 Prior Authorizations and Referrals

Payer name and ID

Your Payer Name is Highmark BCBS, and the Payer ID is **00246**
(If you use a billing company or clearinghouse for your EDI transmissions, please work with them on which payer ID they want you to use).

To send claims via the Availity EDI Gateway, log in to the Availity site or visit
providerpublic.mybcbswny.com/western-new-york-provider/claims/electronic-data-interchange

Contact Availity

Please contact Availity Client Services with any questions at **1-800-AVAILITY** (**282-4548**)

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 120 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 120 days of the date of service. Corrected claims must be submitted within 90 days of the date of the EOP. Both must be submitted to the following address:

New York Claims
P.O. Box 61010
Virginia Beach, VA 23466-1010

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 healthcare 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 120 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:

Encounter Data
P.O. Box 62509
Virginia Beach, VA 23466-2509

HEDIS/QARR 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 120 days from the date the service is rendered; or for inpatient claims filed by a hospital, within 120 days from the date of discharge.
- In the case of other insurance, submit the claim within 120 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 120 days from the date the eligibility is added and we're notified of the eligibility/enrollment.
- Claims submitted after the 120-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 **1-866-231-0847 (TTY 711)**. 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 Availity website or call **1-866-231-0847 (TTY 711)** to check claims status.
Training on checking claims status can be found on the Availity Learning Hub -
Learn about Availity (mybcbswny.com)

Reimbursement Policies

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Highmark Blue Cross Blue Shield (Highmark BCBS) covered the service for the member's benefit plan. These policies can be accessed on the provider site**.** 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, including using industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. The codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to participating and non-participating professional providers and facilities.

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

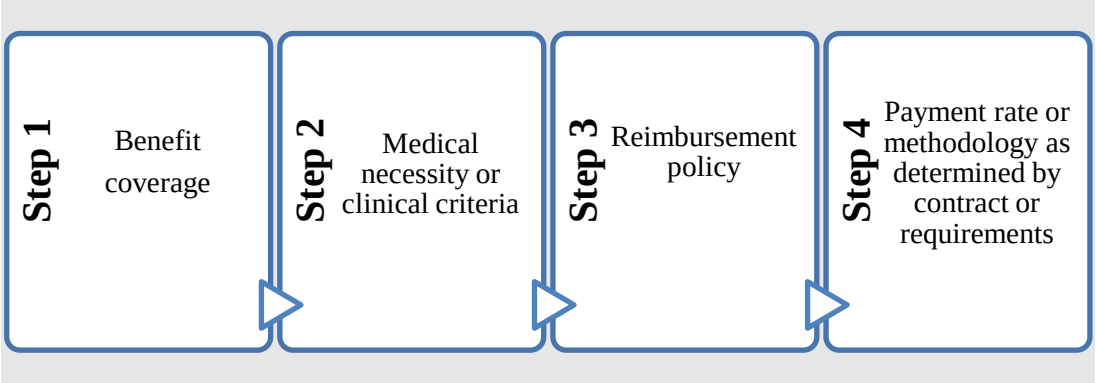
- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Highmark BCBS strives to

minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

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 benefits coverage, medical necessity/clinical criteria, authorization requirements and/or stipulations within a reimbursement policy. Neither payment rates nor methodology are considered to be conditions of payment.



Review Schedules and Updates to Reimbursement Policies

Reimbursement policies undergo reviews for updates to state contracts, federal or CMS requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to a Highmark BCBS business decision. We reserve the right to review and revise our policies when necessary. When there is an update, we will publish the most current policies to our provider website.

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 definitions or descriptors unless otherwise noted by state or provider contracts, or state, federal or CMS requirements. There are eight CPT sections:

1. Evaluation and management
2. Anesthesia
3. Surgery
4. Radiology (nuclear medicine and diagnostic imaging)

5. Pathology and laboratory
6. Medicine
7. Category II codes: supplemental tracking codes that can be used for performance measurement
8. Category III codes: temporary codes for emerging technology, services or procedures

Outlier Reimbursement - Audit And Review Process

Requirements and Policies

This section includes guidelines on reimbursement to Providers and Facilities for services on claims paid by DRG with an outlier paid at percent of billed charge or where the entire claim is paid at percent of billed charge. Our vendor-partner or our internal team may review these claims as part of our itemized bill review (IBR) program to ensure appropriate reimbursement. Upon completion of the review, documentation, including a summary of adjusted charges, will be provided for each claim. Disputes related to the review may be submitted according to the instructions in the Claims Payment Disputes section of this manual.

