Disclaimer

Disclaimer

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Individual situations are governed by the terms of the specific applicable Love *settlement agreement provisions,* contracts and/or medical policy. Current telephone numbers are included throughout the manual. If you have specific questions about individual situations, please contact your Highmark Provider Relations Representative.

Some information in the *Highmark Blue Shield Office Manual* is subject to change without prior notice. Such changes may be published in the *PRN* (Policy, Review and News) or sent in special mailings. The *Highmark Blue Shield Office Manual* (*HBSOM*) is binding upon providers and may be supplemented or superseded, in whole or in part, by other Highmark Blue Shield guidance *and/or requirements furnished or otherwise made available to providers, provided supplements do not conflict with the applicable federal and state laws and regulations or the Love settlement agreement. Highmark Blue Shield complies with all state and federal laws related to Medicare and our Medicare Advantage products. In cases where Highmark Blue Shield policy, Highmark Blue Shield medical policy, Love settlement agreement provisions and/or the Highmark Blue Shield Office Manual conflict with CMS laws, regulations or directives, the CMS laws, regulations and/or directives shall apply.*

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Highmark Blue Shield Office Manual

A Procedural Guide for Providers

Purpose

The *Highmark Blue Shield Office Manual* contains an integrated set of procedures and policies that apply to Highmark network provider offices within Pennsylvania and bordering counties. The manual is designed to give you access to information such as claims filing, researching patient benefits, and joining one of Highmark's networks. It also includes important information on how to communicate with Highmark through automated and electronic systems, which is the most efficient and convenient method for you and your office staff.

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What Region Am I?

Copyright Information can be viewed by clicking the region specific link below.

Central and Eastern Region Copyright Information

Western Region Copyright Information

Northeastern Region Copyright Information

Introduction

A Guide to Highmark Blue Shield

In This Introduction

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Providing Access, Information and Direction

Overview & Manual History

This document is designed to be your primary reference guide to Highmark Blue Shield.

The *Highmark Blue Shield Office Manual (HBSOM)* gives you access to the information you need to do such things as file claims, research patient benefits and join one of our many networks. It also lists additional informational resources should your question(s) require a more in-depth explanation.

The *HBSOM* is intended to be a companion to other Highmark provider publications. The *HBSOM* contains information specific to procedures required of Highmark's network practitioners. Information for this consolidated manual is the combination and renovation of the former *Highmark Blue Shield Reference Guide* and the *Highmark Blue Shield Reference Guide – Western Version.* Combining the information contained in both manuals gives practitioners from any of Highmark's regions a comprehensive understanding of Highmark's health insurance programs.

This online manual replaces any older versions of the *HBSOM* and/or *Highmark Blue Shield Reference Guide* and/or *Highmark Blue Shield Reference Guide – Western Version.*

Who Should Use This Manual

The policies and procedures outlined in this manual primarily focus on medical services provided in a medical office or non-facility setting. Professional medical services provided at a facility may be impacted by Highmark's facility policies and procedures with regard to claims submission and reimbursement. Facility manuals are available via NaviNet on the Provider Resource Center under 'Facility Manuals'. The HBSOM is binding upon providers and may be supplemented or superseded, in whole or in part, by other Highmark guidance and/or requirements furnished or otherwise made available to providers.

Ancillary providers are encouraged to visit Chapter 2, Unit 7 of the Highmark Blue Shield Office Manual and other ancillary-specific material throughout the manual as primary reference points for ancillary reference materials. This unit is a consolidation of the Ancillary Reference Guide, formerly in the central region only and a general overview of Highmark Blue Shield to ancillary providers and their staffs.

Continued on next page

Providing Access, Information and Direction, Continued

Who Should Use This Manual, continued

Behavioral Health providers are encouraged to visit Chapter 2, Unit 6 of the Highmark Blue Shield Office Manual and where applicable throughout the manual as primary reference points for behavioral health materials.

Information in the HBSOM is subject to regulatory review, and may be changed at any time in accordance with regulatory requirements. Such changes may also be published in the PRN (Policy, Review and News), BTS (Behind The Shield), or sent in special mailings. Individual situations are governed by the terms of the specific, applicable contracts and/or medical policy.

Highmark Blue Shield complies with all state and federal laws related to Medicare and our Medicare Advantage products. In cases where Highmark Blue Shield policy, Highmark Blue Shield medical policy, Love settlement agreement provisions and/or the Highmark Blue Shield Office Manual conflict with CMS laws, regulations or directives, the CMS laws, regulations and/or directives shall apply.

Please check the Provider Resource Center's (PRC's) Publication and Mailings section often for policy and procedure updates as well as the PRC's Administrative Reference Materials section for recent revisions to the Highmark Blue Shield Office Manual.

How To Use This Manual

The Highmark Blue Shield Office Manual is organized by topic to make it easier for you to find answers. The first page of each unit provides a detailed list of the topics covered in that unit by page.

The HBSOM is a special section of our Provider Resource Center specifically dedicated to professional providers and contains helpful information and resources to help in your daily interactions with Highmark members and with Highmark. Highmark encourages you to bookmark the Office Manual site to take full advantage of this convenient reference tool.

The HBSOM is intended to be an online resource. Keeping the HBSOM electronic allows us to keep our promise to provide you with the most up-to-date information. All revisions to this manual are controlled electronically. You may request a paper copy by contacting your Provider Relations Representative, however paper copies and screen prints are considered uncontrolled and may not be the most recent revision.

Continued on next page

Providing Access, Information and Direction , Continued

How To Use This Manual, *continued*

The most recent changes are presented in *blue italic* print to denote areas of revision or addition. This visually attractive format works in conjunction with up-to-the minute revision dates in the upper right corner of each page. This style is designed to show you important updates in less time.

Tip Sheets New!

Based on user feedback from our 2007 Usability Labs, Highmark has incorporated a new printable 'tip sheet' feature to the HBSOM. The link for tip sheets will be incorporated throughout the manual where available.

Please click the link Tip Sheet embedded in applicable sections for a quick, printable 1-page desk reference.

How To Provide Feedback

This manual is the result of your feedback. To ensure this manual continues to fulfill its objective, Highmark is interested in comments by readers.

If you would like to recommend improvements to the *Highmark Blue Shield Office Manual*, please

- e-mail your comments to hbsomeditor@highmark.com or
- fax 1-412-544-4014, Attention: Editor, *Highmark Blue Shield Office Manual*.

Please include your name and telephone number so the Editor can contact you for further clarification of your recommendations, if necessary.

About Highmark

A Brief Highmark History

Highmark was created in 1996 by the consolidation of two Pennsylvania licensees of the Blue Cross and Blue Shield Association:

- Pennsylvania Blue Shield now Highmark Blue Shield, serving the 21 counties of central Pennsylvania and the Lehigh Valley as a full-service health plan and a
- Blue Cross plan in western Pennsylvania (now Highmark Blue Cross Blue Shield serving the 29 counties of western Pennsylvania).

Highmark also provides services in conjunction with Blue Cross Plans in northeastern and southeastern Pennsylvania.

Prior to this merger, Highmark Blue Shield had been paying physician medical claims for more than 60 years throughout the state. Highmark has a long history of serving our members and our communities. In the 1930s, Highmark's predecessor companies were established to help Pennsylvania's residents pay for health care. Today, that remains our mission — to provide access to affordable, quality health care enabling individuals to live longer, healthier lives. It guides our actions throughout Highmark's businesses.

The Highmark Brand

This manual is a consolidation of the former Western and Central Region *Highmark Blue Shield Reference Guides*. Because this office manual combines information from all Pennsylvania regions, you will only see a reference to the Highmark Blue Shield brand.

Where business applies to one region only, information will be broken out into regional links. These links contain information specific to a particular region. If you are uncertain of your region, please click the icon for What Region Am I? throughout the manual.

Highmark Medicare Services

Highmark Medicare Services, a wholly-owned subsidiary of Highmark Inc., has administered Medicare Part A and Part B fee-for-service contracts and been a valued partner with the Centers for Medicare and Medicaid Services in the Medicare Program, serving as both a carrier and an intermediary, since the Program's inception in 1966. Highmark Medicare Services serves beneficiaries, health care providers and the federal government through provider enrollment, claims processing, customer service and other administrative accountabilities. The company also provides Medicare programs for parts C & D.

Continued on next page

About Highmark, Continued

An Ongoing Commitment To Pennsylvania's Health Care Professionals

Highmark Blue Shield has been a partner with the medical community since 1939 and understands the tremendous value that physicians and other health care professionals bring to its organization and to its members. That is why Highmark is constantly striving to make its relationships stronger and better, through:

- Enhancing electronic communications and the exchange of data electronically, through Web sites like NaviNet.
- Providing a number of different ways for health care professionals to obtain information, from Web sites, to toll-free telephone numbers, fax-back services and Provider Relations representatives.
- Partnering with providers to implement programs that lead to better medical outcomes for our members.
- Restructuring our credentialing process to make it easier and more efficient.

Physicians Heavily Involved In Governance And Policy Decisions

At Highmark Blue Shield, physicians and other health care professionals play an important role in the company's governance and policy-making. They have more representation on Highmark Blue Shield's governing bodies than many other insurance companies. Over 500 independent health care professionals are active in a variety of positions that influence the core of Highmark Blue Shield's operations – they make up the majority of committees that help define medical policy, resolve claims disputes and promote the delivery of quality medical care to Highmark Blue Shield members. Health care professionals are also involved at various key junctures during the development of Highmark Blue Shield's medical policy – the guidelines used in our coverage and reimbursement determinations.

Board of Directors/ Members of the Corporation

Highmark Blue Shield's Board of Directors includes health care professionals (referred to as "Professional Members") and representatives from customers, hospitals and the community (referred to as "Lay Members"). The Highmark Inc. Bylaws stipulate that at least 25 percent of the Board must be Professional Members. The Board decides and adopts the rules and regulations that define both general and medical policy for the company. Twenty-five percent of the Corporate Membership are Professional Members. The remaining 75 percent are Lay Members. The Corporate Membership elects the Board of Directors and provides counsel to the Board on general issues.

Professional Consultant Network

This approximately 250-member group is comprised of health care professionals in active practice throughout Pennsylvania.

Highmark Blue Shield relies on their expert counsel to ensure the accurate and fair disposition of medical reviews and to provide guidance when developing medical policy.

Continued on next page

Highmark's Program Committees, Continued

Highmark's Program Committees

The Program Committee are made up predominantly of Health Care Professionals and are established by the Board of Directors.

- The Medical Affairs Committee is responsible for evaluating medical procedures and techniques, and for recommending medical necessity guidelines for covered procedures.

- The Quality Improvement Committee (QIC) works to ensure that Highmark Blue Shield's policies and procedures promote the delivery of high quality health care services to Highmark's subscribers. The Advisory Task Force reports to the QIC. Representatives from approximately 53 medical societies and medical organizations throughout the state comprise this task force. It meets every eight to nine months to provide feedback and to consider quality of care and cost of care issues.

Highmark's Medical Review Committees

Highmark Review Committees	*The Review Committees are made up predominantly of health care professionals and are established pursuant to the Bylaws of Highmark, Inc.* • *The Medical Review Committee investigates and resolves claim disputes arising out of the relationship between the Corporation and professional health care providers. Its decisions are based on current medical practices and Highmark Blue Shield medical policy.*
What Is The MRC?	*The Medical Review Committee investigates and resolves claim disputes arising out of the relationship between the Corporation and professional health care providers.*
Breakdown Of Committee Members	*The Medical Review Committee consists of at least eight (8) members. A majority of the members of the Medical Review Committee are providers who are participating providers, preferred providers or network providers ("provider members"), and the balance are consumers covered under health care contracts issued by the Corporation ("consumer members"). At least three fourths of the provider members of the Highmark Medical Review Committee shall be medical doctors or doctors of osteopathy.*
Organization Members	*At least two thirds of the members of the Medical Review Committee shall have no relationship with Highmark (other than as providers who submit claims in the ordinary course of business or members covered under one of Highmark's health care programs). No member shall be a member of the board of directors of Highmark.*
Provider Members	*The provider members of the Medical Review Committee are representative of the various health care professions and specialties whose services are covered by Highmark and the western region network.*
Conflict Of Interest	*No member of the Medical Review Committee that have any conflict of interest that would prevent him or her from rendering a fair and impartial decision or is in economic competition with a provider shall participate in the decision making process with respect to such practitioner.*

Highmark's Medical Review Committee

MRC Process

The Medical Review Committee investigates and resolves disputes arising out of the relationship between Highmark and professional health care professionals who render health services to Highmark members. Certain restrictions apply. Determinations made by the committee are based on current medical practice and Highmark Blue Shield medical policy. If you choose the MRC, their decision is considered your final level of appeal. You will be notified of the MRC decision in writing. The committee is made up of a variety of degree specialties and lay members. The Review Committee Selection Committee is responsible for appointing MRC members. The Medical Review Committee, under the Highmark Inc. Bylaws, is charged with the following responsibilities:

- *to consider unresolved matters, disputes or controversies arising out of the relationship between the Corporation and any provider, including any questions involving professional ethics*
- *review any matter affecting the status of a health care professional as a network provider of the Corporation*
- *conduct hearings to resolve disputes involving the status of health care professionals as Participating Providers in accordance with Article IX of the Bylaws of the Corporation.*
- *consider appeals by providers who are rejected or terminated as network providers in any network provider panel operated by the Corporation under Pennsylvania's preferred provider legislation*

Determinations made by the committee are based on current medical practice and Highmark Blue Shield medical policy. The MRC is empowered to take a wide range of actions to resolve disputes. A provider has the right to be present throughout the proceedings and may be represented by legal counsel. MRC consideration is the provider's final level of appeal.

Possible MRC Actions

In considering any matter brought before it, the MRC may take any one or more of the following actions:

- *refer the case for recommendation or action by any appropriate committee, board or division of the state professional society or local professional society of the provider involved;*
- *refer the matter to an appropriate law enforcement officer or agency of the Federal, State, or any Local Government if the Committee has probable cause to believe that the provider involved secured payment from the Corporation for services performed by the provider for a subscriber on the basis of material false information submitted to the Corporation with the intention of defrauding it;*

Continued on next page

Highmark's Medical Review Committee, Continued

Possible MRC Actions, *continued*	▪ *refer the matter to the state professional licensure board of the health care professional involved;* ▪ *render a finding that the Corporation is entitled to a refund of fees paid to the provider;* ▪ *render a finding that authorizes the Corporation to collect any refund by withholding future payments due from the Corporation to the provider involved and/or;* ▪ *render such a decision or take any other such action as may be necessary or appropriate to fully resolve any dispute presented to the Committee.*
How To Submit A Matter To The MRC	*After other appeals are exhausted, the practitioner may submit a matter for review to the Medical Review Committee in writing at the address below:* *Medical Review Committee* *P.O. Box 890039* *Camp Hill, PA 17089-0039*
Problem Resolution	*Following a decision by the MRC, the responsible parties are notified of the committee's decision.*

Developing Medical Policy

Developing Medical Policy

Medical policies are documents that provide medical necessity and coverage guidelines for all of our medical-surgical products, including managed care. These guidelines address hundreds of medical issues, including diagnostic and therapeutic procedures, injectable drugs, and durable medical equipment. In addition to commercial products, Highmark also maintains medical policy guidelines for our Medicare Advantage products. Highmark's Medical Policies and Medicare Advantage Medical Policies are housed on the Provider Resource Center under 'Medical Policy'.

Health care professionals play an important role in Highmark Blue Shield's medical policy development.

- They provide medical expertise that helps in the development of coverage and reimbursement guidelines.
- To begin the process of adding or revising its policy guidelines, Highmark's Medical Policy Department reviews published, peer-reviewed medical literature, along with information and determinations from multiple sources – including the FDA and professional medical societies.
- After the Medical Policy Department has performed its initial research, it solicits opinions from appropriate Highmark Professional Consultants. If the procedure in question is performed by a particular specialty, consultants within that specialty are contacted.
- The Medical Policy Department utilizes input from all of these sources to develop a draft policy.
- The Medical Policy Department then collaborates with the Clinical Policy Management Committee (CPMC) in making a final determination on the policy prior to publication. The CPMC consists of staff Medical Directors working under the direction of Highmark's Chief Medical Officer.
- When necessary, the CPMC and the Medical Policy Department recommend that a specific issue be brought before the Medical Affairs Committee (MAC).
- The MAC typically meets quarterly and makes its recommendations to the Highmark Board of Directors on specific policy issues.
- Ultimately, the Board of Directors makes the final decision as to those finite matters which are presented to the Medical Affairs Committee.

Prioritizing Electronic Claims Submission

Prioritizing Electronic Claims Submission

Highmark Blue Shield has placed a high priority on electronic claims filing and the electronic exchange of information. This process is more efficient and cost-effective than conventional means – benefiting health care professionals, members and insurers. The company's electronic commerce division, Highmark EDI Services, provides a host of services that make filing claims and accessing information faster and easier. These include:

- An interactive Web site (NaviNet) that allows you to verify enrollment, eligibility, and claims status and much more.
- A claims clearinghouse where you can electronically submit claims and inquiries for Highmark Blue Shield and other insurers.
- A toll-free, fax-back service that allows health care professionals to query the status of claims by using their touch-tone telephone. Your inquiries are answered within minutes through your fax machine.
- Convenient technical support through a toll-free hotline.
- Information on getting started in electronic claims filing – including a VIP list of vendors who can help you with the appropriate computer equipment and software. These vendors can also help you use your PC to automate other office processes.
- See Chapter 5, Unit 1 of the Highmark Blue Shield Office Manual, Benefits of Electronic Communication for a complete overview of Highmark's electronic capabilities and offerings.

Professional Members of the Corporation

Professional Members of the Corporation as of May, 2008

The Professional Members of the Corporation represent health care professionals in our networks. They understand the Corporation and are a channel through which Highmark receives and distributes information on issues facing the Corporation.

This annual list is updated each spring.

*Cynthia G. Ayers, MD Internal Medicine Pittsburgh	M. Bruce Dratler, MD Northwest Physicians Associates, P.C. Gastroenterology Meadville
Bernard J. Bernacki, DO Family Practice Pittsburgh	Rodolfo L. Furigay, MD Surgical Associates of Windber Windber
*David A. Blandino, MD Family Practice Pittsburgh	Mary C. Goessler, MD, M.P.M. Bellevue Pediatric Assoc. Pittsburgh
Joseph B. Blood, Jr., MD Internal Medicine Athens	Enrique Hernandez, MD Temple Gynecology Oncology Associates Philadelphia
*Thomas J. Castellano, MD Gastroenterology Edwardsville	Jae U. Hong, MD Somerset Internal Medicine Somerset
William K. Daiber, DO Urology Harrisburg	Seth M. Jones, MD Neurology Scranton
Daniel J. Daley, Jr., DDS Oral & Maxillofacial Surgery Drexel Hill	Joseph J. Kernich, MD Punxsutawney Medical Associates, P.C. Family Practice Punxsutawney
*John H. Damcott, D.MD Plaza Dental Associates Erie	Craig G. Kriza, Sr., DPM, JD Premier Orthopedics & Sports Medicine Assoc., Ltd. Upland
Carlo J. DiMarco, DO Lake Erie College of Osteopathic Medicine Opthalmology Erie	Debbie M. Lewis, DMD Family Dentistry Pittsburgh

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Professional Members of the Corporation, Continued

Professional Members of the Corporation as of May, 2008 (continued)

Robert T. Lindner, DDS Oral & Maxillofacial Surgery, Retired Pittsburgh	William K. Sherwin, MD, Ph.D. Dermatology Bala Cynwyd
Stanley M. Marks, MD UPMC Cancer Centers & Oncology-Hematology Assn. Pittsburgh	Audra W. Sieber, OD Leading Edge Eye Care Optometry Harrisburg
*Kenneth R. Melani, MD President & CEO Highmark Inc. Pittsburgh	Linda Ann Marie Slavoski, MD Wyoming Valley Infectious Disease Assoc. Infectious Disease Wilkes-Barre
Ralph J. Miller, Jr., MD Triangle Urological Group Urology Pittsburgh	Dean W. Spencer, MD Northwest Physicians Associates, P.C. Family Practice Meadville
David B. Nash, MD, MBA, FACP Jefferson Medical College Internal Medicine Philadelphia	Michael R. Weitekamp, MD Internal Medicine/Infectious Disease Penn State Hershey Medical Center Hershey
Donald B. Parks, MD Parkstone Medical Associates Family Medicine Philadelphia	Randy S. Zelen, MD Northwest Physicians Associates, P.C. Nephrology Meadville
John C. Reefer, MD Butler Medical Associates Internal Medicine Butler	Michael A. Ziev, DO Family Practice Philadelphia
Michael A. Schlossberg, MD Premier Medical Assoc. Internal Medicine Monroeville	* Board of Directors

Chapter 1

Provider Services and Information Sources

Unit 1: Quick Reference Directory

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1.1 Overview

Overview

This document includes information on claims mailing addresses, inquiry mailing addresses, telephone and fax numbers in the:

- Western Region
- Central Region
- Northeastern Region
- Eastern Region

1.1 Mailing Addresses

Claim Filing Addresses

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

If you wish to begin to submit claims electronically, you may contact the EDI Operations support line at 1-800-992-0246 to speak with a representative.

Western Region Claims Filing Addresses

What Region Am I?

Central, Eastern, and Northeastern Regions Claims Filing Addresses

Three Ways To Order Forms

- **The Provider Resource Center** has some recommended forms that providers may use when communicating with Highmark, Highmark members or other providers in the network. Please visit 'Provider Forms' on the Provider Resource Center to find a complete list. If you require forms that are not listed on the Provider Resource Center, please choose a method for ordering forms below. Highmark no longer supplies its version of the 1500A universal claim form. For most efficient processing, please use the CMS-1500A (08/05) claim form. To obtain a supply of the CMS-1500 (08/05) claim form, please contact your forms distributor. If your forms distributor needs a negative or PDF of the claim form the should e-mail or call

    - TFP Data Systems, e-mail: 1500form@tfpdata.com or 1-800-482-9367, extension 1770 or,
    - Government Printing Office at 1-202-512-0455

- **By Mail:** Forms may be ordered by writing to: Shipping Control, Highmark Blue Shield, P.O. Box 890089, Camp Hill, PA 17089-0089. Please include the form number requested along with the title, quantity and address to be shipped to.

- **By Phone**: Forms may be ordered by calling Highmark Blue Shield Shipping Control at 717-302-5105.

Continued on next page

1.1 Mailing Addresses, Continued

PremierBlue Shield Allowances And UCR Profile	To obtain a copy of PremierBlue Shield allowances for the most frequently reported codes for your specialty, or a copy of your Highmark Blue Shield UCR profile, send a letter of request to: Fee Based Pricing and Analysis Highmark Blue Shield P.O. Box 890089 Camp Hill, PA 17089-0089 Include your Highmark provider ID number, full name, address, and indicate whether you are requesting your UCR profile, PremierBlue Shield allowances or both. This information is also available via NaviNet for those NaviNet-enabled offices.
Refund Checks	Highmark Blue Shield Attention: Cashier P.O. Box *890150* Camp Hill, PA 17089

1.1 Telephone and Fax Numbers

Authorizations

What Region Am I?

Western Region Only:

Medical/Surgical or Home Health: 1-800-248-4180, option 1
Behavioral Health Services: 1-800-628-0816, option 3
Healthcare Management Services via Provider Line: 1-800-547-3627, option *2*

Central, Eastern, and Northeastern Region Only:

Acute Care Facilities and Ancillary Providers: 1-866-731-8080, option 1
Professional Providers: 1-866-731-8080, option 2

InfoFax

Claims status and enrollment information: 1-800-891-1856

InfoFax Helpline: 1-800-985-2032

OASIS

Eligibility, benefits and status of claims: 1-800-462-7474 or 1-717-302-5125

Medicare

Medicare Part A Provider Inquiries: 1-800-488-0545
Medicare Part B Provider Inquiries: 1-800-488-0548
FreedomBlue Provider Service Center: 1-866-588-6967

For a complete list of Medicare Part A and Part B customer service lines, please visit www.highmarkmedicareservices.com

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Precertification Inquiries

What Region Am I?

In the Western Region Only, please call:
Healthcare Management Services via the Provider Line at 1-800-547-3627, Option *2*

In the Central Region Only, please call:
Healthcare Management Services at 1-866-731-8080

In Northeastern Pennsylvania Only, please call:
Blue Cross of Northeastern Pennsylvania at 1-800-638-0505

In Eastern Pennsylvania Only, please call:
Independence Blue Cross at 1-800-862-3648

Continued on next page

1.1 Telephone and Fax Numbers, Continued

Provider Information Management

What Region Am I?

Requests to change data about a practice, e.g., address, specialty, etc., must be in writing.

- In the Western, Central and Eastern Region: Fax written requests to 1-800-236-8641
- In the Northeastern PA Region: Fax written requests to 570-200-6880.

To follow-up on a requested change to practice information:

- In the Western, Central and Eastern PA Regions, please call 1-866-763-3224.
- In the Northeastern PA Region, please call 1-800-451-4447

To submit information to credential a provider for one of Highmark Blue Shield's networks:

- In the Western, Central and Eastern PA Regions: fax documents to 1-800-236-5907
- In the Northeastern PA Region: fax documents to 570-200-6890

Highmark-hosted NaviNet-enabled providers can update addresses, office hours, telephone numbers and other data via the NaviNet system.

Chapter 1

Provider Services and Information Sources

Unit 2: Highmark's Informational Resources

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1.2 A Variety of Information Sources

Highmark's Communication Process

Highmark Blue Shield is committed to providing timely and pertinent information about our policies and programs to the provider community. Highmark has a number of easy-to-use electronic sources of information accessible through your computer, telephone or fax machine.

What Region Am I?

A variety of informational sources are available for use including:

- Highmark's Provider Resource Centers
  - Central, Eastern and Northeastern Region Provider Resource Center
  - Western Region Provider Resource Center
- Highmark's Informational Member Web sites
  - Central, Eastern and Northeastern Region
  - Western Region
- Automated Inquiry Mechanisms, such as NaviNet, InfoFax, and OASIS (Office Assistance Information System)
- *Provider* Service representatives
- Provider Relations representatives
- Newsletters for professional offices: *Policy, Review and News (PRN), and Behind the Shield (in Central and Western Regions), FreedomBlue News* in the Northeastern Region
- Special mailings

The Provider Resource Center

What Region Am I?

The Provider Resource Center is a repository of pertinent reference materials. This special section of our Web site is specifically dedicated to providers and contains lots of helpful information and resources to help in your daily interactions with Highmark members and with Highmark. We encourage you to bookmark the site and take advantage of this convenient reference tool. Click the links below to access the Resource Center applicable to your region.

- Central, Eastern and Northeastern Region Provider Resource Center
- Western Region Provider Resource Center

The Resource Centers also contain information, including but not limited to:

- Current and Archived Newsletters, Recent Mailings
- Radiology Management Program
- BlueCard
- Clinical Reference Materials
- Quick Links To Provider Manuals
- The QualityBLUE Program
- Medical & Claim Payment Guidelines
- Pharmacy/Formulary Information
- EDI Services

Continued on next page

1.2 A Variety of Information Sources, Continued

Highmark's Informational Member Web Sites

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

What Region Am I?

Highmark has two region specific sites for member information.

- Central, Eastern and Northeastern Region Member Site
- Western Region Member Site

- Benefit Information – Highmark Individual Benefits and Highmark Group Benefits – provides information on Highmark's full-service health insurance programs. This information is included to assist your office in directing Highmark members when they have these types of questions. Benefit information can be found under the 'Members' section of Highmark's informational member sites.

- Locate a Pharmacy – this site allows members to find a pharmacy near their home. Pharmacy information can be found under the 'Find a Pharmacy' selection on Highmark's informational member sites.

Physician Information on Member Web Sites

Highmark's member sites also contain directories of information about each provider under the "Find a Provider" feature. The Highmark Provider Directory includes a fast, easy way for our members to find providers near their homes or their workplace.

If you determine that your information is inaccurate, please provide written notice to Highmark of the revision to be made. Please visit the Provider Information Management (formerly Provider Data Services) selection under Provider Forms on the Provider Resource Center to find the form titled, Directory Information Changes. Complete the form and either:

return via e-mail to: pimftupdates@highmark.com or

fax to: 1-800-236-8641

If Highmark agrees with the change the invalid information will be removed and replaced with the corrected update. Highmark will make every effort to process this request within twenty (20) business days after receipt of the notice. If Highmark disputes that there is an inaccuracy, it will notify the physician. The information will also be revised in our next printed edition.

1.2 Automated Inquiries

NaviNet[SM]

NaviNet[SM] is a free, Internet-based application for providers to streamline data exchanges between their offices and Highmark. NaviNet gives users real-time access to Highmark's membership, claims and provider and payment systems, making your job easier. NaviNet seamlessly integrates all insurer-provider transactions into one system, such as inquiries on referrals/authorizations, eligibility, benefits, claims status, claims investigations, codes, and provider/facility searches. NaviNet can also be used to submit authorization requests, recredentialing applications, and provider information changes. NaviNet-enabled providers are expected to use this tool for all routine eligibility, benefits and claim status inquiries.

Practices who have NaviNet in at least one office location must use NaviNet for routine inquiries that can easily be answered online. The expertise of the *Provider* Service staff will remain available for non-routine inquiries that require analysis and/or research.

Remember that NaviNet:

What Region Am I?

- is available from 5:00 a.m. through 12 midnight, Monday through Saturday, and from 5:00 a.m. through 5:00 p.m. on Sunday.
- eliminates waiting in a "call queue" (on hold).
- has no limits to the number of issues you can research online.
- presents information for *all* Highmark-supported product lines, including traditional indemnity, managed care, Medicare Advantage and the Federal Employee Program.
- presents the most current information on Highmark's systems. What you view on your screen is the same information Highmark staff views when they talk to you on the phone

If your staff requires training or a "refresher course" on how to use any of the NaviNet applications, please direct them to NaviNet's Customer Service Page (NaviNet Customer Care section). They'll find easy-to-use training modules called User Guides. Contact your Highmark Provider Relations representative should you have specific questions on the use of NaviNet in your practice.

NaviNet is the preferred Highmark tool for inquiring about member information; however, network providers who are not NaviNet enabled may use InfoFax and/or OASIS to obtain information about their Highmark patients.

If you are a provider who participates with Highmark and are interested or want more information about NaviNet, call your Highmark Provider Relations representative. You can also visit the NaviMedix Web site at www.navimedix.com.

Continued on next page

1.2 Automated Inquiries, Continued

What Region Am I?

InfoFax – *To Be Eliminated January 2009*

InfoFax is an option for your office to receive information on the status of claims, benefits, and enrollment through your fax machine. After entering the patient's information into the system via your touch-tone phone, the information is faxed to you within minutes of your request, *however this system will be eliminated effective January 23, 2009. It has been determined that its system limitations do not provide the most efficient ways for our providers to receive information and are not as current as many of our newer tools. Highmark encourages all providers to use NaviNet for convenient, accurate and timely information on eligibility and benefits, as well as claim status and a wide variety of other helpful information, including authorizations, claim investigations, medical policy, practice information updates and more. Providers who do not yet have access to NaviNet can continue to call the Provider Service Center for assistance, using the regional number appropriate for you.*

Western Region Provider Service: 1-800-547-3627
Central Pennsylvania, Lehigh Valley and Northeastern Pennsylvania: 1-866-731-8080
Southeastern Pennsylvania: 1-866-975-7290

InfoFax can be used to check enrollment and status of claims for patients enrolled in many programs including but not limited to:

- *adultBasic*
- *BlueCare PPO (formerly Access Care II*
- *CHIP*
- *Comprehensive/PremierBlue Shield*
- *Concurrent Processing (Eastern Region Only)*
- *FEP (Federal Employee Program)*
- *Medicare Supplemental**
- *Traditional Blue Shield/PremierBlue Shield*
- *Medicare Advantage HMO (Western Region Only)*
- *Individual Preferred-Provider Program (Western Region Only)*
- *EPOBlue*
- *FreedomBluePPO*
- *PPOBlue*
- *ClassicBlue*
- *DirectBlue*
- *Comprehensive*
- *SpecialCare*
- *Major Medical*

***Benefit information is currently available for Medicare Supplemental contracts only.** You must use the patient's HIC (Medicare ID #) for information regarding this program.

InfoFax is available from:

7:00 a.m. to 9:00 p.m. (Weekdays)
7:00 a.m. to 2:00 p.m. (Saturday)

Continued on next page

1.2 Automated Inquiries, Continued

How To Gain Access To InfoFax

Simply call 1-800-891-1856 and enter your fax number including area code when prompted. An authorization form will be sent to your fax machine. Complete the authorization form and fax it to 1-800-985-6275. Once authorized to use InfoFax, a User Guide with complete instructions will be faxed to you. This process takes approximately 24-48 hours to complete.

If you would like any additional information about InfoFax, please contact the InfoFax Helpline at 1-800-985-2032.

OASIS (Office Assistance Information System) – *To Be Eliminated January 2009*

OASIS is Highmark Blue Shield's automated voice-response system that gives you quick enrollment and claim status information, *however this system will be eliminated effective January 23, 2009. It has been determined that its system limitations do not provide the most efficient ways for our providers to receive information and are not as current as many of our newer tools. Highmark encourages all providers to use NaviNet for convenient, accurate and timely information on eligibility and benefits, as well as claim status and a wide variety of other helpful information, including authorizations, claim investigations, medical policy, practice information updates and more. Providers who do not yet have access to NaviNet can continue to call the Provider Service Center for assistance, using the regional number appropriate for you.*

Western Region Provider Service: 1-800-547-3627
Central Pennsylvania, Lehigh Valley and Northeastern Pennsylvania: 1-866-731-8080
Southeastern Pennsylvania: 1-866-975-7290

OASIS

The OASIS system allows you to access our data files through your touch-tone telephone. Because we have a toll-free number and extended hours, you can reduce administrative costs by calling OASIS. Any provider who has a valid Highmark Blue Shield provider number or National Provider Identifier (NPI) may call OASIS. When you call OASIS, the system leads you through the information-gathering process with pre-recorded messages. Press the buttons on your telephone to access desired information.

To access OASIS, call:
Toll-free: 1-800-462-7474
In the Harrisburg area: 1-717-302-5125

Hours of operation:
Weekdays: 7:00 a.m. to 9:00 p.m.
Weekends: 7:00 a.m. to 5:00 p.m.
NOTE: OASIS can not provide status of a claim to a network provider if the claim processed through BlueCard and the member's coverage is through a plan outside of Pennsylvania.

Continued on next page

1.2 Automated Inquiries, Continued

Elimination of OASIS Automated Benefit Option	Effective October 20, 2007, the OASIS automated benefits telephone option was eliminated. This change came as a result of the increased use of NaviNet's online eligibility and benefits claim selection and low usage of the automated option. This change only impacts the benefits portion of OASIS. OASIS can still be used for enrollment and claims status inquiries.
OASIS and InfoFax Accept NPI	Both OASIS and InfoFax accept National Provider Identifiers (NPIs) as long as the provider's NPI is on file with Highmark. Simply input your NPI when requesting information from each system.

1.2 *Provider* Service Representatives

***Provider* Service Representatives**

Provider Service representatives can provide information about Highmark Blue Shield programs and are available to answer questions concerning claims.

What Region Am I?

- *In the Western Region*, please contact the *Provider* service department at 1-800-294-9568. Hours of operation are 8:00 a.m. to 5:00 p.m. EST.
  - FreedomBlue *Provider* Service 1-866-588-6967
- *In the Central Region*, please contact the *Provider* Service department at 1-866-731-8080. Hours of operation are 9:00 a.m. to 12:00 noon and 1:00 p.m. to 4:30 p.m. EST.
  - FreedomBlue *PPO Provider* Service 1-866-588-6967
  - *FreedomBlue PFFS Provider Service 1-866-675-8635*
- In the Eastern Region, please contact the *Provider* Service department at 1-866-975-7290. Hours of operation are 9:00 a.m. to 12:00 noon and 1:00 p.m. to 4:30 p.m. EST.
- In the Northeastern Region, if your main office is located in one of the following counties: Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne, or Wyoming, please contact the *Provider* Service department for the following:
  - Traditional Participating Providers: 1-888-827-7117
  - BlueCare PPO *(formerly Access Care II)* and PremierBlue Shield providers: 1-866-262-5635
  - Hours of operation are 8:00 a.m. to 5:30 p.m. EST.

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

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

1.2 Provider Relations Representatives

Provider Relations Representatives

The Provider Relations Department at Highmark Blue Shield provides personalized administrative and operational support to health care providers who participate with Highmark. They accomplish this through interactive training, personal visits, telephone conversations and written communication. Your Provider Relations representative can assist you with:

- Initiating electronic connectivity/billing
- Training for your office staff
- Clarification of Highmark policies/procedures
- Resolving a trend in claims processing errors
- Assistance with the credentialing process
- Advocating for your interests at Highmark

Please do not call your Provider Relations representative with routine claim inquiries. Immediate answers to most inquiries can be found by using NaviNet, InfoFax and OASIS. Provider Relations representative are available to help when needs go beyond these common inquiries.

The Provider Relations representatives are available to speak at professional society meetings and hospital staff meetings to familiarize providers and their staff with Highmark Blue Shield policies and procedures. Information about Highmark Blue Shield's Provider Relations staff is available on the Provider Resource Center.

1.2 Provider Relations Representatives, Continued

New Office Assistant Training

Provider Relations representatives are available to conduct training sessions for new office assistants. In these sessions, new members of your office staff are introduced to Highmark Blue Shield's terminology, electronic billing and review of procedures. If you have questions about office assistant training, contact your Provider Relations representative.

How Do I Find My Provider Relations Representative?

What Region Am I?

Finding your Provider Relations Representative is quick and easy on the Provider Resource Center. From the Resource Center choose Provider Relations Representatives from the list. Then select the type of Provider Relations Representatives that are available to assist you: professional or facility.

In the Western Region, each page is driven by a ZIP code or Provider Number search function. Simply enter the required information and click the search button.

In the Central Region, you will be able to determine your Provider Relations Representative with the information provided. Please call the appropriate Provider Service phone number based on your county/region.

Information about Highmark Blue Shield's Provider Relations staff is also available on the Provider Relations Representative search page.

Blue Connections®/ Provider Meetings

Highmark Blue Shield periodically conducts informational and educational meetings called Blue Connections meetings for network providers and their office staffs.

When you receive an announcement about these meetings, please be sure to complete and return*/email* your reservation promptly to guarantee that you and/or your staff can attend.

Provider Relations representatives cover a variety of topics at these meetings, including:

- Current contract, policy and claim preparation information.
- Electronic claim submissions and communications.
- New Highmark Blue Shield programs

Continued on next page

1.2 Provider Service Representatives, Continued

Blue Connections/ Provider Meetings, continued

Topics covered during the meetings are included in a packet of reference materials given to each attendee.

Blue Connections meetings provide an opportunity for providers and their staffs to discuss areas of mutual interest and concern with each other and with their Provider Relations representative and other Highmark Blue Shield personnel. A portion of each meeting is set aside for questions and answers. You may submit written questions of a more complex nature or questions requiring follow-up at these meetings.

1.2 Mailings

Policy, Review and News (PRN)

One of the most important ways Highmark Blue Shield communicates with providers is through its bi-monthly publication, *PRN*. This newsletter is designed to:

- Inform providers and their staffs of new programs that Highmark Blue Shield plans to offer to its members.
- Alert providers and their staffs to changes in existing medical policy or the adoption of new policies.
- Provide billing information.
- Announce other items of interest, for example, changes to payment mechanisms.
- Announce changes to the terms and conditions of providers' contracts with Highmark Blue Shield.

PRN often contains information about group accounts in the provider's particular region of the state, plus information about group accounts that affect providers statewide.

PRN's content is tailored to the "nuts and bolts" issues every practice faces in its relationship with Highmark Blue Shield – how to submit claims accurately and quickly, what's new or changed in our procedures, coding and policy, and how you can accelerate the claims payment process.

It is important that all providers and their office assistants review *PRN*. This publication serves as one of Highmark Blue Shield's official notifications of new and revised policies and procedures.

We've designed *PRN* as a reference tool that you may want to keep in a three-ring binder. Each issue is three-hole punched and each year we provide an index.

Electronic Subscription of The PRN

Effective with the December 2007 issue of the PRN, you can subscribe for free electronic delivery. To receive an electronic copy of the PRN direct to your e-mail box, please visit the Provider Resource Center and select e-subscribe. Follow the steps to sign up and watch your e-mail box for confirmation. *On this page you may also sign up for several other options for e-subscriptions including the electronic Behind The Shield (for Western and Central Region providers).*

Highmark is offering this option not only to reduce paper waste but to improve efficiency and evolve with changing business practices. By subscribing to electronic delivery of the PRN, you'll always be in the know when it comes to the latest Highmark news. If you do not subscribe to electronic delivery of the PRN, you will continue to receive a paper PRN.

Continued on next page

1.2 Mailings, Continued

Electronic Subscription of The PRN, continued

The PRN is also available under Publications and Mailings on the Provider Resource Center through NaviNet or online at either of Highmark's Member Web sites.

We Welcome Your *PRN* Feedback!

We welcome your comments on *PRN*. If you have a question or comment, call your Provider Relations representative or write to the editor of *PRN* at:

Highmark Blue Shield
Editor, *PRN*
Medical Policy, SP - 3N
1800 Center Street
Camp Hill, PA 17011

Behind the Shield

Behind the Shield is a newsletter for practicing physicians and other professional providers to keep them informed of key developments and issues at Highmark Blue Shield.

What Region Am I?

NOTE TO WESTERN REGION PROVIDERS: As part of Highmark's continuing efforts to streamline the provider communications formats, as of January 2007, *Network Provider News* was renamed *Behind the Shield.*

Electronic Subscription of *Behind the Shield*

Effective with the July/August 2008 issue of the Behind the Shield, you can subscribe for free electronic delivery. To receive an electronic copy of Behind the Shield direct to your e-mail box, please visit the Provider Resource Center and select e-subscribe. Follow the steps to sign up for this electronic newsletter. This page also allows you to sign up for several other types of e-subscriptions including electronic delivery of the PRN.

By subscribing to electronic delivery of the Behind the Shield, you'll always be "in the know" when it comes to the latest Highmark news. At this time you will continue to receive a paper copy of Behind the Shield, however Highmark is working toward eliminating this paper mailing upon electronic subscription. Watch Plan Central and the Highmark Blue Shield Office Manual for updates.

Behind the Shield is also available under Publications and Mailings on the Provider Resource Center, accessible through NaviNet or online in the Provider section of Highmark's public Web site.

Continued on next page

1.2 Mailings, Continued

Special *Bulletins/* Mailings

In addition to our regular publications, Highmark Blue Shield uses special mailings to inform providers of changes in group benefits and changes to claims payment policies and procedures. Special mailings are used when we want to broadcast information quickly, when the information is too complicated or lengthy to include in *PRN* or when the information pertains to a limited group of providers.

Highmark Blue Shield also communicates updated information through brochures, fact sheets, or flyers included with checks and/or Explanation of Benefits and through Special Bulletins.

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

Our mailings and Special Bulletins can be found on our Provider Resource Center.

1.2 e-Subscribe

e-Subscribe
New!

The Provider Resource Center now has a link to even more free provider e-subscriptions available through Highmark Blue Shield. In addition to electronic delivery of the

- PRN

you may sign up for electronic delivery of:

- Behind the Shield,
- Provider Resource Center Updates, and
- Highmark Blue Shield Office Manual Updates

The new e-subscribe feature allows you to subscribe to various online publications and information updates. To subscribe to receive free e-mail notifications with current publications or information updates, complete the requested information and click on subscribe. If you select PRN, you will receive an e-mail notification to confirm your request and your paper mailing will be discontinued.

If you select Behind the Shield, you will continue to receive a paper copy of Behind the Shield, however, Highmark is working toward eliminating this paper mailing upon electronic subscription. Watch NaviNet's Plan Central and the Highmark Blue Shield Office Manual for updates.

Electronic copies of Behind the Shield and the PRN are also still available under Publications and Mailings on the Provider Resource Center through NaviNet or either of Highmark's Member Web sites.

The Highmark Blue Shield Office Manual is also available on the Provider Resource Center under Administrative Reference Materials.

Chapter 2

Provider Responsibilities

Unit 1: How To Participate in Highmark's Networks

In This Unit

Topic	See Page
Unit 1: How To Participate In Highmark's networks	
How To Obtain A Provider Number	2
How To Become A Traditional Participating Provider	4
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Assignment Accounts	7
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2.1 How to Obtain a Provider Number

Who Is An Eligible Provider?

Highmark Blue Shield pays claims for services performed by licensed, eligible health service providers, as defined by state law. These providers include:

- Doctor of Medicine;
- Doctor of Osteopathy;
- Doctor of Dental Surgery;
- Doctor of Podiatry;
- Doctor of Optometry;
- Doctor of Chiropractic;
- Nurse midwives;
- Licensed physical therapist;
- Independent clinical laboratories;
- Licensed psychologist;
- Certain certified registered nurses;
- Licensed audiologist;
- Licensed speech-language pathologist; and
- Licensed teachers of persons who are hearing impaired

NOTE: All providers who submit claims electronically must obtain an individual National Provider Identifier (NPI) number from The National Plan and provider Enumeration System (NPPES) at https://nppes.cms.hhs.gov by May 23, 2007. After May 23, 2007 no payments can be made to you, or your patient, for eligible services until you have secured an NPI. Note: Highmark plans to use the NPI as the identifier for all providers eligible to receive one, regardless of electronic status.

How To Obtain An Individual Provider Identification Number From Highmark Blue Shield

What Region Am I?

In the Western, Central and Eastern Regions Only:
To be registered on Highmark Blue Shield's file, you must obtain an individual Highmark provider ID. The Provider Application can be found on the Provider Resource Center by hovering over Provider Application and clicking the Provider Application link.