In addition to any header in this section, please refer to all other service specific sections which may have more stringent guidelines. There may be multiple sections that apply to any given reimbursable service.

Audits/Records Requests
At any time, a request may be made for on-site, electronic or hard copy medical records, utilization review documentation and/or itemized bills related to Claims for the purposes of conducting audit or reviews.

Blood, Blood Products, and Administration

Blood and blood products such as platelets or plasma are reimbursable. Administration of Blood or Blood Products by nursing/facility personnel are not separately reimbursable on inpatient claims. Administration of Blood or Blood Products by nursing/facility personnel billed on outpatient claims is separately reimbursable when submitted without observation/treatment room charges.

Charges for blood storage, transportation, processing, and preparation such as thawing, splitting, pooling, and irradiation are also not separately reimbursable. Lab tests such as typing, Rh, matching, etc., are separately reimbursable charges.

Emergency Room Supplies and Services Charges

The Emergency Room level reimbursement includes all monitoring, equipment, supplies, and time and staff charges. Reimbursement for the use of the Emergency Room includes the use of the room and personnel employed for the examination and treatment of patients. This reimbursement does not typically include the cost of physician services.

Facility Personnel Charges

Charges for Inpatient Services for Facility personnel are not separately reimbursable and the reimbursement for such is included in the room and board rate or procedure charge. Examples include, but are not limited to, lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions (including IV or PICC line insertion at bedside), call back charges, nursing increments, therapy increments, and bedside respiratory and pulmonary function services. Charges for Outpatient Services for facility personnel are also not separately reimbursable and are included in the reimbursement for the procedure or Observation charge.

Implants

Implants are objects or materials which are implanted such as a piece of tissue, a tooth, a pellet of medicine, a medical device, a tube, a graft, or an insert placed into a surgically or naturally formed cavity of the human body to continuously assist, restore or replace the function of an organ system or structure of the human body throughout its useful life. Implants include, but are not limited to: stents, artificial joints, shunts, pins, plates, screws, anchors and radioactive seeds, in addition to non-soluble, or solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. Instruments that are designed to be removed or discarded during the same operative session during which they are placed in the body are not implants. In addition to meeting the above criteria, implants must also remain in the Member's body upon discharge from the inpatient stay or outpatient procedure.

Staples, sutures, clips, as well as temporary drains, tubes, similar temporary medical devices and supplies shall not be considered implants. Implants that are deemed contaminated and/or considered waste and/or were not implanted in the Member will not be reimbursed.

IV sedation and local anesthesia

Charges for IV sedation and local anesthesia administered by the provider performing the procedure, and/or nursing personnel, are not separately reimbursable and are included as part of the Operating Room (OR) time/procedure reimbursement. Charges for medications/drugs used for sedation and local anesthesia are separately reimbursable.

Lab Charges

The reimbursement of charges for specimen collection are considered facility personnel charges and the reimbursement is included in the room and board or procedure/Observation charges. Examples include venipuncture, urine/sputum specimen collection, draw fees, phlebotomy, heel sticks, and central line draws.

Processing fees, handling fees, and referral fees are considered included in the procedure/lab test performed and not separately reimbursable.

Claims that are submitted for laboratory services subject to the Clinical Laboratory Improvement Amendments of 1988 (CLIA) statute and regulations require additional information to be considered for payment.