In the Northeastern Region Only:
For a Northeastern Region Provider Application please contact Provider Relations at 1-800-451-4447.

Mailing Addresses for Applications

What Region Am I?

Provider Applications can be submitted to:

In the Central, Eastern, & Western Regions:
Highmark Blue Shield
Provider Information Management
P.O. Box 898842
Camp Hill, PA 17089-8842

Continued on next page

2.1 How to Obtain a Provider Number, Continued

Mailing Addresses for Applications, continued

In the Northeastern Region:
Blue Cross of Northeastern Pennsylvania (BCNEPA)
Attn: Provider Relations
19 North Main Street
Wilkes-Barre, PA 18711

After reviewing and approving your application, Highmark or BCNEPA (where applicable) will establish a provider identification number for your practice and notify you of that number in writing.

If You Already Have An NPI Number

If you already have a National Provider Identifier (NPI) number this will be used as your individual Highmark number. The individual NPI number will replace the individual Highmark number after May 23, 2007.

Please see the end of this unit for more information on how to apply for an NPI number.

2.1 How To Become A Traditional Participating Provider

Overview

Highmark Blue Shield has agreements with thousands of Participating Providers – eight out of ten in the state – representing every major discipline.

How To Become A Traditional Participating Provider

Complete a Participating Provider agreement and send the agreement with a copy of your current Pennsylvania license to:

Western, Central, and Eastern PA
Highmark Blue Shield
Provider Information Management
PO Box 898842
Camp Hill, PA 17089-8842

Northeastern PA
Blue Cross of Northeastern PA (BCNEPA)
Attn: Provider Relations
19 North Main Street
Wilkes-Barre, PA 18711

Look at the form titled Participating Provider Agreement on the Provider Resource Center by hovering over Provider Forms, clicking on Provider Information Management Forms to see the Participating Provider Agreement. Regulations for Participating Providers includes the rules and regulations of participation as well as bylaws of Highmark Inc. After the agreement is processed, you will be notified in writing of the effective date of your participation.

How To Resign From The Traditional Participating Provider Network

To resign from participation with the Participating Provider Agreement Network, send a signed, written request to Highmark Blue Shield's Provider Information Management department at one of the addresses above. A resignation may be submitted at any time. It is effective thirty (30) days after receipt by Provider Information Management. A letter will be sent to you advising you of the effective date of your resignation.

For Northeastern Region Only:
If you are a provider with a main office located in one of the following counties in the Northeastern Region (Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Susquehanna, Tioga, Wayne, or Wyoming), please fax a signed, written request to Blue Cross of Northeastern Pennsylvania's Provider Relations Department at 1-570-200-6880.

For More Information On Becoming A Traditional Participating Provider

For more information about how to become a Participating Provider, please contact your region's Provider Line:

What Region Am I?

Western Region: 1-*866-763-3224*
Central Region: 1-*866-731-8080*
Eastern Region: 1-866-362-6116
Northeastern Region: 1-800-451-4447

2.1 How To Become A PremierBlue Shield Provider

Overview

PremierBlue Shield is Highmark Blue Shield's statewide, selectively contracted preferred provider network that was implemented in January 1994. The network services various statewide products, as well as the national BlueCard PPO program.

Please see Chapter 2, Unit 2, of the Highmark Blue Shield Office Manual titled, PremierBlue Shield Network Procedures, for more information about the PremierBlue Shield network.

How To Become A PremierBlue Shield Provider

For Western, Central and Eastern PA Providers:

If you are a Primary Care Physician (PCP) – Family Practice, General Practice, Internal medicine or Pediatrics), please complete PremierBlue Shield Preferred Provider Agreement for Primary Care Physicians in Managed Care Programs (PCPs) based on your area of expertise.

If you are a Specialist, please complete the PremierBlue Shield Preferred Provider Agreement (Specialists)

If your specialty is Family Practice, Internal Medicine, or Pediatrics and you want to be recognized as both a PCP and a Specialist, please complete both forms noted above.

These forms are located on the Provider Resource Center under Provider Application. After hovering over Provider Application, drag to Provider Application and select the proper form from the list.

Northeastern PA:
To obtain a provider application, call 1-800-451-4447.
The PremierBlue Shield selection criteria includes:

- Unrestricted licensing in the state in which you practice
- DEA certificate (if applicable)
- Medical Education and Training (initial credentialing)
- Board certification (if applicable)
- History of liability claims
- Malpractice coverage amounts
- Work history (initial credentialing)
- Medicare participating status (if applicable)
- National Practitioner Data Bank (NPDB)
- Office of the Inspector General Medicare and Medicaid sanctions list
- National Provider Identifier (NPI) number

Continued on next page

2.1 How To Become A PremierBlue Shield Provider, Continued

How To Become A PremierBlue Shield Provider, continued

After careful review of your application, Highmark Blue Shield will advise you in writing of your acceptance or non-acceptance into the PremierBlue Shield network. A formal appeals process is available to any provider whose application is not accepted. This information is detailed in the communication you will receive.

For more information about the application process or for an application package, please visit the Provider Resource Center and select Provider Application or contact your Provider Relations representative.

How To Resign From PremierBlue Shield

To resign from participation with PremierBlue Shield, send a signed, written request to Highmark Blue Shield's Provider Information Management department at one of the addresses listed below. A resignation may be submitted at any time.

It is effective 60 days after receipt by Provider Information Management. A letter will be sent to you advising you of the effective date of your resignation.

Western, Central, and Eastern PA
Highmark Blue Shield
Provider Information Management
P.O. Box 898842
Camp Hill, PA 17089-8842

Northeastern PA
Blue Cross of Northeastern PA (BCNEPA)
Attn: Provider Relations
19 North Main Street
Wilkes-Barre, PA 18711

2.1 Assignment Accounts

Overview

An Assignment Account (AA) is established by Highmark Blue Shield to permit practices of one or more individual providers to direct Highmark Blue Shield payments to an entity other than the individual provider.

All members of an AA must participate in a Highmark Blue Shield Provider Network in order for the AA to be recognized as participating in that network. Any AA member not participating in the network must complete the proper agreement(s) with Highmark Blue Shield in order to be added to an existing AA.

How To Establish An Assignment Account

To establish an assignment account, the following conditions must be met:

1. The billing entity must be arranged in one of these manners:
   - **Incorporated solo practitioner** – An incorporated solo practitioner who desires to have the corporation recognized as the entity or to use a tax identification number (TIN) to receive payment from Highmark Blue Shield.
   - **Group practice** – Two or more providers practicing as a group may establish an assignment account to have the group recognized as a single entity for purposes of billing and payment. Examples of a typical group practice arrangement are:
     - Two or more providers practice as a partnership;
     - A group of providers form a professional corporation and the corporation becomes the employer of the providers;
     - A provider employs one or more other providers as associates in his or her practice.

2*. a. All members of the group must be a professional provider designated as an M.D. or D.O

OR

b. All members of the group must be of the same degree (i.e. D.C., P.T., O.T.)

3. All members of the group must be either participating or non-participating in the Highmark Blue Shield network(s) in which the group practices.

*Exceptions apply in the Medicare Advantage networks for M.D. and D.O. groups only.

Continued on next page

2.1 Assignment Accounts, Continued

What Region Am I?

AA Forms Available Through Provider Information Management

To establish an assignment account, complete the form 'Request for an Assignment Account'. The request form can be found on the Provider Resource Center by hovering over Provider Forms, then dragging to Provider Information Management Forms and clicking Assignment Account Paperwork. Return completed forms for processing to:

Western, Central, and Eastern PA
Highmark Blue Shield
Provider Information Management
P.O. Box 898842
Camp Hill, PA 17089-8842

Northeastern PA
Blue Cross of Northeastern PA (BCNEPA)
Provider System Support
19 North Main Street
Wilkes-Barre, PA 18711
Or Fax to: 570-200-6880

To establish a Medicare assignment account, call Medicare Provider Enrollment Services at 1-866-488-0549.

To Make Changes To Your Assignment Account

***For Western, Central & Eastern Region Providers*:** Send notification of changes in writing to:
Highmark Blue Shield
Provider Information Management
P.O. Box 898842
Camp Hill, PA 17089-8842

***For Northeastern Region Providers*:** Send notification of changes in writing to:
Blue Cross of Northeastern Pennsylvania (BCNEPA)
Attn: Provider System Support
19 North Main Street
Wilkes-Barre, PA 18711

Keep AA Information Up To Date

Please inform Highmark Blue Shield of any changes to your assignment account. Failure to keep this data current may lead to incorrect listing in directories viewed by Highmark members, missed mailings or checks, and, possibly, incorrect payments. When any of the following information changes, please notify Highmark Blue Shield immediately:

- Hours of Operation
- Practice address (physical location)
- Mailing address if different from practice address
- Specialty (needs signatures of AA members if you are changing their individual specialties as well)
- Tax Identification Number (TIN)

Continued on next page

2.1 Assignment Accounts, Continued

Keep AA Information Up To Date, continued

- Additions/deletions of AA members
- Telephone number, including area code (member access telephone number)
- Fax Number

***For Western, Central & Eastern Region Providers*:**
Send notification of changes by using the Provider Information Change function in NaviNet or in writing to:

Highmark Blue Shield
Provider Information Management
P.O. Box 898842
Camp Hill, PA 17089-8842

***For Northeastern Region Providers*:** Send notification of changes only in writing to: Blue Cross of Northeastern Pennsylvania (BCNEPA)
Attn: Provider System Support
19 North Main Street
Wilkes-Barre, PA 18711

When A Provider Leaves Or Joins An AA

You should notify Highmark Blue Shield's Provider Information Management or Blue Cross of Northeastern Pennsylvania's Provider System Support *within 30 days* when an existing provider leaves your assignment account or when a new provider joins the account. The appropriate form can be found on the Provider Resource Center under Provider Forms. Click on the form 'Request for Addition/Deletion to existing assignment account' to report the change.

Highmark Blue Shield's Provider Information Management or Blue Cross of Northeastern Pennsylvania's Provider System Support will send written notification to the members of the assignment account who are leaving, to advise them of the transfer of profiles to their individual provider number. Please be sure to notify Highmark Blue Shield of a departing provider's new address and tax identification number – an employer identification number or Social Security Number, as appropriate. If you notify us that there are no providers left in the account, we will send you written notification of the cancellation date of the entire account.

Restrictions

Highmark has the right to deny a request to add to or delete any practitioner from an Assignment Account. Highmark will always deny such a request when a utilization case is open that is pending resolution.

2.1 Non-network Provider Payment Guidelines

Overview

Non-network providers do not sign an agreement with Highmark Blue Shield. Therefore, they have no contractual obligation to accept Highmark Blue Shield's allowances as payment-in-full. However, non-network providers are required to accurately report services performed and fees charged.

Highmark Blue Shield sends payment for covered services performed by non-network providers directly to the member who is responsible for reimbursing the non-network provider. Non-network providers do not receive Explanation of Benefits (EOB) statements.

2.1 How to Obtain an NPI

How to Obtain An NPI

Although May 23, 2007 was the official deadline for HIPAA-covered entities to obtain and begin using NPIs on electronic transactions, Highmark still encourages you to obtain an NPI now if you haven't already done so. Highmark also encourages you to then begin including your NPI on all electronic transactions as soon as possible to ensure seamless transactions.

Health care providers can apply for NPIs in one of three ways:

- Complete the Web-based application process online at: https://nppes.cms.hhs.gov.
- Download and complete a paper application from the NPPES Web site, and mail it to NPPES.
- Call NPPES at: 1-800-465-3203 (TTY: 1-800-692-2326) for a paper application.

For more information about the NPI, visit the National Provider Identifier page on the Resource Center. This page is conveniently located under the *HIPAA* link.

How To Notify Highmark Of Your New NPI

Once you receive your NPI, please report this new number to Highmark, by forwarding a copy of your NPPES confirmation e-mail to Highmark via Fax, e-mail, or U.S. Mail. Please be sure to include your name, Highmark provider number, and the NPI associated with that Highmark provider number on any submission.

You may also complete our NPI Submission Form and return it to Highmark via Fax to U.S Mail.

Fax: 1-800-236-8641
E-mail: **PDSNPIUpdate@highmark.com**
U.S. Mail: Provider Information Management
P.O. Box 898842
Camp Hill, PA 17089-8842

Chapter 2

Provider Responsibilities

Unit 2: PremierBlue Shield Network Procedures

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2.2 PremierBlue Shield Network Procedures

Introduction

This section explains our procedures for managing the PremierBlue Shield network. Where this network is utilized to support managed care products, Highmark Blue Shield must credential and utilize procedures to comply with National Committee for Quality Assurance (NCQA), the Centers for Medicare and Medicaid Services (CMS), and Pennsylvania Department of Health regulations.

Practitioner Credentialing/ Recredentialing

Highmark Blue Shield staff follows an established process to credential providers for the PremierBlue Shield network. In addition, we have delegated credentialing arrangements with a limited number of institutions that we have audited to assess their compliance with our credentialing standards.

Providers are initially credentialed prior to network admission and recredentialed every three years for the Western, Central and Northeastern Regions. Highmark Blue Shield and BCNEPA conducts verification of the practitioners as defined by its policies, state and federal regulations and in accordance with accrediting standards. The initial credentialing process includes:

- Completion of an application
- Signed attestation verifying all information on the application and stating any reasons for inability to perform essential duties, lack of illegal drug use, loss of license/privileges, felony and disciplinary action
- Primary source verification
- Inquiry to National Practitioner Data Bank for sanction history
- Other verification as needed
- Results of onsite reviews for primary care physicians and ob/gyns and high-volume behavioral health providers

The recredentialing process includes the same components as initial credentialing with the exception of an onsite review that is conducted during the initial process and/or as needed. At the time of recredentialing a review of quality information which includes, when available, member satisfaction, member complaints related to both administrative and quality of care issues, malpractice history, medical record reviews, office site review information, and information regarding clinical quality actions or sanction activity will be considered for continued network participation.

2.2 Network Responsibilities for PCPs

PCP Responsibilities

Responsibilities specific to PCPs include but are not limited to:

- *Office visits*
- *Inpatient hospital, emergency room, skilled nursing and home visits*
- *Routine pediatric and adult immunizations*
- *Maintenance allergy injections*
- *Routine diagnostic procedures*

- *Minor surgeries performed in office*
- *Lab services performed in office*
- *Preventive and early detection interventions*
- *Most acute and chronic services*
- *Other services as necessary*

- *Maintaining organized medical record-keeping practices and ensuring accurate medical records*
- *Maintaining active staff privileges at a minimum of one Highmark-or western region network-contracted hospital*
- *Providing 24-hour telephone availability year-round*
- *Providing physician coverage at all times*
- *Obtaining authorization for DME and other care*

- *Informing Medicare Advantage members about advance directives.*
- *Cooperating with Highmark and the western region quality management programs to the extent permitted by federal and state law including, but not limited to the following:*
    - *Clinical initiatives*
    - *Condition management and shared decision-making*
    - *Credentialing*
    - *Clinical studies*
    - *Health Plan Employer Data and Information Set (HEDIS)*
    - *Providing access to members' medical records*
    - *Risk Adjustment Data Verification (RADV)*

Note: *Routine adult and pediatric physicals and pediatric immunizations must be performed by the member's PCP, if applicable, to receive coverage.*

2.2 Preventive Care Responsibilities For Network Physicians

Overview

Highmark Blue Shield network physicians have a unique opportunity to recommend or administer certain services and lifestyle improvements that can prevent future illness or injury. Highmark Blue Shield charges its primary care physicians and specialists with promoting and helping to maintain the health of members, through the preventive services noted below.

Primary Care Physician Responsibilities

- Administer *required* childhood and adolescent immunizations
- Administer *all recommended immunizations, i.e.* influenza and pneumococcal vaccines to at-risk and age-appropriate members
- Provide timely and comprehensive well-care exams

Primary Care Physician And Ob/Gyn Responsibilities

- *Provide or recommend screening mammograms, cervical cancer screenings, and chlamydia screenings. A member can self-refer for her annual mammogram; but she should be encouraged to consult her primary care physician or ob/gyn for help with coordination of care*
- *Provide or recommend age/risk-appropriate colorectal cancer screenings*
- *Provide or recommend prenatal care, especially in the first trimester*
- *Provide or recommend post-partum exams by the 42nd day after delivery*
- *Provide appropriate counseling to women for menopause and domestic violence*

Primary Care Physician And Specialist Responsibilities

- *Provide obesity screening, prescribe appropriate screening labs and recommend nutritional and exercise counseling*
- *Prescribe and monitor ongoing beta-blocker treatment after heart attack (unless contraindicated).*
- *Advise smokers to quit and refer members to smoking cessation support programs*
- *Recommend the Dr. Dean Ornish Program for Reversing Heart Disease to members who could benefit from participating in the program (nine(I don't know the number of locations – check with Prev. Health Services) locations in the Western Region)*
- *Provide or recommend adequate care for diabetics, including lab testing, foot and eye exams*
- *When appropriate, refer members to disease management programs including heart failure, diabetes, chronic obstructive pulmonary disease and asthma*
- *Provide appropriate and comprehensive care for members with hypertension*
- *Prescribe and monitor appropriate medication for members with asthma*
- *Assess member medications for contraindications, drug-drug interactions and avoidance of potentially harmful medications in the elderly.*

What Region Am I?

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2.2 Preventive Care Responsibilities For Network Physicians, Continued

Primary Care Physician And Specialist Responsibilities (continued)

Network providers should submit accurate claims and document their preventive care services and recommendations in the member's chart. If performed by a specialist, the interventions, dates they were performed, and their results should be communicated in writing to the primary care physician. Likewise, information about such interventions performed by the primary care physician should be communicated to a specialist when the information is pertinent to the condition the specialist is treating.

2.2 Obstetrical And Gynecological Services

Ob/Gyn Network Participation

Obstetricians and gynecologists in the PremierBlue Shield network play a very important role by providing health care to our female members. Network ob/gyns are paid fee-for-service. Women have direct access to any network ob/gyn for their healthcare needs.

Communication Procedure

Direct access enables members to have contact with their ob/gyns without going through their primary care physicians. While this enhances member satisfaction, communication between ob/gyns and primary care physicians is still vital, especially when routine annual gynecological exams and mammograms are provided.

The following should be faxed or mailed within 30 days to the member's primary care physician for each office visit:

- Clinical findings
- Test results
- Treatment plans
- A summary report at the conclusion of the treatment period
- Acceptable formats include typed letters, physician forms and progress notes

Direct Access

Direct access to women's health care means that no members in need of gynecological or obstetrical services need to obtain referrals from their primary care physicians.

Direct access offers the following advantages for members seeing a credentialed network ob/gyn:

- No referral for annual routine gynecological exam
- No referral for sick visits
- No referral for follow-up care
- No referral for maternity services

Direct access does not extend to services provided by ob/gyn residents or to gynecological services provided in a hospital clinic setting.

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2.2 Obstetrical And Gynecological Services, Continued

Ob/Gyn Referrals	If an ob/gyn sees a member and determines that the member may need the services of another specialty practitioner, the ob/gyn should recommend that the member return to their primary care physician. Ob/gyns are not authorized to refer members to other specialty practitioners. If a member requests a visit for symptoms that do not appear to be gynecological in nature, the ob/gyn should refer the member back to her primary care physician.
Mammography Screening vs. Diagnostic Mammography	A screening mammogram is an ordinary check-up intended to detect any problems. A diagnostic mammogram is a test intended to follow-up on a confirmed or suspected irregularity or diagnosis. A prescription is all that is required for mammograms.

2.2 Availability and Accessibility Of Network Practitioners

Availability Of Network Practitioners

Network evaluations are performed annually on the number and geographic distribution of the provider network in relationship to the location of its members.

In addition, Highmark Blue Shield takes into consideration the special and cultural needs of members in maintaining its network of providers.

Accessibility

Health Plan members are expected to receive an appointment with a qualified primary care/specialty practitioner based on the following time standards:

PRIMARY CARE PRACTITIONER AND MEDICAL SPECIALIST STANDARDS		
Patient's Need	Definition	Performance Standard
Emergency/life threatening care	An emergency medical condition (as defined by the Balanced Budget Act [BBA] of 1997) is: A condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part	Immediate response
Urgent care appointments (e.g., high fever, persistent vomiting/ diarrhea)	An urgently needed service is a medical condition that requires rapid clinical intervention as a result of an unforeseen illness, injury, or condition	Within 1 day Within 24 hours--HHIC only

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2.2 Availability and Accessibility Of Network Practitioners,
Continued

Accessibility, continued

PRIMARY CARE PRACTITIONER AND MEDICAL SPECIALIST STANDARDS		
Patient's Need	**Definition**	**Performance Standard**
Regular and routine care appointments	• Non-urgent but in need of attention appointment (e.g. headache, cold, cough, rash, joint/muscle pain, etc.) • Routine wellness appointments (e.g., asymptomatic/ preventive care, well child/patient exams, physical exams, etc.)	• Within 2-7 days • Within 7 days—HHIC only • Within 30 days
After-hours care	Access to practitioners after the practice's regular business hours	Practitioners are expected to return calls within 30 minutes
Telephone service	Refer to separate Member Services policy titled: Telephone Standards	
In-office waiting time	Practitioners are encouraged to see patients with scheduled appointments within 15 minutes of their scheduled appointment time. A reasonable attempt should be made to notify patients of delays.	Within 15 minutes Within 60 minutes—HHIC only
Number of patients seen per hour (PCPs and OB/GYNs)	Practitioners are encouraged to schedule no more than six (6) patients per hour.	No more than six (6) patients per hour
Open office hours (PCPs only)	The minimum number of hours that a PCP practice or coverage is available to see and treat members	Minimum of 20 hours per week at each practice site. Minimum of 16 office hours per week—HHIC only

2.2 Availability and Accessibility Of Network Practitioners,
Continued

Behavioral Health Care Providers

Health Plan members are expected to receive an appointment with a qualified Behavioral Health Practitioner within the following time standards:

Patient's Need	Definition	Performance Standard
Care for a life-threatening emergency	Immediate intervention is required to prevent death or serious harm to patient or others.	Immediate response
Care for a non-life-threatening emergency	Rapid intervention is required to prevent acute deterioration of the patient's clinical state that compromises patient safety.	Within 6 hours
Urgent care	Timely evaluation is needed to prevent deterioration of the patient's condition.	Within 48 hours
An appointment for a routine office visit	Patient's condition is considered to be stable	Within 10 business days
Telephone access to behavioral health screening and triage	Callers reach a non-recorded voice within 30 seconds and abandonment rates do not exceed 5% at any given time	• Callers reach a non-recorded voice (operator) within 30 seconds • Hang-up rates do not exceed 5%

2.2 Primary Care/Specialist Essentials

Basics for Primary Care Physicians

Primary care physicians in the PremierBlue Shield network play an important role in managing all aspects of health care for members who select their practice. The information below serves as an introduction to the roles and responsibilities of the primary care physician. Primary care physicians in the PremierBlue Shield network are paid fee-for-service.

Basics For Specialists

Specialists in the PremierBlue Shield network play the important role of providing specialty services to members. Network specialists are paid fee-for-service.

Advising Members Of Treatment Options Policy

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

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

Highmark's network contract for all products does not (and never did) contain such a "gag clause" relating to treatment advice, and complies with Pennsylvania Act 68 requirements.

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

Voluntary Or Involuntary Specialist Termination From the Network

In the event of the voluntary or involuntary termination of the PremierBlue Shield Preferred Provider Agreement, the specialist/specialty group must cooperate with Highmark Blue Shield in its obtaining information regarding those members enrolled in DirectBlue products that may be affected by such termination because they are undergoing an ongoing course of treatment or are otherwise active patients of the specialist/specialty group. Such information includes the name, address, and identification number of affected DirectBlue members. This information must be provided timely so that affected members may be notified prior to the effective date of the termination. Highmark Blue Shield has a process in place to notify these members, as obligated by state regulation and federal law.

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2.2 Primary Care/Specialist Essentials, Continued

How Members Select A Primary Care Physician

Members may be asked to choose a primary care physician at the time of enrollment. DirectBlue members who have the option to select a primary care physician, may select any network primary care physician listed in the provider directory they receive at enrollment, as long as the following conditions are met:

- The primary care physician practice is open to new members.
- The member fits into the primary care physician's patient age range as specified by specialty, e.g., pediatrics.

DirectBlue members may switch primary care physicians at any point after enrollment, upon notification to Highmark Blue Shield.

There are no administrative requirements for primary care physicians associated with PPOBlue. Therefore, PPOBlue members may select or switch PremierBlue Shield primary care physicians as they choose without notifying Highmark Blue Shield.

Responsibilities Specific To Primary Care Physicians

- Office visits
- Inpatient hospital, emergency room, skilled nursing and home visits
- Routine pediatric and adult immunizations
- Maintenance allergy injections
- Routine diagnostic procedures
- Minor surgeries performed in office
- Lab services performed in office
- Preventive and early detection interventions
- Most acute and chronic services
- Other services as necessary
- Coordinating specialty care services
- Keeping accurate medical records
- Maintaining active staff privileges at a minimum of one Highmark Blue Shield-contracted hospital
- Providing 24-hour telephone availability year-round
- Providing physician coverage at all times
- Directing members to network providers when specialty care is required
- Cooperating with Highmark Blue Shield's quality improvement programs to the extent permitted by federal and state law including, but not limited to the following:
    - Clinical initiatives
    - Disease management programs
    - Credentialing
    - Clinical studies
- Providing access to members' medical records

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2.2 Primary Care/Specialist Essentials, Continued

Communication Procedure

PremierBlue Shield network primary care physicians and specialists, including medical, surgical and behavioral health must communicate with one another in order to assure continuity and coordination of care for members. Following is the communication procedure:

- Before the member's visit to the specialist, the primary care physician must provide relevant clinical information to the specialist. Acceptable forms of communication are formal letter, referral form and/or copies of relevant portions of the patient's medical chart. Referrals are not required for behavioral health services.

- Within 10 business days of the first visit, the specialist must provide the primary care physician with information about his or her visit with the member. Acceptable methods of communication are the standardized form, formal letter and/or copies of relevant portions of the patient's medical chart.

- In the case of behavioral health, member's consent is needed for the behavioral health specialist to release information to the primary care physician. If a patient refuses to give consent, the behavioral health specialist must document this refusal in the patient's behavioral health treatment record.

- The primary care physician must document his or her review of the reports, labs, X-rays and other diagnostic tests received from the specialist or health care facility in the patient's chart. The primary care physician must also indicate any subsequent action necessary. To indicate that he or she has reviewed the information, the primary care physician should initial each page.

Neither primary care physicians nor specialists should ask members to communicate findings, reports, lab results, etc. to another provider.

Compliance Monitoring

Where the network supports managed care products, Highmark Blue Shield will monitor compliance of the communication procedure as part of the medical record review program. During medical record review, representatives will check for the provider's initials on the patient's chart and ensure that any necessary follow-up actions are addressed. The goal is to ensure the exchange of information in an effective, timely and confidential manner to promote appropriate diagnosis, treatment, and referral for members.

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2.2 Primary Care/Specialist Essentials, Continued

Organizational Provider Communication

Highmark Blue Shield network organizational providers, such as hospitals, emergency facilities, ambulatory surgery centers, home health agencies, and skilled nursing facilities must promote continuity and coordination of care for network members by communicating with primary care physicians when care is delivered to their patients. Primary care physicians should expect a written description of the care given to their patients any time services have been rendered by these providers.

2.2 Credentialing and Recredentialing: An Overview

Introduction To Credentialing

To be considered a participating practitioner and support the Highmark Blue Shield managed care products, all new practitioners must be approved by the PremierBlue Shield Credentials Committee and sign a contract.

A contract is only issued to new practitioners after they have been approved by the PremierBlue Shield Credentials Committee. Therefore, your participation and ability to treat Highmark members does not begin until you have signed and returned the contract and the contract has been executed by Highmark. A welcome letter that specifies the effective date of your participation will be sent to you, along with a copy of the executed contract. NaviNet-enabled practitioners who are seeking recredentialing must obtain a username and password from NaviMedix and complete their application online.

Introduction To Recredentialing

At least once every three years, Highmark completes the recredentialing process with any applicable physicians and any applicable allied health professionals in our managed care network. Our internal policies require recredentialing for the protection of our members. Additionally, the recredentialing program adheres to NCQA guidelines and helps us to meet CMS and Pennsylvania Department of Health requirements.

Purpose

The credentialing and recredentialing processes are performed by Highmark employees who work cooperatively with network practitioners to ensure that they meet credentialing and recredentialing standards.

Credentialing And Recredentialing Status

To learn the status of your credentialing application, call 1-866-763-3224.

2.2 PremierBlue Shield Network Credentialing Policy

Policy

PremierBlue Shield network physicians and any applicable allied health professionals must be credentialed by Highmark.

Malpractice Information

Credentialing representatives may ask detailed questions regarding malpractice cases. If physicians do not submit the requested information, they could be denied from the network(s). In order to receive an accurate score, please submit the requested information regarding malpractice.

Confidentiality

All practitioner information obtained in the credentialing process, except as otherwise provided by law, is kept confidential.

When Must Practitioners Be Credentialed?

If the practitioner is...	*and is...*	*then the practitioner...*
Completely new, has never been credentialed	*Beginning to practice solo in the network area*	*Must be credentialed.*
	Beginning to practice with an established network practice	
Established, has already been credentialed	*Joining another established network practice in a different geographic area within six months*	*Has already completed the credentialing process and will be recredentialed every three years.*
	Joining another established network practice in the same geographic area within six months	
	Leaving a group practice to begin a solo practice	

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2.2 PremierBlue Shield Network Credentialing Policy, Continued

Practitioners Returning To The PremierBlue Shield	*In situations where a practitioner submits a signed, explicit document stating that he/she no longer wishes to be a PremierBlue Shield participating practitioner and there is a break in service/contract of greater than 30 days, the practitioner will be required to undergo initial credentialing if he/she subsequently wishes to return to the network.*
Special Edition Behind The Shield	*Every year, Highmark publishes a Special Edition Behind The Shield that includes the most recent information about credentialing and recredentialing requirements. The latest credentialing special edition and past issues can always be found in the Provider Resource Center under Publications & Mailings.*

2.2 Practitioners' Credentialing Rights

Policy

Physicians who are applying to the PremierBlue Shield network have the right to review information submitted in support of their credentialing application.

Right To Review Information

Physicians who apply to the network have the right to review any information that we receive from outside primary sources during the credentialing process.

The following primary sources may be contacted as part of the credentialing process:

- *State Licensing Bureau*
- *Drug Enforcement Agency*
- *Educational program(s) the practitioner completed*
- *American Board of Medical Specialties, if applicable*
- *National Practitioner Data Bank*
- *Office of the Inspector General participation/sanction data*
- *Federation of Chiropractic Licensing Board, if applicable*
- *Federation of Podiatric Medical Board, if applicable*
- *American Osteopathic Association*
- *Other recognized board certification agencies*

How Practices Can Review Information

In cases where Highmark Credentialing Department representatives receive information from other sources that vary substantially from that provided by the practitioner to the extent that it would jeopardize the physician's admission to the network, a representative will contact the physician in writing.

Alternatively, the practitioner may specifically request that the information submitted by other sources be sent to him or her unless disclosure is prohibited by law. To do so, the practitioner must submit a written request to Highmark within 30 days of submitting an application. The practitioner must specify which information he or she would like to review and send the request to:

Attn: Credentialing Manager
Suite P4501
P.O. Box 1040
Pittsburgh, PA 15222

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2.2 Practitioners' Credentialing Rights, Continued

Right To Revise Inaccurate Information	*During the credentialing process, practitioners also have the right to correct any inaccurate or erroneous information we receive from another source if it varies substantially from the information provided by the practitioner.*
How Practitioners Can Revise Inaccurate Information	*Directions as to how to revise information will be sent with the notification of the conflicting information.*
NaviNet Makes Credentialing And Recredentialing Easy!	*NaviNet's Recredentialing Transaction makes it easier for practitioners with Highmark-hosted NaviNet access to save time by completing the recredentialing application online. NaviNet notifies you that your recredentialing application is due. The notice will include an electronic recredentialing application form that is pre-populated with the information Highmark already has on file.* *If you are not NaviNet enabled, please contact your Provider Relations Representative.*

2.2 Credentialing Process

Steps For Credentialing Using NaviNet

Step	Action
1	*Log in to NaviNet. Click on Provider File Management.*
2	*From the selection list, choose Initial Credentialing.*
3	*From the Drop Down List, choose the provider you would like apply for.*
4	*Click 'New Credentialing Application.'*
5	*Add all requested information to the application and click submit.*

Steps For Credentialing Non-NaviNet Enabled Providers

The process for credentialing new providers and recredentialing existing network providers is essentially the same. Network practitioners must be credentialed at least every three years.

Stage	Description
1	*A practice either visits the Provider Resource Center online or calls 1-866-763-3224 and requests an application. If the practice submits electronically, proceed to step 3. If the practice submits on paper, proceed to step 2.*
2	*A Credentialing Department representative mails an application packet to the practice.*
3	*The practice completes the application, electronic or otherwise, attaches all applicable documentation, and returns it to the credentialing address indicated in the application packet.*
4	*The Credentialing Department representative reviews the application.* *Is all of the information complete?* ***If yes,*** *proceed to Stage 6.* ***If no,*** *proceed to Stage 5.*
5	*The Credentialing Department representative contacts the practice to request the missing information.* *Does the practice send the requested information within the required period?* ***If yes,*** *proceed to Stage 6.* ***If no,*** *process is halted.*

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2.2 Credentialing Process, Continued

***Steps For Credentialing Non-NaviNet Enabled Providers** (continued)*

Stage	***Description***
6	*The Credentialing Department may verify or confirm State Licensing Bureau* • *National Practitioner Data Bank* • *Educational program the provider completed* • *Drug Enforcement Agency* • *State Licensing Bureau* • *American Board of Medical Specialties or American Osteopathic Association, if applicable* • *OIG sanction data* *Have all sources provided notification to meet standards?* ***If yes,** proceed to Stage 11.* ***If no,** the process may be delayed.*
7	*The Credentialing Department will also review the application for the following requirements:* • *Ability to enroll new members (PCP)* • *Ability to provide urgent/routine care* • *24/7 coverage (if applicable)* • *Practice availability 20 hours/week (PCP)*
8	*A Credentialing Department Specialist verifies that all information required for NCQA and/or State and Federal Regulatory Agencies is complete. The PremierBlue Shield network is required to verify all application information within 180 days from the date the practitioner signs the application. If verification cannot be completed within 180 days, the applicant will be asked to re-sign and re-date the application and provide valid, current information.*

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2.2 Credentialing Process, *Continued*

Credentialing Process, *continued*

Stage	Description
9	*The Highmark PremierBlue Shield Credentialing Committee reviews practitioners who do not meet Highmark credentialing criteria based on the application information. The Medical Director approves all routine practitioners who meet all Highmark credentialing criteria.* *Does the Committee or Medical Director approve the provider for entrance into the network?* ***If yes**, proceed to Stage 12.* ***If no**, the Quality Management medical director sends written notification to the provider within 60 calendar days.* *The process is complete.* ***Note:** In some instances, the Committee may require additional information from the provider before rendering a decision.*
10	*A contracting representative prepares the appropriate forms. A Provider Relations representative delivers the unsigned contract to the practitioner for signature, at which time orientation is performed. The practitioner signs the contract and returns the original contract and a copy to Highmark.*
11	*A Highmark representative signs the contract validating the contract.*
12	*Provider information is entered into the PremierBlue Shield network Provider File that feeds the Provider Directory and the claims payment system.*
13	*A copy of the executed contract and a welcome letter stating the effective date is mailed to the new PremierBlue Shield network practitioner. Process complete.*

Caution! *Participation in the PremierBlue Shield network is effective only upon completion of a signed executed contract. The participation effective date is stated within the welcome letter (see Stage 13).*

2.2 Recredentialing Process

Recredentialing Process

The recredentialing process is performed by Highmark employees who work cooperatively with network practitioners to ensure that they are still meeting the same high standards that they met when they entered the PremierBlue Shield network.

Online Submission Required

NaviNet-enabled practices are required to submit recredentialing applications using the streamlined online process through NaviNet.

Online Recredentialing Process

NaviNet's recredentialing transaction simplifies the recredentialing process by allowing you to submit information online and reducing the number of requests for additional information or clarification. If you need further details about how to complete this process, you may view the online user guide. On the NaviNet toolbar, hover over Customer Service. Select NaviMedix Customer Care, then User Guides.

Step	Action
1	Six (6) months before the end of your credentialing cycle you will receive notification that your recredentialing application is due. The message will appear through the Action Items function. The message includes an application form pre-populated with the information currently on file.
2	Complete and submit the online form. You may complete portions of the form and return to it later. The form also contains a log of the portions that remain incomplete. The system automatically checks your entries before accepting them. So, it will not permit you to submit an incomplete form.
3	You may print a copy for your records if you desire.
4	Within 180 days from the date the practitioner signs and mails the attestation statement, a Credentialing Department representative conducts primary source verification.
5	The Credentialing Committee or the Medical Director reviews the practitioner's qualifications.
6	The practitioner is notified of any adverse decision through a letter within 60 calendar days.

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2.2 Recredentialing Process, Continued

Paper Recredentialing Process

The steps below describe the paper recredentialing process.

Stage	Description
1	A Credentialing Department representative mails a copy of credentialing information on file.
2	Verify the credentialing information and make any necessary corrections.
3	Mail the form to the Credentialing Department at the address indicated in the packet.
4	A Credentialing Department representative reviews the document to ensure all information is present. The document may be returned to the practitioner for additional information.
5	Within 180 days from the date the practitioner signs the attestation statement, a Credentialing Department representative conducts primary source verification.
6	The Credentialing Committee or Medical Director reviews the practitioner.
7	The practice is notified of the outcome through a letter.

2.2 Credentialing Requirements for Pathologists, Anesthesiologists, Radiologists, and Emergency Medicine Physicians

Ancillary Service Credentialing Policy	*PremierBlue Shield network physicians and any applicable allied health professionals must be credentialed according to established criteria. This standard includes all specialists including those who provide ancillary services:* • *Pathologists* • *Anesthesiologists* • *Radiologists* • *Emergency medicine physicians* *NOTE: Ancillary service providers who practice only in acute care facilities, do not need to be credentialed.*
Emergency Medicine Qualification Requirements	*Emergency medicine physicians who are not board certified in Emergency Medicine must have:* • *Board certification in one of the following:* – *Family practice* – *Internal medicine* – *Pediatrics* – *General surgery* • *Current certification in all of the following:* – *Advanced cardiac life support (ACLS)* – *Advanced trauma life support (ATLS)* – *Pediatric advanced life support (PALS)*

2.2 Credentialing Requirements for Behavioral Health Care Providers

Behavioral Health Practitioner Requirements	*Behavioral Health Practitioners considered for participation must provide evidence of one of the following:* • *A current license in their specialty at the highest level in the state in which they practice. Licensure must be for independent practice, if applicable.* • *Minimum malpractice and liability insurance coverage amounts of $1 million per claim and $3 million per year or that required by state law.*
National Professional Organization Membership	*Membership in a national professional organization that ascribes to a professional code of ethics, such as the American Psychiatric Association or the American Psychological Association is preferred.*
Psychologist Requirements	*Psychologists must be licensed as a psychologist in the state in which they practice and have one of the following:* • *Certification from the American Board of Professional Psychology. Diplomat in clinical counseling, family psychology, neuropsychology or health psychology* • *A dissertation for the doctoral degree that is primarily psychological in nature with a specialty in clinical, counseling or professional-scientific psychology* • *Certificate of graduation from an APA-approved internship or successful completion of an APA-equivalency form.*

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2.2 Credentialing Requirements for Behavioral Health Care Providers, Continued

Clinical Social Worker Requirements	*Clinical social workers must hold a master's degree or doctoral degree in social work from a school accredited by the Council on Social Work education. Additionally, they must be licensed at the highest level for independent practice in the state in which they practice.*
Clinical Nurse Specialist Requirements	*Clinical nurse specialists must be licensed as a registered nurse in the state in which they practice. They must hold a certificate of clinical nurse specialty in psychiatric mental health nursing as issued by the ANA/ANCC.*
Psychiatric Certified Registered Nurse Practitioner (CRNP) Requirements	*Psychiatric certified registered nurse practitioners (CRNPs) must meet the following three criteria:* ▪ *Must be licensed as a registered nurse and a CRNP in the state in which they practice* ▪ *Must have a current, valid certification from the American Nurses Credentialing Center or Commonwealth of Pennsylvania Psychiatric Nurse Practitioner Certification* ▪ *Must have a collaborative agreement with a PremierBlue Shield network psychiatrist*

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2.2 Credentialing Requirements for Behavioral Health Care Providers, Continued

Master's-Prepared Therapist Criteria	*Master's-prepared therapists (other than clinical social workers or nurses) must hold licensure or certification in the state in which they practice at an independent practice level in an accepted human services specialty, such as one of the following:* • *Master's-level psychologist* • *Licensed professional counselor (LPC)* • *Marriage and family therapists (MPT)*

2.2 Dual Credentialing and Recredentialing as Both PCP and Specialist

Dual Contracts	*PremierBlue Shield contracts with network physicians as either Primary Care Physicians (PCPs) (i.e. family practitioners, general practitioners, internists, or pediatricians) or as specialists (all other MDs or DOs).* *Dual contracts for both categories of practitioners may be allowed when an individual practitioner meets credentialing standards for each specialty requested.*
Criteria	*A practitioner identified as both PCP and specialist must meet the following criteria:* • *Demonstrate that the practice adequately provides primary care services to PremierBlue Shield network members.* • *Meet the standards for PCPs* • *Provide documentation of an average of 50 CME hours per year for the past three years if not board certified in both areas of practice.*
Recredentialing	*Dual credentialed practitioners will undergo full recredentialing for PCP and specialist participation every three years.*
Provider Directory	*All dual-credentialed physicians will appear in the provider directories as both PCPs and specialists and can receive referrals from other PCPs.*

2.2 Practitioner Office Site, Quality Medical Record Documentation Review, and Process Improvement Reviews

Review Process Changed
New!

Effective July 1, 2008, Highmark's office site review process was changed. In lieu of credentialing-related site visits previously performed for all PCPs, Ob/Gyns and potential high-volume behavioral health practitioners, Quality Management nurses will conduct Practitioner Office Site Quality, Medical/Treatment Record and Process Improvement evaluations for ***any practitioner within the network*** *based on the following:*

Reviews Performed

Reviews are performed on:

- *Member Dissatisfactions:*

A member dissatisfaction submission is received about the quality of any practitioner (PCP, specialist or allied practitioner) office when care is delivered related to the categories listed below

  - *Physical accessibility*
  - *Physical appearance*
  - *Adequacy of waiting room and examining/treatment room space*

- *Random Sample:*

Annually, using a statistically valid sampling methodology, practice sites will be selected to have practitioner office site quality, medical/treatment record and process improvement evaluations performed.

Scoring Requirements

Follow-up reviews will be conducted for all practice sites which score below Highmark's threshold of 80 percent for the Practitioner Office Site Quality and Medical/Treatment Record evaluations and below 50 percent for the Process Improvement evaluation. Practitioners in offices with continuous opportunities for improvement after three consecutive visits at six-month intervals will be presented to the Credentials Committee as exception practitioners for further recommendation. Practices failing to correct deficiencies may be sanctioned and become ineligible for QualityBLUE^{SM} incentive payments. Practices with office deficiencies on repeated re-evaluations may be terminated from network participation.