To be considered for reimbursement of clinical laboratory services, a valid CLIA certificate identification number must be reported on a 1500 Health Insurance Claim Form (CMS-1500) or its

electronic equivalent for clinical laboratory services. The CLIA certificate identification number must be submitted in one of the following manners:

Claim format and elements	CLIA number location options	Referring provider name and NPI number location options	Servicing laboratory physical location
CMS-1500 (formerly HCFA-1500)	Must be represented in field 23	Submit the referring provider name and NPI number in fields 17 and 17b, respectively.	Submit the servicing provider name, full physical address and NPI number in fields 32 and 32A, respectively, if the servicing address is not equal to the billing provider address. The servicing provider address must match the address associated with the CLIA ID entered in field 23.
***HIPAA* 5010 837 Professional**	Must be represented in the 2300 loop, REF02 element, with qualifier of X4 in REF01	Submit the referring provider name and NPI number in the 2310A loop, NM1 segment.	Physical address of servicing provider must be represented in the 2310C loop if not equal to the billing provider address and must match the address associated with the CLIA ID submitted in the 2300 loop, REF02.

To be considered for reimbursement of reference laboratory services, the referring laboratory must be an independent clinical laboratory. Modifier 90 must be submitted to denote the referred laboratory procedure. Per the Centers for Medicare & Medicaid (CMS), an independent clinical laboratory that submits claims in paper format may not combine non-referred or self-performed and referred services on the same CMS-1500 claim form. Thus, when the referring laboratory bills for both non-referred and referred tests, it must submit two separate paper claims: one claim for non-referred tests and the other for referred tests. If submitted electronically, the reference laboratory must be represented in the 2300 or 2400 loop, REF02 element, with qualifier of F4 in REF01.

Providers who have obtained a CLIA Waiver or Provider Performed Microscopy Procedure accreditation must include the QW modifier when any CLIA waived laboratory service is reported on a CMS-1500 claim form.

Laboratory procedures must be rendered by an appropriately licensed or certified laboratory having the appropriate level of CLIA accreditation for the particular test performed. Thus, any claim that does not contain the CLIA ID, has an invalid ID, has a lab accreditation level that does not support the billed service code, does not have complete servicing provider demographic information and/or applicable

reference laboratory provider demographic information, will be considered incomplete and rejected or denied.

Labor Care Charges

Reimbursement will be made for appropriately billed room and board or labor charges. Payment will not be made on both charges when billed concurrently.

Nursing Procedures

Fees associated with nursing procedures or services provided by Facility nursing staff or unlicensed Facility personnel (technicians) performed during an inpatient (IP) admission or outpatient (OP) visit will not be reimbursed separately. Examples include, but are not limited, to intravenous (IV) injections or IV fluid administration/monitoring, intramuscular (IM) injections, subcutaneous (SQ) injections, IV or PICC line insertion at bedside, nasogastric tube (NGT) insertion, urinary catheter insertion, point of care/bedside testing (such as glucose, blood count, arterial blood gas, clotting time, pulse oximetry, etc.) and inpatient blood transfusion administration/monitoring (with the exception of OP blood administration, OP chemotherapy administration, or OP infusion administration which are submitted without a room charge, observation charges, treatment room charges, or procedure charges other than blood, chemotherapy, or infusion administration.)

Operating Room Time and Procedure Charges

The operating room (OR) charge will be based on a time or procedural basis. When time is the basis for the charge, it should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes. The Operating Room is defined as surgical suites, major and minor, treatment rooms, endoscopy labs, cardiac cath labs, Hybrid Rooms, X-ray, pulmonary and cardiology procedural rooms. The operating room charge will reflect the cost of:

- The use of the operating room
- The services of qualified professional and technical personnel
- Any supplies, items, equipment, and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services. Refer to Routine Supplies section of the manual.

Personal Care Items and services

Personal care items used for patient convenience are not separately reimbursable. Examples include but are not limited to: breast pumps, deodorant, dry bath, dry shampoo, eye lubricants, lotion, non-medical personnel, mouthwash, powder, soap, telephone calls, television, tissues, toothbrush and toothpaste, .

Pharmacy Charges

Pharmacy charges will be reimbursed to include only the cost of the drugs prescribed by the attending physician. Medications furnished to patients shall not include an additional separate charge for administration of drugs, the cost of materials necessary for the preparation and administration of drugs, and the services rendered by registered pharmacists and other pharmacy personnel. All other services are included in the drug reimbursement rate. Example of pharmacy charges which are not separately reimbursable include, but are not limited to: IV mixture fees, IV diluents such as saline and sterile water,

IV Piggyback (IVPB), Heparin and saline flushes to administer IV drugs, and facility staff checking the pharmacy (Rx) cart.

Portable Charges
Portable Charges are included in the reimbursement for the procedure, test, or x-ray, and are not separately reimbursable.

Pre-Operative Care or Holding Room Charges
Charges for a pre-operative care or a holding room used prior to a procedure are included in the reimbursement for the procedure and are not separately reimbursed. In addition, nursing care provided in the pre-operative care areas will not be reimbursed separately. Reimbursement for the procedure includes all nursing care provided.

Preparation (Set-Up) Charges
Charges for set-up, equipment, or materials in preparation for procedures or tests are included in the reimbursement for that procedure or test.

Recovery Room Charges
Reimbursement for recovery room services (time or flat fee) includes the use of all and/or available services, equipment, monitoring, and nursing care that is necessary for the patient's welfare and safety during his/her confinement. This will include but is not limited to cardiac/vital signs monitoring, pulse oximeter, medication administration fees, nursing services, equipment, supplies, (whether disposable or reusable), defibrillator, and oxygen. Separate reimbursement for these services will not be made.

Recovery Room services related to IV sedation and/or local anesthesia
Separate reimbursement will not be made for a phase I or primary recovery room charged in connection with IV sedation or local anesthesia. Charges will be paid only if billed as a post procedure room or a phase II or step-down recovery room (for example, arteriograms).

Respiratory Services

Mechanical ventilation/CPAP/BIPAP support and other respiratory and pulmonary function services provided at the bedside are considered facility personnel, equipment, and/or supply charges and not eligible for separate reimbursement.

Routine Supplies

Any supplies, items, and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and supplies and not separately reimbursable in the inpatient and outpatient environments. Reimbursement for routine services and supplies is included in the reimbursement for the room, procedure, or observation charges.

Special Procedure Room Charge
Charges for Special procedure room, billed in addition to the procedure itself, are included in the reimbursement for the procedure. If the procedure takes place outside of the OR (Refer to Operating Room Time and Procedure Charges for OR definition), then OR time will not be reimbursed to cover OR personnel/staff being present in the room. Example: procedures performed in the ICU, ER, etc.

Stand-by Charges
Standby equipment and consumable items such as oxygen, which are on standby, are not reimbursable. Only actual use is covered. Standby charges for facility personnel are included in the reimbursement for the procedure and not separately reimbursable.

Stat Charges
Stat charges are included in the reimbursement for the procedure, test, and/or X-ray. These charges are not separately reimbursable.

Supplies and Equipment
Charges for medical equipment, including but not limited to, IV pumps, PCA Pumps, isolation carts, mechanical ventilators, continuous positive airway pressure (CPAP)/ bilevel positive airway pressure (BIPAP) machines, and related supplies are not separately reimbursable. Oxygen charges, including but not limited to, oxygen therapy per minute/per hour when billed with room types ICU/CCU/NICU or any Specialty Care area are not separately reimbursable.

Tech Support Charges

Pharmacy Administrative Fees (including mixing medications), any portable fees for a procedure or service, patient transportation fees when taking a patient to an area for a procedure or test are not separately reimbursable. Transporting a patient back to their room following surgery, a procedure, or test, are not separately reimbursable.

Telemetry
Telemetry charges in ER/ ICU/CCU/NICU or telemetry unit (step-down units) are included in the reimbursement for the place of service. Additional monitoring charges are not reimbursable.

Time Calculation

- **Operating Room (OR)** –Time should be calculated on the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes.
- **Hospital/ Technical Anesthesia** - Reimbursement of technical anesthesia time will be based on the time the patient enters the operating room (OR) until the patient leaves the room, as documented on the OR nurse's notes. The time the anesthesiologist spends with the patient in pre-op and the recovery room will not be reimbursed as part of the hospital anesthesia time.
- **Recovery Room** – The reimbursement of Recovery Room charges will be based on the time the patient enters the recovery room until the patient leaves the recovery room as documented on the post anesthesia care unit (PACU) record.
- **Post Recovery Room** – Reimbursement will be based on the time the patient leaves the Recovery Room until discharge.