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2.2 Practitioner Office Site, Quality Medical Record Documentation Review, and Process Improvement Reviews, *Continued*

Review Tool Elements *The following list includes the basic elements included on the review tool. A detailed list is available by calling 412-544-2623.*

Practitioner Office Site Quality	***Medical Records Documentation***
• *Physical Accessibility* • *Physical appearance of the office* • *Adequacy of waiting room and examining/treatment room space* • *Secure, organized medical record systems* • *Adequate, up-to-date equipment* • *Patient confidentiality* • *Office Accessibility* • *Availability of emergent, urgent, routine and preventive appointments* • *Coverage availability 24 hours a day, seven days per week*	• *Individual clinical records are established and easily retrievable* • *Current problem lists* • *Up to date preventive services flow sheet* • *Up to date medication flow sheet* • *Medication allergies and adverse reactions* • *All entries in the record contain author's identification, which may be a handwritten signature, unique electronic identifier handwritten and are legible to someone other than the writer* • *Past medical history* • *History and physical identifies pertinent subjective and objective data* • *Appropriate subjective and objective data for each visit* • *Diagnostic impressions are consistent with the findings* • *Treatment or therapy plans are consistent with diagnoses* • *Use of tobacco, alcohol and/or other substance abuse* • *Coordination of care and notation of follow-up plans* • *Discussion of advance directives* • *Documentation and treatment are consistent within the scope of the licensure of the practitioner* • *Medical/treatment records should reflect:* • *All services provided directly by the practitioner* • *All ancillary services and diagnostic tests ordered by a practitioner* • *All diagnostic and therapeutic services for which a member was referred by practitioners, such as:* • *Home health nursing reports* • *Specialty physician reports* • *Hospital discharge reports* • *Physical therapy reports*

2.2 Practitioner Office Site, Quality Medical Record Documentation Review, and Process Improvement Reviews

Treatment Record Documentation Evaluation (for behavioral health practitioners)	***Process Improvement Evaluation***
• *Medical and psychiatric history* • *Presenting problems* • *Mental Status Exam* • *Special status situations, such as imminent risk of harm, suicidal ideation or elopement potential* • *DSM-IV diagnoses are identified and consistent with presenting problems, history and mental status, etc.* • *Treatment plans and goals*	• *Members with chronic conditions are proactively notified to schedule appropriate appointments.* • *Members due for age-appropriate, preventive appointments are proactively notified to schedule appropriate appointments.* • *Members who either "no show" or cancel appointments are contacted and encouraged to reschedule their appointment.* • *Reminder calls are made prior to scheduled appointments.* • *When a consultation is requested, the office communicates to the specialist/organization provider the reason for the referral.* • *Process confirming laboratory, diagnostic procedures and/or consultation appointments were performed*

2.2 Practitioner Quality And Board Certification

Policy	*To be credentialed in the western region network, PCPs and specialists (including podiatrists and oral maxillofacial surgeons) are required to be board certified in the specialty in which they practice.*
Highmark Recognized Boards For Certification	*Highmark recognizes the following boards for certification: America Board of Medical Specialties, The American Osteopathic Boards, The American Board of Podiatric Orthopedics and Primary Podiatric Medicine, American Board of Podiatric Surgery, American Board of Oral and maxillofacial Pathology, American Board of Oral and Maxillofacial Surgery and American Academy or Oral and Maxillofacial Radiology.*
Exceptions	*Some practitioners may be exempt from the board-certification requirement. Those practitioners without board certification who qualify for a board certification exception must provide documentation of an average of at least 50 continuing medical education hours per year for the previous three years.* *The requirements for board-certification exception are as follows:* • *Practitioners who have completed an approved, applicable residency or fellowship in the specialty of practice and have graduated from an accredited medical, osteopathic, dental or podiatric school, and finished training prior to December 31, 1987.* • *Practitioners who have not practiced for a sufficient length of time to complete board certification. (Practitioners must complete the board certification within two years of meeting the eligibility requirement.)* • *At the time of the practitioner's credentialing or recredentialing, 50 percent or more of the existing practice's credentialed associates (including the practitioner who is undergoing the credential/recredentialing process) are already board certified in the specialty being requested, and the practitioner has completed an approved, applicable residency or fellowship in the specialty of practice.* • *Rural practitioners who have greater than five years of experience in the specialty in which they practice and have completed an approved applicable residency or fellowship in the specialty of practice.*
Additional Requirements For Certain Specialties	*In addition to the standard requirements for specialist, certain specialties must satisfy other criteria:*

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2.2 Practitioner Quality And Board Certification, *Continued*

Additional Requirements For Certain Specialties *(continued)*

- *Emergency medicine physicians may satisfy the board certification requirement with board certification in emergency medicine, family medicine, internal medicine, pediatrics or general surgery and completion of two or more years of post-medical school residency training. Emergency medicine physicians (and any physician who works in the Emergency Department) must also have current certification in advanced cardiac life support (ACLS), advanced trauma life support (ATLS) and pediatric advanced life support (PALS) unless they are board certified in emergency medicine.*

- *Highmark does not require facility-based pathologists, oral maxillofacial pathologists, anesthesiologists, radiologists, oral maxillofacial radiologists or emergency medicine specialists who practice exclusively in an acute care hospital setting to complete the standard Highmark credentialing or recredentialing process for the network(s). However, these providers must complete the appropriate provider agreements to participate with Highmark Blue Shield's Participating Provider network. Please contact your Highmark Provider Relations representative if you have questions regarding this process.*

Requirements When Credentialing or Recredentialing Is Not Required

Highmark does not require credentialing or recredentialing for the network(s) when these requirements are met:

The practitioner must:
• provide 100 percent of his or her services to members exclusively in the acute-care or general hospital setting
• possess a current Pennsylvania medical license in good standing
• have current active malpractice insurance that meets or exceeds Pennsylvania state requirements
• actively participate with Medicare or Medicaid and have never been debarred from or excluded from participation in any Medicare or Medicaid government programs
• sign an Affirmation of Medical Practice Statement (Form No. 282)

Credentialing For Services To Members Outside of a Blue-Participating Hospital

If a provider begins to provide medical services to members outside of a Blue Shield network-participating acute care hospital, the practitioner will be required to complete a Provider Application and go through the credentialing process.

Psychologists must be licensed as a psychologist in the state in which they practice and meet one of the following criteria:

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2.2 Practitioner Quality And Board Certification, Continued*Continued*

Credentialing For Services To Members Outside of a Blue-Participating Hospital *(continued)*

- *Certification from the American Board of Professional Psychology, Diplomat in Clinical Counseling, Family Psychology, Neuropsychology or Health Psychology*
- *A dissertation for the doctoral degree that is primarily psychological in nature with a specialty in clinical counseling or professional-scientific psychology*
- *Graduation from an APA-approved internship or successful completion of an APA-equivalency form*
- *Licensed clinical social workers (LCSWs) must hold a master's degree or doctoral degree in social work from a school accredited by the Council on Social Work education and must be licensed at the highest level for independent practice in the state in which they practice.*
- *Clinical nurse specialists must be licensed as a registered nurse in the state in which they practice and hold a certificate of Clinical Nurse Specialty in psychiatric mental health nursing as issued by the ANA/ANC.®*
- *Psychiatric-certified, registered nurse practitioners (CRNPs) must be licensed as a registered nurse and a CRNP in the state in which they practice. A CRNP with a secondary license type in mental health must have a collaborative agreement with a credentialed western region network psychiatrist. ®*
- *Master's-prepared therapists (other than clinical social workers or nurses) must hold licensure or certification in an accepted human services specialty, such as master's level psychologist, licensed professional counselor (LPC), marriage and family therapists, etc., at an independent practice level in the state in which they practice.*

2.2 Mergers And Acquisitions

Mergers And Acquisitions

You must send written notification on your practice letterhead of anticipated mergers, acquisitions, etc., to the address listed above at least 60 days before the change(s) occur. The managing partner of the practice must sign the written notification. Include the following information:

- Effective date of the change
- Highmark Blue Shield provider number or NPI, new tax identification number* (if applicable)
- Changes to physician staffing
- Changes to physician location

*When reporting a new tax identification number, include the IRS Tax Notification as evidence. New Assignment Account paperwork will need to be completed. Providers in Western, Central and Eastern PA, please access Provider Forms on the Provider Resource Center of our Web site to obtain the Assignment Account forms. Providers in Northeastern PA, please call 1-800-451-4447.

Consequences To Not Giving 60 Days' Notice

Most changes will require Highmark Blue Shield to revise existing provider files. In most cases, membership or claims payment will be affected by major changes in your practice. Therefore, if you do not give advance notification, we cannot guarantee accurate membership information and/or claims payments.

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2.2 Mergers And Acquisitions, continued

Sample Practice Change Notification Letter

Please include information in your letter as shown below.

XYZ Medical Associates
1000 Main Street
Somewhere, PA 15000
1-717-555-4000

10/1/07

Re: Highmark Blue Shield Provider Number 999999 or NPI

To: Provider Information Management (if Western, Central or Eastern PA provider)
OR
To: Provider System Support (if Northeastern PA provider)
The following changes are occurring in our practice:

Old information was as follows:

Phone number 1-717-555-3900

New information is as follows:

Phone number 1-717-555-4000

New information effective as of:

January 1, 2008

Signature of Managing Partner,

John Smith, MD

2.2 Network Compliance

Policy

Network providers must comply with the terms and conditions of their provider agreement and meet acceptable standards for quality of clinical care, resource utilization and administrative compliance in order to ensure that the network operates in an effective and efficient manner. This also ensures that members receive high quality, medically appropriate and cost-effective care.

Providers who are not compliant are subject to the network corrective action policy providing for corrective action, sanctioning, suspension and termination of providers arising from non-compliance with contractual obligations or failure to meet acceptable standards of clinical care, resource utilization and/or administrative compliance.

Categories Of Non-Compliance

Non-compliance can be divided into three categories:

- Quality of care concerns
- Unacceptable resource utilization
- Administrative non-compliance

Quality Of Care Concerns

A quality of care concern arises when an episode of care deviates from accepted medic standards. The occurrence of an adverse outcome does not, in and of itself, indicate a breach of accepted medical standards and/or warrant action.

Examples Of Quality Of Care Concerns

Examples include, but are not limited to:

- Actions or omissions that result or may result in an adverse effect on a patient's well being
- Delayed services/referrals
- Missed diagnoses
- Medication errors
- Delayed diagnosis/treatment
- Unexpected operative complications
- Invasive procedure complications
- Inappropriate procedures
- Unanticipated, unexplainable death
- Actions requiring a report to the National Practitioner Data Bank or other adverse actions

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2.2 Network Compliance, Continued

Unacceptable Resource Utilization

Unacceptable resource utilization is defined as a pattern of utilization that is at variance with recognized standards of clinical practice or with specialty-specific aggregated data.

Examples of patterns of unacceptable resource utilization include, but are not limited to:

- Inappropriate or unnecessary admissions
- Inappropriate utilization of emergency services
- Inappropriate or unnecessary inpatient hospital stay days
- Patterns of inappropriate utilization of outpatient surgery
- Patterns of inappropriate PCP-scheduled encounters per member per year – often times, the member is the one making excessive appointments
- Patterns of inappropriate utilization of referrals
- Under utilization (i.e., withholding) of necessary and appropriate medical services

Administrative Non-Compliance

Administrative non-compliance is defined as behavior that is detrimental to the successful functioning of Highmark. Examples include, but are not limited to:

- Direct or unauthorized billing for services
- Balance billing a member for services
- Failure to cooperate/comply with Highmark's administrative, quality improvement, utilization review, member service, reimbursement and other procedures
- Conduct that is unprofessional toward the member, family members and/or staff of Highmark
- Failure to comply with any contractual obligation
- Failure to comply with policies and procedures of Highmark
- Failure to comply with or violation of state or federal laws or regulations

2.2 Medical Record Review

Overview

Highmark periodically engages in the review of members' medical records as well as inspection of network providers' offices. Highmark reviews medical records for a number of reasons pertaining to the administration of high quality managed care benefit programs. The reasons include, but are not limited to:

- Performing utilization review
- Measuring the standard of quality achieved by the network providers
- Credentialing and recredentialing network providers (Does NOT apply to Participating Provider network.)
- Conducting condition management for the benefit of members
- Investigating complaints about the quality of clinical care provided to Highmark members
- Verifying immunization of pediatric and adult patients

Consent To Review Medical Records

To review medical records, Highmark has received a general consent from our members. Each member completes and signs an enrollment form that provides for the release of most information relating to past, present or future health care examinations or treatments for anyone covered under the enrollment form. Such consent is necessarily broad to enable Highmark to administer high-quality benefit programs.

Information collected is handled with a high level of security and respect for privacy. However, member records which include information relating to Behavioral Health, Human Immunosuppressant Virus (HIV), Sexually Transmitted Diseases (STDs), and/or Substance Abuse could be subject to extra protections regarding disclosure under Pennsylvania law, as well as other states' laws. In such cases, the records should contain consent to disclose the protected information.

Alternatively, providers may choose to delete the personally identifying details from those records containing any such protected information prior to submitting the medical records to Highmark for review.

Provider Cooperation

The terms of the network agreement require the full cooperation of network providers with all office reviews. Failure to supply requested copies of medical records or failure to cooperate with office inspections of medical records may result in termination from Highmark network participation.

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2.2 Medical Record Review, Continued

Network Corrective Action Process

Certain circumstances, acts or omissions of a professional network provider may result in a requirement that the provider engage in a corrective action or a series of corrective actions in order to continue participation in the network. Treatments, procedures and services that are subject to corrective action include any treatments, procedures or services which indicate a professional provider is practicing in a manner that is not consistent with reasonable standards of care (including, when applicable, accepted standards of medical care) and service, ethical expectations, contractual obligations or the administrative requirements of the plan. Examples of such circumstances, acts or omissions which may be subject to corrective action include but are not limited to, the following:

- Clinical quality of care
- Administrative non-compliance
- Unacceptable resource utilization
- Service-related issue

Providers identified with one of these issues will be reported to a network medical director. The determination to take corrective action shall be made by a medical director. Corrective action may vary according to the situation and may include, but is not limited to, one or more of the following actions as they relate to the circumstance, action or omission that requires corrective action:

- Sending a written warning to the provider
- Engaging in a discussion or a series of discussions with the provider
- Monitoring the provider's performance
- Requiring that the provider complete a continuing medical education course regarding the treatment, procedure, or service in question
- Limiting the provider's authority to perform certain procedures
- Requiring that the provider enter a preceptor relationship with another provider
- Monitor and observe the provider subject to corrective action
- Termination or suspension

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2.2 Medical Record Review, Continued

Network Corrective Action Process (continued)

The determination to take corrective action on a Clinical Quality of Care issue shall be based on an assessment of the severity level of the action based on the judgment of a network medical director. The following are general guidelines used by the medical directors when assigning severity levels.

Severity Level	Guideline
Minor – Low	Deviation from the standard of care without harm to the member.
Moderate – Medium	Deviation from the standard of care with temporary harm to the member.
Severe – High	Deviation from the standard of care with harm to the member resulting in permanent sequelae or death.

Sanctioning

Sanctioning of a provider will occur whenever an assessment of the severity level of action is moderate or severe, and/or the corrective action was a result of an administrative non-compliance circumstance, act, or omission. Sanctioning may result in a provider's practice not being eligible for participation in certain programs, including the QualityBLUE Physician Pay for Performance bonus payments.

Appeals

An appeal shall be made available to a professional network provider before a subcommittee of the applicable Credentials Committee if the practitioner is placed under corrective action. If an appeal is available, the procedure will be as follows:

Step	Action
1	The provider will be given written notice of the proposed action including: (a) the action that has been proposed to be taken against the provider; (b) the reason(s) for the action; (c) that the provider may request an appeal on the proposed action; (d) that the practitioner may participate via phone or in person (e) that the provider will waive any appeal rights if an appeal is not requested within 30 days of receipt of the notice of the action.
2	If the provider requests an appeal on a timely basis, the Highmark Quality Management Department will notify the provider of the time and date of the Subcommittee meeting.

Continued on next page

2.2 Medical Record Review, Continued

Appeals (continued)	3	The appeal shall be held before a subcommittee of the applicable Credentials Committee which is comprised of network practicing providers, who will review the information presented and render a decision. The members of the subcommittee shall not be in direct economic competition with the provider. The provider has the right during the meeting to have representation by an attorney or other person of the provider's choice. For any appeal the Credentials Subcommittee may consider the report of a specialist regarding the issue at hand.
	4	After completion of the appeal the provider has the right to receive the written decision of the Credentials Subcommittee from the Medical Director, including a statement of the basis for the decision. The decision of the Credentials Subcommittee is not subject to further appeal.

2.2 Reporting Changes In Your Practice

How To View Real Time Billing Information

You may view real time detailed billing vendor information under NaviNet's Provider File Management section. Select Provider File Management, then Provider Information to view the summary.

If you are not NaviNet-enabled please contact Provider Information Management to request a copy of the summary.

Policy For Changing Practice Information

The provider database maintained by Highmark Blue Shield contains vital information regarding each network provider.

By keeping your practice information updated, you help Highmark do the following:

- Process claims correctly
- Notify members of the names and addresses of network providers
- Notify primary care physicians of available specialists to whom they may refer

Most changes will require Highmark Blue Shield to revise existing provider files. In most cases, membership or claims payment will be affected by changes in your practice. Therefore, if you do not give advance notification, we cannot guarantee accurate membership information, claims and/or payments.

Using NaviNet To Report Updated Practice Information

NaviNet enabled providers should use NaviNet's 'Provider File Management' function to complete updates to the practices information.

Click 'Provider Information Change' under 'Provider File Management.' Choose the billing provider number and location to send the updates. This function can be used to change the practice's Address, Current Contact Information, Address Types, Affiliated Practitioners and more.

If you do not have a button for 'Provider Information Change' please contact NaviMedix at 1-888-482-8057.

How To Update Practice Information For Non-NaviNet Enabled Providers

What Region Am I?

Non-NaviNet enabled providers in the Western, Central and Eastern regions must notify Highmark Blue Shield of any change to their practices. Network providers in Northeastern PA must notify Blue Cross of Northeastern Pennsylvania.

Notification should occur 60 days before the change. This is a requirement of your network agreement.

Continued on next page

2.2 Reporting Changes In Your Practice, Continued

Types Of Changes To Report

The following is a list of changes in your practice that must be communicated to Highmark Blue Shield:

- Practice location change
- Billing/mailing address change
- Telephone number change
- Fax number change
- Hospital affiliation change
- Office hours change
- New tax identification number
- Practice name change
- Providers joining the practice
- Providers leaving the practice (including through retirement or death)
- Changes in Malpractice Insurance Coverage Levels (10 days in advance of any reduction or termination of coverage)
- Practice mergers
- Practice acquisitions
- Addition or closure of a practice site

* Highmark-hosted NaviNet-enabled practices should make their address, telephone and contact name information changes via the Provider Information changes functionality. Simply check Provider Information Changes, choose the billing provider number, choose the location and send the updates.

Important!

All providers joining or leaving an established practice or leaving a Highmark Blue Shield network must notify Highmark Blue Shield 60 days before the event. Refer to the following page regarding how to report changes in your practice.

New providers in Western, Central and Eastern PA who are not participating with Highmark Blue Shield but wish to join the network may call 1-866-763-3224 to request the appropriate paperwork. Or, they may access the Provider Forms link on the Provider Resource Center of our Web site to access the forms. New providers in the 13 northeastern counties should call 1-800-451-4447.

The provider agreement between Highmark Blue Shield and network providers is not assignable. In cases of practice mergers, acquisitions, etc., it is necessary to send written notification, on practice letterhead, to:

What Region Am I?

Western, Central and Eastern PA:
Highmark Blue Shield
Provider Information Management
P.O. Box 898842
Camp Hill, PA 17089-8842
Fax: 1-800-236-8641

Northeastern PA:
Blue Cross of Northeastern Pennsylvania
Provider System Support
19 North Main Street
Wilkes-Barre, PA 18711
Fax: 1-570-200-6880

2.2 Reporting Changes In Your Practice, Continued

How To Use NaviNet To Update Existing Assignment Account Information

Western, Central and Eastern Region NaviNet-enabled providers can use NaviNet's Provider File Management section to update enabled providers on their assignment accounts. Click Provider File Management.

Choose Provider Add/Delete to add new practitioners to the assignment account or delete practitioners who are leaving a practice.

Choose the assignment account to update and follow prompted instructions throughout to complete your update.

How To Make Changes To Existing Assignment Account Information For Non-NaviNet-Enabled Providers

Send or fax the *Request for Addition/Deletion to Existing Assignment Account* form, signed by the managing partner, to the addresses or fax numbers shown below. This form is located under Provider Forms on the Provider Resource Center.

What Region Am I?

Western, Central and Eastern PA:
Highmark Blue Shield
Provider Information Management
P.O. Box 898842
Camp Hill, PA 17089-8842

Northeastern PA:
Blue Cross of Northeastern Pennsylvania
Provider System Support
19 North Main Street
Wilkes-Barre, PA 18711

Western, Central and Eastern Region Fax: 1-800-236-8641
Northeastern Region Fax: 1-570-200-6880

NOTE: If you are adding a new physician to an existing practice, the new physician must sign the letter or form.

2.2 Malpractice Insurance Requirement

Overview	A provider must carry, at their own cost and expense, the minimum required amount of malpractice insurance at all times to maintain credentialing.
Network Malpractice Insurance Criteria	Providers must carry and maintain at all times liability and professional liability (malpractice) insurance to insure the group provider and each individual practitioner against any claim or claims for damages arising by reason of personal injury or death occasioned, directly or indirectly, in connection with the performance or omission of any provider service. The amount of coverage carried should not be less than the amounts required by any applicable state laws or less than those coverage levels required by Highmark. Network providers must provide evidence of coverage to the network upon request. Providers must also notify Highmark at least thirty days in advance of any reduction or termination of malpractice coverage.
If You Are MCARE-fund Eligible	Medical doctors, doctors of osteopathy, podiatrists and nurse midwives are required by Pennsylvania law to participate in the Pennsylvania Medical Care and Reduction of Error Fund ("MCARE Fund"). By law, these providers must maintain primary medical malpractice insurance with liability limits of $500,000 per medical incident and $1.5 million in the annual aggregate in addition to the limits provided by the MCARE Fund of $500,000 per medical incident and $1.5 million in the annual aggregate.
If You Are Not MCARE-Fund Eligible	All network practitioners who are not required to participate in the MCARE Fund must carry minimum medical malpractice insurance with liability limits of $500,000 per medical incident and $1.5 million in the annual aggregate. These practitioners include, but are not limited to the following: • audiologists, • doctors of chiropractic, • optometrists, • oral maxillofacial surgeons and • physical therapists. CRNPs are required to carry $1 million per incident and $3 million in the annual aggregate.

2.2 Termination From The Network

Valid Reasons For Termination

Professional network providers shall be terminated in accordance with the relevant terms of their provider contracts for failure to satisfy the following criteria, which includes, but is not limited to:

1. Maintain an active license to practice.
2. Maintain an active DEA certificate, where applicable.
3. Maintain coverage for malpractice insurance in the minimum amounts required and participate in the MCARE Fund.
4. Maintain acceptable professional liability claims history.
5. Participate in recredentialing, which includes providing all requested recredentialing information, and be recredentialed for network participation.
6. Provide acceptable clinical quality of care to members.
7. Meet appropriate recredentialing requirements.

Professional network providers shall also be terminated if, in the plan's sole discretion, any of the following occur, or are in imminent danger of occurring:

1. Acts or omissions that jeopardize the health or welfare of a member.
2. Acts or omissions that negatively affect the operation of the network.
3. Acts or omissions which cause the Plan to violate any law or regulation or which negatively impact the Plan under any regulatory or certification requirements.
4. Failure to provide an acceptable level of care.

Invalid Reasons For Termination

A provider may not be terminated for any of the following reasons or actions:

1. Advocating for medically necessary and appropriate health care consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable legal standard of care.
2. Filing a grievance against the Plan in response to a disapproval of payment for a requested service, an approval of the requested service at a lower scope or duration, or a disapproval of the requested service but an approval of payment of an alternative service.
3. Protesting a decision, policy or practice that the provider, consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable legal standard of care, reasonably believes interferes with the provider's ability to provide medically necessary and appropriate health care.
4. The provider has a practice that includes a substantial number of patients with expensive medical conditions.

Continued on next page

2.2 Termination From The Network, Continued

Invalid Reasons For Termination (continued)

5. Objection to the provision of or refusal to provide a health care service on moral or religious grounds.
6. Any refusal to refer a patient for health care services when the refusal of the provider is based on moral or religious grounds and the provider has made adequate information available to the members in the provider's practice.
7. Discussing (a) the process that the plan uses or proposes to use to deny payment for a health care service, (b) medically necessary and appropriate care with or on behalf of a member, including information regarding the nature of treatment, risks of treatment, alternative treatments, or the availability of alternate therapies, consultations or tests; or (c) the decision of the plan to deny payment for a health care service.

Decisions to terminate a provider may be made by the Medical Director(s) of Quality Management in urgent situations or by the Credentials Committees. A provider shall be provided with a written decision of the intention to terminate with the specific reason for the decision and any appeal/reconsideration rights. Termination decisions will negatively affect the provider's reimbursement for services provided to members in the Highmark products serviced by the western region network and PremierBlue Shield networks.

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2.2 Termination From The Network, Continued

Reconsideration Process for An Intention To Terminate Action Or Denial

A request for a reconsideration of an intention to terminate decision or denial by the Credentials Committees is available to a professional network provider in the following instances:

1. The termination action or denial by a Medical Director or by the applicable Credentials Committee was due to the lack of required qualifications at the time of credentialing/recredentialing. This includes, but is not limited to, loss of an unrestricted state license, loss of DEA license, failure to obtain or keep appropriate board certification, lack of adequate hospital privileges, and/or insufficient malpractice insurance coverage.
2. The termination action or denial by a Medical Director or by the Credentials Committees was due to any other reason not reportable to the National Practitioner Data Bank.

The provider must request the reconsideration in writing within 30 days of notice of the termination. The provider shall be given the opportunity to present information to the Credentials Committee by one or any of the following options.

1. In writing, to the Credentials Committee for consideration which shall take place during a Credentials Committee meeting.
2. Appearing in person at a Credentials Committee meeting.
3. Participating via a telephone conference call at a Credentials Committee meeting.

After the meeting, the provider shall receive written notice of the final decision of the Credentials Committee, which will include the basis for the decision, the appeal process and the practitioner's right to a final appeal to the Medical Review Committee within 30 days if the decision is upheld. The provider will remain in the network until the Credentials Committee's final decision to terminate and an effective date of termination is established.

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2.2 Termination From The Network, Continued

Appeals Of Credentials Committee Final Decision

In the event of an appeal, the Plan's Medical Review Committee (comprised of professional peers) shall be available, upon written request, to any professional network provider who has been notified of the final termination decision, denial, or suspension from the Plan's network.

The provider must request the appeal, in writing, within thirty- (30) days of receipt of written notification of an adverse decision. The provider remains in the Plan's network until the appeal process is completed, unless the provider has been subject to an immediate termination. No appeal is available if the provider has waived or forfeited the right to an appeal.

Step	Action
1	If an appeal is requested, the provider may submit to the Secretary of the Medical Review Committee any documentation believed to be relevant for consideration during the appeal process.
2	The provider will then receive a notice of the hearing place, date and time and an explanation of the Committee hearing process. This includes the practitioner's right to representation by legal counsel and/or other individuals to support his/her position, a record of the proceedings, and his/her ability to call witnesses, etc.
3	All relevant documentation, including but not limited to, the provider's credentialing file and minutes of the applicable Credentials Committee meeting(s); and all applicable recommendations and decisions will be presented at a meeting of the plan's Medical Review Committee. The Medical Review Committee's members shall be peers and not be in direct economic competition with the provider. The plan's Medical Review Committee will determine if: • The termination process was handled correctly according to the plan's Policies and Procedures. • The provider was afforded a reasonable opportunity to address the issues, concerns or deficiencies that led to the decision. • The denial, intention to terminate action or immediate termination process was performed with merit and without bias, conflict of interest or inadequate attention to the documentation presented.

Continued on next page

2.2 Termination From The Network, Continued

Appeals Of Credentials Committee Final Decision, continued	**4**	The plan's Medical Review Committee will decide whether to uphold or reverse the decision. The plan's Medical Review Committee's decision is final and not subject to further appeal.
	5	The Quality Management/Medical Director Committee Representative will notify the provider, in writing, of the plan's Medical Review Committee's decision, including a statement of the basis of the decision. The notification will address any future action that may be forthcoming as a result of that appeal decision.

Chapter 2

Provider Responsibilities

Unit 3: Western Region Network Procedures

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2.3 Network Responsibilities for PCPs

Introduction

PCPs in the western region network play an important role in managing all aspects of health care for members who select their practice. The information below serves as an introduction to the roles and responsibilities of the PCP.

How PCPs Are Reimbursed

PCPs in the western region network are paid fee-for-service.

How Members Select A PCP

Members are asked to select a PCP at the time of enrollment. HMO, POS, and open access members having the option to select a PCP may select any network PCP listed in the provider directory they receive at enrollment, as long as the following conditions are met:

- The PCP practice is open to new members.
- The member fits into the PCP's patient age range as specified by specialty, e.g., pediatrics.

How Members Change PCPs

Members may switch PCPs at any point after enrollment.

If the member calls in…	PCP changes are effective…
From the 1st through the 15th day of the month,	the first of the next month following the date of the call.
After the 15th day of the month,	the first of the second month following the date of the call.

For example, if a member calls to switch PCPs:

- January 4, the change will be effective February 1.
- January 20, the change will be effective March 1.

Transfer Of Medical Records

When a member chooses a new PCP within the western region network, the original PCP must transfer the member's complete medical record to the new PCP in a timely manner.

PPO, EPO, And Open Access Members

Since there are no administrative requirements for PCPs for PPOBlue, EPOBlue, PreferredBlue, and FreedomBlue, members may select or switch PCPs as they choose without notifying Highmark.

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2.3 Network Responsibilities for PCPs, Continued

PCP Responsibilities

Responsibilities specific to PCPs include but are not limited to:

- Office visits
- Inpatient hospital, emergency room, skilled nursing and home visits
- Routine pediatric and adult immunizations
- Maintenance allergy injections
- Routine diagnostic procedures

- Minor surgeries performed in office
- Lab services performed in office
- Preventive and early detection interventions
- Most acute and chronic services
- Other services as necessary

- Maintaining organized medical record-keeping practices and ensuring accurate medical records
- Maintaining active staff privileges at a minimum of one Highmark-or western region network-contracted hospital
- Providing 24-hour telephone availability year-round
- Providing physician coverage at all times
- Obtaining authorization for DME and other care

- Informing Medicare Advantage members about advance directives.
- Cooperating with Highmark and the western region quality management programs to the extent permitted by federal and state law including, but not limited to the following:
    - Clinical initiatives
    - Condition management and shared decision-making
    - Credentialing
    - Clinical studies
    - Health Plan Employer Data and Information Set (HEDIS)
    - Providing access to members' medical records
    - Risk Adjustment Data Verification (RADV)

Note: Routine adult and pediatric physicals and pediatric immunizations must be performed by the member's PCP, if applicable, to receive coverage.

2.3 Preventive Care Responsibilities For Network Physicians

Overview

Highmark Blue Shield network physicians have a unique opportunity to recommend or administer certain services and lifestyle improvements that can prevent future illness or injury. Highmark Blue Shield charges its primary care physicians and specialists with promoting and helping to maintain the health of members, through the preventive services noted below.

Primary Care Physician Responsibilities

- *Administer required childhood and adolescent immunizations*
- *Administer all recommended immunizations, i.e. influenza and pneumococcal vaccines to at-risk and age-appropriate members*
- *Provide timely and comprehensive well-care exams*

Primary Care Physician And Ob/Gyn Responsibilities

- *Provide or recommend screening mammograms, cervical cancer screenings, and chlamydia screenings. A member can self-refer for her annual mammogram; but she should be encouraged to consult her primary care physician or ob/gyn for help with coordination of care*
- *Provide or recommend age/risk-appropriate colorectal cancer screenings*
- *Provide or recommend prenatal care, especially in the first trimester*
- *Provide or recommend post-partum exams by the 42nd day after delivery*
- *Provide appropriate counseling to women for menopause and domestic violence*

What Region Am I?

Primary Care Physician And Specialist Responsibilities

- *Provide obesity screening, prescribe appropriate screening labs and recommend nutritional and exercise counseling*
- *Prescribe and monitor ongoing beta-blocker treatment after heart attack (unless contraindicated).*
- *Advise smokers to quit and refer members to smoking cessation support programs*
- *Recommend the Dr. Dean Ornish Program for Reversing Heart Disease to members who could benefit from participating in the program (nine(I don't know the number of locations – check with Prev. Health Services) locations in the Western Region)*
- *Provide or recommend adequate care for diabetics, including lab testing, foot and eye exams*
- *When appropriate, refer members to disease management programs including heart failure, diabetes, chronic obstructive pulmonary disease and asthma*
- *Provide appropriate and comprehensive care for members with hypertension*
- *Prescribe and monitor appropriate medication for members with asthma*
- *Assess member medications for contraindications, drug-drug interactions and avoidance of potentially harmful medications in the elderly.*

Continued on next page

2.3 Preventive Care Responsibilities For Network Physicians, Continued

Primary Care Physician And Specialist Responsibilities *(continued)*	*Network providers should submit accurate claims and document their preventive care services and recommendations in the member's chart. If performed by a specialist, the interventions, dates they were performed, and their results should be communicated in writing to the primary care physician. Likewise, information about such interventions performed by the primary care physician should be communicated to a specialist when the information is pertinent to the condition the specialist is treating.*

2.3 Obstetrical And Gynecological Services

Ob/Gyn Network Participation

Obstetricians and gynecologists in the PremierBlue Shield network play a very important role by providing health care to our female members. Network ob/gyns are paid fee-for-service. Women have direct access to any network ob/gyn for their healthcare needs.

Communication Procedure

Direct access enables members to have contact with their ob/gyns without going through their primary care physicians. While this enhances member satisfaction, communication between ob/gyns and primary care physicians is still vital, especially when routine annual gynecological exams and mammograms are provided.

The following should be faxed or mailed within 30 days to the member's primary care physician for each office visit:

- *Clinical findings*
- *Test results*
- *Treatment plans*
- *A summary report at the conclusion of the treatment period*
- *Acceptable formats include typed letters, physician forms and progress notes*

Direct Access

Direct access to women's health care means that no members in need of gynecological or obstetrical services need to obtain referrals from their primary care physicians.

Direct access offers the following advantages for members seeing a credentialed network ob/gyn:

- *No referral for annual routine gynecological exam*
- *No referral for sick visits*
- *No referral for follow-up care*
- *No referral for maternity services*

Direct access does not extend to services provided by ob/gyn residents or to gynecological services provided in a hospital clinic setting.

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2.3 Obstetrical And Gynecological Services, Continued

Ob/Gyn Referrals	*If an ob/gyn sees a member and determines that the member may need the services of another specialty practitioner, the ob/gyn should recommend that the member return to their primary care physician. Ob/gyns are not authorized to refer members to other specialty practitioners.* *If a member requests a visit for symptoms that do not appear to be gynecological in nature, the ob/gyn should refer the member back to her primary care physician.*
Mammography Screening vs. Diagnostic Mammography	*A screening mammogram is an ordinary check-up intended to detect any problems. A diagnostic mammogram is a test intended to follow-up on a confirmed or suspected irregularity or diagnosis. A prescription is all that is required for mammograms.*

2.3 Availability and Accessibility Of Network Practitioners

Availability Of Network Practitioners

Network evaluations are performed annually on the number and geographic distribution of the provider network in relationship to the location of its members.

In addition, Highmark Blue Shield takes into consideration the special and cultural needs of members in maintaining its network of providers.

Accessibility

Health Plan members are expected to receive an appointment with a qualified primary care/specialty practitioner based on the following time standards:

PRIMARY CARE PRACTITIONER AND MEDICAL SPECIALIST STANDARDS		
Patient's Need	*Definition*	*Performance Standard*
Emergency/life threatening care	*An emergency medical condition (as defined by the Balanced Budget Act [BBA] of 1997) is: A condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part*	*Immediate response*
Urgent care appointments (e.g., high fever, persistent vomiting/ diarrhea)	*An urgently needed service is a medical condition that requires rapid clinical intervention as a result of an unforeseen illness, injury, or condition*	*Within 1 day Within 24 hours*

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2.3 Availability and Accessibility Of Network Practitioners
Continued

Accessibility, *continued*

PRIMARY CARE PRACTITIONER AND MEDICAL SPECIALIST STANDARDS		
Patient's Need	***Definition***	***Performance Standard***
Regular and routine care appointments	• *Non-urgent but in need of attention appointment (e.g. headache, cold, cough, rash, joint/muscle pain, etc.)* • *Routine wellness appointments (e.g., asymptomatic/ preventive care, well child/patient exams, physical exams, etc.)*	• *Within 2-7 days* • *Within 7 days—HHIC only* • *Within 30 days*
After-hours care	*Access to practitioners after the practice's regular business hours*	*Practitioners are expected to return calls within 30 minutes*
Telephone service	*Refer to separate Member Services policy titled: Telephone Standards*	
In-office waiting time	*Practitioners are encouraged to see patients with scheduled appointments within 15 minutes of their scheduled appointment time. A reasonable attempt should be made to notify patients of delays.*	*Within 15 minutes* *Within 60 minutes—HHIC only*
Number of patients seen per hour (PCPs and OB/GYNs)	*Practitioners are encouraged to schedule no more than six (6) patients per hour.*	*No more than six (6) patients per hour*
Open office hours (PCPs only)	*The minimum number of hours that a PCP practice or coverage is available to see and treat members*	*Minimum of 20 hours per week at each practice site.* *Minimum of 16 office hours per week—HHIC only*

2.3 Availability and Accessibility Of Network Practitioners, Continued

Behavioral Health Care Providers

Health Plan members are expected to receive an appointment with a qualified Behavioral Health Practitioner within the following time standards:

Patient's Need	***Definition***	***Performance Standard***
Care for a life-threatening emergency	*Immediate intervention is required to prevent death or serious harm to patient or others.*	*Immediate response*
Care for a non-life-threatening emergency	*Rapid intervention is required to prevent acute deterioration of the patient's clinical state that compromises patient safety.*	*Within 6 hours*
Urgent care	*Timely evaluation is needed to prevent deterioration of the patient's condition.*	*Within 48 hours*
An appointment for a routine office visit	*Patient's condition is considered to be stable*	*Within 10 business days*
Telephone access to behavioral health screening and triage	*Callers reach a non-recorded voice within 30 seconds and abandonment rates do not exceed 5% at any given time*	• *Callers reach a non-recorded voice (operator) within 30 seconds* • *Hang-up rates do not exceed 5%*

2.3 Credentialing and Recredentialing: An Overview

Introduction To Credentialing

To be considered a participating practitioner and support the Highmark Blue Shield managed care products, all new practitioners must be approved by the Western Region Credentials Committee and sign a contract.

A contract is only issued to new practitioners after they have been approved by the Western Region Credentials Committee. Therefore, your participation and ability to treat Highmark members does not begin until you have signed and returned the contract and the contract has been executed by Highmark. A welcome letter that specifies the effective date of your participation will be sent to you, along with a copy of the executed contract. NaviNet-enabled practitioners who are seeking recredentialing must obtain a username and password from NaviMedix and complete their application online.

Introduction To Recredentialing

At least once every three years, Highmark completes the recredentialing process with any applicable physicians and any applicable allied health professionals in our managed care network. Our internal policies require recredentialing for the protection of our members. Additionally, the recredentialing program adheres to NCQA guidelines and helps us to meet CMS and Pennsylvania Department of Health requirements.

Purpose

The credentialing and recredentialing processes are performed by Highmark employees who work cooperatively with network practitioners to ensure that they meet credentialing and recredentialing standards.

Credentialing And Recredentialing Status

To learn the status of your credentialing application, call 1-866-763-3224.

2.3 Western Region Network Credentialing Policy

Policy

Western region network physicians and any applicable allied health professionals must be credentialed by Highmark.

Malpractice Information

Credentialing representatives may ask detailed questions regarding malpractice cases. If physicians do not submit the requested information, *they could be denied from the network(s)*. In order to receive an accurate score, please submit the requested information regarding malpractice.

Confidentiality

All practitioner information obtained in the credentialing process, except as otherwise provided by law, is kept confidential.

When Must Practitioners Be Credentialed?

If the practitioner is...	and is...	then the practitioner...
Completely new, has never been credentialed	Beginning to practice solo in the network area	Must be credentialed.
	Beginning to practice with an established network practice	
Established, has already been credentialed	Joining another established network practice in a *different* geographic area within six months	Has already completed the credentialing process and will be recredentialed every three years.
	Joining another established network practice in the *same* geographic area within six months	
	Leaving a group practice to begin a solo practice	

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2.3 Western Region Network Credentialing Policy, Continued

Practitioners Returning To The Western Region Network	In situations where a practitioner submits a signed, explicit document stating that he/she no longer wishes to be a western region participating practitioner and there is a break in service/contract of greater than 30 days, the practitioner will be required to undergo initial credentialing if he/she subsequently wishes to return to the network.
Special Edition Behind The Shield	*Every year, Highmark publishes a Special Edition Behind The Shield that includes the most recent information about credentialing and recredentialing requirements. The latest credentialing special edition and past issues can always be found in the Provider Resource Center under Publications & Mailings.*

2.3 Practitioners' Credentialing Rights

Policy

Physicians who are applying to the western region network have the right to review information submitted in support of their credentialing application.

Right To Review Information

Physicians who apply to the network have the right to review any information that we receive from outside primary sources during the credentialing process.

The following primary sources may be contacted as part of the credentialing process:

- State Licensing Bureau
- Drug Enforcement Agency
- Educational program(s) the practitioner completed
- American Board of Medical Specialties, if applicable
- National Practitioner Data Bank
- Office of the Inspector General participation/sanction data
- Federation of Chiropractic Licensing Board, if applicable
- Federation of Podiatric Medical Board, if applicable
- American Osteopathic Association
- Other recognized board certification agencies

How Practices Can Review Information

In cases where Highmark Credentialing Department representatives receive information from other sources that vary substantially from that provided by the practitioner to the extent that it would jeopardize the physician's admission to the network, a representative will contact the physician in writing.

Alternatively, the practitioner may specifically request that the information submitted by other sources be sent to him or her unless disclosure is prohibited by law. To do so, the practitioner must submit a written request to Highmark within 30 days of submitting an application. The practitioner must specify which information he or she would like to review and send the request to:

Attn: Credentialing Manager
Suite P4501
P.O. Box 1040
Pittsburgh, PA 15222

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2.3 Practitioners' Credentialing Rights, Continued

Right To Revise Inaccurate Information	During the credentialing process, practitioners also have the right to correct any inaccurate or erroneous information we receive from another source if it varies substantially from the information provided by the practitioner.
How Practitioners Can Revise Inaccurate Information	Directions as to how to revise information will be sent with the notification of the conflicting information.
NaviNet Makes Credentialing And Recredentialing Easy!	*NaviNet's Recredentialing Transaction makes it easier for practitioners with Highmark-hosted NaviNet access to save time by completing the recredentialing application online. NaviNet notifies you that your recredentialing application is due. The notice will include an electronic recredentialing application form that is pre-populated with the information Highmark already has on file.* *If you are not NaviNet enabled, please contact your Provider Relations Representative.*

2.3 Credentialing Process

Steps For Credentialing Using NaviNet

Step	*Action*
1	*Log in to NaviNet. Click on Provider File Management.*
2	*From the selection list, choose Initial Credentialing.*
3	*From the Drop Down List, choose the provider you would like apply for.*
4	*Click 'New Credentialing Application.'*
5	*Add all requested information to the application and click submit.*

Steps For Credentialing Non-NaviNet Enabled Providers

The process for credentialing new providers and recredentialing existing network providers is essentially the same. Network practitioners must be credentialed at least every three years.

Stage	Description
1	A practice either visits the Provider Resource Center online or calls 1-866-763-3224 and requests an application. If the practice submits electronically, proceed to step 3. If the practice submits on paper, proceed to step 2.
2	A Credentialing Department representative mails an application packet to the practice.
3	The practice completes the application, electronic or otherwise, attaches all applicable documentation, and returns it to the credentialing address indicated in the application packet.
4	The Credentialing Department representative reviews the application. Is all of the information complete? **If yes,** proceed to Stage 6. **If no,** proceed to Stage 5.
5	The Credentialing Department representative contacts the practice to request the missing information. Does the practice send the requested information within the required period? **If yes,** proceed to Stage 6. **If no,** process is halted.

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2.3 Credentialing Process, Continued

Steps For Credentialing Non-NaviNet Enabled Providers (continued)

Stage	Description
6	The Credentialing Department may verify or confirm State Licensing Bureau • National Practitioner Data Bank • Educational program the provider completed • Drug Enforcement Agency • State Licensing Bureau • American Board of Medical Specialties or American Osteopathic Association, if applicable • OIG sanction data Have all sources provided notification to meet standards? **If yes,** proceed to Stage 11. **If no,** the process may be delayed.
7	The Credentialing Department will also review the application for the following requirements: • Ability to enroll new members (PCP) • Ability to provide urgent/routine care • 24/7 coverage (if applicable) • Practice availability 20 hours/week (PCP)
8	A Credentialing Department Specialist verifies that all information required for NCQA and/or State and Federal Regulatory Agencies is complete. The western region network is required to verify all application information within 180 days from the date the practitioner signs the application. If verification cannot be completed within 180 days, the applicant will be asked to re-sign and re-date the application and provide valid, current information.

Continued on next page

2.3 Credentialing Process, Continued

Credentialing Process, continued

Stage	Description
9	The Highmark Western Region Credentialing Committee reviews practitioners who do not meet Highmark credentialing criteria based on the application information. The Medical Director approves all routine practitioners who meet all Highmark credentialing criteria. Does the Committee or Medical Director approve the provider for entrance into the network? **If yes**, proceed to Stage 12. **If no**, the Quality Management medical director sends written notification to the provider within 60 calendar days. The process is complete. **Note:** In some instances, the Committee may require additional information from the provider before rendering a decision.
10	A contracting representative prepares the appropriate forms. A Provider Relations representative delivers the unsigned contract to the practitioner for signature, at which time orientation is performed. The practitioner signs the contract and returns the original contract and a copy to Highmark.
11	A Highmark representative signs the contract validating the contract.
12	Provider information is entered into the western region network Provider File that feeds the Provider Directory and the claims payment system.
13	A copy of the executed contract and a welcome letter stating the effective date is mailed to the new western region network practitioner. Process complete.

Caution! Participation in the western region network is effective only upon completion of a signed executed contract. The participation effective date is stated within the welcome letter (see Stage 13).

2.3 Recredentialing Process

Recredentialing Process

The recredentialing process is performed by Highmark employees who work cooperatively with network practitioners to ensure that they are still meeting the same high standards that they met when they entered the western region network.

Online Submission Required

NaviNet-enabled practices are required to submit recredentialing applications using the streamlined online process through NaviNet.

Online Recredentialing Process

NaviNet's recredentialing transaction simplifies the recredentialing process by allowing you to submit information online and reducing the number of requests for additional information or clarification. If you need further details about how to complete this process, you may view the online user guide. On the NaviNet toolbar, hover over Customer Service. Select NaviMedix Customer Care, then User Guides.

Step	Action
1	Six (6) months before the end of your credentialing cycle you will receive notification that your recredentialing application is due. The message will appear through the Action Items function. The message includes an application form pre-populated with the information currently on file.
2	Complete and submit the online form. You may complete portions of the form and return to it later. The form also contains a log of the portions that remain incomplete. The system automatically checks your entries before accepting them. So, it will not permit you to submit an incomplete form.
3	You may print a copy for your records if you desire.
4	Within 180 days from the date the practitioner signs and mails the attestation statement, a Credentialing Department representative conducts primary source verification.
5	The Credentialing Committee or the Medical Director reviews the practitioner's qualifications.
6	The practitioner is notified of any adverse decision through a letter within 60 calendar days.