Undocumented or Unsupported Charges

Charges that are not documented on medical records or supported with documentation are not reimbursed.

Video or Digital Equipment used in Procedures
Charges for video or digital equipment used for visual enhancement during a procedure are included in the reimbursement for the procedure and are not separately reimbursable. Examples include but not limited to Ultrasound and Fluoroscopy guidance. Charges for batteries, covers, film, anti-fogger solution, tapes etc., are also not separately reimbursable.

Additional Reimbursement Guidelines for Disallowed Charges
For any Claims that are reimbursed at a percent of charge, only Charges for Covered Services are eligible for reimbursement. The disallowed charges (charges not eligible for reimbursement) include, but are not limited to, the following, whether billed under the specified Revenue Code or any other Revenue Code. These Guidelines may be superseded by the Provider or Facility Agreement. Refer to the contractual fee schedule for payment determination.

The tables below illustrate examples of non-reimbursable items/services codes.

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0990 – 0999	Personal Care Items • Courtesy/Hospitality Room • Patient Convenience Items (0990) • Cafeteria, Guest Tray (0991) • Private Linen Service (0992) • Telephone, Telegraph (0993) • TV, Radio (0994) • Non-patient Room Rentals (0995) • Beauty Shop, Barber (0998) • Other Patient Convenience Items (0999)
0220	Special Charges
0369	Preoperative Care or Holding Room Charges
0760 – 0769	Special Procedure Room Charge
0111 – 0119	Private Room* (subject to Member's Benefit)
0221	Admission Charge
0480 – 0489	Percutaneous Transluminal Coronary Angioplasty (PTCA) Stand-by Charges
0220, 0949	Stat Charges
0270 – 0279, 0360	Video or Digital Equipment Used in Procedures

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0270, 0271, 0272	**Supplies and Equipment** • Blood Pressure cuffs/Stethoscopes • Thermometers, Temperature Probes, etc. • Pacing Cables/Wires/Probes • Pressure/Pump Transducers • Transducer Kits/Packs • SCD Sleeves/Compression Sleeves/Ted Hose • Oximeter Sensors/Probes/Covers • Electrodes, Electrode Cables/Wires • Oral swabs/toothettes; • Wipes (baby, cleansing, etc.) • Bedpans/Urinals • Bed Scales/Alarms • Specialty Beds • Foley/Straight Catheters, Urometers/Leg Bags/Tubing • Specimen traps/containers/kits • Tourniquets • Syringes/Needles/Lancets/Butterflies • Isolation carts/supplies • Dressing Change Trays/Packs/Kits • Dressings/Gauze/Sponges • Kerlix/Tegaderm/OpSite/Telfa • Skin cleansers/preps • Cotton Balls; Band-Aids, Tape, Q-Tips • Diapers/Chucks/Pads/Briefs • Irrigation Solutions • ID/Allergy bracelets • Foley stat lock • Gloves/Gowns/Drapes/Covers/Blankets • Ice Packs/Heating Pads/Water Bottles • Kits/Packs (Gowns, Towels and Drapes) • Basins/basin sets • Positioning Aides/Wedges/Pillows • Suction Canisters/Tubing/Tips/Catheters/Liners • Enteral/Parenteral Feeding Supplies (tubing/bags/sets, etc.) • Preps/prep trays

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	• Masks (including CPAP and Nasal Cannulas/Prongs) • Bonnets/Hats/Hoods • Smoke Evacuator Tubing • Restraints/Posey Belts • OR Equipment (saws, skin staplers, staples & staple removers, sutures, scalpels, blades etc.) • IV supplies (tubing, extensions, angio-caths, stat-locks, blood tubing, start kits, pressure bags, adapters, caps, plugs, fluid warmers, sets, transducers, fluid warmers, heparin and saline flushes, etc.)
0220 – 0222, 0229, 0250	• Pharmacy Administrative Fee (including mixing meds) • Portable Fee (cannot charge portable fee unless equipment is brought in from another Facility) • Patient transport fees
0223	Utilization Review Service Charges
0263	IV Infusion for therapy, prophylaxis (96365, 96366) IV Infusion additional for therapy IV Infusion concurrent for therapy (96368) IV Injection (96374, 96379)
0230, 0270 – 0272, 0300 – 0307, 0309, 0390-0392, 0310	Nursing Procedures and 99001 – Handling and/or conveyance of specimen from patient (charge for specimen handling
0230	Incremental Nursing – General
0231	Nursing Charge – Nursery
0232	Nursing Charge – Obstetrics (OB)
0233	Nursing Charge – Intensive Care Unit (ICU)
0234	Nursing Charge – Cardiac Care Unit (CCU)