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2.3 Recredentialing Process, Continued

Paper Recredentialing Process

The steps below describe the paper recredentialing process.

Stage	Description
1	A Credentialing Department representative mails a copy of credentialing information on file.
2	Verify the credentialing information and make any necessary corrections.
3	Mail the form to the Credentialing Department at the address indicated in the packet.
4	A Credentialing Department representative reviews the document to ensure all information is present. The document may be returned to the practitioner for additional information.
5	Within 180 days from the date the practitioner signs the attestation statement, a Credentialing Department representative conducts primary source verification.
6	The Credentialing Committee or Medical Director reviews the practitioner.
7	The practice is notified of the outcome through a letter.

2.3 Credentialing Requirements for Pathologists, Anesthesiologists, Radiologists, and Emergency Medicine Physicians

Ancillary Service Credentialing Policy

Western region network physicians and any applicable allied health professionals must be credentialed according to established criteria. This standard includes all specialists including those who provide ancillary services:

- Pathologists
- Anesthesiologists
- Radiologists
- Emergency medicine physicians

NOTE: Ancillary service providers who practice only in acute care facilities, do not need to be credentialed.

Emergency Medicine Qualification Requirements

Emergency medicine physicians who are not board certified in Emergency Medicine must have:

- Board certification in one of the following:
  - Family practice
  - Internal medicine
  - Pediatrics
  - General surgery
- Current certification in all of the following:
  - Advanced cardiac life support (ACLS)
  - Advanced trauma life support (ATLS)
  - Pediatric advanced life support (PALS)

2.3 Credentialing Requirements for Behavioral Health Care Providers

Behavioral Health Practitioner Requirements	Behavioral Health Practitioners considered for participation must provide evidence of one of the following: • A current license in their specialty at the highest level in the state in which they practice. Licensure must be for independent practice, if applicable. • Minimum malpractice and liability insurance coverage amounts of $1 million per claim and $3 million per year or that required by state law.
National Professional Organization Membership	Membership in a national professional organization that ascribes to a professional code of ethics, such as the American Psychiatric Association or the American Psychological Association is preferred.
Psychologist Requirements	Psychologists must be licensed as a psychologist in the state in which they practice, hold a doctoral degree in psychology, and have one of the following: • Certification from the Council for the National Register of Health Service Providers in psychology • Certification from the American Board of Professional Psychology. Diplomat in clinical counseling, family psychology, neuropsychology or health psychology • A dissertation for the doctoral degree that is primarily psychological in nature with a specialty in clinical, counseling or professional-scientific psychology • Certificate of graduation from an APA-approved internship or successful completion of an APA-equivalency form.

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2.3 Credentialing Requirements for Behavioral Health Care Providers, Continued

Clinical Social Worker Requirements	Clinical social workers must hold a master's degree or doctoral degree in social work from a school accredited by the Council on Social Work education. Additionally, they must be licensed at the highest level for independent practice in the state in which they practice.
Clinical Nurse Specialist Requirements	Clinical nurse specialists must be licensed as a registered nurse in the state in which they practice. They must hold a certificate of clinical nurse specialty in psychiatric mental health nursing as issued by the ANA/ANCC.
Psychiatric Certified Registered Nurse Practitioner (CRNP) Requirements	Psychiatric certified registered nurse practitioners (CRNPs) must meet the following three criteria: ▪ Must be licensed as a registered nurse and a CRNP in the state in which they practice ▪ Must have a current, valid certification from the American Nurses Credentialing Center or Commonwealth of Pennsylvania Psychiatric Nurse Practitioner Certification ▪ Must have a collaborative agreement with a western region network psychiatrist

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2.3 Credentialing Requirements for Behavioral Health Care Providers, Continued

Master's-Prepared Therapist Criteria

Master's-prepared therapists (other than clinical social workers or nurses) must hold licensure or certification in the state in which they practice at an independent practice level in an accepted human services specialty, such as one of the following:

- Master's-level psychologist
- Licensed professional counselor (LPC)
- Marriage and family therapists (MPT)

2.3 Dual Credentialing and Recredentialing as Both PCP and Specialist

Dual Contracts	*Western region contracts with network physicians as either Primary Care Physicians (PCPs) (i.e. family practitioners, general practitioners, internists, or pediatricians) or as specialists (all other MDs or DOs).* *Dual contracts for both categories of practitioners may be allowed when an individual practitioner meets credentialing standards for each specialty requested.*
Criteria	*A practitioner identified as both PCP and specialist must meet the following criteria:* • *Demonstrate that the practice adequately provides primary care services to western region network members.* • *Meet the standards for PCPs* • *Provide documentation of an average of 50 CME hours per year for the past three years if not board certified in both areas of practice.*
Recredentialing	*Dual credentialed practitioners will undergo full recredentialing for PCP and specialist participation every three years.*
Provider Directory	*All dual-credentialed physicians will appear in the provider directories as both PCPs and specialists and can receive referrals from other PCPs.*

2.3 Practitioner Office Site, Quality Medical Record Documentation Review, and Process Improvement Reviews

Review Process Changed
New!

Effective July 1, 2008, Highmark's office site review process was changed. In lieu of credentialing-related site visits previously performed for all PCPs, Ob/Gyns and potential high-volume behavioral health practitioners, Quality Management nurses will conduct Practitioner Office Site Quality, Medical/Treatment Record and Process Improvement evaluations for ***any practitioner within the network*** *based on the following:*

Reviews Performed

Reviews are performed on:

- *Member Dissatisfactions:*

A member dissatisfaction submission is received about the quality of any practitioner (PCP, specialist or allied practitioner) office when care is delivered related to the categories listed below

  - *Physical accessibility*
  - *Physical appearance*
  - *Adequacy of waiting room and examining/treatment room space*

- *Random Sample:*

Annually, using a statistically valid sampling methodology, practice sites will be selected to have practitioner office site quality, medical/treatment record and process improvement evaluations performed.

Scoring Requirements

Follow-up reviews will be conducted for all practice sites which score below Highmark's threshold of 80 percent for the Practitioner Office Site Quality and Medical/Treatment Record evaluations and below 50 percent for the Process Improvement evaluation. Practitioners in offices with continuous opportunities for improvement after three consecutive visits at six-month intervals will be presented to the Credentials Committee as exception practitioners for further recommendation. Practices failing to correct deficiencies may be sanctioned and become ineligible for QualityBLUE[SM] incentive payments. Practices with office deficiencies on repeated re-evaluations may be terminated from network participation.

Continued on next page

2.3 Practitioner Office Site, Quality Medical Record Documentation Review, and Process Improvement Reviews, *Continued*

Review Tool Elements *The following list includes the basic elements included on the review tool. A detailed list is available by calling 412-544-2623.*

Practitioner Office Site Quality	***Medical Records Documentation***
• *Physical Accessibility* • *Physical appearance of the office* • *Adequacy of waiting room and examining/treatment room space* • *Secure, organized medical record systems* • *Adequate, up-to-date equipment* • *Patient confidentiality* • *Office Accessibility* • *Availability of emergent, urgent, routine and preventive appointments* • *Coverage availability 24 hours a day, seven days per week*	• *Individual clinical records are established and easily retrievable* • *Current problem lists* • *Up to date preventive services flow sheet* • *Up to date medication flow sheet* • *Medication allergies and adverse reactions* • *All entries in the record contain author's identification, which may be a handwritten signature, unique electronic identifier handwritten and are legible to someone other than the writer* • *Past medical history* • *History and physical identifies pertinent subjective and objective data* • *Appropriate subjective and objective data for each visit* • *Diagnostic impressions are consistent with the findings* • *Treatment or therapy plans are consistent with diagnoses* • *Use of tobacco, alcohol and/or other substance abuse* • *Coordination of care and notation of follow-up plans* • *Discussion of advance directives* • *Documentation and treatment are consistent within the scope of the licensure of the practitioner* • *Medical/treatment records should reflect:* • *All services provided directly by the practitioner* • *All ancillary services and diagnostic tests ordered by a practitioner* • *All diagnostic and therapeutic services for which a member was referred by practitioners, such as:* • *Home health nursing reports* • *Specialty physician reports* • *Hospital discharge reports* • *Physical therapy reports*

2.3 Practitioner Office Site, Quality Medical Record Documentation Review, and Process Improvement Reviews

Treatment Record Documentation Evaluation (for behavioral health practitioners)	***Process Improvement Evaluation***
• *Medical and psychiatric history* • *Presenting problems* • *Mental Status Exam* • *Special status situations, such as imminent risk of harm, suicidal ideation or elopement potential* • *DSM-IV diagnoses are identified and consistent with presenting problems, history and mental status, etc.* • *Treatment plans and goals*	• *Members with chronic conditions are proactively notified to schedule appropriate appointments.* • *Members due for age-appropriate, preventive appointments are proactively notified to schedule appropriate appointments.* • *Members who either "no show" or cancel appointments are contacted and encouraged to reschedule their appointment.* • *Reminder calls are made prior to scheduled appointments.* • *When a consultation is requested, the office communicates to the specialist/organization provider the reason for the referral.* • *Process confirming laboratory, diagnostic procedures and/or consultation appointments were performed*

2.3 Practitioner Quality And Board Certification

Policy	*To be credentialed in the western region network, PCPs and specialists (including podiatrists and oral maxillofacial surgeons) are required to be board certified in the specialty in which they practice.*
Highmark Recognized Boards For Certification	*Highmark recognizes the following boards for certification: America Board of Medical Specialties, The American Osteopathic Boards, The American Board of Podiatric Orthopedics and Primary Podiatric Medicine, American Board of Podiatric Surgery, American Board of Oral and maxillofacial Pathology, American Board of Oral and Maxillofacial Surgery and American Academy or Oral and Maxillofacial Radiology.*
Exceptions	*Some practitioners may be exempt from the board-certification requirement. Those practitioners without board certification who qualify for a board certification exception must provide documentation of an average of at least 50 continuing medical education hours per year for the previous three years.* *The requirements for board-certification exception are as follows:* • *Practitioners who have completed an approved, applicable residency or fellowship in the specialty of practice and have graduated from an accredited medical, osteopathic, dental or podiatric school, and finished training prior to December 31, 1987.* • *Practitioners who have not practiced for a sufficient length of time to complete board certification. (Practitioners must complete the board certification within two years of meeting the eligibility requirement.)* • *At the time of the practitioner's credentialing or recredentialing, 50 percent or more of the existing practice's credentialed associates (including the practitioner who is undergoing the credential/recredentialing process) are already board certified in the specialty being requested, and the practitioner has completed an approved, applicable residency or fellowship in the specialty of practice.* • *Rural practitioners who have greater than five years of experience in the specialty in which they practice and have completed an approved applicable residency or fellowship in the specialty of practice.*
Additional Requirements For Certain Specialties	*In addition to the standard requirements for specialist, certain specialties must satisfy other criteria:*

Continued on next page

2.3 Practitioner Quality And Board Certification, Continued

Additional Requirements For Certain Specialties (continued)

- *Emergency medicine physicians may satisfy the board certification requirement with board certification in emergency medicine, family medicine, internal medicine, pediatrics or general surgery and completion of two or more years of post-medical school residency training. Emergency medicine physicians (and any physician who works in the Emergency Department) must also have current certification in advanced cardiac life support (ACLS), advanced trauma life support (ATLS) and pediatric advanced life support (PALS) unless they are board certified in emergency medicine.*

- *Highmark does not require facility-based pathologists, oral maxillofacial pathologists, anesthesiologists, radiologists, oral maxillofacial radiologists or emergency medicine specialists who practice exclusively in an acute care hospital setting to complete the standard Highmark credentialing or recredentialing process for the network(s). However, these providers must complete the appropriate provider agreements to participate with Highmark Blue Shield's Participating Provider network. Please contact your Highmark Provider Relations representative if you have questions regarding this process.*

Requirements When Credentialing or Recredentialing Is Not Required

Highmark does not require credentialing or recredentialing for the network(s) when these requirements are met:

The practitioner must:
• provide 100 percent of his or her services to members exclusively in the acute-care or general hospital setting
• possess a current Pennsylvania medical license in good standing
• have current active malpractice insurance that meets or exceeds Pennsylvania state requirements
• actively participate with Medicare or Medicaid and have never been debarred from or excluded from participation in any Medicare or Medicaid government programs
• sign an Affirmation of Medical Practice Statement (Form No. 282)

Credentialing For Services To Members Outside of a Blue-Participating Hospital

If a provider begins to provide medical services to members outside of a Blue Shield network-participating acute care hospital, the practitioner will be required to complete a Provider Application and go through the credentialing process.

Psychologists must be licensed as a psychologist in the state in which they practice and hold a doctoral degree in psychology and meet one of the following criteria:

• Certification from the Council for the National Register of Health Service Providers in Psychology Certification from the American Board of Professional

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2.3 Practitioner Quality And Board Certification, Continued Continued

Credentialing For Services To Members Outside of a Blue-Participating Hospital (continued)

Psychology, Diplomat in Clinical Counseling, Family Psychology, Neuropsychology or Health Psychology

- *A dissertation for the doctoral degree that is primarily psychological in nature with a specialty in clinical counseling or professional-scientific psychology*
- *Graduation from an APA-approved internship or successful completion of an APA-equivalency form*
- *Licensed clinical social workers (LCSWs) must hold a master's degree or doctoral degree in social work from a school accredited by the Council on Social Work education and must be licensed at the highest level for independent practice in the state in which they practice.*
- *Clinical nurse specialists must be licensed as a registered nurse in the state in which they practice and hold a certificate of Clinical Nurse Specialty in psychiatric mental health nursing as issued by the ANA/ANC.®*
- *Psychiatric-certified, registered nurse practitioners (CRNPs) must be licensed as a registered nurse and a CRNP in the state in which they practice. A CRNP with a secondary license type in mental health must have a collaborative agreement with a credentialed western region network psychiatrist. ®*
- *Master's-prepared therapists (other than clinical social workers or nurses) must hold licensure or certification in an accepted human services specialty, such as master's level psychologist, licensed professional counselor (LPC), marriage and family therapists, etc., at an independent practice level in the state in which they practice.*

2.3 Reporting Changes In Your Practice

How To View Real Time Billing Information

You may view real time detailed billing vendor information under NaviNet's Provider File Management section. Select Provider File Management, then Provider Information to view the summary.

If you are not NaviNet-enabled please contact Provider Information Management to request a copy of the summary.

Policy For Changing Practice Information

The provider database maintained by Highmark Blue Shield contains vital information regarding each network provider.

By keeping your practice information updated, you help Highmark do the following:

- Process claims correctly
- Notify members of the names and addresses of network providers
- Notify primary care physicians of available specialists to whom they may refer

Most changes will require Highmark Blue Shield to revise existing provider files. In most cases, membership or claims payment will be affected by changes in your practice. Therefore, if you do not give advance notification, we cannot guarantee accurate membership information, claims and/or payments.

Using NaviNet To Report Updated Practice Information

NaviNet enabled providers should use NaviNet's 'Provider File Management' function to complete updates to the practices information.

Click 'Provider Information Change' under 'Provider File Management.' Choose the billing provider number and location to send the updates. This function can be used to change the practice's Address, Current Contact Information, Address Types, Affiliated Practitioners and more.

If you do not have a button for 'Provider Information Change' please contact NaviMedix at 1-888-482-8057.

How To Update Practice Information For Non-NaviNet Enabled Providers

What Region Am I?

Non-NaviNet enabled providers in the Western, Central and Eastern regions must notify Highmark Blue Shield of any change to their practices. Network providers in Northeastern PA must notify Blue Cross of Northeastern Pennsylvania.

Notification should occur 60 days before the change. This is a requirement of your network agreement.

Continued on next page

2.3 Reporting Changes In Your Practice, Continued

Types Of Changes To Report

The following is a list of changes in your practice that must be communicated to Highmark Blue Shield:

- Practice location change
- Billing/mailing address change
- Telephone number change
- Fax number change
- Hospital affiliation change
- Office hours change
- New tax identification number
- Practice name change
- Providers joining the practice
- Providers leaving the practice (including through retirement or death)
- Changes in Malpractice Insurance Coverage Levels (10 days in advance of any reduction or termination of coverage)
- Practice mergers
- Practice acquisitions
- Addition or closure of a practice site

* Highmark-hosted NaviNet-enabled practices should make their address, telephone and contact name information changes via the Provider Information changes functionality. Simply check Provider Information Changes, choose the billing provider number, choose the location and send the updates.

Important!

All providers joining or leaving an established practice or leaving a Highmark Blue Shield network must notify Highmark Blue Shield 60 days before the event. Refer to the following page regarding how to report changes in your practice.

New providers in Western, Central and Eastern PA who are not participating with Highmark Blue Shield but wish to join the network may call 1-866-763-3224 to request the appropriate paperwork. Or, they may access the Provider Forms link on the Provider Resource Center of our Web site to access the forms. New providers in the 13 northeastern counties should call 1-800-451-4447.

The provider agreement between Highmark Blue Shield and network providers is not assignable. In cases of practice mergers, acquisitions, etc., it is necessary to send written notification, on practice letterhead, to:

What Region Am I?

Western, Central and Eastern PA:
Highmark Blue Shield
Provider Information Management
P.O. Box 898842
Camp Hill, PA 17089-8842
Fax: 1-800-236-8641

Northeastern PA:
Blue Cross of Northeastern Pennsylvania
Provider System Support
19 North Main Street
Wilkes-Barre, PA 18711
Fax: 1-570-200-6880

2.3 Reporting Changes In Your Practice, Continued

How To Use NaviNet To Update Existing Assignment Account Information

Western, Central and Eastern Region NaviNet-enabled providers can use NaviNet's Provider File Management section to update enabled providers on their assignment accounts. Click Provider File Management.

Choose Provider Add/Delete to add new practitioners to the assignment account or delete practitioners who are leaving a practice.

Choose the assignment account to update and follow prompted instructions throughout to complete your update.

How To Make Changes To Existing Assignment Account Information For Non-NaviNet-Enabled Providers

Send or fax the *Request for Addition/Deletion to Existing Assignment Account* form, signed by the managing partner, to the addresses or fax numbers shown below. This form is located under Provider Forms on the Provider Resource Center.

What Region Am I?

Western, Central and Eastern PA:
Highmark Blue Shield
Provider Information Management
P.O. Box 898842
Camp Hill, PA 17089-8842

Northeastern PA:
Blue Cross of Northeastern Pennsylvania
Provider System Support
19 North Main Street
Wilkes-Barre, PA 18711

Western, Central and Eastern Region Fax: 1-800-236-8641
Northeastern Region Fax: 1-570-200-6880

NOTE: If you are adding a new physician to an existing practice, the new physician must sign the letter or form.

2.3 Malpractice Insurance Requirement

Overview

A provider must carry, at their own cost and expense; the minimum required amount of malpractice insurance at all times to maintain credentialing.

Network Malpractice Insurance Criteria

Providers must carry and maintain at all times liability and professional liability (malpractice) insurance to insure the group provider and each individual practitioner against any claim or claims for damages arising by reason of personal injury or death occasioned, directly or indirectly, in connection with the performance or omission of any provider service. The amount of coverage carried should not be less than the amounts required by any applicable state laws or less than those coverage levels required by Highmark.

Network providers must provide evidence of coverage to the network upon request. Providers must also notify Highmark at least thirty days in advance of any reduction or termination of malpractice coverage.

If You Are MCARE-fund Eligible

Medical doctors, doctors of osteopathy, podiatrists and nurse midwives are required by Pennsylvania law to participate in the Pennsylvania Medical Care and Reduction of Error Fund ("MCARE Fund").

By law, these providers must maintain primary medical malpractice insurance with liability limits of $500,000 per medical incident and $1.5 million in the annual aggregate in addition to the limits provided by the MCARE Fund of $500,000 per medical incident and $1.5 million in the annual aggregate.

These practitioners include, but are not limited to the following:

- Medical Doctors
- Doctors of Osteopathy
- Podiatrists
- Dental Specialists
- General Dentists

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2.3 Malpractice Insurance Requirement, Continued

If You Are Not MCARE-Fund Eligible

All network practitioners who are not required to participate in the MCARE Fund must carry minimum medical malpractice insurance with liability limits of $500,000 per medical incident and $1.5 million in the annual aggregate.

These practitioners include, but are not limited to the following:

- Audiologists,
- Doctors of Chiropractic,
- Certified registered nurse anesthetists*
- Nurse Practitioners
- Optometrists,
- Oral maxillofacial surgeons and
- Physical therapists
- Speech Therapists.

*CRNPs are required to carry $1 million per incident and $3 million in the annual aggregate.

2.3 Termination From The Network

Valid Reasons For Termination

Professional network providers shall be terminated in accordance with the relevant terms of their provider contracts for failure to satisfy the following criteria, which includes, but is not limited to:

1. *Maintain an active license to practice.*
2. *Maintain an active DEA certificate, where applicable.*
3. *Maintain coverage for malpractice insurance in the minimum amounts required and participate in the MCARE Fund.*
4. *Maintain acceptable professional liability claims history.*
5. *Participate in recredentialing, which includes providing all requested recredentialing information, and be recredentialed for network participation.*
6. *Provide acceptable clinical quality of care to members.*
7. *Meet appropriate recredentialing requirements.*

Professional network providers shall also be terminated if, in the plan's sole discretion, any of the following occur, or are in imminent danger of occurring:

1. *Acts or omissions that jeopardize the health or welfare of a member.*
2. *Acts or omissions that negatively affect the operation of the network.*
3. *Acts or omissions which cause the Plan to violate any law or regulation or which negatively impact the Plan under any regulatory or certification requirements.*
4. *Failure to provide an acceptable level of care.*

Invalid Reasons For Termination

A provider may not be terminated for any of the following reasons or actions:

1. *Advocating for medically necessary and appropriate health care consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable legal standard of care.*
2. *Filing a grievance against the Plan in response to a disapproval of payment for a requested service, an approval of the requested service at a lower scope or duration, or a disapproval of the requested service but an approval of payment of an alternative service.*
3. *Protesting a decision, policy or practice that the provider, consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable legal standard of care, reasonably believes interferes with the provider's ability to provide medically necessary and appropriate health care.*
4. *The provider has a practice that includes a substantial number of patients with expensive medical conditions.*

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2.3 Termination From The Network, Continued

Invalid Reasons For Termination *(continued)*

5. *Objection to the provision of or refusal to provide a health care service on moral or religious grounds.*
6. *Any refusal to refer a patient for health care services when the refusal of the provider is based on moral or religious grounds and the provider has made adequate information available to the members in the provider's practice.*
7. *Discussing (a) the process that the plan uses or proposes to use to deny payment for a health care service, (b) medically necessary and appropriate care with or on behalf of a member, including information regarding the nature of treatment, risks of treatment, alternative treatments, or the availability of alternate therapies, consultations or tests; or (c) the decision of the plan to deny payment for a health care service.*

Decisions to terminate a provider may be made by the Medical Director(s) of Quality Management in urgent situations or by the Credentials Committees. A provider shall be provided with a written decision to terminate with the specific reason for the decision and any appeal/reconsideration rights. Final termination decisions will negatively affect the provider's reimbursement for services provided to members in the Highmark products serviced by the western region network and PremierBlue Shield networks.

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2.3 Termination From The Network, Continued

Reconsideration Process for An Intention To Terminate Action Or Denial

A request for a reconsideration of an intention to terminate decision or denial by the Credentials Committees is available to a professional network provider in the following instances:

1. *The termination action or denial by a Medical Director or by the applicable Credentials Committee was due to the lack of required qualifications at the time of credentialing/recredentialing. This includes, but is not limited to, loss of an unrestricted state license, loss of DEA license, failure to obtain or keep appropriate board certification, lack of adequate hospital privileges, and/or insufficient malpractice insurance coverage.*
2. *The termination action or denial by a Medical Director or by the Credentials Committees was due to any other reason not reportable to the National Practitioner Data Bank.*

The provider must request the reconsideration in writing within 30 days of notice of the termination. The provider shall be given the opportunity to present information to the Credentials Committee by one or any of the following options.

1. *In writing, to the Credentials Committee for consideration which shall take place during a Credentials Committee meeting.*
2. *Appearing in person at a Credentials Committee meeting.*
3. *Participating via a telephone conference call at a Credentials Committee meeting.*

After the meeting, the provider shall receive written notice of the final decision of the Credentials Committee, which will include the basis for the decision, the appeal process and the practitioner's right to a final appeal to the Medical Review Committee within 30 days if the decision is upheld. The provider will remain in the network until the Credentials Committee's final decision to terminate and an effective date of termination is established.

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2.3 Termination From The Network, Continued

Appeals Of Credentials Committee Final Decision

In the event of an appeal, the Plan's Medical Review Committee (comprised of professional peers) shall be available, upon written request, to any professional network provider who has been notified of the final termination decision, denial, or suspension from the Plan's network.

The provider must request the appeal, in writing, within thirty- (30) days of receipt of written notification of an adverse decision. The provider remains in the Plan's network until the appeal process is completed, unless the provider has been subject to an immediate termination. No appeal is available if the provider has waived or forfeited the right to an appeal.

Step	*Action*
1	*If an appeal is requested, the provider may submit to the Secretary of the Medical Review Committee any documentation believed to be relevant for consideration during the appeal process.*
2	*The provider will then receive a notice of the hearing place, date and time and an explanation of the Committee hearing process. This includes the practitioner's right to representation by legal counsel and/or other individuals to support his/her position, a record of the proceedings, and his/her ability to call witnesses, etc.*
3	*All relevant documentation, including but not limited to, the provider's credentialing file and minutes of the applicable Credentials Committee meeting(s); and all applicable recommendations and decisions will be presented at a meeting of the plan's Medical Review Committee. The Medical Review Committee's members shall be peers and not be in direct economic competition with the provider. The plan's Medical Review Committee will determine if:* • *The termination process was handled correctly according to the plan's Policies and Procedures.* • *The provider was afforded a reasonable opportunity to address the issues, concerns or deficiencies that led to the decision.* • *The denial, intention to terminate action or immediate termination process was performed with merit and without bias, conflict of interest or inadequate attention to the documentation presented.*

Continued on next page

2.3 Termination From The Network, Continued

Appeals Of Credentials Committee Final Decision, *continued*	***4***	*The plan's Medical Review Committee will decide whether to uphold or reverse the decision. The plan's Medical Review Committee's decision is final and not subject to further appeal.*
	5	*The Quality Management/Medical Director Committee Representative will notify the provider, in writing, of the plan's Medical Review Committee's decision, including a statement of the basis of the decision. The notification will address any future action that may be forthcoming as a result of that appeal decision.*

Chapter 2

Provider Responsibilities

Unit 4: PCP Policies and Procedures For All Products

In This Unit

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2.4 Arranging For PCP Absence

Introduction

The purpose of this section is to explain what the PCP needs to do before leaving for vacation or other time off.

Making The Necessary Arrangements

1. Find a PCP who participates in the same network(s) as you to provide medical treatment to members during your absence.
2. Resolve payment arrangements, including co-payments
3. Inform office staff of the above arrangements and ask that the covering physician inform his or her office staff of the arrangements.
4. Be sure that your answering service informs patients of the arrangement.

Appointments

Most members will be able to wait for their regular PCP's return. However, there will be some cases when a member will require an office visit during his or her PCP's absence. For such cases, the covering PCP's office staff should make an appointment or arrangements and give the member clear directions.

Important: Authorization Requests During The PCP's Absence

If the PCP is planning to be away for a short duration (less than 5 days), the covering PCP can request authorizations, and advise members to go to specialists or the emergency room during the PCP's absence. The covering physician may keep a list of these incidents, which he or she then shares when the member's PCP returns. For the treatment that took place during the absence, the member's PCP should submit any authorization requests expediently to avoid payment delays.

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2.4 Arranging For PCP Absence Continued

Reimbursement And Co-payments	We advise physicians to work out their own payment arrangements prior to covering for one another. We do not provide additional reimbursement to practitioners who are covering for other PCPs. The collection of co-payments works the same way. The two physicians involved should come to an agreement as to how this will be handled.
Informing The Office Staff	It is imperative that both the regular and the covering physicians' office staffs be aware of any temporary coverage arrangements. Failing to notify the office staffs may decrease continuity of care to network members.

2.4 Locum Tenens Policy

Overview

Highmark allows providers with established assignment accounts to utilize the services of a locum tenens to cover for a credentialed provider of the group or provide additional coverage for increased demands or cover while recruiting additional providers.

Rules To Utilize Locum Tenens

In order for a provider to obtain this type of coverage the locum tenens:

- must be licensed to provide services in Pennsylvania
- can only provide services for a total of six months or less within any 12-month period beginning with the first date of active service.

Procedure

Step	Action
1	Practice must notify their Provider Relations Representative (PRR) of their request for locum tenens.
2	The PRR must obtain the following information from the provider: • A Participating Provider Agreement with Highmark Blue Shield form signed by the locum tenens (if they do not currently have a valid individual Highmark provider number or are currently nonparticipating). • A Request for Addition/Deletion to Existing Assignment Account form signed by the locum tenens assigning payment for their services. • The Locum Tenens form, available on the Provider Resource Center under Provider Forms, completed by the practice indicating, if applicable, who the locum tenens is covering for and the specific dates they will be providing services • The Locum Tenens UPIN, Medicare welcome letter and NPI number if the group provides services to Medicare Advantage members.
3	The PRR will verify that the Locum Tenens was added to the assignment account and has not provided or will provide services in a time frame not to exceed 6 months. The PRR will notify applicable Highmark internal departments.
4	The PRR will notify the Assignment Account of the start and end dates of the locum tenens or of the reason the Locum Tenens cannot be added and notify the requesting provider.

2.4 Requesting A Contract Copy

Overview

Highmark allows participating providers to request copies of their participating physician contract, as required. Highmark will provide a copy of the contract with participating physicians including certain contracts with physician organizations or physician groups where participating physicians participate.

Highmark is restricted, however, to provide contracts to requesters if the terms of the contract restrict the request.

If you have further questions about this process, please contact your Provider Relations Representative.

How To Request A Copy/Track The Status Of Your Participating Physician Contract

Providers must direct a written request for a copy of their contract to:

Highmark Blue Shield
Provider Information Management
P.O. Box 898842
Camp Hill, PA 17089-8842

Upon receipt of the request, Highmark's Provider Maintenance department will provide the requestor one copy of their participating physician contract, unless otherwise requested.

To check the status of your request, please call 1-866-763-3224, option 4. Requests generally take 15 business days to process. Please allow ample time for processing before checking the request status.

2.4 Member Removal Policy – Western Region Only

Policy

All members of Highmark Blue Shield and the Western Region's managed care programs have a responsibility to maintain a cooperative physician/patient relationship. Documented occurrences of members not fulfilling their responsibilities may result in a practitioner requesting discharge of the member from his or her practice.

Background

The relationship between a PCP and his or her members is crucial in the managed care environment. However, sometimes problems can occur which cause a serious rift in the doctor/patient relationship. In such cases, we ask the PCP to attempt to resolve the matter directly with the member. If this does not correct the problem, the PCP is supported in his or her effort to remove the member from the practice.

Valid Reasons For Member Removal

Valid reasons for discharge of a member include:

Patient fraud: All cases of potential fraud and abuse should be reported to Highmark Special Investigations Department at 1-800-438-2478 by either the practitioner or the Highmark employee.

Abusive behavior: Examples include profanity or threats of physical violence. For mentally competent members over the age of 21, the noted behavior must be exhibited by the member and not by family members. For mentally incompetent adults or minors, the noted behavior must be exhibited by the immediate family members and/or guardians.

Medical non-compliance: This includes a member failing to follow a recommended course of treatment. The practitioner must be able to demonstrate that non-compliance has jeopardized, or could likely jeopardize the health/safety of the member.

Network procedures non-compliance: This includes a member who has missed more than two appointments within the past 12-month period without appropriate notification. The practitioner must have a written policy that informs the member of the consequences of missed appointments.

Continued on next page

2.4 Member Removal Policy – Western Region Only, Continued

Valid Reasons For Member Removal **(continued)**

Member fails to meet the financial obligation of the plan: This includes non-payment of copayments after reasonable effort has been made to collect monies. This does not include outstanding charges the member owes the practitioner prior to the effective date with Highmark or the western region network managed care programs.

Legal action: This includes past legal action by the member or legal action that has been threatened against the practitioner or the practitioner's staff. It does not include legal action involving providers other than the practitioner requesting the discharge.

Out-of-area members: Members must reside permanently in the network area. For Highmark's western region Medicare Advantage HMO, members may be out of the service area for up to six months while retaining their in-area PCP. Highmark's western region medicare advantage HMO considers any greater period to be a permanent move and the member will be involuntarily disenrolled from the program.

Exceptional circumstances: This includes circumstances where the doctor/patient relationship could be jeopardized due to irreconcilable differences between the practitioner and the member. The practitioner should be able to demonstrate/document incidents as shown in the medical record.

Providers may also discharge (or not accept) members who were previously removed from the practice but attempt to select the practice again.

Members who unknowingly select a practice during open enrollment that has been closed may not be added to the practice. Member Services shall promptly notify the member that the practice is closed and that they will need to select another practice.

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2.4 Member Removal Policy – Western Region Only, Continued

Invalid Reasons For Removing A Member

Invalid reasons for removing a member include:

- Race
- Sexual orientation
- Age (Unless the member's age is outside of the scope of the practice. For example, an adult patient in a pediatric practice.)
- National origin
- Diagnosis
- Physical disability
- Religion
- Gender
- Health status factors (e.g., medical condition, claims experience, receipt of healthcare medical history, genetic information or evidence of insurability)
- Health care insurance coverage

Before You Request Removal...

Removing a member from your practice should be used as a last resort.

You must make a sincere attempt to resolve the situation with the member prior to requesting his or her removal. Your efforts must be documented in the member's chart.

2.4 Member Removal Procedure – *Western Region Only*

Member Removal

The following steps describe the member removal procedure.

Stage	Who Does It	What Happens
1	PCP	Identifies the problem, communicates the problem to member or member's legal representative, and documents the problem in the member's medical record.
2	PCP	In those situations, where documented evidence of physician/member relationship breakdown exists, the practitioner must send a written request on practice letterhead via mail or fax to the Provider Relations Department. What Region Am I? NOTE: It is not necessary to send a written request for PPOBlue, EPOBlue, ClassicBlue or DirectBlue products as they do not require PCP selection. In The Western Region: Provider Relations Member Disenrollment Fifth Avenue Place, Suite 721 120 Fifth Avenue Place Pittsburgh, PA 15222-3099 Western Region Fax: 412-544-8871 The request must contain the following information: • Member name • Member ID # and insurance product • Member address • Member telephone number • Specific documentation of the situation as evidenced in the medical record • Evidence that practitioner tried to resolve the situation A practitioner or designee from the practice must sign the request.

Continued on next page

2.4 Member Removal Procedure – Western Region Only,
Continued

Member Removal **(continued)**

Stage	Who does it	What happens
3	Provider Relations	Review the PCP's request: Does the request contain all required information? **If yes,** proceed to stage 5. **If no,** and the PCP is unwilling or unable to provide more information**,** forward the request to the medical director.
4	Medical Director	Review PCP's request: Is the request valid? **If yes,** proceed to stage 5. **If no,** call PCP to discuss alternative resolution. Document resolution and forward to Provider Relations.
5	Provider Relations	Forward the request to the appropriate member service department.
6	Member Services	Contact the member and assist with selecting a new PCP. Contact Provider Relations with the effective date of the change. The effective date of the change is the first day of the month after the member has been provided at least 30 days advance notice, unless both provider and member agree to an earlier discharge date. (New provider effective date must always be the first day of a month.)
7	Provider Relations	Contact PCP by telephone to confirm the member's removal and effective date.
8	PCP	• Provide access to services until the termination date • Provide urgent care if necessary. • If requested to do so by the member or Highmark, the practitioner must, at no cost to the patient, forward medical records to the new PCP within thirty days.

2.4 How To Close And Re-Open Your Practice To Members

Introduction

This section is intended to explain how to close and re-open your practice to new members.

Definition: Closed Practices

When a practice is "closed to new members," it means that the PCP practice is temporarily not available for selection by new members.

Definition: New Member

A new member is one who has:

- Never been seen by a physician of the practice
- Not been seen by a physician of the practices within the past 36 months.

Rationale

By closing to new members, your practice can limit the number of new members. This can be especially helpful to practices that are new to managed care, or to practices that have a shortage of physicians or office staff.

Guidelines

- Your practice must provide written notice to the western region network 60 days prior to the anticipated closing date and/or re-opening date.
- Closure takes place on the first day of the month following the 60-day period.
- You must continue to accept new members up to the end of the 60-day period when closure is in place. You must accept existing members who choose you as their PCP.
- You must close to all new Highmark plan members.

How To Close Or Re-Open Your Practice

To close or to re-open your practice to new members, simply mail or fax written notification on practice letterhead, including practice name, address, vendor number, effective date, and authorized signature for the requested change, to:

What Region Am I?

Western, Central and Eastern PA Regions:	**Northeastern PA Region:**
Highmark Blue Shield Provider Information Management P.O. Box 898842 Camp Hill, PA 17001-9937 Fax: 1-800-236-8641	Blue Cross of Northeastern Pennsylvania Provider System Support 19 North Main Street Wilkes-Barre, PA 18711 Fax: 1-570-200-6880

2.4 Eligibility Rosters

Definition

The Eligibility Roster is a list of members currently enrolled with a specific primary care practice.

Purpose

The Eligibility Roster is intended to give PCP practices a way to identify which members are assigned to their practice for any given month. The Eligibility Roster contains no financial information other than the co-payment that you may collect from the member for office visits.

Report Frequency

Eligibility rosters are available online monthly through NaviNet. For those practices that do not have NaviNet, the rosters are mailed at the end of each month. The roster contains enrollment information for the following month.

How To Download Eligibility Rosters

1. In the NaviNet toolbar, select Report Inquiry.
2. Select 'Eligibility Roster' in the Report Type Field. Click Search.
3. Choose month desired. Click Select.
4. Select Download. The generated file will be in .txt format. Select Save or Open based on your preference.

Single Roster

Each PCP practice receives a single roster that is separated by product.

Rosters are available for the following products: DirectBlue, Western Region Individual HMO and Western Region Medicare Advantage HMO.

Rosters for DirectBlue (group) members will only be printed if the member selected a PCP. Members do not formally choose a PCP for certain products including, but not limited to DirectBlue (individual), PPOBlue EPOBlue and ClassicBlue so a roster is not produced for those products.

Information Contained On The Roster

Eligibility rosters list the names and identification numbers of all members enrolled in a PCP's practice.

2.4 How To Read The Eligibility Roster

Information Fields On The Roster

This table lists each field on the roster with an explanation of its function. Please refer to the example illustration following the table.

Field	Function
RUN DATE RUN TIME	Run date and time indicates when the roster was printed for the monthly period identified on the roster.
PRODUCT	The roster is separated by product. The product's name and code appear at the top of the roster to identify the product.
PRACTICE NAME PCP NUMBER	The practice name and PCP number. The field will also show the reimbursement method of the practice for each product: FFS (fee-for-service).
STAT CHG	Status change indicates new or terminated members to the provider since the last eligibility roster. A = New member added T = Member terminated
MEMBER NAME	Member name listed alphabetically (last name, first name)
MEMBER ID	Identification number is the subscriber's unique member identifier assigned to all members of the family who are enrolled under the subscriber's coverage.
MEM NUM	Member number is a two-digit number that notes the member covered. For example: 00 = subscriber 01 = spouse or dependent 02 and up = additional dependents
GROUP NUMBER	Group number identifies the employer group or the benefit plan for which the member is eligible.
SEX	Shows the member's sex.
AGE	Shows the member's age.

Continued on next page

2.4 How To Read The Eligibility Roster, Continued

Information Fields On The Roster **(continued)**

Field	Function
BEGIN DATE	Begin date is the date the member enrolled with the provider under the given group number.
END DATE	End date is the date the member cancelled with the provider under the given group number.
FINANCIAL INDICATOR	Financial indicator shows the member's employer group's financial arrangements relative to managed care. F = Fee-for-service
COPAY	Shows the co-payment that you may collect from the member for office visits.

Continued on next page

2.4 How To Read The Eligibility Roster, Continued

Illustration An illustration of an *Eligibility Roster* appears below. This statement is for example purposes only. Line and/or page totals may be mathematically inaccurate.

HIGHMARK BLUE SHIELD

RUN DATE: 09-20-2007 ELIGIBILITY ROSTER
RUN TIME: 09:36:57
David Smith, MD PC ASSOC
123 MAIN STREET
YOUR TOWN PA 15222-1477

SELECT BLUE POS (PRODUCT CODE 200)
OCTOBER 01, 2007 THROUGH OCTOBER 31, 2007
DAVID SMITH MD PC ASSOC
PCP # 9999999999 REIMBURSEMENT METHOD FFS

STAT CHG	MEMBER NAME	MEMBER ID	MEM NUM	GROUP NUMBER	SEX	AGE	BEGIN DATE	END DATE	FINANCIAL INDICATOR	COPAY
A	ADAMS, JOHN	UPP222222222	02	333333	M	03	02-01-05		F	10.00
A	JEFFERSON, THOMAS	UPP333333333	01	333333	M	18	03-08-07		F	10.00
A	MADISON, JAMES	UPP444444444	02	333333	M	15	03-08-07		F	10.00

TOTAL SELECT BLUE POS MEMBERS: 3

KEYSTONE BLUE HMO (PRODUCT CODE 400)
OCTOBER 01, 2007 THROUGH OCTOBER 31, 2007
CARLOS FLORES MD PC ASSOC
PCP # 9999999999 REIMBURSEMENT METHOD FFS

STAT CHG	MEMBER NAME	MEMBER ID	MEM NUM	GROUP NUMBER	SEX	AGE	BEGIN DATE	END DATE	FINANCIAL INDICATOR	COPAY
A	MONROE, JAMES	1234567890000	00	98765432	M	07	08-01-07		F	0.00
A	ADAMS, JOHN	1234567891000	00	98765432	M	17	12-01-05		F	0.00
A	DOE, JANE	1234567891001	00	98765432	F	18	04-01-01		F	0.00
A	AUSTIN, JANE	1234567891002	00	98765432	F	17	04-01-01		F	0.00
A	JACKSON, ANDREW	1234567891003	00	98765432	M	11	01-01-07		F	0.00
A	VAN BUREN, ANDREW	1234567891004	00	98765432	M	18	10-01-05		F	0.00
A	POLK, JAMES	1234567891005	00	98765432	M	16	10-01-05		F	0.00
T	PIERCE, FRANKLIN	1234567891006	00	98765432	M	19	08-01-04	09-01-07	F	0.00

Chapter 2

Provider Responsibilities

Unit 5: Specialist Basics

In This Unit

Topic	See Page
Unit 5: Specialist Basics	
Participation in the Highmark's Networks as a Specialist	2
Specialist and Personal Physician Communication	3
Directing Care to Network Providers	6
Preventive Care Responsibilities for All Network Physicians	8
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Participation in Highmark's Networks As An OB/gyn	11
Obstetrical Services	12
Gynecological Services	13

2.5 Participation in Highmark's Networks as a Specialist

Introduction	As a specialist, you play the important role of providing specialty services to our network members.
How Specialists Are Reimbursed	Network specialists are paid fee-for-service. For more information on reimbursement methods, see Chapter 3, Unit 3 of the Highmark Blue Shield Office Manual on Payment Methodology.
How Auxiliary Personnel Are Reimbursed	When physicians employ auxiliary (i.e., non-physician, such as a certified registered nurse) personnel to assist in rendering services to their members and include the charges for those services in their own bills, the services of such personnel are considered to be "incident to" the physician's services. Services of auxiliary personnel are covered when there is a physician's service rendered to which the services of such personnel are an incidental part and there is *direct personal supervision* by the physician. More detailed information about supervision guidelines of ancillary personnel and employment guidelines can be found in Medical Policy Bulletins Z-27 and Z-33. Highmark's Medical Policies are available on the Provider Resource Center under *Medical & Claim Payment Guidelines*.

2.5 Specialist and Personal Physician Communication

The Policy

Network personal physicians and specialists, including medical, surgical and behavioral health, must communicate with one another in order to assure continuity and coordination of care for members. Following is the communication procedure:

Purpose

The goal is to ensure the exchange of information in an effective, timely and confidential manner to promote appropriate diagnosis and treatment for members.

Communication Procedure

- Before the member's visit to the specialist, the personal physician must provide relevant clinical information to the specialist. Acceptable forms of communication are a formal letter and/or copies of relevant portions of the member's medical chart.

- Within 10 business days of the first visit, the specialist must provide the personal physician with information about his or her visit with the member. Acceptable methods of communication are a formal letter and/or copies of relevant portions of the member's medical chart. Behavioral Health Providers may use the Communication Form For Behavioral Health Specialist to Primary Care Physician (Personal Physician) found under Provider Forms on the Provider Resource Center.

- In the case of behavioral health, member's consent is needed for the behavioral health specialist to release information to the personal physician. If a member refuses to give consent, the behavioral health specialist must document this refusal in the member's behavioral health treatment record.

- The personal physician must document his or her review of the reports, labs, X-rays and other diagnostic tests received from the specialist or health care facility in the member's chart. The personal physician must also indicate any subsequent action necessary. To indicate that he or she has reviewed the information, the personal physician should initial each page.

Continued on next page

2.5 Specialist and Personal Physician Communication,
Continued

Members' Role In Communication

Neither PCPs nor specialists should ask members to communicate findings, reports, lab results, etc. to another practitioner.

Compliance Monitoring

Where the network supports managed care products, Highmark Blue Shield will monitor compliance of the communication procedure as part of the medical record review program. During medical record review, representatives will check for the provider's initials on the member's chart and ensure that any necessary follow-up actions are addressed. The goal is to ensure the exchange of information in an effective, timely and confidential manner to promote appropriate diagnosis, and treatment for members.