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0235	Nursing Charge – Hospice
0239	Nursing Charge – Emergency Room (ER) or Post Anesthesia Care Unit (PACU) or Operating Room (OR)
0250 – 0259, 0636	• Pharmacy (Medication prep • Nonspecific descriptions • Anesthesia Gases – Billed in conjunction with Anesthesia Time Charges • IV Solutions 250 cc or less, except for pediatric claims • Miscellaneous Descriptions • Compounding fees
0270, 0300 – 0307, 0309, 0380 – 0387, 0390 – 0392	• Specimen collection • Draw fees • Venipuncture • Phlebotomy • Heel stick • Blood storage and processing blood administration Thawing/Pooling Fees
0270, 0272, 0300 – 0309	• Bedside/Point of Care/Near Patient Testing (such as glucose, blood count, arterial blood gas, clotting time, etc.)
0222, 0270, 0272, 0410, 0460	Portable Charges
0270 – 0279, 0290, 0320, 0410, 0460	Supplies and Equipment • Oxygen Instrument Trays and/or Surgical Packs • Drills/Saws (All power equipment used in O.R.) • Drill Bits • Blades • IV pumps and PCA (Patient Controlled Analgesia) pumps • Isolation supplies • Daily Floor Supply Charges • X-ray Aprons/Shields • Blood Pressure Monitor • Beds/Mattress • Patient Lifts/Slings

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	• Restraints • Transfer Belt • Bair Hugger Machine/Blankets • SCD Pumps • Heel/Elbow Protector • Burrs • Cardiac Monitor • EKG Electrodes • Vent Circuit • Suction Supplies for Vent Patient • Electrocautery Grounding Pad • Bovie Tips/Electrodes • Anesthesia Supplies • Case Carts • C-Arm/Fluoroscopic Charge • Wound Vacuum Pump • Bovie/Electro Cautery Unit • Wall Suction • Retractors • Single Instruments • Oximeter Monitor • CPM Machines • Lasers • Da Vinci Machine/Robot
0370 – 0379, 0410, 0460, 0480 – 0489	Anesthesia (Specifically, conscious/moderate sedation by same physician or procedure nurse • Nursing care • Monitoring • Intervention • Pre- or Post-evaluation and education • IV sedation and local anesthesia if provided by same physician or procedure nurse • Intubation/Extubation • CPR
0410	Nursing Respiratory Functions: • Oximetry • Vent management • Medication Administration via Nebs, Metered dose (MDI), etc. • Postural Drainage

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	• Suctioning Procedure •
0940 – 0945	Education/Training

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 Healthcare 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 **providerpublic.mybcbswny.com**. 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 **1-866-231-0847 (TTY 711)** 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, healthcare 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:

   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:

   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 not 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 healthcare 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 **1-866-231-0847 (TTY 711)**.

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 do not cover:

- 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 120-day filing deadline
- Failure to submit a corrected claim within 90 days of the date of the EOP
- 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: _____

Disclaimers:

Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services on behalf of the health plan.

CarelonRx, Inc. is an independent company providing pharmacy benefit management services on behalf of the health plan.

866-231-0847 | https://providerpublic.mybcbswny.com

Amerigroup Partnership Plan, LLC provides management services for Highmark Blue Cross Blue Shield of Western New York's managed Medicaid. Amerigroup Partnership Plan, LLC brinda servicios administrativos para Medicaid administrado de Highmark Blue Cross Blue Shield of Western New York.

Highmark Blue Cross Blue Shield of Western New York is a trade name of Highmark Western and Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield Association. Highmark Blue Cross Blue Shield of Western New York es un nombre comercial de Highmark Western y Northeastern New York Inc., un licenciatario independiente de Blue Cross Blue Shield Association.