Organizational Provider Communication

Highmark Blue Shield network organizational providers, such as hospitals, emergency facilities, ambulatory surgery centers, home health agencies and skilled nursing facilities must promote continuity and coordination of care for network members by communicating with personal physicians when care is delivered to their members. Personal physicians should expect a written description of the care given to their members any time services have been rendered by these providers.

Forms To Assist Ob/gyns To Communicate

Two forms have been developed to assist ob/gyns to communicate clinical information to the PCP:

- *Communication Document for Gynecological Services*
- *Communication Document for Obstetrical Services*

The information contained on these forms must be communicated to the PCP. However, the forms themselves need not be used if ob/gyns choose to communicate all of the information included on the forms via another written format. Acceptable formats include typed letters, physician forms and progress notes.

Continued on next page

2.5 Specialist and Personal Physician Communication,
Continued

Highmark's Communication Policy	From time to time, Highmark will announce changes to administrative or reimbursement policies. In cases where such changes have a direct impact on the provider, it is Highmark's policy to give providers adequate notice regarding these changes. Informational changes will be announced in no less than 30 days, unless required by law or regulation.

2.5 Directing Care to Network Providers

Background

Many of Highmark's products have a requirement which obliges members to have all of their care rendered by providers who hold a contract with the appropriate Highmark network.

Product Specifics

The HMO products provide no benefits for non-emergent services rendered by non-network providers and the member is responsible for the entire cost of the non-network service unless in rare cases where the service is not available in the network. The HMO products include:

- Western Region Only Individual HMO
- Western Region Medicare Advantage HMO

The POS, PPO and open access products feature a lower level of payment when non-emergent services are rendered by an out-of-network provider. A POS, PPO or DirectBlue member who receives a service from an out-of-network provider is responsible for out-of-network deductible and coinsurance amounts before his or her health insurance begins to cover the expense unless in rare cases where the service is not available in the network.. The POS, PPO and open access products include:

- PPOBlue
- DirectBlue
- FreedomBlue
- EPOBlue*

*The EPO product has no benefits when non-emergent services are rendered by an out-of-network provider. If a member chooses to use services provided by an out-of-network provider, the member will be responsible for the entire cost of the non-network service.

2.5 Directing Care to Network Providers, continued

Your Responsibility

As a provider who participates in a managed care network, it is your obligation to provide services at the most appropriate level and to protect Highmark members from business practices which expose them to unnecessary out-of-pocket expenses.

This means, among other things, that when your Highmark members require services that you are not able to provide, you are obligated to direct those members to other providers who participate in the network associated with their benefit program. You are not permitted to direct Highmark members to out-of-network providers unless the member elects to use an out-of-network provider, has out-of-network coverage and/or the use of such providers has been authorized by Healthcare Management Services (HMS) or, in some cases, by Highmark's Medical Director.

The most current listing of network providers can be accessed through our member and provider Web sites.

2.5 Preventive Care Responsibilities for All Network Physicians

Preventive Care

Network physicians have a unique opportunity to recommend or administer certain services and lifestyle improvements that can prevent future illness or injury. Benefits are provided for prevention, early detection and minimization of ill effects and causes of disease. Highmark charges its PCPs and specialists with promoting and helping to maintain the health of members through the HEDIS® measures and other preventive services as noted below.

PCP And Specialist Responsibilities

- Adhere to nationally accepted preventive health guidelines as approved by Highmark.
- Provide or recommend beta-blocker treatment after heart attack and promoting long-term therapy.
- Recommend and promote timely and age-appropriate preventive services, e.g., screening for breast, cervical, colorectal and prostate cancers.
- Recommend a follow-up behavioral health visit within 7 days and no later than 30 days after hospitalization for mental illness and ensuring compliance with medication and long-term follow-up.
- Evaluate members to determine tobacco use. Advise and assist members to cease tobacco use.
- Recommend the Dr. Dean Ornish Program for Reversing Heart Disease® and/or the Baby BluePrints® program to members who could benefit from participating in these programs.
- Provide or recommend adequate care for diabetics, including foot and eye exams.
- Use recommended depression screening tools to identify depression in members and initiate appropriate, ongoing treatment.
- When appropriate, recommend members to condition management programs including congestive heart failure, diabetes, chronic obstructive pulmonary disease, and asthma.
- Provide appropriate and comprehensive care for members with hypertension.
- Prescribe appropriate medications for members based on current national standards of care.
- Promote exercise and physical activity to all members, especially the senior population.

Note: Routine adult and pediatric physicals and pediatric immunizations must be performed by the member's PCP, if applicable, to receive coverage.

Continued on next page

2.5 Preventive Care Responsibilities for All Network Physicians, Continued

More Information About Clinical Practice And Preventive Health Guidelines

On an annual basis, the Quality Management Department, along with participating network physicians, review and update the *Clinical Practice and Preventive Health Guidelines.*

These guidelines are available online to the provider community as a reference tool to encourage and assist you in planning your members' care. The guidelines can be found under the Clinical Reference Materials selection on the Provider Resource Center.

Additional Responsibilities Relating To Ob/gyn Care

- Provide or recommend screening mammograms, cervical cancer screenings and Chlamydia screenings.
- Recommend Baby BluePrints® to expectant Highmark members so that they may better understand and enjoy every stage of pregnancy and make more informed care and lifestyle decisions.
- Provide or recommend prenatal care, especially in the first trimester.
- Provide or recommend post-partum exams 4-6 weeks after delivery.
- Provide appropriate counseling for menopause.
- Evaluate the risk of child abuse, domestic violence and elder abuse.
- Evaluate the risk of post-partum depression.

Documentation

Network physicians should submit accurate encounters/claims and document their preventive-care services and recommendations in the member's chart. If performed by a specialist, the intervention, including dates they were performed and their results should be communicated in writing to the PCP. Likewise, information about such interventions performed by the PCP should be communicated to a specialist when the information is pertinent to the condition the specialist is treating.

2.5 Specialist Termination from Highmark's Networks

Specialist Termination From The Network

In the event of voluntary or involuntary termination the specialist or specialty group from any of Highmark's networks, upon request, are required to cooperate with network policies in obtaining a list of members that may be affected by such termination because they are undergoing an ongoing course of treatment or are otherwise active plan members. The list must include name, address, and identification number.

Highmark will use the member list to initiate its member notification process to alert them that the specialist or group will no longer be a part of the network.

2.5 Participation in Highmark's Networks As An OB/gyn

Introduction	Obstetricians and gynecologists in Highmark's networks play a very important role by providing health care to our female members. Because this area of medicine is so specialized it is important for our network ob/gyns to review this section in addition to above information for specialists only.
How Ob/gyns Are Reimbursed	Network ob/gyns are paid fee-for-service. For more information on reimbursement methods, see Chapter 3, Unit 3 of this Office Manual on Payment Methodology.
Services Provided By Other Specialists	If a member requests a visit for symptoms that do not appear to be gynecological in nature, please direct the member to contact her PCP.

2.5 Obstetrical Services

Maternity Authorizations

Maternity authorizations from HMS are unnecessary unless the care is provided out-of-network.

- You must verify a member's benefit for tubal ligation.
- You must verify a member's dependent daughter's eligibility for maternity benefits.
- Some hospital employees and their dependents may have coverage or high-level coverage only at their employer hospitals.

Note: To verify benefits, please use the Eligibility and Benefits feature on NaviNet.

If you do not have access to NaviNet, please call:
1-800-258-9808 in the Western Region or
1-800-628-0816 in the Central Region.

What Region Am I?

Case Management Available

Case management is a systematic, proactive and collaborative approach to effective assessment, monitoring and evaluation of options and services required to meet an individual member's health needs. Case Management is a collaborative process involving the physician, the patient and support system, the case manager, and other healthcare service providers to encourage and assist patients to achieve their optimum level of wellness, self-management, and functional capability.

In cases where the obstetrician feels there is a need for case management due to a high-risk pregnancy, please contact the Healthcare Management Services case management staff at 1-800-596-9443 to discuss your patient's needs.

Baby BluePrints® Program Available!

Baby BluePrints® is a free program that offers expectant Highmark members educational information on all aspects of pregnancy through multiple printed and online resources during each trimester of pregnancy. Topics include prenatal care, proper use of medications, avoiding alcohol and tobacco, working, travel considerations, nutrition and weight gain, exercise, body changes and many others.

For complete information on this program, please visit see Chapter 3, Unit 1 of this Office Manual on Product Information.

Spontaneous Abortions

In the case of a spontaneous abortion, the obstetrician should retrospectively bill for all prenatal visits.

2.5 Gynecological Services

Annual Routine Gynecological Exams

Annual routine gynecological exams include, but are not limited to, the following services:

- Pelvic exam
- Pap test
- Clinical breast exam
- Interval history

Follow-Up Visits

Follow-up visits may include the following services:

- Screening mammography
- Diagnostic mammography
- Selected diagnostic and surgical procedures, **only** if not on the list of procedures requiring preauthorization.
- Lab services referred by the ob/gyn
- Additional office visits, if necessary

Mammography

A prescription is necessary to order a mammography.

Infertility Services Require A Benefit

Not all members have a benefit to cover testing and/or treatment for infertility and/or assisted fertilization. To verify coverage, please use the Eligibility and Benefits feature on NaviNet.

If you do not have access to NaviNet, please call:
1-800-258-9808 in the Western Region or
1-800-628-0816 in the Central Region.

What Region Am I?

Chapter 2

Provider Responsibilities

Unit 6: Behavioral Health Care Specialists

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2.6 General Information

Objectives

The key objectives of Highmark's behavioral health care management program are as follows:

- Ensure timely access to appropriate quality outpatient specialty services.
- Encourage adherence to evidence-based treatment standards.
- Support behavioral health care needs of members in active treatment with primary care physicians.
- Increase communication and coordination of care between primary care physicians, psychiatrists and other behavioral health professionals.
- To work closely with health care providers to coordinate all aspects of services for its members with both medical and behavioral health needs, especially members with chronic medical conditions complicated by conditions such as depression and anxiety.

Role of Highmark's Behavioral Health Services

For members enrolled in Highmark Blue Shield programs, Highmark's Behavioral Health Services provides:

- Medical management of behavioral health services.
- Assistance for members to locate a behavioral health care provider.
- Intensive Case Management services to proactively coordinate health care services.
- Outreach Case Management services to assist in gaps in care educational supports, health and wellness or care coordination.
- Depression Management Program services assist in monitoring and coordinating health care services for members with depression
- Assistance with discharge planning.

Contact Information For Medical Management Services

To reach Highmark's behavioral health services department please call:

What Region Am I?

In the Western Region: 1-800-258-9808
In the Central Region: 1-800-628-0816

This line is answered 24 hours a day, 7 days a week by the Highmark Behavioral Health Services.

Continued on next page

2.6 General Information, Continued

Standard Business Hours	Standard business hours are 8:30 a.m. to 4:45 p.m., Monday through Friday.
After-Hours Calls	Calls received during non-business hours are triaged to an after-hours vendor. All crisis calls and urgent requests for authorization will be processed immediately. If you are calling about a non-urgent issue, you will be advised to call again during standard business hours.
No Clinical Information On Voice Mail	When calling a behavioral health care manager directly, your call may be answered by voice mail. To uphold a member's right to privacy and in consideration of HIPAA regulations and the importance of documentation, **please do not leave clinical information about members on voice mail.**
Timely Utilization Management Determinations	Highmark's behavioral health unit provides timely utilization management determinations for all members and providers. Each utilization management determination is handled in a manner consistent with the clinical urgency of the situation and with legal and regulatory and compliance requirements.
Benefits Vary By Group	Behavioral health benefits vary by group. In some instances, a group may purchase medical health care coverage through Highmark, but behavioral health care coverage through another company. To be sure a member has behavioral health care coverage through Highmark check benefits through NaviNet or perform an electronic transaction. If you do not have access to NaviNet, call the benefits telephone number on the member's identification card.
Additional Information	Address administrative questions with your Highmark provider relations representative.

2.6 Highmark's Behavioral Health Programs

Overview

The need for more access to behavioral health resources is a growing trend among health care consumers. To meet the needs of our members, Highmark is taking a hands-on approach to enhancing various behavioral health programs available to our members. Professionally trained staff are available to members, their families, significant others and providers to coordinate the services needed to meet our members' needs.

Providers are encouraged to recommend members who may benefit from these programs. To verify patient eligibility, please check the Eligibility & Benefits selection in NaviNet.

Objectives of Highmark's Behavioral Health Outreach Programs

The following are the objectives of the Highmark Behavioral Health Outreach Programs.

- Outreach Case Management will provide post episodic mental health intervention.
- Promote care that is clinically appropriate, efficient, timely and sensitive to the special needs of high-risk members.
- Document the provision of appropriate, high-quality services to the high-risk member population.
- Identify opportunities to improve resource management and quality of care.
- Facilitate communication with treating hospitals and practitioners to ensure quality of care for high-risk members.
- Demonstrate positive outcomes for high-risk members.
- Promote patient safety.
- Prevent inappropriate hospital admissions.
- Improve treatment compliance
- Improve effectiveness of the treatment plan.
- Coordinate Behavioral Health members with Medical Case Management when appropriate.
- Management of Postpartum Depression Screening Program.

Behavioral Health Programs

Through Healthcare Management Services (HMS) care and case manager-supported efforts, Highmark continues to encourage outreach and two-way communication with its members, allowing them to receive the right treatment at the right time. Highmark currently offers four behavioral health programs available to current members and providers.

- Intensive Case Management
- Outreach Case Management
- Depression Management
- Care Management

Continued *on next page*

2.6 Highmark's Behavioral Health Programs, Continued

Behavioral Health Intensive Case Management Program

The Intensive Case Management Program is a collaborative process involving HMS case managers, members, their families, significant others and providers. It assesses plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual's health needs using communication, education and available resources to promote quality cost-effective outcomes.

Highmark's case managers are required to participate in continuing education relevant to today's issues. This allows each case manager to stay in touch with current member needs. Issue plans are also constantly revisited to identify additional gaps in care. Because of the mandatory education received by our case managers and constant attention to improvement, our members are able to build interactions around their issue plans resulting in a defined use of the interventions and a completion of goals.

Behavioral Health Outreach Case Management Program

The purpose of the Outreach Case Management is to educate and assess the member regarding case management, assess for gaps in care coordination, knowledge, medication management, support system, wellness and prevention intervention. Highmark strives to ensure that members have timely follow up and resolution to gaps in care, support, knowledge and resources.

Outreach Case Management is for members who need brief follow up of 1-3 calls and focuses on episodes of care.

This proven program has increased member recommendations to the Depression Management program, intensive case management program, medical case management programs, and Blues On Call.

Behavioral Health Depression Management Program

The Depression Management Program is an intensive telephonic outcome based case management program that helps members identify symptoms of depression, overcome the reluctance that many people have to getting help, decide if formal treatment is indicated and, if so what the right treatment may be, locate services, manage barriers, and assist in tracking progress.

Members with depressive symptoms are offered an intensive telephonic case management program. Special areas of focus include post-partum depression, depression post-acute MI, depression as a co-morbidity in members with chronic conditions and members who are newly prescribed an antidepressant medication.

Continued on next page

2.6 Highmark's Behavioral Health Programs, Continued

Behavioral Health Depression Management Program, continued

Recommendations for member participation in this program come from various sources including:

Internal referrals
- Medical care/case management
- Behavioral healthcare/case management
- Pharmaceutical claims
- Blues On Call

and/or

External Referrals
- Medical/Behavioral health practitioners
- EAP providers
- Family members
- Self Referral

Behavioral Health Care Management Program

The care management team assists in applying medical necessity criteria to avoid variation in the delivery of services, recommends clinically appropriate alternative levels of care, and assists in discharge planning. The care management area is where providers request authorization for treatment when required by a benefit.

Highmark behavioral health care management has become an integral part of ensuring timely and appropriate discharge planning, assisting the member in connecting to resources through post-discharge telephonic calls, and triaging referrals to multiple other programs in Highmark.

The Behavioral Health Care Management Program identifies members for other programs offered through their benefit package. The care managers promote continuity of care.

Recommending A Member To A Behavioral Health Outreach Program

To recommend patients to any or all of Highmark behavioral health outreach programs, providers should call Highmark's behavioral health services department at:

What Region Am I?

Western Region: 1-800-258-9808
Central Region: 1-800-628-0816

This line is answered 24 hours a day, 7 days a week by the Highmark Behavioral Health Services. Recommendations to any of Highmark's behavioral health programs should be made during business hours.

Continued on next page

2.6 Highmark's Behavioral Health Programs, Continued

Behavioral Health Management: Coordination Of Resources

Highmark Behavioral Health Outreach and Intensive Case Management program works to identify members at risk and to reduce their risk factors, through frequent contact with and coordination of the following resources:

- Member
- Provider
- Family members
- Individuals and organizations providing mental health social support services to the member

2.6 Accessibility Standards For Behavioral Health Providers

Accessibility

Health Plan members are expected to receive an appointment with a qualified Behavioral Health Practitioner within the following time standards:

Patient's Need	***Definition***	***Performance Standard***
Care for a life-threatening emergency	*Immediate intervention is required to prevent death or serious harm to patient or others.*	*Immediate response*
Care for a non-life-threatening emergency	*Rapid intervention is required to prevent acute deterioration of the patient's clinical state that compromises patient safety.*	*Within 6 hours*
Urgent care	*Timely evaluation is needed to prevent deterioration of the patient's condition.*	*Within 48 hours*
An appointment for a routine office visit	*Patient's condition is considered to be stable*	*Within 10 business days*
Telephone access to behavioral health screening and triage	*Callers reach a non-recorded voice within 30 seconds and abandonment rates do not exceed 5% at any given time*	• *Callers reach a non-recorded voice (operator) within 30 seconds* • *Hang-up rates do not exceed 5%*

2.6 Treatment Information and Patient Privacy

Consent Is Required For Release Of Treatment Information	Under Federal and Pennsylvania law, providers of substance abuse and mental health treatment may be required to obtain members' written consent before releasing certain mental health and substance abuse information to insurers and/or to other healthcare providers for the management of patient care. As a contracted provider, it is your responsibility to obtain appropriate consent for release of information.
Restrictions On Substance Abuse Information	Pennsylvania Code Subsection 255.5(b) limits the substance abuse treatment information providers can release to an insurer, even with written member consent. Providers are advised to ensure that the information they communicate to Highmark's behavioral health unit is compliant with these regulations as well as any applicable federal or state regulations.

2.6 Behavioral Health Care Specialist and PCP Communication

Introduction

Patient care and clinical outcomes are enhanced when health care professionals share information and coordinate patient care. Communication between behavioral health care specialists and PCPs is vital, especially when medications are prescribed or changed or when counseling is provided. Open and timely communication is particularly important considering that members may contact their behavioral health care specialists without coordinating care with PCPs.

Member Consent

The member's consent may be required to permit the behavioral health specialist to release certain information to the PCP. The member should be informed of your policy about sharing information with other healthcare professionals involved in coordinating treatment. If a patient refuses to give consent, the behavioral health specialist should document this refusal in the patient's behavioral health treatment record.

Specialist And PCP Communication

Highmark's network behavioral health care specialists and PCPs are encouraged to communicate with one another to ensure continuity and coordination of care for members.

Member's Role In Communication

Neither PCPs nor specialists should require members to take responsibility for communicating findings, reports, lab results, etc. to another practitioner.

Continued on next page

2.6 Behavioral Health Care Specialist and PCP Communication, Continued

Communication Procedure

PCPs and behavioral health care specialists should communicate in the following ways to ensure continuity of patient care, provided patient consent has been granted:

- If the PCP has directed the member, the PCP should provide relevant clinical information to the specialist before the member's visit to the specialist. Acceptable forms of communication are formal letter and/or copies of relevant portions of the patient's medical chart.
- Within one week after the second visit and/or after changes in the member's treatment or condition, the behavioral health care specialist should provide the PCP with information about his or her visit with the member, with the member's consent, if applicable, using the same forms of communication.

Communication As A Component Of The Quality Management Program

The communication to the PCP from the behavioral health care specialist is regularly monitored as part of Highmark's Quality Management Program.

Highmark Blue Shield will monitor network compliance of the coordination of care process via annual PCP survey of communication from specialists. The goal is to ensure the exchange of information in an effective, timely and confidential manner to promote appropriate diagnosis and treatment for members.

What Should Be Communicated?

The following list indicates the type of information that may be communicated:

- Clinical findings/diagnosis (include written description other than ICD-9 code)
- Test results
- Treatment plans
- A summary report at the conclusion of the treatment period

Continued on next page

2.6 Behavioral Health Communication Forms

Communication Form for Behavioral Health Specialists and PCPs

The Communication Document for Behavioral Health Specialists to Primary Care Physician has been developed to help the behavioral health care specialist communicate clinical information to the PCP. To get a copy of the form, go to the online Provider forms section of the Provider Resource Center or fax a request to the Quality Management department at 412-544-2619. The forms need not be used if behavioral health care specialists choose to communicate all of the information included on the form via another written format. Acceptable formats include typed letters, physician forms and progress notes.

Authorization Form for Behavioral Health Providers to Release Medical Information To Highmark

The form 'Authorization for Behavioral Health Providers to Release Medical Information' was developed to assist behavioral health specialists gain the proper permissions to provide behavioral health clinical information to Highmark Blue Shield, its subcontractors and business associates. The form should be kept in the members chart for future reference.

This form releases of past, present or future behavioral health clinical information that may also include, alcohol and drug abuse treatment, psychological/psychiatric testing and evaluation information, and other information regarding medical diagnosis, treatments and/or conditions.

Members may withdraw this voluntary authorization at any time by giving written notice to the behavioral health office where the form was initially submitted.

To obtain a copy of the form, please visit the Behavioral Health Forms section of the Provider Forms category on the Provider Resource Center.

2.6 Authorizations

Definition

Authorization (preauthorization) is the process whereby the behavioral health care practitioner must contact Highmark's behavioral health unit to determine the eligibility of coverage for and/or the medical necessity or appropriateness of behavioral health services.

When Authorization Is Required For Outpatient Services

Authorization must be obtained **within 30 business days** of providing behavioral health services for the member. When issuing authorizations, Highmark's Behavioral Health Unit adheres to timeliness and other standards as required by law and determined by accrediting agencies such as URAC.

If Authorization Is Not Obtained

When the behavioral health care practitioner is required to obtain authorization but provides covered services without obtaining authorization, the member will not be responsible for payment other than any applicable copayment.

Services That Require Authorization

For most products, authorization is required to receive coverage for all behavioral health services except emergencies. However, if the emergency service results in an inpatient admission, an authorization is required. Additionally, care provided following an emergency requires authorization.

What Region Am I?

Products Requiring Authorization

All of the following Highmark Blue Shield products require authorization:

- Western Region Individual HMO
- Western Region Medicare Advantage HMO
- DirectBlue (group)
- DirectBlue (individual)*
- PPOBlue*
- FreedomBlue
- EPOBlue*

* These products generally require authorization only for inpatient care depending on benefit design.

Continued on next page

2.6 Authorizations, Continued

Authorizing Services In The Appropriate Network

When requesting authorization, be sure that the member is to receive care from a provider who participates in the network associated with the member's program.

Basis Of Authorization Decisions

Highmark Behavioral Health Services bases its decisions to authorize care upon the following:

- Availability to the member of the appropriate behavioral health benefit.
- Clinical information available to the care manager or physician advisor at the time of review.
- The safety of the patient and, when applicable, the safety of others.
- Availability and appropriateness of other effective but less restrictive treatment settings.
- Application of the appropriate medical necessity criteria.

Methods To Obtain An Authorization

Highmark Behavioral Health Services has established three different methods for obtaining an authorization:

- NaviNet: practices who have electronic capabilities are strongly encouraged to submit all authorization requests through NaviNet.
- Telephonic: non-NaviNet practices can call Highmark Behavioral Health Services at:
  In the Western region: 1-800-258-9808
  In the Central region: 1-800-628-0816
- Fax: non-NaviNet practices can complete the appropriate forms and fax them to Highmark Behavioral Services at 1-800-667-9304.

What Region Am I?

2.6 Authorizing Initial Outpatient Services: NaviNet Users

The Process To request authorization for initial outpatient services, follow the steps listed below.

Step	Action
	For NaviNet users:
1	Hover over the Referral/Auth Submission button on Plan Central
2	Click on The Behavioral Health Submission fly out
3	On the Selection Form: • Choose the referred from provider from the dropdown • Enter the member information • Choose the category and service that you are requesting authorization for
4	On the Request Form: • Enter the case information being requested, such as: o Referred to billing provider o Referred to facility o Diagnosis o Number of visits • You may enter additional information pertinent to the authorization request in the clinical comments block located at the bottom of the Request Form
5	Survey or Treatment Plan: • Please complete these survey or treatment plan questions asked. These questions will provide information necessary for review of your authorization request
6	Response Form: • The response form will provide you with a tracking number and status of your authorization request. • The case information is made available for your review (the only piece of data that can be changed via NaviNet is the proposed date of service. This date may only be changed once on an authorized request)

2.6 Authorizing Initial Outpatient Services: Non-NaviNet Users

The Process

There are two ways to request an authorization for initial outpatient services for non-NaviNet users.

Telephonic

What Region Am I?

Step	Action
1	In the Central Region call 1-800-628-0816, option 3 In The Western Region call 1-800-258-9808, option 3
2	A representative will collect information and check benefit availability. Provide the following information: • Patient demographics including name and patient ID. • Requesting provider name • Performing provider name • Diagnosis code • Number of visits requested • Start date and anticipated end date • Type of service requested Additional questions will be asked in order to assess the patient's outpatient treatment needs.
3	The Behavioral Health Unit will notify you by NaviNet message, telephone or letter indicating the status of the treatment request. **Note:** A denial letter will be sent if the member does not have coverage for behavioral health services with Highmark, has exhausted their benefit for the contract period/lifetime benefit limit and/or services do not meet medical necessity criteria.

Fax

Step	Action
1	Print the Request for Authorization of Behavioral Health Outpatient Services Initial Request Form. This form is available on the Provider Resource Center under Provider Forms. Select Behavioral Health forms and choose the appropriate form from the list.
2	Complete all pertinent information and fax to the Highmark Behavioral Unit at **1-800-667-9304**. *Please be aware that the form must be completed in its entirety. Otherwise, the authorization process may be delayed.

2.6 Authorizing Continued Outpatient Services

The Process

To request an authorization for the continuation of outpatient services, follow the steps listed below.

Step	Action
1.	At least one week before the current authorization expires, submit an authorization request for additional outpatient services either through NaviNet or by calling: 1-800-258-9808 in the Western Region or 1-800-628-0816 in the Central Region. The provider may also complete the Continuation of Outpatient Treatment Request for Authorization of Behavioral Health Services Form and fax it to 1-800-667-9304.
2.	A care manager will review the request.
3.	The Behavioral Health Unit will notify you by NaviNet message, telephone or letter indicating the status of the treatment request. **Note:** A denial letter will be sent if the member does not have coverage for behavioral health services with Highmark, has exhausted their benefit for the contract period/lifetime benefit limit and/or services do not meet medical necessity criteria.

What Region Am I?

2.6 Medical Necessity Criteria For Mental Behavioral Health And Substance Abuse

Medical Management Services

The Highmark Behavioral Health Unit provides behavioral health medical management services for members enrolled in Highmark Blue Shield programs.

Medical Necessity Criteria For Behavioral Health Services

Except where any applicable law, regulation, or government body requires a different definition (i.e., the Federal Employees Health Benefits Program, CMS as to the Medicare Advantage program, etc.), Highmark Blue Shield has adopted a universal definition of medical necessity. The term "Medically Necessary," "Medical Necessity" or such other comparable term in any provider contract shall mean health care services (or such similar term as contained in the applicable benefit agreement or plan document to include, but not be limited to, "health services and supplies," "services and supplies" and/or "medications and supplies") that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Medical Necessity Criteria For Substance Abuse Treatment

Highmark Behavioral Health Services uses the current version of the American Society of Addiction Medicine (ASAM) Criteria when reviewing the medical necessity of substance abuse treatment.

Copies of this criterion set can be obtained by contacting Highmark Behavioral Health Services by calling

What Region Am I?

1-800-258-9808 in the Western Region or
1-800-628-0816 in the Central Region.

Continued on next page

2.6 Medical Necessity Criteria For Mental Behavioral Health And Substance Abuse, Continued

Criteria Review	Highmark's utilization management committee, which includes practicing physicians and psychiatrists, reviews and approves all behavioral health medical necessity criteria at least annually.
Prudent Layperson Laws For Emergency Services	Highmark adheres to state "prudent layperson" laws which require payment of benefits for mental health services in the event of an emergency under prudent layperson laws. An emergency department Physician can make a decision regarding admission or physical or chemical restraints. Highmark agrees that where a physician has not entered into a different agreement with Highmark or the hospital or other mental health care facility where services are rendered, and where Highmark has not entered into a different agreement with such hospital or mental health care facility, in the event of an emergency, Highmark will pay for medically necessary emergency care mental health covered services provided by such physician in accordance with applicable prudent laypersons standards, the definition of medical necessity as defined above, and the terms and conditions of the plan member's plan and Highmark will pay for medically necessary mental health covered services provided by physicians resulting from the admission in accordance with the definition of medical necessity and the terms and conditions of the member's plan.

2.6 Appeal Rights Overview

When Coverage Is Not Authorized

Whenever a utilization management decision results in a non-authorization of coverage for the requested services, a non-authorization notice and information about appeal rights is given verbally to the specialist.

Please visit Chapter 4.4 Denials and Appeals of the Highmark Blue Shield Office Manual for more information of appeal rights.

2.6 Levels of Care

Levels of Care

The Highmark Behavioral Health Unit has defined five common, but not limited to behavioral health levels of care.

- Acute Inpatient Hospitalization for mental health related disorders
- Inpatient Rehabilitation services for substance-related disorders
- Partial Hospitalization Programs (PHP)
- Intensive Outpatient Programs (IOP)
- Outpatient treatment

Coverage And Requirements Vary By Product

Please note that some products may not cover all levels of care. In addition, authorization requirements apply and may vary by benefit plan. Always verify benefit plan specifics, such as the applicable provider network, session limits and copayment information, by accessing NaviNet. If you do not have access to NaviNet, call the phone number on the patient's ID card.

Inpatient Hospitalization

Inpatient hospitalization is the highest level of psychiatric and substance-abuse services provided in a facility, such as a freestanding psychiatric hospital or a distinct-part psychiatric or detoxification unit of a general hospital. Settings eligible for this level of care are licensed at the hospital level and provide 24-hour medical and nursing care.

Continued on next page

2.6 Levels of Care, Continued

Inpatient Rehabilitation Services

Rehabilitation services is a level of care provided in a non-hospital setting that offers 24-hour care to people with substance-related disorders. These programs feature the following:

- Treatment with a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs
- Training in the basic skills of living, as determined to be necessary for each patient

Settings eligible for this level of care are licensed at the residential intermediate level or as an intermediate care facility (ICF). Licensure requirements for this level vary by state. It is essential that prior to admission it is verified that the facility provided the intensity of care required by the benefit.

Partial Hospitalization: Day, Night or Evening Treatment

Partial hospitalization programs are defined as structured and medically supervised day and evening programs. Although the patient is not considered a resident, the services provided are of similar nature and have similar intensity to those provided as an inpatient.

The services offered are designed to address a mental health and/or substance abuse disorder through an individualized treatment plan provided by a coordinated multidisciplinary treatment team. Program services are provided at least three days per week, at least four hours per day. A psychiatric/medication evaluation must occur one time per week for mental health services.

Continued on next page

2.6 Levels of Care, Continued

Intensive Outpatient Programs

Intensive outpatient programs provide planned and structured services at least two hours per day or six hours per week to address a mental-health or substance-abuse disorder and include:

- Group, individual, family or multi-family group psychotherapy
- Multiple or extended treatment/rehabilitation/counseling visits
- Professional supervision and support
- Crisis intervention, psychiatric/psychosocial rehabilitation or day treatment models
- Psycho-educational services
- Adjunctive services, such as medical monitoring

Note: These services are provided by an intensive outpatient program-contracted facility or agency.

Please also note that these visits would count against the member's outpatient mental health or substance abuse benefit limits and any Outpatient Mental Health and/or Substance Abuse copayments are applicable.

Self-help programs: While treatment for substance abuse typically involves participation in self-help programs, such as Alcoholics Anonymous or Narcotics Anonymous, these programs are offered without charge by community volunteers and cannot be included as billable time in an intensive outpatient program.

Outpatient Treatment

Outpatient treatment provides individual, family and/or group psychotherapy and consultative services (including nursing home consultation and psychiatric home health visits). Service duration ranges from 15 minutes (e.g., medication checks) to 50 minutes (e.g., individual or family psychotherapy) and can extend as long as 2 hours (e.g., group psychotherapy).

2.6 Psychological Testing

Reviewed For Medical Necessity

When prior authorization is required for psychological (96101) and neuropsychological (96118) testing, Highmark's behavioral health unit reviews those authorization requests for medical necessity

Provider Restrictions

Psychological testing authorization requests will only be approved for network participating psychologists.

Authorization Requirements Vary

PPO and indemnity benefit programs *do not* require authorization for psychological testing. All HMO and open access products *do* require authorization for these services. Be sure to check the member's benefit requirements by submitting a HIPAA 270 Eligibility inquiry transaction or through NaviNet. If you do not have access to NaviNet, please call

1-800-258-9808 in the Western Region or
1-800-628-0816 in the Central Region.

How To Request Authorization

To request authorization for psychological testing, the psychologist must obtain, complete, and submit a Request for Psychological Testing Pre-Certification or submit a HIPAA 278 Authorization transaction.

	There are three ways to obtain and complete the form:
1	Complete and submit the online form through NaviNet.
2	Print a copy of the Request for Pre-Certification of Psychological Testing and fax it to **1-800-667-9304.** To access this form via the Provider Resource Center, please visit Provider Forms and select Behavioral Health Forms and select the appropriate form.
3	Call the behavioral health care unit at: 1-800-258-9808 in the Western Region or 1-800-628-0816 in the Central Region to obtain a copy of the form.

What Region Am I?

Authorization For Psychological Testing

NaviNet users will receive an authorization approval online through NaviNet, When an authorization request is approved for non-NaviNet users, an authorization letter is generated. The provider will receive a copy of the authorization letter. In most cases, the member also receives a copy of the authorization letter; however, Western Region Medicare Advantage HMO members and FreedomBlue PPO members will not receive authorization letters.

2.6 Psychological Testing, continued

Adverse Decisions can Be Appealed	As with all other behavioral health services, an adverse decision on a request for authorization can be appealed. A statement of appeal rights and a description of the appeal process are included with all non-authorization letters.
Benefit Information	Outpatient mental health visit limits and/or copayments are not applicable to psychological testing.

2.6 Inpatient Consultations for Patients on a Medical Unit

Inpatient Consultations On A Medical Unit

Some patients admitted to a medical unit may require a psychiatric consultation.

When Authorization Is Required For Consultation

Whether authorization is required for an inpatient consultation depends upon the credentials of the performing provider:

IF the inpatient consultation is performed by a…	THEN authorization…
Psychiatrist	IS NOT required
Psychologist	IS required

The Process

To request authorization for psychiatric consultation with a patient in an acute-care medical unit:

Step	Action
1	Call: 1-800-258-9808 in the Western Region or 1-800-628-0816 in the Central Region What Region Am I?
2	The care manager gathers the following data about the request: • Patient's location • Source of the referral for the psychiatric consultation • Reason for the consultation
3	The care manager enters an authorization for CPT code 99254.

2.6 Discharge Planning and Follow-Up After Hospitalization

Overview

Ensuring that psychiatric inpatients receive appropriate care after an inpatient stay can be challenging. Patient failure to keep an initial outpatient appointment following discharge has been linked to a high risk of relapse and re-hospitalization. Therefore, Highmark has been working to help members who receive such treatment stay connected to the behavioral health care network following discharge, in an effort to improve their health and quality of life.

Discharge Planning

Discharge planning should begin within the first 24 hours of an admission to an inpatient facility. At the time of authorization, the behavioral health care manager will alert follow-up specialists to the admission so that they can work with the facility to identify appropriate follow-up services to assist the member.

Member Contact After Inpatient Discharge

Behavioral Health Clinical Staff attempt to contact all members by phone following discharge from an inpatient mental health admission within 1 business day of the discharge.

Information collected during the call will be used to

- *Identify gaps and/or barriers to services*
- *Identify appropriate case and condition management referrals*
- *Increase adherence to the discharge plan*

If a member is unable to be reached within 7 days a letter will be mailed to the member. If contact is made via phone or postal mail, the Behavioral Health Clinician will assist the member in obtaining an appointment within 7 days of discharge and will provide education about the importance of adhering to scheduled appointments. This contact increases the likelihood that the member will receive appropriate after-care.

Importance Of The Follow-Up Appointment

It is very important that the member leaves the hospital having scheduled a follow-up appointment with a psychiatrist or other behavioral health care specialist within seven days post discharge. If the appointment was not kept, the Behavioral Health Clinician will work with the member to resolve any barriers and assist in rescheduling the appointment.

When Medication Is Prescribed

The follow-up appointment is particularly important when a patient is discharged with a prescription for psychotropic medication. Follow-up care should be arranged with a behavioral health care specialist.

Continued on next page

2.6 Discharge Planning and Follow-Up After Hospitalization, Continued

If No Follow-Up Appointment Is Made	If a member leaves an inpatient facility without an appointment for any reason, the Highmark outreach case manager will assist the member with obtaining after-care services.
Continuing Care Coordination	Highmark is committed to working with providers to support members in maintaining the gains made during their inpatient treatment. *Behavioral health clinicians* will contact the provider scheduled to treat the member on an outpatient basis to verify whether the member kept his or her scheduled post-discharge appointment. The purpose of the call is to learn as soon as possible whether the discharge plan of treatment is being followed. The follow-up call to the outpatient provider will occur within 7 to 30 days after discharge from inpatient hospitalization or the day of the scheduled appointment. If the member does not keep the scheduled follow-up appointment, please make every effort to reschedule as soon as possible.
Member Contact	An outreach case manager will attempt to contact members to encourage active participation in treatment.

2.6 Highmark Behavioral Health Case Management

Behavioral Health Management: Coordination Of Resources

Highmark Behavioral Health Outreach and Intensive Case Management program works to identify members at risk and to reduce their risk factors, through frequent contact with and coordination of the following resources:

- Member
- Provider
- Family members
- Individuals and organizations providing mental health social support services to the member

Behavioral Health Outreach and Intensive Case Management Program

Highmark Behavioral Health Outreach and Intensive Case Management Program provides for an increased intensity of care management for a subset of members who meet certain high-risk criteria.

Highmark Behavioral Health Outreach and Intensive Case Management Program Objectives

The following are the objectives of the Highmark Behavioral Health Outreach and Intensive Case Management Program.

- Case Management will provide post episodic mental health intervention.
- Promote care that is clinically appropriate, efficient, timely and sensitive to the special needs of high-risk members.
- Document the provision of appropriate, high-quality services to the high-risk member population.
- Identify opportunities to improve resource management and quality of care.
- Facilitate communication with treating hospitals and practitioners to ensure quality of care for high-risk members.
- Demonstrate positive outcomes for high-risk members.
- Promote patient safety.
- Prevent inappropriate hospital admissions.
- Improve treatment compliance
- Improve effectiveness of the treatment plan.
- Coordinate Behavioral Health members with Medical Intensive Case Management when appropriate.
- Management of Postpartum Depression Screening Program.

Continued on next page

2.6 Highmark Behavioral Health Case Management, Continued

How To Request the Highmark Behavioral Health Program

You may request case management services at any time during an episode of treatment by calling the Highmark Behavioral Health Unit at

1-800-258-9808 in the Western Region or
1-800-628-0816 in the Central Region.

What Region Am I?

The Highmark Behavioral Health Program treatment team will review the request and the supporting clinical information to evaluate whether the services they provide are appropriate for the member.

High-Risk Criteria: Federal Employee Program

The criteria above listed under serious mental illness are used in identifying high-risk members with coverage through the Federal Employee Program (FEP) for participation in the Highmark's Behavioral Health Program.

Chapter 2

Provider Responsibilities

Unit 7: Ancillary Providers

In This Unit

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Submitting Claims for DME, Prosthetics, Orthotics, and Respiratory Equipment Authorized through DMEnsion, Inc. (formerly Wright & Filippis)	6
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Diabetic Testing Devices for Medicare Advantage Members	14
Medicare Prescription Drug Coverage under Medicare Advantage	15
DME Supplies Provided In a Physician Office	16

2.7 DME/Respiratory Supplies Management Program

Overview

The DME/Respiratory Supplies Management Program requires that specific items be authorized for all Medicare Advantage program members by DMEnsion, Inc. (formerly Wright & Filippis), a nationally recognized DME company that supports Highmark's efforts by administrating utilization management, claims processing and provider support.

DME Not Requiring Authorization

DME that does not require authorization simply requires a prescription written by the ordering physician.

DME Requiring Authorization

Physicians should contact DMEnsion, Inc. (formerly Wright & Filippis) or HMS to request authorization for DME and supplies furnished through a stand-alone, Highmark Ancillary DME, prosthetics and orthotics supplier for the items listed in the Procedures/DME that Require Authorization list. The Procedures/DME that require authorization can be found on the Provider Resource Center under Administrative Reference Materials.

Authorization Requirements Vary By Product

The DME/Respiratory Supplies Management Program requires that specific items be authorized for all HMO and Medicare Advantage HMO and PPO program members by DMEnsion, Inc. (formerly Wright & Filippis), a nationally recognized DME company that supports the network's efforts by administrating utilization management, claims processing and provider support. For all other members, these items should be authorized through HMS Care Management.

What Region Am I?

For these products…	Authorization is through…
Western Region HMO Medicare Advantage HMO (Western Region Only) FreedomBlue PPO	**DMEnsion, Inc. (formerly Wright & Filippis)**
DirectBlue (group)	**HMS Care Management**
DirectBlue (individual) PreferredBlue PPOBlue EPOBlue	**No authorization required**

2.7 Authorizing DME, Prosthetics, Orthotics, and Respiratory Supplies for Medicare Advantage HMO and PPO Products

Applicable Products

This program applies to all HMO and Medicare Advantage HMO and PPO Products.

Process

The steps listed below describe the process to obtain authorization for durable medical equipment, prosthetics, orthotics, and respiratory equipment.

Step	Action
1	The ordering physician determines whether the request must be sent to DMEnsion, Inc. (formerly Wright & Filippis).
2	If required, the ordering physician submits the request for authorization to DMEnsion, Inc. (formerly Wright & Filippis) through one of the following methods: • Submit the request through NaviNet℠. • Fax an authorization request form to 1-248-844-8614. • Mail an authorization request form to: DMEnsion, Inc. P.O. Box 81460 Rochester Hills, MI 48308-1460 • Call DMEnsion, Inc. (formerly Wright & Filippis) at 1-877-345-4774.
3	DMEnsion, Inc. (formerly Wright & Filippis) will review the request for benefits, eligibility, prior utilization, diagnosis, etc. • If benefits are not available, go to step 4. • If medical appropriateness cannot be determined, go to step 5. • If the request is approved, go to step 8.
4	If benefits are not available for the requested item or service, DMEnsion, Inc. (formerly Wright & Filippis) will deny the authorization request and an explanation letter from Highmark will be sent to the ordering physician and the member. Proceed to Step 9.

Continued on next page

2.7 Authorizing DME, Prosthetics, Orthotics, and Respiratory Supplies for Medicare Advantage HMO and PPO Products, Continued

Process, **(continued)**

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>5</td><td>If medical appropriateness cannot be determined from the documentation provided by the ordering physician, DMEnsion, Inc. (formerly Wright & Filippis) will contact the ordering physician for additional information. This information must be returned to DMEnsion, Inc. (formerly Wright & Filippis) within 48 hours or the request may be voided and must be resubmitted. Proceed to step 6.</td></tr>
<tr><td>6</td><td>If the documentation does not substantiate the request, the authorization request is denied and an explanation from Highmark will be sent to the ordering physician and member. If medical necessity cannot be determined, the authorization request is pended and sent to the Highmark Physician Advisor Office for review. Proceed to step 7.

If the documentation substantiates the request, proceed to step 8.</td></tr>
<tr><td>7</td><td>If the Highmark Physician Advisor Office determines that the authorization
<table>
<tr><th>Is medically appropriate</th><th>Is not medically appropriate</th></tr>
<tr><td>DMEnsion, Inc. (formerly Wright & Filippis) will approve the pended authorization
Proceed to step 8</td><td>Highmark will send a denial letter to the PCP and the member and instruct DMEnsion, Inc. (formerly Wright & Filippis) to deny the pended authorization.
Proceed to step 9</td></tr>
</table></td></tr>
<tr><td>8</td><td>DMEnsion, Inc. (formerly Wright & Filippis) gives the ordering physician the appropriate HCPCS codes and the authorization number.</td></tr>
</table>

Continued on next page

2.7 Authorizing DME, Prosthetics, Orthotics, and Respiratory Supplies for Medicare Advantage HMO and PPO Products, Continued

Process **(continued)**

Step	Action
9	The ordering physician receives the completed authorization (approved or denied) and communicates the information to the DME, respiratory, prosthetic, or orthotic network participating supplier.
10	If the supplier believes that the equipment or supplies authorized by the ordering physician are inadequate, the supplier must contact the PCP to correct the previous authorization. The supplier may contact DMEnsion, Inc. (formerly Wright & Filippis) to make adjustments to the original request or provide additional information as long as the authorized benefits do not change. This can be done through one of the following methods: • Fax an authorization request form to 1-248-844-8614. • Call DMEnsion, Inc. (formerly Wright & Filippis) at 1-877-345-4774 (1-877-FILIPPI). The supplier must provide patient information and the reason the original order is inappropriate.

2.7 Submitting Claims for DME, Prosthetics, Orthotics, and Respiratory Equipment Authorized through DMEnsion, Inc.

Submitting Claims

The steps listed below describe the process for submitting claims.

Step	Action
1	The DME supplier submits the claim to DMEnsion, Inc. (formerly Wright & Filippis) on a CMS-1500 form by mailing it to: DMEnsion, Inc. P.O. Box 81460 Rochester Hills, MI 48308-1460
2	DMEnsion, Inc. (formerly Wright & Filippis) verifies benefits eligibility and authorization and processes the claim.
3	The check and remittance are sent to the supplier (or member, if appropriate).
4	Claim information is sent to Highmark for administrative purposes and historical record.

2.7 Pre-Service Denials for Medicare Advantage Products

Definition

A pre-service denial occurs when a physician tells a member that a specific requested service cannot be provided or continued due to lack of medical necessity or because the service is a non-covered benefit.

If the member accepts the physician's decision, this is not a pre-service denial. However, if the member continues to request the service, a pre-service denial has occurred.

Background

The Centers for Medicare & Medicaid Services (CMS) requires all contracting Medicare Advantage programs and their physicians to advise members of their right to appeal any denial of a service to which they believe they are entitled.

Policy

All Medicare Advantage HMO and Medicare Advantage PPO members have the right to appeal a pre-service denial and to be informed in a timely manner of their right to appeal an adverse decision. CMS requires that all Medicare Advantage programs must comply with pre-service denial regulations.

Pre-Service Denials After The Member Leaves The Office

If the member agrees with the physician's decision not to supply the service at the time of the visit, **but later reconsiders** and decides that he or she wants to have the service, this is a pre-service denial.

If the member calls the physician's office to communicate this disagreement, the physician's office must send the pre-service denial notice and statement of member appeal rights to the member within one business day. However, if the member calls Member Services instead, a Highmark representative will issue the pre-service denial notice and statement of member appeal rights to the member.

New Members Who Have Never Been Seen At The Office

If a Medicare Advantage HMO or PPO member, who has never been examined by the physician, telephones and requests a service, the physician has the right to ask the member to come for an office visit. If the member refuses, this does not constitute a pre-service denial because the member is not following the plan's rule that members must coordinate all non-urgent, non-emergent care. If the member is not in agreement, the physician should advise the member to contact their Member Service Department.

2.7 Medicare Advantage Home Oxygen Therapy

Introduction

Medicare Advantage HMO and PPO products provide coverage for medically necessary home oxygen therapy and the equipment necessary for the safe, effective delivery of that therapy.

Equipment Included

The equipment necessary for delivery of home oxygen therapy includes the following:

- Oxygen furnishing system
- Oxygen storage vessels
- Tubing
- Administration sets

Supplies	Codes
Stationary oxygen delivery system only ***(One code per patient per month)***	E0424 E0439 E1390
Portable oxygen delivery system only ***(One code per patient per month)***	E0431 E0434 E0443 contents payable only when stationary liquid is used with portable gaseous (E0431)
Patient owned equipment	E0425 E0430 E0435 E0440 E0441 E0442 A4615 (cannula) A4616 (tubing) E0550 (humidifier) E0555 (humidifier) E0560 (humidifier)

Continued on next page

2.7 Medicare Advantage Home Oxygen Therapy, Continued

Conditions For Which Coverage Is Available

Home oxygen therapy coverage is available for rented, not purchased, oxygen equipment for members with significant hypoxemia in the chronic stable state provided all of the following conditions are met:

1. The attending or consulting physician has determined that the patient suffers a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy.
2. The patient's blood gas levels indicate the need for oxygen therapy
3. Alternative treatment measures have been tried or considered and have been deemed clinically ineffective.

Conditions For Which Coverage Is Unavailable

Coverage for oxygen therapy for Medicare Advantage members is not available for the following conditions:

1. Angina pectoris in the absence of hypoxemia. This condition is generally not the result of a low oxygen level in the blood, and there are other preferred treatments.
2. Dyspnea without cor pulmonale or evidence of hypoxemia.
3. Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities. There is no evidence that increased PO_2 will improve the oxygenation of tissues with impaired circulation.
4. Terminal illnesses that do not affect the respiratory system.

Portable Oxygen Systems

Coverage of a portable oxygen system alone or to complement a stationary oxygen system may be allowed if the patient is mobile within the home. When submitting an authorization request, check both boxes, "portable" and "stationary."

Spare Tanks Or Emergency Inhalators

Spare tanks of oxygen or emergency oxygen inhalators are considered not medically necessary since these items are precautionary and not therapeutic in nature.

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2.7 Medicare Advantage Home Oxygen Therapy, Continued

Blood Oxygen Determinations

Initial orders for oxygen therapy must also include the results of a blood gas study, usually a measurement of the partial pressure of oxygen (PO_2) in arterial blood. **The study must be performed within 30 days before the date of service.**

The study should be performed under one of the following circumstances:

- Ordered and evaluated by the attending or consulting physician
- Ordered and evaluated by the attending physician and performed under his or her supervision
- Performed by a qualified provider or supplier of laboratory services

Note: Medicare does not recognize DME suppliers as qualified to provide or supply blood oxygen determinations.

Conditions Of Blood Gas Studies

The conditions under which the blood gas study was performed must be specified in writing and submitted on the *Certificate of Medical Necessity* (CMN) form. Examples of this documentation may include the following:

- At rest
- While sleeping
- While exercising
- On room air
- On oxygen

Note: If the study is performed while the patient is receiving oxygen, indicate the following:

- Amount
- Body position during testing
- Additional information required for interpretation

Continued on next page

2.7 Medicare Advantage Home Oxygen Therapy, Continued

Blood Gas Level Criteria

The table below describes three groups of blood gas levels for which coverage is provided.

Group	Blood gas level criteria
Group 1 *Medically necessary*	Arterial PO_2 is at or below 55 mm Hg, or arterial oxygen saturation is at or below 88% taken at rest. OR Arterial PO_2 is at or below 55 mm Hg, or arterial oxygen saturation is at or below 88% taken during sleep for a patient who demonstrates arterial PO_2 at or above 56 mm Hg or arterial oxygen saturation at or above 89% while awake. OR A greater than normal fall in oxygen level during sleep (arterial PO_2 decreases more than 10 mm Hg, or arterial oxygen saturation decreases more than 5%) associated with symptoms or signs reasonably attributable to hypoxemia (e.g., cor pulmonale, "P" pulmonale on EKG, documented pulmonary hypertension and erythrocytosis). OR Arterial PO_2 is at or below 55 mm Hg or arterial oxygen saturation at or below 88%, taken during activity for a patient who demonstrates arterial PO_2 at or above 56 mm Hg or arterial oxygen saturation at or above 89%, during the day while at rest. In this case, supplemental oxygen is provided during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the patient was breathing room air.

Continued on next page

2.7 Medicare Advantage Home Oxygen Therapy, Continued

Blood Gas Level Criteria, **continued**

Group	Blood gas level criteria
Group 2 *Medically necessary*	Arterial PO_2 is 56 to 59 mm Hg or arterial blood oxygen saturation is 89% if any of the following are documented: • Dependent edema suggesting congestive heart failure • Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale of EKG (P wave is greater than 3 mm in Standard Leads II, III, or AVF) • Erythrocythemia with a hematocrit greater than 56%
Group 3 ***Not*** *medically necessary*	Home use of oxygen is not medically necessary for members with PO_2 levels at or above 60 mm Hg, or arterial blood oxygen saturation at or above 90%.

Additional Studies

Retesting between the 61st and 90th day of home oxygen therapy is required in order to establish continued medical necessity when a patient's initial certification for oxygen is approved based on one of the following criteria:

- Arterial PO_2 was 56 mm Hg or greater
- Oxygen saturation was 89% or greater

Certificate Of Medical Necessity

A *Certificate of Medical Necessity* (CMN) form for home oxygen is necessary for the following:

- Initial certification
- Recertification
- Changes in the oxygen prescription

The CMN must be completed, signed, and dated by the ordering physician.

Continued on next page

2.7 Medicare Advantage Home Oxygen Therapy, Continued

Obtaining Authorization

DMEnsion, Inc. (formerly Wright & Filippis) must authorize all home oxygen therapy for Medicare Advantage members. Follow the steps listed below to obtain authorization.

Step	Action
1	The physician enters a request for oxygen into NaviNet[SM]. The physician should also fax a CMN form to DMEnsion, Inc. at 1-248-844-8614 at the same time.
2	The electronically submitted request is automatically sent to DMEnsion, Inc. (formerly Wright & Filippis). Fax paper referral forms to DMEnsion, Inc. at 1-248-844-8614.
3	If the physician has not included a CMN form, DMEnsion, Inc. will send or fax a CMN form to the physician for completion.
4	Physician returns completed CMN form to DMEnsion, Inc.
5	DMEnsion, Inc. sends an authorization approval through ROAR or by fax.
6	The physician sends the approved request to a DME supplier.
7	The DME supplier provides services to the patient.

Recertification

Recertification must include the results of a recently performed arterial blood gas (ABG) or oximetry test; and it is required one to three months after initial certification under the following circumstances:

- If the patient's arterial PO_2 was 56 mm HG or greater at the initial certification
- If the patient's oxygen saturation was 89% or greater at the initial certification
- If the physician initially estimated that oxygen was needed for one to three months

Note: Once recertification establishes medical necessity for continued therapy, subsequent recertification is not required except when there is a change in the oxygen prescription or the attending physician.

2.7 Diabetic Testing Devices for Medicare Advantage HMO and PPO Members

Changes Effective January 1, 2006

Medicare Advantage HMO and PPO products provide coverage for medically necessary diabetic testing devices including glucometers, test strips and lancets effective January 1, 2006. Insulin pens and insulin pumps are also being covered under DME. Insulin and syringes will not be covered as DME, but will be covered under the Medicare Part D Prescription Drug Benefit.

Purchasing Diabetic Testing Devices

Members are now able to purchase these items from any participating, in-network DME vendor with applicable member cost-sharing under Medicare Advantage.

Part B Drugs are covered in full after a copayment when they are obtained from an in-network specialty pharmacy, DME vendor, or furnished in a physician's office. Any out of network supplies, are subject to additional copayments and coinsurance.

Although FreedomBlue PPO members have out-of network benefits, those members who elect to go out-of-network to purchase DME supplies will incur additional out-of-pocket expenses. Please review the patient's specific benefit design to determine possible authorization requirements and/or coinsurance amounts and maximum annual coinsurance amounts.

Prescriptions For Multiple, Daily Diabetic Testing

If a patient is instructed to test multiple times in the same day for diabetes, treatment prescriptions for DME diabetic supplies should be written to clearly state the correct frequency of testing (Ex. To be tested three times daily). This will ensure that the correct amount of supplies are ordered and submitted for DME coverage under a Medicare Advantage product.

Many of the in-network DME vendors can supply increased supplies in a timely manner. If a patient requires additional supplies the treating physician will need to provide the patient with a new prescription detailing the testing frequency. After receiving the new prescription, the patient will need to contact the DME vendor to indicate that their testing needs have increased and that their physician wrote a new prescription detailing the change.

Mail Order Diabetic Testing Supplies

Members are still able to order 90-day supplies of diabetic supplies via mail order. The physician must write the prescription to reflect the long term supply so that the member is able to submit the prescription to the mail order DME vendor and receive accurate long term supplies.

For More Information

If you have specific questions about diabetic testing devices for Medicare Advantage members, please contact Provider Service.

2.7 Medicare Prescription Drug Coverage under Medicare Advantage

Prescription Drug Coverage

Medicare Advantage HMO and PPO products provide Part B prescription drug coverage (MA-only plans). Some Medicare Advantage plans may also include Medicare Part D Prescription Drug Coverage benefits (MA-PD plans). Effective January 1, 2006, Medicare Advantage members can obtain the following Part B drugs from the following providers/suppliers:

- oral medication for cancer from specialty pharmacies including Medmark and
- nebulizer solution from approved Durable Medical Equipment (DME) vendors.

Medicare Advantage HMO and PPO members are **not** able to purchase any Part B drugs, including those listed above, at a retail pharmacy.

Medicare Advantage HMO and PPO members can obtain oral medication for cancer from a specialty pharmacy when it is covered under their Part D benefit, but are not required to do so.

Coverage Levels for In And Out Of Network Purchases

Part B drugs are covered in full after a co-payment when they are obtained from an in-network specialty pharmacy or a DME vendor.

If FreedomBlue PPO members purchase these drugs at an out-of-network specialty pharmacy or DME vendor, in addition to a co-payment, they are responsible for 20-30% coinsurance on the lesser of the out-of-network charge or network allowed amount as well as any difference between the out-of-network charge and network amount. Highmark's Western Region Medicare Advantage HMO product does not have an out-of network benefit.

Members Can Buy Supplies From A Listing Of Vendors And Pharmacies

There are several network specialty pharmacies and DME vendors from which members can choose. A listing of specialty pharmacy providers and DME vendors are now available on NaviNet[SM] and via www.highmark.com.

For More Information

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

2.7 DME Supplies Provided in the Physician Office

Simple DME Supplies Can Be Provided In The Office Setting

Minor DME items, prosthetics, orthotics, and supplies incidental to a physician or facility that do not require authorization can be furnished to members for their convenience in the physician office setting.

What Region Am I?

Applicable Products

The supplies listed below can be provided in the office setting for Medicare Advantage HMO and PPO members as well as other Highmark managed care members enrolled in many Highmark Blue Shield products.

Submit A Claim For The Appropriate Charge

Under no circumstances should a member be charged for such items or supplies. Include the charge for the item/supply on a claim and submit to Highmark following normal billing protocols.

Eligible Supplies/Items

Following is a list of those items that can be supplied to members in the office setting and billed to Highmark for reimbursement at fee-for-service. *These supply items do not require authorization.*

Item	Code
Crutches, underarm, wood, adjustable or fixed, pair with pads, tips and handgrips	E0112
Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips and handgrips	E0114
Cervical, Flexible, non-adjustable (foam collar)	L0120
Knee orthosis, immobilizer, canvas longitudinal, prefabricated, includes fitting and adjustment	L1830
Plastazote sandal-each	L3265
Wrist hand Orthosis, wrist extension control cock-up, non molded, prefabricated, includes fitting and adjustment	L3908
Ankle control orthosis, stirrup style, rigid, includes any type interface (e.g., pneumatic, gel) prefabricated, includes fitting and adjustment	L4350
Pneumatic knee splint, prefabricated, includes fitting and adjustment	L4380
Peak Expiratory Flow Rate Meter, Hand Held (Effective 03/01/06)	A4614
Spacer, Bag or Reservoir, with or without mask, for use with metered dose inhaler (Effective 03/01/06)	A4627

IMPORTANT! All Other DME And Supplies

Requests for all other DME, prosthetic and orthotic supplies must be directed to a network DME, prosthetic and orthotic provider. Search in NaviNet[SM] for eligible providers within each managed care product.

Chapter 2

Provider Responsibilities

Unit 8: Policies and Procedures For MDs/DOs Only

In This Unit

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2.8 Overview

Overview

Highmark entered into a Settlement Agreement dated as of October 19, 2007 in connection with the Love class action litigation filed against Highmark and certain other licensees of the Blue Cross Blue Shield Association in the United States District Court for the Southern District of Florida, Miami Division. Similar litigation was filed against other large commercial insurers. As part of the settlement, Highmark agreed to certain commitments and undertakings with respect to Medical Doctors (MDs) and Doctors of Osteopathic Medicine (DOs) which are comparable to those agreed to by the other settling Blue plans and commercial insurers. This section sets forth procedures and policies as a result of those commitments and undertakings. The section applies exclusively to MDs and DOs.

Where conflicting procedures and policies contained in this manual exist, except as otherwise required by an applicable federal or state law or regulation or by an applicable federal or state governmental body, the procedures and policies contained in this unit shall apply to for MDs and DOs.

The language in this unit may also apply to the BlueCard Program, where applicable.

Who Should Read This Section

This section is intended to act as a reference point for Highmark Blue Shield's participating MDs and DOs. All other provider types may reference parts of the manual applicable to their network and/or specialty.

The Highmark Blue Shield Office Manual (HBSOM) is binding upon providers and may be supplemented or superseded, in whole or in part, by other Highmark Blue Shield guidance and/or requirements furnished or otherwise made available to providers, provided supplements do not conflict with applicable federal and state laws and regulations of the Love settlement agreement.

Unit Terms – Participating Physician

In reference to this unit, the term 'participating physician' includes participating physicians, participating physician groups, or participating physician organizations.

2.8 Policies and Procedures for MDs/DOs Only

What Region Am I?

Fee Schedule Availability

Participating physicians can request a fee schedule for 100 CPT codes (plus E&M codes) customarily and routinely used by such physician. Fee Schedule info can also be found under Allowance Inquiry feature within NaviNet on a code by code basis. In the western region, a complete Western Region network fee schedule is available under Administrative Reference Materials on the Provider Resource Center.

Participating physicians may also request a CD-ROM or a hard copy with complete fee information showing applicable fee schedule amounts for the requesting physician. Please include your provider name and address and Highmark Blue Shield Provider Number or NPI and send request to:

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

The fee information will be provided by the fee for service dollar amount allowable for each CPT code. For those CPT codes that a participating physician in the same specialty typically uses in providing covered services. This information is available electronically via 'Most Frequently Billed Codes" in NaviNet. Highmark Blue Shield will not require the participating physician to provide Highmark Blue Shield with billing rates as a precondition to providing fee information.

Highmark Blue Shield will honor two such requests annually.

Precertification Requirements

Please visit the Procedures that Require Authorization list under Administrative Reference Materials on the Provider Resource Center. Please also visit Chapter 4, Unit 2 of the Highmark Blue Shield Office Manual for more information on procedures that require authorization.

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2.8 Policies and Procedures for MDs/DOs Only, Continued

Prompt Notification Of Policy and Procedure Changes

Highmark Blue Shield will provide participating physicians written notification of material adverse changes in the terms of its contracts at least ninety (90) days in advance of the change. This policy is possible except in cases where a shorter notice period is required to comply with changes in applicable law.

A participating physician must within 30 days of the date of the notice of change give written notice to terminate the physician's contract with Highmark Blue Shield the termination will be effective at the end of the notice period of the material adverse change unless within 65 days of the date of the original notice of change Highmark Blue Shield gives written notice to the objecting participating physician that it will not implement the material adverse changes to which the participating physician objected.

Claim Information Guidelines

Certain edits within Highmark's processing system may require the submission of additional clinical information, in addition to the diagnosis(es) reported on the claim.

These include:

- Potentially Cosmetic Procedures
- Procedures of Questionable Current Usefulness
- Individual Consideration

Providers wanting a rejected claim considered for payment will need to submit clinical information to support payment of rejected services. For more information on the procedures to submit additional clinical information, please visit Clinical Information Requirements under Medical & Claim Payment Guidelines on the Provider Resource Center.

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2.8 Policies and Procedures for MDs/DOs Only, Continued

Your Right To Terminate A Highmark Blue Shield Contract

Any party to this physician contract shall have the right to terminate the contract without cause upon prior written notice provided to the other, which period shall be no less than sixty (60) calendar days. If a current notice period is shorter than sixty (60) calendar days, such provision is hereby amended to require sixty (60) calendar days notice. If a current notice period is more than one hundred twenty (120) calendar days, such provision is hereby amended to require one hundred twenty (120) calendar days notice. All other termination without cause and applicable notice provisions remain unmodified.

Please visit Chapter 2, Unit 2 of the Highmark Blue Shield Office Manual for more information on termination procedures.

Provider Termination Due To Fee Schedule Reduction

Not withstanding the forgoing, if an annual revision made by CMS results in a reduction in the fees in a fee schedule that is directly tied to the CMS fee schedules as established and maintained by Highmark, a participating physician has the right to terminate the Highmark contract within thirty (30) days of the date the annual CMS revision was published. The termination will be effective ninety (90) days after the date of the notice was published. Applicable continuation of care provisions apply to such contract termination.

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2.8 Policies and Procedures for MDs/DOs Only, Continued

Continuation Of Care Throughout A Contract Termination

In the event of a contract termination by either party, the provider will continue to render necessary care to Highmark Blue Shield's plan member(s) consistent with contractual or legal obligations.

Continuation of Care (COC) is a process followed to permit a member to continue an on-going course of treatment with a Primary Care Physician (PCP), a specialist, or a facility whose contract has been terminated by Highmark Inc. for reasons other than for cause, for up to 90 days from the effective date of termination. COC also covers a member in the second or third trimester of pregnancy; the transition period shall last through post-partum care related to the delivery.

The provider must notify Highmark Blue Shield that the member is in a continuation of care situation. If Highmark Blue Shield does not take actions to make alternative care available to the member within ninety (90) days after receipt of the provider notice, then for continuation of care services provided after termination Highmark Blue Shield will pay the provider the standard rates paid to non-participating providers for that geographical area.

Notwithstanding the foregoing obligations, Highmark Blue Shield's obligations under this provision do not apply to the extent that other Participating Physicians are not available to replace the terminating participating physician due to:

- geographic or travel-time barriers; or
- contractual provisions between the terminating physician and a facility at which Highmark Blue Shield's member receives care that limits or precludes other participating physicians from rendering replacement services to Highmark Blue Shield's members (e.g., an exclusive services agreement between the terminating participating physician and a facility where Plan Member receives services).

Continued on next page

2.8 Policies and Procedures for MDs/DOs Only, Continued

Establishment Of Fee Schedules

Highmark Blue Shield establishes one or more fee schedules of fee for service payments to its participating physicians for each geographic market in which Highmark Blue Shield maintains a provider network.

Payment Rules for Injectibles, DME, Administration of Vaccines, and Review of New Technologies

Highmark Blue Shield agrees to pay a fee for the administration of vaccines and injectibles by a participating physician. Highmark Blue Shield also agrees to pay for the vaccines and injectibles themselves. Highmark Blue Shield pays for newly recommended vaccines as of the effective date of a recommendation made by any of the following: the U.S. Preventive Services Task Force; the American Academy of Pediatrics; and the Advisory Committee on Immunization Practices. Other than as specified in the preceding sentence with respect to newly recommended vaccines, if a physician specialty society recommends as an appropriate standard of care a new technology or treatment, or a new use for an established technology or treatment, Highmark Blue Shield evaluates such recommendations and issue a coverage statement not later than 120 days after Highmark Blue Shield learns of such physician specialty society recommendation.

This does not apply to Medicare Advantage products which follow medical and pharmacy coverage policies as required by the Medicare program.

Continued on next page

2.8 Policies and Procedures for MDs/DOs Only, Continued

Definition of Medical Necessity

Except where any applicable law, regulation, or government body requires a different definition (i.e., the Federal Employees Health Benefits Program, CMS as to the Medicare Advantage program, etc.), Highmark Blue Shield has adopted a universal definition of medical necessity. The term "Medically Necessary," "Medical Necessity" or such other comparable term in any provider contract shall mean health care services (or such similar term as contained in the applicable benefit agreement or plan document to include, but not be limited to, "health services and supplies," "services and supplies" and/or "medications and supplies") that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

This definition is located in units Chapter 2, Unit 6, Chapter 3, Unit 6 and Chapter 4, Unit 1 of the Highmark Blue Shield Office Manual.

Medical Policy

In formulating and adopting medical policies with respect to covered services, Highmark Blue Shield relies on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community. Highmark Blue Shield medical policies are available on the Provider Resource Center.

Continued on next page

2.8 Policies and Procedures for MDs/DOs Only, Continued

Highmark Blue Shield Claims Processing

For more information on Claims Submission and Billing Information, please visit Chapter 5, Unit 2 of the Highmark Blue Shield Office Manual.

Overpayment Recovery Procedures for MDs and DOs Who Are Class Members Of The Love Settlement Agreement

Highmark Blue Shield will not initiate overpayment recovery efforts more than eighteen (18) months after the payment was received by Physician; provided, however, that no time limit applies to the initiation of Overpayment recovery efforts:

- based on a reasonable belief of fraud or other intentional misconduct, or
- required by a Self-Insured Plan, or
- required by a state or federal government program.

For more information on overpayments, please visit Chapter 5, Unit 2 of the Highmark Blue Shield Office Manual.

Preauthorization Policies

If Highmark Blue Shield authorizes or preauthorizes that a proposed service is medically necessary for one of our members, Highmark Blue Shield will not subsequently revoke that medical necessity determination absent evidence of fraud, evidence that the information submitted was materially erroneous or incomplete, or evidence of material change in the member's health condition between the date that the certification or Preauthorization was provided and the date of the service that makes the proposed service no longer medically necessary for such Plan Member.

In the event that a Highmark Blue Shield certifies or preauthorizes the medical necessity of a course of treatment limited by number, time period or otherwise, then a request for services beyond the certified course of treatment will be deemed to be a new request and that Highmark Blue Shield's denial of such request will not be deemed to be inconsistent with the preceding sentence.

Continued on next page

2.8 Policies and Procedures for MDs/DOs Only, Continued

Revising Physician Information On Our Websites

Highmark's member sites contain directories of information about each provider under the "Find a Provider" feature. The Highmark Provider Directory includes a fast, easy way for our members to find providers near their homes or their workplace. If you determine that your information is inaccurate, you must contact Highmark to revise.

Please visit Chapter 1, Unit 2 of the Highmark Blue Shield Office Manual to find more information on how to complete this process.

Continued on next page

2.8 Policies and Procedures for MDs/DOs Only, Continued

Highmark Blue Shield's Pharmacy Coverage

Highmark Blue Shield makes accessing formulary information easy for its members. Highmark Blue Shield also maintains the process, as reasonably amended, for covering medications not included in the formulary when Medically Necessary that is in place on the Execution Date. When Highmark Blue Shield provides pharmacy coverage, it continues to provide coverage for off-label uses of pharmaceuticals that have been approved by the FDA (but not approved for the prescribed use) provided that the drug is not contraindicated by the FDA for the off-label use prescribed, and that the drug has been proven safe, effective and accepted for the treatment of the specific medical condition for which the drug has been prescribed, as evidenced by the results of good quality controlled clinical studies published in at least two or more peer reviewed full length articles in respected national professional medical journals.

In reaching a conclusion whether to provide coverage for a drug under the preceding sentence, Highmark Blue Shield considers supporting documentation in either the American Hospital Formulary Service Drug Information or the United States Pharmacopeia Drug Information. Highmark Blue Shield retains the right to preauthorize coverage of specific medications for non-approved use. Highmark Blue Shield's disclosure concerning Precertification and potential restrictions on non-approved use of prescription medications are similar in substance to disclosure concerning formularies, as described above.

Formulary information can be found under the Pharmacy/Formulary section of the Provider Resource Center.

For more information on Highmark Blue Shield's Formulary list, please visit Chapter 3, Unit 4 of the Highmark Blue Shield Office Manual.

Requesting A Contract Copy

Highmark Blue Shield allows participating providers to request copies of their participating physician contract, as required.

For more information on how to request a contract, please visit Chapter 2, Unit 4 of the Highmark Blue Shield Office Manual.

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2.8 Policies and Procedures for MDs/DOs Only, Continued

Force Majeure

No party will be required to meet an obligation under this Manual where the inability to meet such obligation is the result of any act of God, governmental act, act of terrorism, war, fire, flood, earthquake or other natural disaster, explosion or civil commotion ("Force Majeure").

The performance of a party's obligations under this Manual, to the extent affected by the delay, shall be suspended for the period during which the cause, or the party's substantial inability to perform arising from the cause, persists.

If the performance of any obligation under this Manual is excused or delayed by Force Majeure and that obligation is a condition precedent for the performance of an obligation by another party, performance of the obligation by the second party shall be excused or delayed to the same extent as the performance of the obligation by the first party.

The Billing Dispute External Review Board (BDERB)

If an MD or DO who is a member of the Love settlement agreement disagrees with a decision to a billing dispute and have exhausted all of Highmark's internal appeals, they may submit to the Billing Dispute External Review Board (BDERB). The provider may be eligible to choose the Medical Review Committee in lieu of the BDERB however, no matter which dispute process is chosen, individual determinations made by either the BDERB or the MRC are binding for both the provider and Highmark Blue Shield.

The Billing Dispute External Review Board (BDERB) is a national independent review organization contracted by Highmark to review billing disputes. Providers do not have to participate with Highmark Blue Shield to participate in a BDERB dispute; however the dispute must arise from covered services provided to Highmark members.

This process does not apply to medical necessity disputes. For information pertaining to the Denials and Appeals Process related to medical necessity, please visit Chapter 4, Unit 4 of the Highmark Blue Shield Office Manual.

Continued on next page

2.8 Policies and Procedures for MDs/DOs Only, Continued

Requirements To Dispute A Highmark Decision Using The BDERB

- *You must be a class member of the Love Settlement Agreement who did not opt out.*
- *You must have exhausted all internal Highmark billing dispute processes (including all appeals).*
- *Your dispute must arise from denial of payment for services provided to Highmark members.*
- *Billing dispute amount must:*
  a) exceed $500 in denied payments as a single dispute; OR
  b) be multiple disputes filed within a 1-year period from the filing of the original billing dispute must exceed $500 as an aggregate amount (for more information about this process, see section 7.10(c) of the Settlement Agreement – visit http://www.hmosettlements.com/pages/highmark.html for Settlement Agreement).
- *You must have initiated a provider billing dispute with your Highmark Plan and received a written response that you wish to have reconsidered.*
- *The dispute must be filed within 90 calendar days of the date of the final Highmark denial notification letter.*
- *You must complete the Highmark Blue Shield Billing Dispute Form and the BDERB Dispute Resolution Agreement listed below for each dispute and return to Highmark with all required documentation including a copy of the original denial notification.*
- *You must submit the proper filing fee by check. Please note the filing fee will not be charged until the $500 threshold billing dispute amount is reached*.

How To Submit A Matter To The BDERB

To properly submit a complete package to Highmark's external review vendor, you must send the following items:

- a copy of the written denial letter,
- BDERB Dispute Resolution Agreement
- External Review Board Dispute Form
- the proper filing fee

Please visit the Provider Resource Center for more information on BDERB submission and to download applicable forms, agreements and instructions. All items above should be submitted to:

IMEDECS
157 S. Broad Street
Lansdale, PA 19446

2.8 Policies and Procedures for MDs/DOs Only, Continued

Problem Resolution	Following a decision by the BDERB, the responsible parties are notified via postal mail.
For More Information On The BDERB	More information on the BDERB is available by choosing the appropriate selection under the Administrative Reference Materials section of the Provider Resource Center. You may also contact our BDERB vendor, IMEDECS, by calling (215) 855-4633.

2.8 Behavioral Health Physicians

Behavioral Health

Definition of Medical Necessity for Behavioral Health Providers
Medical Necessity Criteria For Behavioral Health Services is defined in Chapter 2, Unit 6 of the Highmark Blue Shield Office Manual.

Participating Physicians In Highmark Blue Shield's Directory
Highmark Blue Shield's participating psychiatrists are listed in the Provider Directory on Highmark Blue Shield's public member web site. Highmark Blue Shield allows its PCPs to direct care to participating psychiatrists.

Prudent Layperson Laws For Emergency Services
Highmark Blue Shield defines Prudent Layperson Laws as defined in Chapter 2, Unit 6 of the Highmark Blue Shield Office Manual.

Authorization Form for Behavioral Health Providers to Release Medical Information To Highmark Blue Shield
The form 'Authorization for Behavioral Health Providers to Release Medical Information' was developed to assist participating and non participating behavioral health specialists gain the proper permissions to provide behavioral health clinical information to Highmark Blue Shield, its subcontractors and business associates. The form is available under the Provider Forms section of the Provider Resource Center.

For more information on how to access the form, please visit Chapter 2, Unit 6 of the Highmark Blue Shield Office Manual.

Chapter 3

Products, Networks and Payment

Unit 1: Product Information

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3.1 Participating and Preferred Provider Networks

Overview

This section provides a description of Highmark Blue Shield's professional provider networks.

Mutual Roles And Obligations For Physicians And Highmark

As a participant in any of Highmark Blue Shield's networks, professional providers agree to a set of regulations that outline their obligations to Highmark Blue Shield members. Highmark Blue Shield has obligations to its network participants as well.

The mutual obligations are contained in the agreements and regulations that professional providers execute when joining the network.

Key contractual provisions include:

- Network providers will accept the network allowance as payment-in-full for covered services, less any applicable copayments, deductibles and/or coinsurance.
- Highmark Blue Shield will make payment directly to network providers and will notify the member of any responsibility they may have (such as, non-covered services, coinsurance or deductibles).
- Network providers will handle basic claims filing paperwork for the member.
- Highmark Blue Shield will encourage members to obtain health care services from network providers, which could increase the provider's patient base.
- Network providers will recommend their patients see other network providers when necessary.

Types of Contracted Health Care Professionals

Highmark Blue Shield pays claims for services performed by licensed, eligible health service providers, as defined by state law. These providers include:

- Doctor of Medicine;
- Doctor of Osteopathy;
- Doctor of Dental Surgery;
- Doctor of Podiatry;
- Doctor of Optometry;
- Doctor of Chiropractic;
- Nurse midwives;
- Licensed physical therapist;
- Independent clinical laboratories;
- Licensed psychologist;
- Certain certified registered nurses;
- Licensed audiologist;
- Licensed speech-language pathologist; and
- Licensed teachers of persons who are hearing impaired

Continued on next page

3.1 Participating and Preferred Provider Networks, Continued

The Participating Provider Network

Highmark Blue Shield has agreements with more than 46,000 Participating Providers – 8 out of 10 health care providers in the state – representing every major specialty.

Any eligible professional provider licensed to practice in Pennsylvania may apply for participating status by completing Highmark Blue Shield's Participating Provider Agreement. This is not a credentialed network – a professional provider's admission to the network is based solely on medical licensure and the execution of the network agreement.

- Highmark Blue Shield Participating Providers agree to perform services for members according to the Regulations for Participating Providers, Pennsylvania state laws, the corporate bylaws governing Highmark Blue Shield and subscription agreements and master contracts.
- Participating Providers accept Highmark Blue Shield's allowances as payment-in-full for covered services, minus any applicable copayments, deductibles or coinsurance. Participating Providers also handle all basic claims filing paperwork for Highmark Blue Shield's members.
- Participating Providers are eligible to become actively involved with Highmark Blue Shield as corporate professional members and as members of the company's various professional committees and advisory councils.
- This network services our traditional Highmark Blue Shield programs, including traditional BlueCard, as well as BlueCard POS and HMO programs.

3.1 PremierBlue Shield Network Information

The PremierBlue Shield Network

The PremierBlue Shield Network is Highmark Blue Shield's statewide selectively contracted preferred provider network. There are more than *41*,000 providers in the PremierBlue Shield network. Any eligible professional provider licensed to practice medicine in Pennsylvania may apply for the PremierBlue Shield network. You must meet the network's credentialing criteria to be accepted into the network. Because PremierBlue Shield supports managed care products. Highmark Blue Shield must ensure the network complies with the regulations of the Pennsylvania Department of Health governing Managed Care Organizations (28 PA Code, Chapter 9). These regulations require that we ensure network providers' offices meet certain standards. As a result, Highmark Blue Shield staff conducts site visits and medical record reviews of primary care physicians, ob-gyns and high volume behavioral health provider offices.

The application for this credentialed network requests information about a provider's qualifications to practice quality medicine, practice location(s), the doctor's medical education, work history, etc.

Network providers are classified as primary care physicians (PCPs) or specialists. PCPs include family practitioners, general practitioners, internists and pediatricians.

PCPs and specialists sign separate network agreements. Members are free to choose any network provider to receive maximum benefits.

What Region Am I?

This network supports a variety of coverage programs. PremierBlue Shield also supports the BlueCard PPO programs, and is used by other carriers who have made an arrangement with Highmark Blue Shield. The Federal Employee Program is the largest customer that utilizes this network in the Central, Eastern and Northeastern Regions. The Western Region network supports the Federal employee Program in the western part of the state. More information on these networks are found throughout this unit.

PremierBlue Shield providers agree to perform services for members according to the Regulations for PremierBlue Shield Providers, Pennsylvania state laws, the corporate bylaws governing Highmark Blue Shield and individual subscription agreements and master contracts. They also agree to accept the PremierBlue Shield allowance as payment in full for covered services, less any applicable copayments, deductibles or coinsurance.

3.1 Facility, Ancillary, and Mid-Level Provider Networks

Facility Network

What Region Am I?

Highmark Blue Shield holds contracts with all 38 acute care facilities in the 21-county Central Pennsylvania and Lehigh Valley areas.
In addition, we contract with substance abuse treatment centers, psychiatric facilities, rehabilitation facilities, skilled nursing facilities, and state-owned psychiatric hospitals.

Mid-Level Provider Network

Mid-level providers who are not eligible to participate in the Participating Provider or PremierBlue Shield networks may be eligible to contract with Highmark Blue Shield to provide services for certain government programs only, i.e., Federal Employees Program (FEP) and Medicare Advantage as follows:

FEP
- Acupuncturist
- Licensed Clinical Social Worker

Medicare Advantage
- Occupational Therapist
- Physician Assistant

Both FEP and Medicare Advantage
- Dietician/nutritionist

Ancillary Provider Network

To supplement the professional provider and facility networks, Highmark Blue Shield has contracted with a network of ancillary providers. These include freestanding and facility-based providers in the specialties including but not limited to:

Ambulatory Surgical Centers	Ambulance
Renal Dialysis	Durable Medical Equipment
Home Health	Home Infusion
Hospice	Orthotics/Prosthetics
Comprehensive Outpatient Rehabilitations Facilities (CORF)	
Independent Laboratories	

Recommending Other Network Providers

In order for our members to receive the highest level of benefit that their plan offers, please be sure to use other network providers when you must recommend members for care.

Continued on next page

3.1 Facility, Ancillary, and Mid-Level Provider Networks, Continued

Recommending Other Network Providers (continued)

You and the member can access our health care directory through NaviNet and Highmark's Informational Member Web sites.

Please visit NaviNet or one of Highmark's Informational Web Sites via www.highmark.com.

Medicare Advantage

The cornerstone of the program is the network:

- When members receive covered services from network providers, those services are paid at the higher level defined in the benefit contract. (Some services require a copayment or coinsurance even when rendered by a network provider.)

- Members can still receive most covered services from non-network providers, but if they choose to do so, they are responsible for a greater share of the financial responsibility for the services. Coverage is generally at the lower level of coverage as defined in the benefit contract after the member has met his or her annual non-network deductible.

To be included in a Medicare Advantage provider network, a provider must participate in the Medicare program itself.

For more information on the Medicare Advantage network, please visit Chapter 3, Unit 6 of this manual.

3.1 Dual Networks

Overview

Some customers choose to have more than one professional provider network support their managed care coverage program. These programs have both a primary provider network and a secondary network comprised solely of Highmark Blue Shield's Participating Provider network. The Pennsylvania Insurance and Health Departments have approved these dual-network programs.

Dual-network managed care programs use a separate, supplemental member contract. This contract applies when a member chooses to receive services from a participating provider not in the primary network. Payment under the supplemental contract is based on UCR. Service benefits apply when a Highmark Blue Shield participating provider renders the services.

The Explanation of Benefits form that accompanies the UCR payment states that a Participating Provider must accept the UCR allowance as payment in full for covered services, in accordance with the terms of the Participating Provider agreement. The participating provider may collect any applicable coinsurance or deductibles from the member.

3.1 Coverage Programs

Overview

Highmark Blue Shield offers a wide range of programs. These programs are supported by the networks previously outlined.

When treating a Highmark Blue Shield member, find out which coverage program they are enrolled in and which network the program uses.

Highmark Blue Shield's programs cover:

- National accounts – large employer groups who have employees living in Pennsylvania and in other states;
- Pennsylvania accounts – large and small groups located in Pennsylvania;
- Individual account members – individuals who do not belong to a group account and who pay for their own coverage.

Customer Contracts Specify Covered Services

All the services covered under our programs are subject to specific contract benefit exclusions. Each program is governed by the specific terms of the applicable contract and medical policy in effect at the time a service is performed, and is subject to change without prior notice.

A reminder: In response to rising health costs, more customers are choosing health plans that require their employees to share in the cost of their health care. These plans include higher deductibles, copayments or coinsurance. Highmark Blue Shield has responded by making these plan designs more widely available to the market place. Be sure to verify a member's benefits and cost-sharing obligations at the time they receive services from you. Member information can be found on NaviNet.

What We Mean By Program And Product

When used in this manual, program and product have approximately the same meaning, but somewhat different usage. They both refer to the patient's type of insurance coverage. They help to differentiate the types of insurance coverage, especially under a single insurance company. Program refers to the type of coverage (i.e., HMO or POS) whereas product refers to the brand name of the program (i.e., PPOBlue or FreedomBlue).

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

3.1 Traditional Fee-For-Service Programs

Indemnity Programs

Under indemnity programs, Highmark Blue Shield members can seek care directly from any Participating Provider, without coordination from a primary care physician (PCP). As long as the service is covered under the member's benefit plan and the services provided are medically necessary, Highmark reimburses the provider. Indemnity programs offer the greatest degree of member choice among all Highmark Blue Shield products.

Indemnity Programs Across The State

What Region Am I?

Please visit www.highmark.com and select the region specific to you. A list of indemnity programs (e.g. ClassicBlue) is provided for you under the 'member' heading. Then, access the "Have a Greater Hand in your Health" section.

Network For Indemnity Products

The foundation of the Highmark Blue Shield indemnity programs is the Participating Provider network of professional and ancillary providers, along with Highmark Blue Shield's network of contracted facility providers.

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

Indemnity Product Payment Levels

Payments made for indemnity products are based on the UCR payment mechanism or Fixed Fee Schedule allowances. You can find additional information about this in Chapter 3, Unit 3, "Payment Methodology."

Continued on next page

3.1 Traditional Fee-For-Service Programs, Continued

ClassicBlue: Traditional and Comprehensive Indemnity Programs

While the particulars of coverage may vary from one employer group to another, these generalizations can be made about the kinds of services covered under each of the three components of ClassicBlue:

- Institutional/hospital - This portion of ClassicBlue indemnity benefit plans typically covers inpatient and outpatient care provided by a Highmark Blue Shield participating facility such as a hospital or a skilled nursing facility.

- Medical-surgical - This portion of ClassicBlue benefit plans typically covers the services of network professional providers such as physicians.

- Major medical - This portion of ClassicBlue benefit plans typically considers eligible services such as durable medical equipment and professional office visits not covered by either of the other two components.

An individual member's benefit plan may provide any or all of these types of coverage. Although ClassicBlue products do not require a member to select a PCP, limited medical management processes do apply.

Two Possible Configurations Of ClassicBlue

Employer groups, as well as individual, direct-pay customers, can purchase ClassicBlue indemnity coverage in either of two configurations:

- **ClassicBlue Traditional**

  Under ClassicBlue Traditional programs, if a member receives institutional services, those charges are processed under the basic institutional portion of the benefit program, with covered services typically paid at 100%.

  If the ClassicBlue Traditional member receives medical-surgical services, these charges are processed under the basic medical-surgical portion of the benefit program, with covered services typically paid at 100% of UCR.

  The major medical component supplements these two coverages and typically provides coverage at 80%, usually after an annual deductible. Concurrent major medical processing is a feature that incorporates the major medical benefit into the traditional benefits. See Chapter 5, Unit 2, "Claims Submission and Billing Information" for additional information.

Continued on next page

3.1 Traditional Fee-For-Service Programs, Continued

Two Possible Configurations Of ClassicBlue, continued

- **ClassicBlue Comprehensive**

  Under ClassicBlue Comprehensive, the three components (basic institutional, basic medical-surgical and major medical) are combined into one product design. ClassicBlue Comprehensive typically provides coverage for the same types of services as ClassicBlue Traditional. However, an annual deductible and 20% member coinsurance typically apply to most services under this design.

UCR Programs

Most fee-for-service programs are supported by the Participating Provider network and reimbursed based on the UCR allowance. (See Chapter 3, Unit 3, "Payment Methodology" for a discussion of the UCR payment mechanism.)

When a member enrolled under this program receives services, Highmark Blue Shield pays the service on the basis of the usual, customary or reasonable criteria.

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

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

- **Highmark Blue Shield 100 (also called UCR 100 or UCR full payment)**
  The Highmark Blue Shield UCR 100 program is currently Highmark Blue Shield's most popular fee-for-service program. Most covered services are reimbursed at 100 percent of the UCR allowance.

Continued on next page

3.1 Traditional Fee-For-Service Programs, Continued

UCR Programs, continued

- **Comprehensive and wraparound major medical programs**
  - Comprehensive programs combine institutional/hospital, medical surgical and major medical coverages into a single package of benefits.
  - Wraparound programs combine Highmark Blue Shield and major medical coverage into a single benefits package. The program "wraps" around the separately provided hospital program.

Most comprehensive and wraparound major medical programs combine all of these different types of coverage into one program and apply a single deductible or copayment to all covered services. Comprehensive and wraparound major medical contracts include services that normally are covered under Highmark Blue Shield's major medical benefit. Examples of such services are home and office visits, drugs, injections and outpatient psychiatric and psychological services.

Medical-surgical benefits within a comprehensive or wraparound major medical program are usually based on the UCR provider reimbursement mechanism.

Benefit packages include various deductibles and program maximums. Various coinsurance alternatives are available; however, payment is typically made at 80 percent of the UCR allowance for covered services, up to a specific "out-of-pocket" maximum. Expenses incurred after the member's out-of-pocket payments have reached the out-of-pocket maximum typically are reimbursed at 100 percent of the UCR allowance. Lifetime maximums and re-instatement options also are available.

These services should be billed to Highmark Blue Shield, instead of asking the patient to pay the full charge at the time the service is performed. Highmark Blue Shield will then make payment directly to the Participating Provider, who must accept the UCR allowance as payment-in-full. Participating providers may bill the patient for any deductible or coinsurance amounts that may apply.

3.1 Fee Schedule Programs

Overview

Highmark Blue Shield's fee schedule programs are 1800S, Plan C and Plan 5000S. They are "fixed-fee" programs. This means that Highmark Blue Shield pays a predetermined amount for specific health care services, or the provider's actual fee -- whichever is less.

These programs differ primarily in the provider reimbursement and income levels. The differences in payment levels are reflected in the rates for these programs. Thus, the lowest-performing fee schedule program is affordable to persons of very low income.

Participating Providers agree to accept the reimbursement made under these fee schedule programs as payment-in-full, when they perform covered services for members whose incomes fall within the designated limits. Members are eligible to receive service benefits under the program with rates proportionate to their incomes.

Providers have the option of charging members who do not fall within the income limits for the difference between the fee schedule allowance and their actual charge. (See Chapter 3, Unit 3, "Payment Methodology" for additional information.)

Fee Schedule Program Income Limits

Highmark Blue Shield defines annual income as total income from all sources of the applicant and his or her eligible dependents. The member's income is based on the full calendar year prior to the date of service. Participating Providers determine initially whether or not a member is of low income. If there is a dispute about the income status of a member, Highmark Blue Shield will make the final determination. Please reference the grid below for Fee Schedule Program Limits.

Plan	Single Income	Family Income
Plan 1800S	$6,000	$12,000
Plan C	$12,000	$24,000
Plan 5000S	$18,000	$36,000

3.1 Major Medical

Major Medical

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

Deductible

Major medical requires an annual deductible for the member and each dependent. The amount of the deductible varies according to the member's contract. A new deductible amount is required each calendar year.

Coinsurance

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

Note: Under most major medical contracts, outpatient psychiatric care is reimbursed at 50 percent of the allowance for covered medical expenses.

Maximum Amounts

Many contracts have annual and/or lifetime maximum amounts that are paid for benefits. The maximums vary according to the contracts.

Major Medical Benefits

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

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

Major Medical Claims

If the member is enrolled in a standalone major medical program and, during a calendar year, the member's or dependent's expenses exceed the deductible, the member should complete a major medical claim form. The member should submit the claim along with itemized bills, to the Blue Plan through which the member is enrolled.

In addition to being offered as a standalone benefit option, major medical can be incorporated into the traditional benefits package. Claims processing is accomplished through a feature called concurrent major medical processing. See Chapter 5, Unit 2, "Claims Submission and Billing Information" for additional information.

3.1 Understanding Managed Care

Defining Managed Care

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

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

3.1 Managed Care Terms

Authorization	The official acknowledgement from Highmark that services/items requested meet the definition of "medically necessary and appropriate."
Covered Services	Those medically necessary and appropriate services and supplies that are provided as part of a benefit program. There are several ways to determine what services are covered as part of a members benefit program. • Benefit information is available online in NaviNet, • Procedures/DME that require authorization can be found on the Provider Resource Center under Administrative Reference Materials, • Requests for authorization are reviewed by Healthcare Management Services, • Medical Policy can be viewed under the Medical & Claim Payment Guidelines heading on the Provider Resource Center.
Exclusions	Items or services that are not covered as part of a program.
Primary Care Physician (PCP)	PCP is the acronym for primary care physician, a physician selected by a member in accordance with the member's managed care program requirements. The physician provides, coordinates, or authorizes the health care services covered by the managed care program. The PCP may be a general practitioner, family practitioner, internist, or pediatrician.

3.1 Managed Care Products - PPOs

PPO Programs

Preferred provider organization (PPO) programs offer members the ability to obtain care from a network-participating provider.
Members may also receive care from providers not participating in a network, for which the member will receive a lower level of reimbursement and will be responsible for the difference between the provider's charges and the actual payment provided by Highmark. All services are subject to specific contract coverage and limitations.

What Region Am I?

PPOBlue

PPOBlue *and ShortTermBlue Individual PPO are* offered in the western and central regions.

General Characteristics

- Members are not required to select PCPs to coordinate their care.
- All practitioners are paid fee-for-service for care rendered to PPO members.
- Members can seek care without coordination or authorization, except for inpatient admission and outpatient therapy services for Medicare Advantage PPO.
- Blues On Call services including preventive care benefits are integral components.
- See specific benefit details for additional Medicare Advantage PPO requirements.

Components Of PPO Programs

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

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

Medical-surgical benefits cover a range of preventive care services, including periodic physical exams and diagnostic tests. Women's care benefits include routine gynecological exams, PAP tests and mammograms. Covered pediatric care includes routine immunizations and check-ups. Members are also covered for emergency and out-of-area care. Although PPO programs do not require members to select a primary care physician, limited medical management processes do apply.

Continued on next page

3.1 Managed Care Products - PPOs, Continued

Network Providers For PPO Program Members With Highmark Blue Shield

The foundation of PPO programs is the PremierBlue Shield network of preferred professional providers located in the 21 counties of Central Pennsylvania and the Lehigh Valley plus institutional and ancillary providers that contract with Highmark Blue Shield in this region. Members also have access to PremierBlue Shield professional providers in the 13 counties of Northeastern Pennsylvania and the five-county Greater Philadelphia area.

In the 29 counties of Western Pennsylvania, members have access to an additional network of professional, institutional and ancillary providers. These providers will be reimbursed at the higher benefit level for covered services.

Please note: The statewide PremierBlue Shield network of preferred professional providers provides high-level access for out-of-area PPO members through BlueCard.

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

Network And Out-Of-Network Reimbursement

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

PPO programs provide higher-level reimbursement for services received from network providers and lower-level reimbursement for services received outside the network. The specific percentages for network and out-of-network services are determined by the particular employer group contract. In the case of lower-level payment (for out-of-network services), members can be billed for any deductibles or coinsurances that apply to the services received, in addition to the difference between the approved amount and the provider's charge.

3.1 Managed Care Programs – PPOs, Continued

Individual PPO Programs

Effective August 1, 2008, Highmark offers ShortTermBlue. ShortTermBlue is designed for those who need health care coverage for a short period of time like seasonal workers, people who are between jobs, new hires whose employer-sponsored coverage does not become effective immediately and others in similar situations.

ShortTermBlue is a medically underwritten product. To apply for it, interested individuals must complete an online or paper application which includes several health screening questions. If the potential member can answer NO to all such questions, he or she can proceed to submit the application.

ShortTermBlue members can select the number of days for which they need coverage, from 31 to 180 days. ShortTermBlue is not automatically renewable.

ShortTermBlue

ShortTermBlue Individual PPO is offered in the western and central regions.

General Characteristics

- *Pre-Existing Condition clause for the entire coverage period (with the 60-month look-back) applies to both medical services and outpatient prescription drugs.*
- *When obtaining prescription drugs, members pay the full Highmark-negotiated discounted price at the pharmacy and then complete and submit a Prescription Drug Claim form for reimbursement.* ***If it is determined that the drug is related to a pre-existing condition, ShortTermBlue will not cover the cost of the drug.*** *A copy of the Prescription Drug Claim form is included with this bulletin. The claim form is also available in the Provider Resource Center via NaviNet or Highmark's public member sites. Hover on Provider Forms and select the Miscellaneous Forms link from the fly-out menu. Then, select ShortTermBlue Member Prescription Drug Claim Form.*
- *No coverage for maternity services.*
- *No coverage for mental health or substance abuse treatment services. (As always, you can verify member benefits for these services under the Behavioral Health/Substance Abuse benefit category in NaviNet.)*
- *For most in-network services, Highmark will reimburse at 80 percent of the allowable amount, after the deductible has been met. Member coinsurance for in-network services is 20 percent. When out-of-network services are covered, Highmark will reimburse at 60 percent of the allowable amount, after the deductible is met, and the member is responsible for a 40 percent coinsurance.*
- *Each inpatient hospital admission (including admissions to inpatient rehabilitation) is limited to 31 days.*
- *Five-visit limit per coverage period for physical medicine. Combined limit of five visits per coverage period for occupational and speech therapy. There is no out-of-network coverage for these services.*

Continued on next page

3.1 Managed Care Programs – PPOs, Continued, Continued

Identifying ShortTermBlue Members

There are three ways to identify a ShortTermBlue member: Confirmation of Enrollment Letter, ID Card, or NaviNet Eligibility and Benefits file. ShortTermBlue coverage becomes effective the day after the application and premium are submitted (or the day after the signature date on a paper application, or a future date within 30 days of the application date, as selected by the member). Once the materials have been received, the member will be sent a letter confirming his or her enrollment. This letter can serve as proof of coverage until the ID card is received.

Identifying Termination Date For ShortTermBlue Members

Providers should pay close attention to effective and termination dates and the applicability of pre-existing condition limitations. ShortTermBlue members could present for services as early as Aug. 2, 2008. To identify the end of the coverage period for a ShortTermBlue member, providers should refer to the Term Date field (located immediately below the Effective Date field) on the NaviNet Eligibility and Benefits screen. (See the sample Eligibility and Benefits screen included with this bulletin.) Providers may be familiar with the Term Date field if they previously reviewed Eligibility and Benefits for members with coverage through the Federal Employee Health Benefits Program (FEP).

Please note that the ShortTermBlue ID card does not display a termination date.

Inquiries About Eligibility, Benefits, Claim Status or Authorizations

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

3.1 Managed Care Products - EPOs

EPO Programs

Exclusive Provider Organizations (EPOs) provide members with coverage for a wide range of services when they are received from in-network providers and facilities. EPOs function like a PPO, but offer no out-of-network benefits except for emergency services. Members are not required to select a PCP to coordinate covered care, but it is recommended. By utilizing the local Blue Plan PPO network, EPOs allow access to the largest provider network in the Highmark service area, as well as a large provider network across the country.

EPOBlue

EPOBlue is offered in the western and central regions.

What Region Am I?

General Characteristics

- Members utilize the existing managed care networks in the western and central region and the local "Blue" Plan PPO providers outside of the 49-county region.
- There is no coverage when a member receives services from an out-of-network provider, except emergency services, which are covered at the in-network level.
- Members are not required to select PCPs to coordinate their care, but it is recommended.
- Providers are required to contact Healthcare Management Services (HMS) to obtain authorization for in-network inpatient admissions within the western and central regions.
- Members are required to contact HMS to obtain authorization prior to in-network inpatient admission outside of the western or central regions.
- Members may be responsible for copayments on such services as, but not limited to, physician office visits, emergency room services, mental health outpatient visits, substance abuse outpatient visits, spinal manipulation, physical therapy, occupational and speech therapy.

3.1 Managed Care Products – Open Access

Open Access Programs

Open access programs do not require members to select a network primary care physician (PCP), though it is recommended. Like POS programs, open access programs allow members to receive care outside of the network. For out-of-network care, benefits are paid at the program's lower level of reimbursement, and the members are responsible for filing claims and pre-certifying care.

DirectBlue

DirectBlue is offered as an open access group product in the western and central regions.

General Characteristics

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

DirectBlue Payment Levels Corresponding To Member Options

DirectBlue is reimbursed according to the PremierBlue Shield fee schedule. The program provides two levels of payment, corresponding to the options the member chooses when accessing care.

- If DirectBlue members choose to receive care from providers associated with the PremierBlue Shield network located in the 21counties of Central Pennsylvania and the Lehigh Valley or the Highmark Managed Care network in the 29-counties of Western Pennsylvania, covered services will be reimbursed at the higher, in-network level provided by the group contract.
- If DirectBlue members choose to seek services from a provider outside the 21-county PremierBlue Shield network or the 29-county Highmark Managed Care network, covered services will be reimbursed at the lower, out-of-network level provided by the group contract.

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3.1 Managed Care Products – Open Access, Continued

DirectBlue Payment Levels Corresponding To Member Options, (continued)	Each employer group offering DirectBlue determines what the higher and lower payment percentages will be for its own members. A DirectBlue member who chooses out-of-network care is responsible for any resulting deductible, coinsurance and/or copayment amounts, as well as the difference between the provider's charge and the plan allowance.
When Care Cannot Be Provided By A Network Provider	Healthcare Management Services, Highmark Blue Shield's medical management division, may authorize a DirectBlue member to receive services from a non-network provider if the care he or she requires cannot be provided within the network. In such situations, reimbursement will be made at the higher, in-network level.

3.1 Managed Care Products – HMOs – *Western Region Only*

What Region Am I?

Overview

A health maintenance organization (HMO) is a healthcare plan that provides comprehensive medical, surgical, hospital, and ancillary medical services including preventive care services.

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

HMO Products

In the western region only, Highmark, through its western region network offers two HMO products. HMO coverage requires you to select a primary care physician (PCP) who will become familiar with all aspects of your health and health care and, as your personal physician, will be responsible for treating you for your basic health care needs. While you are required to get your preventive care (such as adult and pediatric routine physicals and pediatric immunizations) from your PCP, you can go directly to a network specialist for other covered services - without a referral.

For more information on western region Medicare Advantage HMO products, please visit Highmark's member sites.

General Characteristics

- HMO products require members to select a network-participating primary care physician who provides preventive care services, directs patients to seek specialty care if required, and communicates with specialists to ensure continuity and coordination of care.
- For all HMO products except the Western Region Medicare Advantage HMO, routine adult and pediatric physicals and pediatric immunizations must be performed by the member's PCP to receive coverage.
- Members may change PCPs upon request.
- For services requiring an authorization, the ordering physician should obtain the authorization.
- Blues On Call[SM] services including disease management and preventive care benefits are integral components.

3.1 Commercial Group/Direct Pay HMO Members Who Require Services Outside The Local Area -- Western Region Only

Introduction

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

- the care required and
- whether they are traveling or living outside the service area.

What Region Am I?

Western Region Network Service Area

The commercial western region HMO network extends across the 29 counties of western Pennsylvania as shown below.

Allegheny	Armstrong	Beaver	Bedford	Blair	Butler
Cambria	Cameron	Centre (partial)	Clairon	Clearfield	Crawford
Elk	Erie	Fayette	Forest	Greene	Huntington
Indiana	Jefferson	Lawrence	McKean	Mercer	Potter
Somerset	Venango	Warren	Washington	Westmoreland	

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3.1 Commercial Group/Direct Pay HMO Members Who Require Services Outside The Local Area -- Western Region Only, Continued

Required Care Definitions For

The required care definitions for commercial group/direct pay HMO are noted below.

Note: These definitions are not applicable to Medicare Advantage HMO products.

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

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3.1 Commercial Group/Direct Pay HMO Members Who Require Services Outside The Local Area -- Western Region Only , Continued

Required Care Definitions For HMO Members (continued)

Care required	Definition
Symptomatic Care	Medical needs that are symptomatic, but can be treated at the discretion of the physician and patient. Reasonable delays will most likely not affect the outcome of service. For HMO members this type of care may be considered "urgent care" when traveling outside of the 29-county western Pennsylvania service area. Urgent care is defined as an unexpected illness or injury that cannot wait to be treated until the member returns home.
Routine Asymptomatic And Preventive Care	Medically asymptomatic conditions that can be addressed at the discretion of the physician and patient. Reasonable delays will not affect the outcome of services. For HMO members, this type of care may be considered "follow-up" care when traveling outside the 29-county western Pennsylvania service area. Follow-up care is defined as ongoing services that a member requires, even, when they are traveling, for care that was initiated while they were home (e.g. allergy shots, suture removal, cast check). **Note:** Routine preventive care services such as routine physicals, immunizations or screening diagnostic tests would not be covered out-of-area as "follow-up" care.

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3.1 Quick Reference Chart for Out-of-Area Care

What Region Am I?

Out-Of-Area Care

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

Product	Emergency care	Symptomatic care	Routine asymptomatic and preventive care
Western Region Commercial HMO Group/Direct Pay Members	May seek emergency care immediately from any provider without contacting PCP. Member should notify his or her PCP within 48 hours or as soon as it is reasonably possible to coordinate any needed follow-up care.	May arrange initial visit for "urgent care" (non-emergency care) with participating physicians in other plan areas through the BlueCard program. Physicians may be located by calling 1-800-810-2583 or online at www.bcbsa.com. May arrange initial appointment with participating physician without contacting PCP; must coordinate any additional care with PCP before receiving services. May choose to coordinate even initial care through PCP.	Must coordinate "follow-up" care with PCP prior to traveling out-of-area. May arrange "follow-up" care with participating physicians in other Plan areas through BlueCard program. Physicians may be located by calling 1-800-810-2583 or online at www.bcbsa.com. Once approved by PCP, member may arrange appointment with participating physician. Other routine asymptomatic or preventive care is not covered out of area.

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3.1 Quick Reference Chart for Out-of-Area Care, Continued

Out-Of-Area Care (continued)

Product	Emergency care	Symptomatic care	Routine asymptomatic and preventive care
PPOBlue **Western Region PPO** **HDHP PPO** **(**high deductible health plan PPOs)	May seek care immediately and receive high-level coverage.	May utilize BlueCard Program by calling 1-800-810-BLUE or online at www.bcbsa.com to find the names of preferred providers in other Plan areas in order to receive the higher level of benefits while traveling out-of-area. Some services may only be covered at the in-network level.	
DirectBlue	May seek care immediately and receive high-level coverage.	May wait until return home to receive in-network care.	
EPOBlue	May seek care immediately and receive high-level coverage.	May seek care out-of-area care, but must be from an in-network provider. Services received from providers within the PPOBlue Network or from any local "Blue" Plan PPO provider are paid at the in-network level. There is no coverage when a member receives services from an out-of-network provider, except in emergency situations.	

3.1 Away From Home Care™ Guest Membership Program (HMO)

AFHC

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

What Is Guest Membership?

The Blue Cross and Blue Shield Association sponsors the AFHC Guest Membership program through participating Blue HMOs at numerous locations throughout the United States. The western region commercial HMO product participates in this program both as a "home" HMO plan, offering this to our members and also as a "host" HMO plan, where members from other Blue HMO plans may have a HMO guest membership in the western PA service area.

NOTE: This program is not available to Medicare Advantage HMO members.

How The Guest Membership Program Works

- Guest membership enables HMO members who are residing outside the 29-county western Pennsylvania service area for at least 90 consecutive days to have an HMO benefit program in another Blue HMO plan location.
- Members should contact Member Services at least 30 days in advance to determine program availability in the location in which they will be temporarily, or in the case of dependents, permanently residing.

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

- Once a member is established as a guest member, he or she receives the services covered under the "host" HMO benefit program, which includes the selection of a PCP and coordination of care based on the rules of the local HMO program.
- During the time HMO members have a guest membership in another Blue HMO, these member's names will not appear on the PCPs These members names will not appear on the PCP's membership roster.

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3.1 Away From Home Care™ Guest Membership Program (HMO), Continued

How To Set Up A Guest Membership

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

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

Continued on next page

3.1 Away From Home Care™ Guest Membership Program (HMO), Continued

What Region Am I?

Members Visiting The Western Region Managed Care Service Area	Our HMO members with a guest membership in another plan area who need non-emergency care when home in the western region service area, may receive care only from a physician in the western region managed care network. If the member had an established relationship with a western region HMO network PCP prior to their guest membership, this is the provider they should contact. If the member did not have an established PCP relationship prior to their guest membership they should contact the Away From Home Care Coordinator at 1-800-249-9579. A physician must authorize any covered services received while at home. In an emergency, no prior approval is required. The member should go to the nearest medical provider. If follow-up care is needed while the member is at home, it can be arranged in the same manner as described above.
Members Returning To The Western Region Managed Care Service Area	When a member who has had a Guest Membership permanently returns to the western region service area, he or she must select a PCP from the western region HMO network and will then receive the covered services included in their "home" HMO benefit program.
Member Questions	If members have questions about how this program works, they should call Member Services at the telephone number listed on the back of their ID card.

3.1 Visiting HMO Members

Introduction

The Away From Home Care (AFHC) Guest Membership program offered through the Blue Cross and Blue Shield Association is for members enrolled in other Blue HMOs across the country. The program allows HMO members temporarily or permanently residing in the 29 county western region.

Hosting Guest Members

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

If a network PCP is chosen to host a member from another plan, they will be contacted by the AFHC coordinator by letter. This letter will notify them of their selection as well as providing member information such as name, address, birthday and member ID.

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

Payment For Treatment Of Guest Members

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

3.1 Medicare Advantage Products

Overview

Medicare Advantage products are available only to individuals who are entitled to Medicare Part A and enrolled in Medicare Part B: those over the age of 65 and/or disabled.

Medicare Advantage Products

Highmark offers three Medicare Advantage products.
For more information on Medicare Advantage Products, please visit Members section of www.highmark.com.

1. Western Region FreedomBlue PPO
   Central and Northeastern FreedomBlue PPO

2. Western Region FreedomBlue Private Fee-for-Service (PFFS)
   Central and Northeastern FreedomBlue Private Fee-for-Service (PFFS)

3. Western Region Medicare Advantage HMO Product Description

Medicare Advantage Eligibility Requirements

To enroll in Highmark's Medicare Advantage HMO, a member must have both Medicare Part A and B and must reside in the 17-county Western Region service area. To enroll in Highmark's FreedomBlue PPO, a member must have both Medicare Part A and B and must reside in the 40-county service area. Effective January 1, 2008 however, Highmark FreedomBlue PPO expanded to 62 counties including all Pennsylvania counties excluding Bucks, Chester, Delaware, Montgomery, and Philadelphia. Additionally, the member cannot have end stage renal disease at the time of enrollment, unless he or she is a current member of a Highmark commercial product.

FreedomBlue PPO

FreedomBlue PPO offers its members additional benefits and services beyond those covered by the Medicare program. These include preventive services, routine dental and vision care and prescription drugs.

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3.1 Medicare Advantage Products, Continued

FreedomBlue Private Fee-For-Service
New!

Effective January 1, 2008 Highmark Blue Shield began offering another Medicare Advantage plan option – Private Fee-for-Service.

FreedomBlue PFFS provides Medicare Parts A and B benefits, as well as routine vision/hearing and SilverSneakers®. As a non-network plan, FreedomBlue PFFS does not require a contract making it different than Highmark's FreedomBlue PPO product.

Members can:

- see any licensed professional provider that has or is eligible for a Medicare billing number, has not opted out of the original Medicare program, and accepts FreedomBlue's PFFS terms and conditions of participation.

- be treated at any Medicare-certified facility that accepts FreedomBlue PFFS terms and conditions of participation

Providers are not required to see FreedomBlue PFFS and elect to do so on a per service basis. If you do provide services, you do so under the terms and conditions of that member's plan.

Providers with questions about claims payment should call the Provider Service Center at 1-866-675-8635 between the hours of 8 a.m. and 4:30 p.m. Monday through Friday, Eastern Standard Time (EST).

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3.1 Medicare Advantage Products, Continued

Becoming A Deemed Provider Under FreedomBlue FFS
New!

Providers, both Medicare participating and nonparticipating, are considered deemed when they meet the following conditions:

1. Are aware in advance that the patient is a FreedomBlue PFFS member. All FreedomBlue PFFS members receive an identification card that includes the FreedomBlue PFFS logo to help identify them as PFFS members.

2. Have a copy of or reasonable access to FreedomBlue PFFS's terms and conditions of participation.

3. Provide services covered by FreedomBlue to a FreedomBlue PFFS member.

Terms and conditions are under Administrative Reference Materials on the Provider Resource Center. Select Medicare Advantage PFFS from the list. Once on the PFFS page, select the appropriate regional terms and conditions of this product. Terms and conditions are also available in the Appendix of the Highmark Blue Shield Office Manual.

For more information on the Medicare PFFS product please visit, www.highmark.com and select the appropriate regional member website.

Appeals and Grievances for FreedomBlue PFFS

The members of FreedomBlue PFFS, their physicians, or authorized representatives on their behalf may request an appeal of an adverse coverage determination made by FreedomBlue PFFS including when services are limited, no provided, not paid for or not allowed. This would also include an appeal regarding a delay in providing or approving drug coverage or services, or any cost sharing the member is required to pay for a drug or a service.

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3.1 Medicare Advantage Products, Continued

Appeals and Grievances for FreedomBlue PFFS

Medical appeals should be sent to:

Provider initiated appeals:
FreedomBlue PFFS
P.O. Box 890392
Camp Hill, PA 17089-0392

Member initiated appeals:
FreedomBlue PFFS
P.O. Box 535047
Pittsburgh, PA 15253-5047

Medicare prescription drug coverage appeals:
FreedomBlue PFFS
P.O. Box 535047
Pittsburgh, PA 15253-5047

Western Region Medicare Advantage PPO *(Western Region Only)*

Western Region Only:

Western Region Medicare Advantage HMO coverage replaces Medicare coverage; however, Western Region Medicare Advantage HMO members may retain their Medicare card while they are covered under the Western Region Medicare Advantage HMO.

A Western Region Medicare Advantage HMO member must show his or her identification card to receive services. Services cannot be paid by traditional Medicare while the person is a member of a Western Region Medicare Advantage HMO, except for services incurred during a hospice election period and routine costs associated with clinical trials paid by Medicare.

Expedited Appeals for Western Region Medicare Advantage HMO

Western Region Medicare Advantage HMO members have a special expedited appeals process. Members of Medicare Advantage programs, or their representatives, may request a 72-hour expedited review of a service if they believe the member's health, life, or ability to regain maximum function may be jeopardized by waiting for the standard review process.

In accordance with Centers for Medicare and Medicaid Services (CMS) guidelines, members may request the initial expedited review without speaking to the PCP first.

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3.1 Medicare Advantage Products, Continued

Out-Of-Service-Area Benefit	An out-of-network benefit applies to the Medicare Advantage FreedomBlue PPO product. Members have access to covered services out-of-network, both in area and out-of-area. Members are responsible for paying any applicable cost sharing for covered services. Renal dialysis services are covered at 100%, on a temporary basis, while outside the 40-county service area. Effective January 1, 2008 this service area expanded to a 62-county service area, including all Pennsylvania counties excluding Bucks, Chester, Delaware, Montgomery, and Philadelphia.
Prescription Drug Coverage	Some drugs are covered at participating pharmacies or through mail order. Coverage varies by product: generic or brand copayments, formulary limitations and annual maximums apply. Employer-sponsored plans may vary copayments and annual maximums. For more information about pharmaceuticals online, refer to the Provider Resource Center under Pharmacy/Formulary Information.
Geriatric Care Guidelines	Highmark's Geriatric Quality Improvement Committee has developed guidelines to use when caring for Western Region Medicare Advantage HMO members. These guidelines have been compiled in a manual titled the Geriatric Resource Binder. The manual is available online, at Highmark's Provider Resource Center under Clinical Reference Materials.

3.1 BlueAccount

Overview

BlueAccount Programs are an option for those members who choose to combine a Highmark plan with a

- Health Savings Account (HSA)
- Health Reimbursement Account (HRA) or
- Flexible Spending Account.

Generally members who choose a BlueAccount HSA are those that chose a qualified high-deductible plan. All of the BlueAccount products allow members to save money to cover the cost of their higher out-of-pocket liabilities.

Using NaviNet To Determine Whether The Member Has A BlueAccount

To determine whether a Highmark member has chosen to have their liability paid directly to your office via a BlueAccount, use NaviNet's Eligibility and Benefits function.

Beginning mid-January 2007, if the member has chosen this option, the Product Field will state, "Direct Payment to Provider – Yes." For members who have not chosen this option, the Product field will contain only the name of the product under which the member has coverage. Members have the capability of selecting or deselecting this option at any time.

Another helpful function on NaviNet is the Benefit Accumulator. This function reflects the status of a member's deductible, based on all claims finalized and processed to date.

Direct Payment To Providers

Members may also choose to have their member deductible or copayments paid directly to the provider via one of these accounts. If a member has chosen this option and money is available in the account, you will receive a separate payment (check or Electronic Funds Transfer (EFT)) and notice (known as an Explanation Of Payment (EOP)) for claims paid under a member's account. If the member's HSA, HRA or FSA does not have the full amount due, you will receive whatever amount is in the account. You can then bill the member directly for the remainder as the member will receive any remaining payments.

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3.1 BlueAccount, Continued

Explanation of Payment (EOP)

Whenever a full or a partial payment is made to you, both the member and the provider's office will receive an Explanation of Payment (EOP), to document the transaction. NaviNet-enabled providers will receive their EOPs via the NaviNet ERA and Remittance Inquiry function. The few facilities without this functionality will receive EOPs in hard-copy format via U.S. mail, courier pickup, or whatever arrangement they currently use for receiving the paper remittance advice.

This new direct payment to provider option from a member's health care account does not eliminate your ability to collect patient liability, such as copayments or other outstanding balances, due at the time of service. Please note, however, that if you collected payment upfront for member liability, and subsequently receive payment via an EOP, be sure to issue the refund directly to the member.

3.1 Healthcare Gift Card – Still Accepted – No Longer Sold

Overview

The Healthcare Gift Card is a tool consumers can use to cover the costs associated with health-related purchases and procedures or to give as a gift to others. Companies also can give the card to employees as a reward or perk to help them cover health and wellness expenses. The card is accepted anywhere that Visa debit cards are accepted and is intended to be used for a variety of health and wellness related purchases.

How Do Patients Use It?

When presented with the card as a form of payment, please accept it as you would a patient or customer's Visa credit card.



The card should be processed the same way you would a normal Visa credit card transaction.

The Healthcare Gift Card is valid for a wide variety of health and wellness expenses, including copays for doctor visits and prescriptions or for vision care, dental care, health products and medical supplies, health club memberships and elective procedures. If a card holder attempts to make purchases outside the list of approved merchant categories, the card will not be accepted at the point of purchase.

Healthcare Gift Card Not Insurance Product

Although it is a Highmark product, the Healthcare Gift Card is not a health insurance product, nor is Highmark coverage required for use or purchase of the card. Purchasers and recipients of the card do not have to have an affiliation to Highmark, although some, of course, will. There is no connection to the Blue Cross Blue Shield Association.

Where Do I Get A Healthcare Gift Card?

You may still see the healthcare gift card as a form of payment in your office, however the gift card is no longer being sold.

Further Questions?

If you have further questions regarding the Healthcare Gift Card, please contact card member services via:

Phone: 1-866-466-8019
Email: eps.cardholder.support@fnis.com
Mail: Card member Services, P.O. Box 550160, Ft. Lauderdale, FL 33355

3.1 Lifestyle Returns℠

Overview

Lifestyle Returns is a consumer-driven program that rewards members for taking responsibility for their health. This program is available in the Western and Central Regions only. It is designed to motivate members to quit smoking, eat sensibly, exercise, take the right prescriptions, as appropriate, get the recommended screenings and use the health care system wisely.

What Region Am I?

What Providers Need to Know About Lifestyle Returns

Members who have the Lifestyle Returns program will be encouraged and motivated to seek appropriate preventive services such as mammography, annual gynecological exams and annual physicals.

Members may also be more motivated to discuss health lifestyle and behavior modification issues. Remember that you can always direct Highmark members to Blues on Call℠ (1-888-BLUE-428) and/or their personalized member Web sites to find lots of helpful information, resources and guidance, including many free services offered by our Preventive Health Division. Members can log in to their personalized Web sites through the links below.

What Region Am I?

Western Region Highmark Member Web Site

Central Region Highmark Member Web Site

The Wellness Scorecard

To encourage members to obtain appropriate preventive care, members have been given a My Wellness Scorecard. The purpose of the scorecard is to help members record when they've received certain services along with the results, then enter the information online.

Payment for Preventive Care

Benefits for preventive care are limited to those services that are covered on the preventive schedule that the employer group provides. Most groups follow Highmark's Preventive Schedule, but others create their own. Therefore, it's important to verify benefits before performing or ordering preventive services.

Most services on Highmark's Preventive Schedule are covered based on age, gender and risk factors. It's important to follow the schedule carefully and use the appropriate codes. If a member requires a test for a medical reason but falls outside of the age/gender/frequency limits on the schedule and a preventive or screening procedure code is used, the claim will be denied. In these situations, since the member has a medical diagnosis, a medical procedure code should be used so the claim will be processed as medical and not routine.

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3.1 Lifestyle Returns℠, Continued

Copay Information for Members with Lifestyle Returns

Members who participate in Lifestyle Returns may have a new copay for routine physical/routine gynecological exams indicated on their ID cards, if their employer elected to offer a different copayment. You may see "RT PHY/RT GYN" on their ID card. The copay amount will vary, depending on the employer's benefit elections.

The Comprehensive Preventive Exam procedure codes included in this copay category include:

What Region Am I?

- Gyn Exams: G0101, S0610, S0612 and in the western region only S0613
- Routine Physical Exams (Pediatric): 99381 through 99384; 99391 through 99394, and 99432
- Routine Physical Exams (Adult): 99385 through 99387; 99395 through 99397

With Your Help We Can Create Rewards that Last a Lifetime

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

3.1 Baby BluePrints®: Maternity Education and Support Program

Tip Sheet

Overview

Effective January, 2008 Highmark launched Baby BluePrints, a maternity education and support program available to expectant Highmark members. This free program is designed to help expectant families better understand and enjoy every stage of pregnancy and make more informed care and lifestyle decisions.

Program Details

Baby BluePrints is a free program that offers expectant Highmark members educational information on all aspects of pregnancy through multiple printed and online resources during each trimester of pregnancy. Topics include prenatal care, proper use of medications, avoiding alcohol and tobacco, working, travel considerations, nutrition and weight gain, exercise, body changes and many others. Baby BluePrints will also provide program participants access to individualized support throughout their pregnancy from a nurse Health Coach.

Providers are encouraged to promote patient enrollment to reinforce medical care and maternity information so that pregnant women may "have a greater hand in their health".

Who Is Eligible For Baby BluePrints?

Baby BluePrints is available to expectant Highmark members enrolled in a commercial group product, direct pay product or social mission product. Baby BluePrints is not available for members enrolled in a Medicare/Medicare Advantage product, an FEP member, Mountain State Blue Cross Blue Shield members or any ASO/ASC opt-out account.

How Members Can Enroll

Enrollment in Baby BluePrints is simple and convenient. Expectant mothers can enroll at no cost over the phone starting January 14, 2008 by calling toll free 1-800-918-5267.

What Members Can Expect

Upon enrollment members will receive a welcome package that contains:

- Comprehensive maternity brochure covering all phases of pregnancy and provides important health information and guidelines
- Directions for using various educational resources and online support programs found on the Highmark member site
- Fliers detailing available discount programs
- Childbirth education class reimbursement form
- Child immunization and preventive care pamphlet
- Vouchers for three gifts included in the program
- And more…

Continued on next page

3.1 Baby BluePrints®: Maternity Education and Support Program, Continued

What Members Can Expect (continued)

Throughout pregnancy members will receive free gifts including:

- A choice of pregnancy/childcare book upon enrollment
- Baby picture album during second trimester
- Book on child emergency/first aid and child dish set after delivery.

Members will also receive access to pregnancy-related information on the member web site and proactive outreach from a nurse health coach. After delivery members may also be referred to enroll in post-partum depression program, when appropriate.

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

For More Information

If you have further questions about Baby BluePrints, please contact the Provider Service Center.

If members have further questions about Baby BluePrints, please encourage them to call member service at the number on their ID card.

Articles and bulletins are also available as a reference on the Provider Resource Center under the Publications and Mailings heading.

3.1 Blues On Call

What is Blues On Call℠

Highmark Blue Shield has an integrated program, Blues On Call, to attempt to address the total health care needs of the patient rather than focusing on one specific condition. Highmark members may contact Blues On Call 24 hours a day, every day of the year. The Blues On Call team includes health coaches who provide support over the telephone to discuss health information, assist with health decisions, and offer educational material including audio and videotapes.

What Blues On Call Is Not

Blues On Call does not:

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

Who Is Eligible

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

When To Refer A Patient

Refer a patient to Blues On Call any time he or she needs more information or assistance about a health care topic or if support by a Blues On Call health coach would benefit the patient.

How To Refer To Blues On Call

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

- Fax the completed Blues On Call Physician Referral Form to the Blues on Call Program. This form is located on the Provider Resource Center under Blues On Call.

Continued on next page

3.1 Blues On Call, Continued

Links To Other Highmark Resources	Blues On Call Health Coaches can provide information on a variety of health and wellness topics. They also work closely with other Highmark resources for members.
How To Access The Web Site	You may access the Healthwise Knowledgebase® through the Provider Resource Center, under Blues On Call.
Blues On Call Program Questions	Providers may call the Blues On Call Physician Support Line at 1-866-348-3504 for answers to questions about the Blues On Call program.

3.1 Blues On Call Program Components

Chronic Condition Support

Blues On Call focuses on helping members manage their chronic illnesses, placing special emphasis on the importance of dealing with the co-morbidities that face most seriously ill individuals. Since most chronically ill members have more than one chronic condition, the Blues On Call "whole patient" approach is a significant improvement over "silo-structured" disease management programs. The program content is objective and evidence-based. Information and material is from national sources such as the American Diabetes Association, and all content is reviewed by the Foundation for Informed Medical Decision Making. The scope of chronic condition support through Blues On Call includes:

- Condition-specific standards of care related to Asthma, CHF, COPD, CAD, and diabetes.
- Medication compliance
- Specific activities related to medical condition monitoring (weight monitoring, blood sugar monitoring)
- Regular physician visits
- Flu and pneumonia vaccines

Medical Decision Support

Using the Shared Decision-Making® information and materials developed by the Foundation for Informed Medical Decision Making, Blues On Call Health Coaches educate and support those facing significant medical decisions related to conditions, such as:

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

Health Coaches provide objective, evidence-based information to help individuals understand their situation, including the potential benefits and potential harms of treatment choices. Health Coaches help patients gain insights into their choices and provide a framework to think through the decision. Most importantly, patients can incorporate their personal values and preferences into the decision and communicate more effectively with their provider.

Continued on next page

3.1 Blues On Call Program Components, Continued

Symptom Management Support

Using the Healthwise Knowledgebase® symptom algorithms, Blues On Call Health Coaches provide support over the telephone to help members interpret and act on symptoms. Coaches are available 24 hours a day, every day of the year. Health Coaches use the Shared Decision-Making® approach to symptom management support. This approach uses algorithms to educate and support patients to help them make informed decisions about their current situation. This approach provides patients with the opportunity to learn skills that can be used when similar situations arise in the future.

3.1 Social Mission Programs

Overview

Highmark makes health care programs available to children and adults in lower income households. These subsidized social mission programs include Special Care, Children's Health Insurance Program of Pennsylvania (CHIP) and adultBasic. The newly expanded CHIP coverage offers programs for all uninsured children regardless of household income.

Health Care Providers Make The Programs Possible

It is only through a partnership with our providers that these programs are successful and Highmark Blue Shield can continue its social mission to provide health care coverage to as many Pennsylvanians as possible. Highmark Blue Shield extends its sincere appreciation to its providers for their continued commitment to provide services to children and families who qualify for these programs. Your help has contributed to Pennsylvania's ranking as one of the states with the lowest rate of uninsured residents.

Please remember that you do not have to verify income or eligibility for these programs. Eligibility and income are determined before enrollment by the Plan.

3.1 Social Mission Programs – Special Care

Special Care

Special Care was introduced in 1992 as a limited benefit product to further reduce the uninsured rate by making specific health benefits more affordable to thousands of low-and-moderate income, uninsured residents. It is a fixed-fee program where some services, such as preventive care benefits, and some office visits are paid at higher level. Specifics about payment levels can be found in Chapter 3, Unit 3, "Payment Methodology."

Today, thousands of Pennsylvanians are enrolled in Special Care.

Highmark Blue Shield determines eligibility upon enrollment for all Special Care members according to their income and family size. In addition, Highmark reviews eligibility of members annually.

Special Care benefits include:

- Hospital and Medical/Surgical
  - Surgery and anesthesia (inpatient or outpatient)
  - Emergency accident and medical treatment (exempt from Diagnostic Maximum)
  - Maternity and newborn care
  - Chemotherapy and radiation therapy
  - 21 days of inpatient care (hospital or medical) – renewable after 90 consecutive days out of the hospital
  - Outpatient diagnostic services ($1,000 annual maximum for hospital and medical surgical)
  - Hospital and surgery programs

Continued on next page

3.1 Social Mission Programs – Special Care, Continued

Special Care, (continued)

- Primary care and wellness
  - Four annual doctor visits per person ($10 copayment)
  - Comprehensive preventive care for children (physician visits and immunizations)
  - Routine annual mammogram and Pap smear for women age 40 and older and for any physician recommended mammogram for women under age 40. Benefit is exempt from the diagnostic maximum.

Special Care does not provide coverage for:

- Substance abuse treatment
- Mental health care
- Allergy testing and injections
- Prescription drugs
- Durable medical equipment and prosthetics
- Skilled nursing care

Physician reimbursement for Special Care is based on the Plan C fee schedule for most services. Preventive care is paid at UCR levels and certain outpatient medical services are paid at Plan 5000S levels. Highmark Blue Shield's Participating Providers agree to accept this allowance as payment-in-full for all eligible services.

3.1 Social Mission Programs - CHIP

CHIP – Children's Health Insurance Program of Pennsylvania

This program is administered on behalf of the Commonwealth of Pennsylvania Insurance Department by Highmark Blue Shield through the adultBasic/CHIP Administrative Units in Central and Western Pennsylvania

CHIP is modeled after the Caring Program for Children, which was pioneered by Highmark through its Caring Foundation more than twenty years ago. CHIP expanded in 2007 with the legislation to Cover All Kids. CHIP now offers coverage to every uninsured child in PA, regardless of income. The more a child's family earns, the more cost sharing they will have in the form of higher premiums and copays. CHIP covers children from birth through 18 years of age.

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

In the Western Region, benefits are provided through the Western Region network, and in the Central Region through the PremierBlue Shield network.

One of the keystones of this program is that families are "held harmless" from balance billing when covered services are provided by a network provider. To achieve that, CHIP uses the PremierBlue Shield professional provider and facility network to provide services to these children in the Central Region and by the western region network in the Western Region. Prescription drugs are provided using the Premier Gold Network. Routine vision coverage is administered by Davis Vision and Dental coverage is provided by United Concordia's Advantage Network.

As with our commercial group programs, Highmark pays PremierBlue Shield network and Western Region network providers directly, and they agree to accept our payments as payment-in-full for covered services. Highmark Blue Shield sends payments for services of out-of-network providers directly to the child's parents, who are responsible for paying the charges.

Out-of-network providers are not obligated to accept Highmark's payment as payment in full. It is critical in all cases that members check the network status of their provider.

NOTE: This does not apply to emergency care.

Continued on next page

3.1 Social Mission Programs - CHIP, Continued

CHIP – Children's Health Insurance Program of Pennsylvania, continued

In the Central Region: Members can go outside the PremierBlue network and receive care at the lower level of coverage. Members who go outside of the PremierBlue network may be responsible for paying any difference between the out-of-network provider's actual charge and the Highmark payment. This occurs even when members are directed to an out-of-network provider by an in-network provider.

In the Western Region: Members must use the Western Region network providers to receive 100% coverage unless the care is pre-authorized.

Eligibility Requirements For CHIP

The adultBasic/CHIP Administrative Unit performs eligibility and enrollment functions for CHIP children. The Individual Markets area performs marketing and outreach for CHIP to locate children and educate the community about the CHIP program. Children must meet these eligibility guidelines:

- Be a resident of Pennsylvania prior to applying for this coverage (except newborns);
- Be a U.S. citizen, a permanent legal alien, or a refugee as determined by the U.S. Immigration and Naturalization Service;
- Be under age 19;
- Not be covered by any health insurance plan, self-insured plan or self-funded plan. And not be eligible for or covered by Medical Assistance offered through the Department of Public Welfare or other governmental health insurance;
- Be eligible based on family size and income;*
- For all new applicants whose annual income falls in the low-cost and at-cost CHIP ranges, they must also show that the child has been uninsured for six months, unless the child is under the age of two, the child has lost health insurance because a parent lost their job or the child is moving from another public insurance program; and,
- At-cost CHIP families must also show that access to coverage is unavailable and unaffordable

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

How To Determine If A Child Is Covered Under CHIP

A child enrolled in CHIP will have the same Highmark insurance card as any commercial or group member.

You may use NaviNet, InfoFax, or OASIS to determine eligibility, coverage, and claim status.

Continued on next page

3.1 Social Mission Programs – CHIP, Continued

CHIP Covered Services

CHIP Hospital Benefits are detailed below:

■ Ambulatory services (in a non-hospital facility) • Chemotherapy • Diagnostic services • Emergency accident and medical care • Surgery	■ Outpatient hospital services • Clinic services (in a hospital-affiliated clinic) • Diagnostic services • Emergency accident and medical care • Radiation therapy, chemotherapy, dialysis treatment, and physical, occupational and speech therapy • Surgery
■ Inpatient hospital services • 90 days inpatient care per calendar year (combined limit with mental health and skilled nursing facility care) • Preadmission review is required • Transplant services	■ Home health care • Maximum 60 visits per calendar year ■ Durable medical equipment including wheelchairs, oxygen and hospital beds.
Medical-surgical ■ Anesthesia ■ Consultation • Limited to one per consultant per stay for inpatient • Unlimited outpatient ■ Diagnostic medical	■ Transplant surgery ■ Second surgical opinion • Only eligible outpatient consultation ■ Allergy testing • Consisting of percutaneous, intracutaneous, patch tests and immunotherapy

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3.1 Social Mission Programs – CHIP, Continued

CHIP Covered Services, (continued)

■ Emergency medical and accident • Within 48 hours of emergency • Includes follow-up care ■ Outpatient medical visits • Symptomatic	■ Routine lead screening ■ Mental health - 90 days inpatient care per calendar year (medical/surgical, SNF, and mental health combined) • Partial hospitalization (may exchange inpatient days for partials on 2:1 basis to obtain up to 180 partials) • 50 outpatient visits • Emergency psychiatric care

Other CHIP Covered Services

Medical-surgical

- Preventive pediatric
  - Follows Highmark Blue Shield Preventive Schedule
- Maternity (including prenatal and postnatal care)
- Routine newborn care (first 31 days)
- Oral surgery for the removal of partial and full bony impacted teeth
- Surgery
- Therapy services
- Substance abuse (follows Mandate)
  - Chemotherapy, radiation, dialysis treatment, and physical, occupational and speech therapy (PT, OT, ST limited to 60 visits)

Prescription drugs

- Open Formulary (copayments required for Low-Cost and At-Cost CHIP)

Hearing

- Hearing benefits
  - Hearing evaluation (once every calendar year)
  - Audiometric examination (once every calendar year)
  - Hearing aid (not more than one per year in any two calendar years)

Continued on next page

3.1 Social Mission Programs – CHIP, Continued

Other CHIP Covered Services, (continued)

Dental (administered by United Concordia)

- Diagnostic services
  - Routine exam (one every 6-month period)
  - Bitewing X-rays (once in any 12-month period)
  - Full mouth X-rays (once every 5-year period)

- Restorative services
  - Amalgam and resin restorations to restore diseased or accidentally broken teeth
  - Amalgam and composite restorations for all permanent and deciduous teeth
  - Resin, porcelain and full cast single crowns for permanent teeth

- Preventive services
  - Routine prophylaxis (one every 6-month period)
  - Topical fluoride application (once every 6-month period)
  - Space maintainers (within approved limits)
  - Sealants (within approved limits)

- General services
  - Palliative emergency treatment of an acute condition requiring immediate care
  - Simple extractions – as necessary
  - Pulpotomies covered for deciduous teeth
  - Administration of anesthesia (within limits)
  - Consultations (within limits and only during inpatient stay)

Vision (administered by Davis Vision**)**

- Eye examination and refraction – one every 6 months
- Frame – one every 12 months
- Lenses – single vision, bifocal, trifocal, aphakic – one pair every 6 months
- Contact Lenses (pair) – covered when medically necessary

Davis Vision network providers accept reimbursements as payment-in-full for standard services. Non-Davis Vision network providers are reimbursed at an out-of-network fee schedule.

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3.1 Social Mission Programs – CHIP, Continued

CHIP Claims Submission

All claims, except dental and vision claims, should be submitted just like any other Highmark Blue Shield claim. They may be submitted electronically or on a paper CMS 1500 claim form. Please note that in all cases, the child is the member. Report "Patient's relationship to insured" as "self." Do not report the name of the parent. Electronic claims are preferred. Submit your paper claims to:

What Region Am I?

In the Central Region ONLY:
Claims
P.O. Box 890173
Camp Hill, PA 17089-0173

In the Western Region ONLY:
Member Services
Penn Avenue Place
501 Penn Avenue
Pittsburgh, PA 15222

Dental
United Concordia Companies, Inc.
Claims Processing
P O Box 69421
Harrisburg, PA 17106-9421

Routine Vision
Davis Vision
Vision Care Claims Unit
PO Box 1501
Latham, NY 12110

CHIP Enrollment

What Region Am I?

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

Highmark adultBasic/CHIP Administrative Unit (Central PA ONLY)
1-866-727-5437
1-866-727-4938 for Hearing Impaired

Highmark adultBasic/CHIP Administrative Unit (Western PA ONLY)
1-800-543-7105
1-877-323-8480 for Hearing Impaired

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3.1 Social Mission Programs – CHIP, Continued

CHIP Enrollment, (continued)

Independence Blue Cross (Eastern PA ONLY)
1-800-464-KIDS
1-800-464-5437

Blue Cross of Northeastern Pennsylvania (Northeastern PA ONLY)
1-800-KIDS-199
1-800-543-7199

For More Information on CHIP

For more information on CHIP including the income guideline chart, a downloadable application, and the monthly premiums and copays, please click the appropriate region-specific link below:

What Region Am I?

Western Region Only
https://www.highmarkbcbs.com/socialmission/CHIPWest/west/index.html

Central Region Only
https://www.highmarkblueshield.com/socialmission/CHIPCentral/central/index.html

3.1 Social Mission Programs – adultBasic

adultBasic Health Insurance For Adult Pennsylvanians

This program is administered by Highmark Blue Shield through the adultBasic/CHIP Administrative Units in Central and Western Pennsylvania. The adultBasic program is a basic health insurance program for uninsured adults from 19 to 64 years of age who meet the eligibility and income guidelines.

adultBasic is funded through Pennsylvania's Tobacco Settlement. Benefits are available to qualified adults who are not eligible for Medical Assistance and who are not covered by a private or public health insurance plan. In the Western Region benefits are provided through the western region network in the western region and in the Central Region through the PremierBlue Shield network.

What Region Am I?

Enrollment in the program is dependent upon meeting the eligibility guidelines. Highmark offers adultBasic coverage in all 29 counties of western Pennsylvania and in 10 counties of central Pennsylvania including: Centre, Columbia, Fulton, Mifflin, Montour, Northumberland, Juniata, Schuylkill, Snyder, and Union.

General Characteristics

One of the keystones of this program is that the adults are "held harmless" from balance billing when covered services are provided by a network provider. To achieve that, adultBasic uses the PremierBlue Shield professional provider and facility network to provide services to these adults in the Central Region and the western region network in the Western Region. There are no dental, vision, hearing or prescription benefits with this program. Members can receive the Highmark Discount on prescription drugs filled at a Premier Gold participating pharmacy. The program does cover two classes of drugs 100% without copays – they are diabetic supplies and insulin and immunosuppressants related to transplant surgery.

As with our commercial group programs, Highmark pays PremierBlue Shield and Western Region network providers directly, and they agree to accept our payments as payment-in-full for covered services. Highmark Blue Shield sends payments for services of non-participating providers directly to the member, who is responsible for paying the charges. Care received outside of the Western Region network is non-reimbursable unless pre-authorized by the Western Region Network. Out-of-network providers are not obligated to accept Highmark's payment as payment in full. It is critical in all cases that members check the network status of their provider.

In the Central Region: Members can go outside the PremierBlue network and receive care at the lower level of coverage. Members who go outside of the PremierBlue network may be responsible for paying any difference between the out-of-network provider's actual charge and the Highmark payment. This occurs even when members are directed to an out-of-network provider by an in-network provider.

In the Western Region: Members must use the Western Region network providers to receive 100% coverage unless the care is pre-authorized.

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3.1 Social Mission Programs – adultBasic, Continued

Eligibility Requirements For adultBasic, (continued)

The adultBasic/CHIP Administrative Unit performs eligibility and enrollment functions for adultBasic. The Individual Markets area performs marketing and outreach for adultBasic to locate eligible adults and educate the community about the adultBasic program. Adults must meet these eligibility guidelines:

- Be a resident of Pennsylvania for 90 days prior to applying for this coverage (except newborns);
- Must be a U.S. citizen, a permanent legal alien or a refugee as determined by the U.S. Immigration and Naturalization Service;
- Not be covered by any health insurance plan, self-insured plan or self-funded plan;
- Not be eligible for or covered by Medical Assistance offered through the Department of Public Welfare or other governmental health insurance;
- Be uninsured for at least 90 days before date of enrollment, except if applicant or spouse are no longer employed or were on CHIP or Medicaid immediately before applying for adultBasic;
- Be eligible based on family size and income;*
- Be eligible based on age guidelines

The adultBasic program requires a monthly premium and has co-pays for office visits and ER services.

Wait List Information

Limited State funding through the Tobacco Settlement funds has resulted in the creation of a statewide wait list by the Pennsylvania Insurance Department. Until a slot opens in the program, an eligible adult will remain on the wait list. Eligible adults on the wait list may purchase adultBasic coverage at full cost while they are waiting.

How To Determine If An Adult Is Covered Under adultBasic

Adults enrolled in the adultBasic program have the same Highmark insurance card as any commercial or group member.

You may use NaviNet, InfoFax or OASIS to determine eligibility, coverage, claim status or service restrictions.

adultBasic Covered Services

adultBasic Hospital Benefits are detailed below:

3.1 Social Mission Programs – adultBasic, continued

adultBasic Covered Services, continued

Ambulatory services (in a non-hospital facility) • Chemotherapy • Diagnostic services • Emergency accident and medical care • Surgery	▪ Outpatient hospital services • Clinic services (in a hospital-affiliated clinic) • Diagnostic services • Emergency accident and medical care • Radiation therapy, chemotherapy, dialysis treatment, and physical, occupational and speech therapy • Surgery
Inpatient Hospital Services • Unlimited inpatient care • Preadmission review is required • Transplant services	• Home Health care, covered in lieu of hospitalization • Skilled nursing facility, covered in lieu of hospitalization
Medical-Surgical • Anesthesia • Consultation • Inpatient only (Limited to one consultant per stay) • Outpatient consultation unlimited • Diagnostic medical	Transplant surgery • Second surgical opinion • Only eligible outpatient consultation • Allergy testing • Testing covered but not extracts or treatment
• Emergency medical and accident • Within 48 hours or emergency • Includes follow-up care • Outpatient medical visits • Symptomatic	• Preventive care, Pap Smear, Gynecological Exam • Mammogram

Continued on next page

3.1 Social Mission Programs – adultBasic, continued Continued

Other adultBasic Covered Services

- Medical-Surgical
- Adult Immunizations
  - Follows Highmark Blue Shield Preventive Schedule
- Maternity (including prenatal and postnatal care)
- Routine newborn care (first 31 days)
- Surgery
- Therapy Services
- Chemotherapy, radiation, dialysis treatment, and physical, occupational and speech therapy (PT, OT, ST limited to 60 visits)

Other adultBasic Covered Services, continued

Prescription drugs.

- 100% coverage without copays for diabetic supplies and insulin and immunosuppressants related to transplants
- For all other drugs, Highmark discount if filled at Premier Gold participating pharmacy

NOTE: There may be copayments required and limits on visits or services under the adultBasic program.

adultBasic Claims Submission

All claims except dental and vision claims, should be submitted just like any other Highmark Blue Shield claim. They may be submitted electronically or on a paper CMS 1500 claim form. Submit your paper claim to:

What Region Am I?

In the Central Region ONLY:
Claims
P.O. Box 890173
Camp Hill, PA 17089-0173

In the Western Region ONLY:
Member Services
Penn Avenue Place
501 Penn Avenue
Pittsburgh, PA 15222

3.1 Social Mission Programs – adultBasic, continued continued

adultBasic Enrollment

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

Highmark adultBasic/CHIP Administrative Unit – **Central Region ONLY**
1-866-727-5437 or 1-866-727-4938 for Hearing Impaired

What Region Am I?

Highmark adultBasic/CHIP Administrative Unit – **Western Region ONLY**
1-800-543-7105 or 1-877-323-8480 for Hearing Impaired

Independence Blue Cross – **Eastern Region ONLY**
1-800-464-KIDS or 1-800-464-5437

Blue Cross of Northeastern Pennsylvania – **Northeastern Region ONLY**
1-800-KIDS-199 or 1-800-543-7199

For More Information on adultBasic

For more information on adultBasic please click the appropriate region-specific link below:

What Region Am I?

Western Region Only
https://www.highmarkbcbs.com/socialmission/ABCWest/west/index.html

Central Region Only
https://www.highmarkblueshield.com/socialmission/ABCCentral/central/index.html

3.1 Traditional Fee-For-Service Programs using the PremierBlue Shield Network

Overview	Payments made under the following products are based on the lesser of the PremierBlue Shield fee schedule allowance or the provider's charge. PremierBlue Shield preferred providers agree to accept the PremierBlue Shield allowance as full payment, except for the copayment, deductible or coinsurance amounts, which are the patient's liability.
Basic 100	Most covered services are payable at 100 percent of the PremierBlue Shield allowance.
Comprehensive And Wraparound Major Medical	Comprehensive and wraparound major medical includes coverage for basic and major medical type services (such as office visits or durable medical equipment) in one comprehensive benefit package. Most programs have an annual deductible and 20 percent coinsurance, which the member is responsible for paying to the provider.

3.1 Medigap Coverage

Medigap Overview

Medigap coverage is health insurance that supplements Medicare's benefits by filling in some of the coverage gaps. These policies only work with the original Medicare Part B Plan. Medigap policies pay most of the coinsurance amounts for Medicare eligible services.

Medigap Coverage

In August 1990, the federal government passed a law (OBRA 90) requiring all states to standardize individual (also called non-group or direct pay) Medigap policies. The law standardized the Medigap policies sold to individuals so consumers could easily compare policies and premiums and make informed decisions.

The National Association of Insurance Commissioners (NAIC) developed 10 standardized Medigap plans, including a basic policy referred to as a "core" benefit package or Plan A. States were permitted to limit the number of plans available to consumers in their state. The standardized plans are identified by letters A through J.

If Payment Under The Supplemental Coverage Has Not Been Received

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

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

- Please do not highlight any information on the EOMB statement. Use an asterisk (*) or some other form of notation to indicate the patient whose claims need to be processed under their supplemental coverage.
- The member's contract identification number and correct address should be on the EOMB statement; otherwise, please submit a completed CMS 1500 claim form.
- In the case of Medicare electronic remittance, a screen print of the electronic remittance and a copy of the CMS 1500 claim form should be sent to the address previously listed.
- The beneficiary's Highmark Blue Shield agreement number and correct address should appear in the upper left hand corner of all documents submitted for processing.

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3.1 Medigap Coverage, Continued

MedigapBlue

The Blue Plans in Pennsylvania offer six of the ten standardized plans, under the name of MedigapBlue Plans A, B, C, E, H and I.

Benefits Available With Each Of The Six Available Plans

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

Service	Plan A	B	C	E	H	I
Basic benefits	X	X	X	X	X	X
Skilled nursing facility coinsurance			X	X	X	X
Part A inpatient hospital deductible		X	X	X	X	X
Part B deductible			X			
Foreign travel emergency			X	X	X	X
Prescription drugs					X*	X*
Preventive Care (first $120 each calendar year some tests and services not covered by Medicare)				X		
Part B Excess						X

**After satisfying the annual deductible, Plan H pays 50 percent of the costs of prescription drugs up to a maximum amount per year.*

Medigap Supplemental General Information

On Sept. 8, 1990, the Medicare Overcharge Measure (MOM) Act was passed. This prevents the majority of all health care providers in the state of Pennsylvania from billing Medicare beneficiaries any amount in excess of the Medicare reasonable charge.

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

When a member is enrolled in Medicare Part B and has supplemental coverage through Signature 65 or MedigapBlue, Medicare is the primary carrier. Submit the claim to the member's Medicare carrier first for processing.

3.1 Signature 65

Overview

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

Core Benefits

Signature 65 is a Highmark Blue Shield group product that provides coverage for the following core benefits:

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

Carve-Out

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

3.1 BlueCard and BlueCard PPO: The 'Out Of Area' program

Overview

The BlueCard® program was developed by the Blue Cross Blue Shield Association to facilitate the national delivery of health care services to members of all Blue Plans when they travel or live outside of their Home Plan area. It is most commonly used in situations in which an employer group with headquarters in one Plan area has employees located in one or several other Plan areas.

At this time, BlueCard® benefits can be delivered in these ways:

- As an indemnity product
- As a Preferred Provider Organization (PPO) product
- As a Point-of-Service (POS) product
- As a Health Maintenance Organization (HMO) product

In Pennsylvania, the BlueCard networks include:

- Participating Provider network (supports all BlueCard programs for members that usually live outside their Blue Plan's service area with traditional, POS and HMO coverage.)
- PremierBlue Shield network (supports the BlueCard PPO programs for members that usually live outside their Blue Plan's service area in a PPO plan)

Definition: Home Plan and Host Plan

For a member with coverage through BlueCard®, the Plan area in which the employer group's headquarters is located is considered the member's **Home Plan**.

The **Host Plan** is the Blue Plan serving the area where the employee resides or is visiting at the time the services are rendered.

Submitting Claims

All claims for BlueCard® members should be submitted to the Host Plan – in this case, to Highmark Blue Shield – unless you contract with the member's Home Plan (i.e., the Plan that issued the member's identification card). If you do contract with the member's Home Plan, the claim should be submitted to that Plan.

What Region Am I?

EXCEPTION: The BlueCard® Program does not apply within the 21-county Central Pennsylvania and Lehigh Valley area where Highmark Blue Shield markets in the same area as another Blue Plan. If you treat a Highmark Blue Shield member who resides within the 21 counties, you must send your claim to Highmark Blue Shield, even if you also participate with the other Blue Plan.

Continued on next page

3.1 BlueCard and BlueCard PPO: The 'Out Of Area' Program, Continued

For More Information On BlueCard

For complete information on BlueCard, please visit the BlueCard Information Center of the Provider Resource Center for complete information on the program.

Also, for your reference, please visit Unit 3.5 of the Highmark Blue Shield Office Manual solely dedicated to BlueCard.

Chapter 3

Products, Networks and Payment

Unit 2: How To Identify Highmark Members

In This Unit

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3.2 Identifying Highmark Members

Identifying Highmark Members

Highmark members can be easily identified by the information on his or her identification (ID) card. Always ask to see the ID card upon the patient's first visit. On subsequent visits, ask the patient if he or she has had a change in health insurance. A patient's insurance information can change at any time, and incorrect information can result in delayed claim payment.

ID Cards

All Highmark Blue Shield members receive an identification card so you can easily identify them and have essential information in order to help you understand their coverage. The identification cards are different for each of the programs. There may be some small variances on cards of each employer group.

Verifying Eligibility For A Highmark Blue Shield Member

If a Highmark member comes to the office without an ID card, you may:

- Consult NaviNet, Highmark's Internet-based inquiry system to determine benefits and eligibility.
- Perform an electronic transaction (ASC X12N 270 Eligibility Transaction) Please refer to the Provider Resource Center, EDI Services, Sign-Up for more information.
- Use an enrollment form in lieu of an identification card if the card has not yet been received.
- Use a Medicare Advantage product letter of confirmation in lieu of an identification card if the card has not yet been received.
- Call InfoFax, our service that responds to inquiries via your fax machine;
- Call OASIS, our automated voice response system using your touch-tone telephone
- Please visit Chapter 1, Unit 2 of the Office Manual titled "Highmark's Informational Resources," to find details about NaviNet, InfoFax and OASIS.

Verifying Coverage

If you are NaviNet enabled, NaviNet is the required method to check benefits and eligibility. If you wish to verify a member's coverage, check benefits and/or eligibility information by using NaviNet or performing an electronic HIPAA transaction.

If you are not a NaviNet enabled provider, please contact your Provider Relations Representative.

For More Information On ID Cards

For more information on ID cards and for samples of branded ID cards, please refer to later pages in this unit.

Continued on next page

3.2 Identifying Highmark Members, Continued

Caution! Medicare Advantage members retain their Medicare cards even after they begin coverage under Highmark Medicare Advantage products. You should always ask Medicare-eligible patients if they have joined a Highmark Medicare Advantage plan.

3.2 Confidentiality of Member Information

Member Rights And Responsibilities

Highmark treats members in a manner that respects their rights, and will clearly communicate Highmark's expectations of our member responsibilities.

Confidentiality Of Member Information

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

Normal Business Operations

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

- Claims management
- Certain types of routine audits by Highmark's group customers
- Coordination of care
- Quality assessment and measurement
- Case management
- Utilization review
- Performance measurement
- Customer service
- Credentialing
- Medical review
- Underwriting

Release Of Information For Non-Routine Use

If member information is needed for reasons other than those listed above under "Normal Business Operations," Highmark must obtain the member's consent via an Authorization for Disclosure form. If a member is unable to give informed consent, Highmark has a process to obtain this permission through a parent or legal guardian signature, signature by next of kin, or attorney-in-fact. The member has the right to limit the purposes for which the information can be used and all concerned are obligated to respect that expressed limitation.

3.2 Confidentiality of Member Information, Continued

Internal And External Controls	Members of Highmark products benefit from the many safeguards Highmark has in place to protect the use of data it maintains. This includes comprehensive privacy and security training of members of Highmark's workforce, requiring Highmark employees to sign statements in which they agree to protect members' confidentiality, using computer passwords to limit access to members' PHI and including confidentiality language in our contracts with doctors, hospitals, vendors and other health care providers.
Providers' Responsibility To Protect PHI	Members must not be interviewed about medical, financial or other private matters within the hearing range of other patients. Practitioners must have procedures in place for informed consent and the storage and protection of medical records. Highmark will verify that these policies/procedures are in place as part of the onsite review process, when applicable.
Others Who Have Occasion To Use Member Data	As a condition of employment, all Highmark employees must sign a statement agreeing to hold member information in strict confidence. Physicians and all other Highmark -participating providers are also bound by their contracts to comply with all state and federal laws protecting the privacy of members' personal health information. Highmark provides aggregate information to employer groups whenever possible.
Member Access To PHI	Members of Highmark products have a right to access (i.e., to review and/or obtain a copy of) their PHI that is contained in a designated record set. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about our members' health care benefits. Therefore, each practitioner must have a mechanism in place to provide this access.
Use Of Measurement Data	Through the use of measurement data, Highmark is able to manage members' health care needs, through appropriate quality improvement programs, such as health, wellness and disease management programs.

3.2 Confidentiality of Member Information, Continued

Protection Of Information Disclosed to Plan Sponsors Or Employers	Highmark, in general, will disclose PHI only to an authorized representative of a self-insured group health plan. However, Highmark may provide summary health and enrollment information, which has been aggregated and de-identified, to fully insured group health plans and plan sponsors.
The Privacy Department	Highmark's Privacy Department reviews and approves policies regarding the handling of PHI and other confidential information. Online privacy policy may be viewed at www.highmark.com. At the bottom of the page, click Privacy.

3.2 Member Rights And Responsibilities For Highmark Products

Overview

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

Member Rights

Members have the right to:

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

Member Responsibilities

Members have the responsibility to:

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

Continued on next page

3.2 Member Rights And Responsibilities For Highmark Products, Continued

How Highmark Will Communicate Member Rights And Responsibilities	Highmark will communicate the members' rights and responsibilities to all newly participating practitioners at the time of orientation via the website of the applicable Highmark Blue Shield Office Manual (HBSOM) and annually to existing practitioners via the website and an article in the provider newsletter. A paper copy will be provided upon request. Highmark will communicate the member rights and responsibilities to the member through the Member Handbook upon enrollment, via the website and annually in the member newsletter.

3.2 Member Rights and Responsibilities for Medicare Advantage Products

Overview

The following information is made available to members through the Medicare Advantage PPO and HMO Evidence of Coverage and updates in the member newsletters.

Member Rights

Members have the right to:

1. Be assured they will not be discriminated against in the delivery of health care services consistent with the benefits covered in their plan based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.
2. Receive considerate and courteous care, with respect for personal privacy and dignity.
3. Select their own personal physician/preferred provider or physician group from Highmark's Medicare Advantage Primary Care Physician networks.
4. Expect their Primary Care Physician's/network provider's team of health care workers to provide or to help them arrange for all the care that they need.
5. Participate in the health care process. If they are unable to fully participate in this discussion, they have the right to name a representative to act on their behalf.
6. Receive enough information to help them make a thoughtful decision before they receive any recommended treatment.
7. Be informed of their diagnosis and treatment plans in terms they understand and participate in decisions involving their medical care.
8. Talk openly with their Primary Care Physician and other network providers about appropriate and medically necessary treatment options for their condition, regardless of cost or benefit coverage.
9. Have reasonable access to appropriate medical services.
10. Be provided with complete information about their Medicare Advantage HMO/Medicare Advantage PPO, including the services it provides, the practitioners who provide care and information on member rights and responsibilities.
11. Confidential health records, except when disclosure is required by law or permitted in writing by the member with adequate notice. Members have the right to review their medical records with their PCP or other network provider.

Continued on next page

3.2 Member Rights and Responsibilities for Medicare Advantage Products, Continued

Member Rights (continued)

12. Express a complaint and to receive an answer to your complaint within a reasonable period of time.
13. Appeal a decision by Medicare Advantage if they feel they have been denied a covered service.
14. Immediate Quality Improvement Organization review of decisions for hospital discharges, as explained in the Centers for Medicare and Medicaid Services' "Important Message," which is given to Medicare members at the time of admission to a hospital, and in the Notice of Discharge and Medicare Appeal Rights given prior to discharge.
15. Call Member Services to request the following information about:
    - How we control the use of medical services.
    - The number of appeals and grievances we have received and how these cases were resolved.
    - How we pay our participating doctors.
    - The financial condition of our plan.
16. Make suggestions about Medicare Advantage PPO and HMO policies on member rights and responsibilities.

Member Responsibilities

Members have the responsibility to:

1. Read all Medicare Advantage HMO and PPO materials carefully and immediately upon enrollment and ask questions when necessary. They have the responsibility to follow the rules of Medicare Advantage HMO/Medicare Advantage PPO membership.
2. Identify themselves as a Medicare Advantage HMO/Medicare Advantage PPO member when scheduling appointments, seeking consultations with their physician, and upon entering any Medicare Advantage HMO/Medicare Advantage PPO provider's office.
3. Treat all Medicare Advantage HMO/Medicare Advantage PPO network physicians and personnel respectfully and courteously as your partners in good health care.
4. Communicate openly with the physician they choose. The member has the responsibility to develop a physician-patient relationship based on trust and cooperation.
5. Keep scheduled appointments or give adequate notice of delay or cancellation.

Continued on next page

3.2 Member Rights and Responsibilities for Medicare Advantage Products, Continued

Member Responsibilities (continued)

6. Ask questions and make certain that they understand the explanations and instructions they are given.
7. Consider the potential consequences if they refuse to comply with treatment plans or recommendations.
8. Pay any applicable copayments at the time of service.
9. Pay any applicable Medicare Advantage HMO/Medicare Advantage PPO premiums on time.
10. Pay their Medicare Part B premiums (and Part A, if applicable).
11. Help maintain their health and prevent illness and injury.
12. Help Medicare Advantage HMO/Medicare Advantage PPO maintain accurate and current medical records by being honest and complete when providing information to their health care professionals.
13. Express their opinions, concerns or complaints in a constructive manner to the appropriate people at Medicare Advantage HMO/Medicare Advantage PPO.
14. Notify the Medicare Advantage HMO/Medicare Advantage PPO Member Service Department, Monday through Sunday, between 8:00 a.m. and 8:00 p.m. at 1-800-935-2583 (Medicare Advantage HMO) or 1-866-306-1061 (Medicare Advantage PPO) of any changes in their personal situation which may affect the Plan's ability to communicate with them or provide health care to them, including any changes in their address or phone number, any extended trips or vacations, and of their return to the service area from a trip of up to six consecutive months. TTY users, please call 1-800-988-0668.
15. Understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.

3.2 Advising Members of Treatment Options Policy

The Policy

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

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

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

Background

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

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

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

3.2 Unit Definitions

Member	A **member** is an individual who is enrolled in a health plan and who meets the eligibility requirements of the program.
Subscriber	A **subscriber** is a member whose employment or other status, except for family dependency, is the basis for eligibility for enrollment in a program.
Dependent	A **dependent** is any member of a subscriber's family who meets the applicable eligibility requirements and is enrolled in a program.
Managed Care Plans	**Managed Care Plans** are delivered through the use of a provider network. Under some plans, members may visit providers in or out of network; however the highest level of benefits are paid for visits to in-network providers. Managed care plans include: Health Maintenance Organizations (HMOs) (sold in the Western Region Only), Point Of Service (POS), Open Access, Preferred Provider Organizations (PPOs), and Exclusive Provider Organizations (EPOs).
Indemnity Plans	**Traditional Indemnity** plans are sometimes referred to as a fee-for-service plan, in that it pays a set amount per health care service performed. It gives members the widest choice of physicians and services, through participating providers. Generally, these plans are subject to a deductible and coinsurance.

What Region Am I?

3.2 Format of Identification Cards

Changes Effective January 1, 2007

Effective January 1, 2007, Highmark will begin to issue new ID cards displaying both the name of the subscriber (the individual under whose name the coverage was established) and the name of the member/patient. The new cards will be issued as employer groups renew their coverage. You can expect to see both the new format and the more traditional one throughout 2007.

New Design/New Process

Pay careful attention throughout 2007 to the new design of the ID card. Remember to capture both the name of the member/patient and the name of the subscriber at the time of admission/registration. At the time of service, if the patient presents an ID card without the subscriber's name the provider will need to ask the patient to verify the name of the subscriber under whom the coverage has been established.

Although rare, in cases where the member/patient's ID card indicates the subscriber is not covered, NaviNet will show that the subscriber does not have eligibility under the same group as the member/patient. Subscriber ineligibility may be due to many reasons, but the subscriber's status does not reflect eligibility of the member/patient and should not impact the filing of member/patient claims.

Questions On ID cards?

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

3.2 Anatomy Of An Identification Card

Helpful Identification Information You Should Know



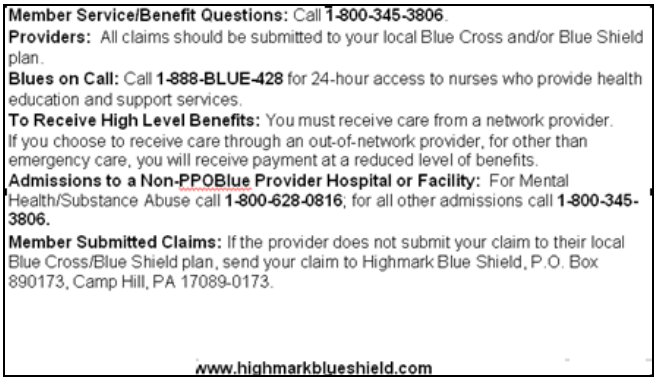
Tip Sheet - New!

- **Product name, logo and/or program description** –This will help you determine which network rules to follow.
- **Rx group number and pharmacy logo** –This will be on the ID card whenever a Highmark prescription drug program is included.
- **Suitcase logo** – Indicates a member of the BlueCard® program. For more information, please refer to Chapter 3, Unit 5 of the Highmark Blue Shield Office Manual.
- **Name of the subscriber** – the individual under whose name the coverage was established.
- **Name of the member/patient –** the individual covered by the policy. Verify that you have the card that corresponds with your patient and not that of another family member/dependent.
- **Identification number**– ID# -- The alpha prefix varies by employer group or account (not applicable to Medicare Advantage products).
- **Group number**–Most often, this will be a number assigned to the group. Sometimes it will be an alpha prefix followed by a number.
- **Copay**–PCP, specialist office, office visit, and/or emergency room co-payments may be listed. Pharmacy co-payments are not listed. Participating pharmacies can verify co-payment amounts online. Specialist co-payments may not be the same for behavioral health care services, or therapies and/or diagnostic services: those co-payments may be found via NaviNet or by calling the phone number on the back of the ID card.
- **Network code**– Number represents corresponding network.
- **BS Plan** –Represents corresponding Blue Shield Plan
- **LSRO–**appears only on Western Region Medicare Advantage HMO cards to identify members of the Deluxe Option
- ***PCP–**If a valid PCP is chosen, the PCP's name will appear in this field.
- ***Phone**–The PCP's main office telephone number
- ***PCP effective date–**The date the member became effective with the PCP under the group number shown on the card.

* only on HMO and POS ID cards

3.2 Anatomy Of An Identification Card

The Back of A Member's ID Card


Member Service/Benefit Questions: Call **1-800-345-3806**.
Providers: All claims should be submitted to your local Blue Cross and/or Blue Shield plan.
Blues on Call: Call **1-888-BLUE-428** for 24-hour access to nurses who provide health education and support services.
To Receive High Level Benefits: You must receive care from a network provider. If you choose to receive care through an out-of-network provider, for other than emergency care, you will receive payment at a reduced level of benefits.
Admissions to a Non-PPOBlue Provider Hospital or Facility: For Mental Health/Substance Abuse call **1-800-628-0816**; for all other admissions call **1-800-345-3806.**
Member Submitted Claims: If the provider does not submit your claim to their local Blue Cross/Blue Shield plan, send your claim to Highmark Blue Shield, P.O. Box 890173, Camp Hill, PA 17089-0173.
www.highmarkblueshield.com

The back of the member's identification card contains information mainly for the member's use. Products may have different information contained on the card including, but not limited to:

Member Service/Benefit questions: Phone number for Member Service.

Blues On Call: Provides a phone number that members can call for health education and support services.

To Receive High Level Benefits: Tells member how to receive the highest level of benefits by receiving care from an in-network provider.

Admissions to a Non-Participating Hospital or Facility: Mental Health and Substance Abuse: Lists telephone number for assistance in obtaining admission to hospital, facility and mental health and substance abuse treatment programs.

Member Submitted Claims: Lists address for a member to submit claims if they choose.

3.2 Examples of Highmark Identification Cards

Examples of Highmark ID Cards

What Region Am I?

The identification cards are different for each of the programs. There may be some small variances on cards of each employer group.

Click your regional link to view samples of Highmark's ID cards.

Central Region Identification Cards – Effective 1/1/2008

Western Region Identification Cards - Effective 1/1/2008

Northeastern Region Identification Card - Effective 1/1/2008

3.2 Member Access to Physicians

PCP And Specialist Standards

The table below illustrates standards for PCP and specialist accessibility.

Patient's Need	Definition	Performance Standard
Emergency/life Threatening Care	An emergency medical condition (as defined by the Balanced Budget Act [BBA] of 1997) is: A condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.	Immediate response
Urgent care appointments (e.g., high fever, persistent vomiting/diarrhea)	An urgently needed service is a medical condition that requires rapid clinical intervention as a result of an unforeseen illness, injury, or condition.	Within 1 day
Regular And Routine Care Appointments	• Non-urgent appointment, but in need of attention (e.g. headache, cold, cough, rash, joint/muscle pain, etc.) • Routine wellness appointments (e.g., asymptomatic/preventive care well child/ patient exams, physical exams, etc.)	• Within 2 to 7 days • Within 30 days

Continued on next page

3.2 Member Access to Physicians, Continued

Patient's Need	Definition	Performance Standard
Telephone Accessibility	Telephone accessibility by the provider or covering provider – 24 hours a day, seven days a week. Coverage can be made available either directly or through an on-call arrangement with another network provider. This arrangement allows the member or another provider direct access to a provider (or his or her designee) in urgent or emergent situations. The 24/7 coverage can be accomplished through an answering service, pager or through direct telephone access whereby the provider (or his or her designee) can be accessed if needed. A referral to a crisis line of the nearest emergency room is not acceptable coverage unless an arrangement has been made between the provider and the crisis line or emergency room whereby the provider (or his or her designee) can be contacted directly. A non-primary care physician should not refer a patient to his or her primary care physician after normal business hours. The following specialties are exempt from this requirement: audiology; dermatopathology; pathology (only if working outside of the acute care setting); physical medicine; preventive medicine; speech language pathology; and speech therapy.	24 hours a day, seven days a week
After-Hours Care	Access to practitioners after the practice's regular business hours	Practitioners are expected to return calls within 30 minutes. This includes covering physicians.

Continued on next page

3.2 Member Access to Physicians, Continued

Behavioral Health Care Standards

The table below illustrates standards for behavioral health care provider accessibility.

Patient's Need	Definition	Performance Standard
Care For A Life-Threatening Emergency	Immediate intervention is required to prevent death or serious harm to patient or others.	Immediate response
Care For A Non-Life-Threatening Emergency	Rapid intervention is required to prevent acute deterioration of the patient's clinical state that compromises patient safety.	Within 6 hours
Urgent Care	Timely evaluation is needed to prevent deterioration of the patient's condition.	Within 48 hours
Routine Office Visit	Patient's condition is considered to be stable.	Within 10 business days
Telephone Access To Behavioral Health screening And Triage	Patient requires behavioral health care needs assessment	• Callers reach a non-recorded voice (operator) within 30 seconds • Hang-up rates do not exceed 5%

Patient Wait Times

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

Continued on next page

3.2 Member Access to Physicians, Continued

After-Hours Accessibility

PCP and specialist practices must be available by telephone 24 hours a day, seven days a week, to direct patient care.

The PCP, specialist or the covering physician is expected to respond to after-hours calls within 30 minutes of the member's telephone call.

Covering Arrangements

For PCPs
If the PCP is unavailable, he or she must arrange with a covering network PCP to respond to patients during and after regular office hours. For more information on covering physician arrangements, please refer to Chapter 2, Unit 4 for detailed information on the Locum Tenens policy.

For All Other Practitioners
It is the responsibility of the network physician to ensure that the physician who is covering for him or her participates in the same network(s) and adheres to these physician accessibility standards.

Office Hour Standards For PCPs

PCP practices must maintain a minimum of 20 office hours per week during which a physician or a physician extender is accessible to patients. Report changes to your office hours online through NaviNet's Practice Information Change function or by using the Request for Addition/Deletion to Existing Assignment Account form located under Forms on the Provider Resource Center. Please also refer to Chapter 2, Unit 4 for more information.

Evaluating Appointment Accessibility

Appointment access is monitored through member satisfaction surveys and through office site reviews that are conducted for applicable initial network practitioners, new and relocated practice sites, and triennially for all dual-credentialed practitioners. Reviews may also be conducted in response to information obtained from quality improvement activities, including member complaints. Additionally, appointment access information is obtained from practices randomly selected for HEDIS® record sampling and clinical studies.

3.2 After-Hours Physician Accessibility Study

After-Hours Physician Accessibility Study

The after-hours physician accessibility study is one of the methods by which physicians are evaluated to determine whether they meet accessibility standards.

When The Study Is Performed

Quarterly, each practice meeting the following requirements participates in the after-hours study:

- Any practice that has joined the network during the previous quarter.
- Any practice for which a member complaint (relating to after-hours access) has been received in the previous quarter.
- Any provider who appeals a credentialing termination decision based on lack of 24/7 coverage.

The Process

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

Stage	Description
1	A Highmark representative calls the practice's main telephone number after normal practice hours and states his or her name and the purpose of the telephone call. Did the caller speak with the doctor? **If yes,** go to Stage 3. **If no,** go to Stage 2.

Continued on next page

3.2 After-Hours Physician Accessibility Study, Continued

The Process (continued)

Stage	Description
2	**Quarterly study:** The Highmark representative asks that the physician call him/her back. Does the physician (or covering physician) return the telephone call within thirty minutes? **If yes**, go to Stage 3. **If no**, go to Stage 4.
3	A letter is sent to the practice acknowledging our appreciation for participation in the after-hours accessibility study. Process complete.
4	A letter is sent to the office informing them of the results and the need for a written corrective action plan. A Highmark representative contacts the office to discuss alternatives that the provider may use to be compliant with the after-hours requirements. Up to two follow-up calls are placed after regular hours to determine if the office has implemented corrective actions. If the practice becomes compliant, go to Stage 3.

If You Do Not Meet Guidelines

Practices that remain noncompliant following Stage 4 above may be subject to additional corrective action, sanctioning, and ultimately, network termination.

3.2 Verifying Eligibility For Out-of-Area BlueCard® Member

What Is BlueCard®?

BlueCard is a national program that enables members of one 'Blue' Plan to obtain healthcare services while traveling or living in another 'Blue' Plan's service area. The program allows providers to conveniently submit claims for patients from other Blue plans, domestic or international, to the local Blue Plan.

Identifying a BlueCard® Member

Identifying a BlueCard® member is not always a straightforward process. Identification card designs vary from Plan to Plan, and not all Blue Plans include 'Blue' branding in their name.

However, the following will appear somewhere on the ID card for members of every Blue Plan:

- The Blue Cross and/or Blue Shield symbols
- The words "An independent licensee of the Blue Cross and Blue Shield Association (BCBSA association)"
- A three-character alphabetical prefix before the member's ID number
- The "suitcase" logo. For BlueCard PPO members, the acronym "PPO" appears inside the suitcase. Otherwise, the suitcase is empty.



BlueCard covers Inpatient, Outpatient and Professional Services while dental, prescription drug, hearing services and the Federal Employee Program (FEP) are not covered. Members' routine vision benefits may process through BlueCard depending on their benefit structure.

How To Verify Eligibility For An Out-Of-Area BlueCard® Member

Highmark Blue Shield does not house eligibility information for members of out-of-area groups whose business is handled through the BlueCard Program. These members can be identified by the "suitcase" logo that appears on their ID card , (described above).

For members whose ID cards display the suitcase logo, there are several ways to determine eligibility.

- Use NaviNet which offers an electronic inquiry called BlueExchange
- Submit a 270 Eligibility Request electronic transaction, or
- Call the BlueCard Eligibility line: 1-800-676-2583.

If you choose to make a phone call, be prepared to provide the member's name and identification number, including the three-character alphabetical prefix, to the service representative who answers your call.

Continued on next page

3.2 Verifying Eligibility For Out Of Area BlueCard® Member, Continued

How to Verify Eligibility For An Out Of Area BlueCard® Member, continued

The operator will connect the caller to the appropriate membership unit at the member's Blue Plan. If the member presents a debit card be sure to verify the copayment amount(s).

Highmark strongly encourages you to photocopy the member's identification card each time he or she visits your office. The primary purpose of the photocopy is to serve as backup information should a problem arise on a claim for the individual. Your billing department or the Highmark Customer Service department may need to compare the identification information on a claim against the identification information on the card. The photocopy may be your only immediate source of verification.

For More Information On BlueCard®

For more information about the BlueCard Program, Highmark's BlueCard Information Center offers valuable tools and information — including a BlueCard online tutorials, frequently asked questions, a hospital and doctor finder and other resources.

Please visit the Provider Resource Center on NaviNet or the Highmark Web Site to access the BlueCard Information Center.

Chapter 3

Products, Networks and Payment

Unit 3: Payment Methodology

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3.3 Payment Methodology

Overview

Highmark Blue Shield uses several mechanisms to reimburse providers for services rendered to its members. These mechanisms vary, depending on the program in which the member is enrolled.

Allowed amounts are updated periodically to respond to changing economic and market circumstances. The timing of updates and methodology employed are subject to approval by the Insurance Department of the Commonwealth of Pennsylvania.

How to Obtain A Usual Charge Profile

A usual charge profile for UCR (Usual, Customary and Reasonable)or PremierBlue Shield allowances for specific codes or for frequently reported procedures can be found on NaviNet, or by writing to:

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

Please include your provider name, address and Highmark Provider ID number or NPI (National Provider Identifier) on your request for a usual charge profile.

For more information about profiles or the data on your usual charge record, contact your Provider Relations Representative.

3.3 Usual, Customary and Reasonable Payment Methodology

Usual, Customary & Reasonable Payment

In 1965, Highmark Blue Shield introduced a payment methodology called the Prevailing Fee Program. In 1979, it was re-named as the UCR Program, or Usual, Customary and Reasonable. UCR is designed to compensate for price variations among providers and to offer affordable, full-service benefits to all members, regardless of income.

How UCR Works

Highmark Blue Shield's UCR allowance is the lowest of:

- the provider's actual charge,
- the provider's Usual fee, or
- the Customary fee.

A Reasonable allowance replaces the Usual or Customary fee when our review process determines that the Usual or Customary fee does not provide appropriate compensation. A Reasonable allowance may be higher or lower than the Usual or Customary fee.

3.3 The Fee-For-Service Method

Definition: Fee-For-Service Payment	Fee-for-service is a method of payment in which a provider (PCP or Specialist) submits a bill for each service rendered and is paid according to the health plan's established fee for that service less any member liability. An additional provider incentive may be included in the payment. Refer to Chapter 7, Unit 1of this manual for detailed information on the QualityBLUE Provider Pay-for-Performance Program.
How Fee-For-Service Works	After rendering appropriate services to members, providers bill for the services rendered and receive a fee-for-service payment.
How Fee-For-Service Claims Are Paid	Fee-for-service claims are paid using their region specific network fee schedule. For each service, the payment calculation selects the lower of the following: • The provider's billed amount, or • Network maximum fee allowance Fee-for-service payments may be subject to member program copayments, coinsurance and deductibles.
Important: Medicare Advantage Claims Are Paid Differently	Medicare Advantage HMO and PPO claims are paid using an amount based on the Medicare fee schedule. Unlike the Medicare program, Medicare Advantage programs require no member deductible or coinsurance, except for certain DME and the dental benefit under the Deluxe option that requires coinsurance.

3.3 Billing for Services

Services That Are Permissible To Bill

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

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

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

Providers Can Not Bill For These Services

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

Providers cannot bill Highmark members for these services:	**Providers cannot bill Highmark for these services:**
• Telephone triage • After-hours calls • Transferring or copying of medical records to other providers as detailed below	• Review of members' test results by phone • Review of members' test results in office without another reason for an office visit • Transferring or copying of medical records to other providers as detailed below

Continued on next page

3.3 Copying & Transferring Medical Records

Copying & Transferring Of Medical Records

Providers must ensure members are guaranteed timely access to their medical records, x-rays and other information that pertains to them. The following requirements apply to the transfer and copying of medical records for Highmark members.

- PCPs must transfer sufficient medical records (or copies thereof) and information to Specialists without charge to the member or Highmark, as is necessary for the Specialist to appropriately treat the member.

- Specialists must provide PCPs, without charge to the member or Highmark, written documentation regarding medical care given or being given to the member. (Additional restrictions may apply to information regarding certain medical conditions, such as mental health, substance abuse and HIV/AIDS.)

- PCPs must transfer, without charge to the member or Highmark, sufficient medical records and information to another if the member requests to change his/her PCP.

- In general, practitioners must transfer to each other appropriate medical information as necessary to ensure quality care for all members. The transfer of medical records must be completed in a timely fashion and without charge to the member or Highmark to ensure continuity of care.

- When releasing records directly to the patient, at the patient's request, the practitioner may charge a reasonable fee to cover copying and postage costs, up to the amount set by state law and as permitted by federal law.

3.3 Copayments

Copayment: A Definition

A copayment is a specific, fixed dollar amount the member is obligated to pay and the provider is obligated to collect, for a specific covered service, at the time the service is rendered or through a pre-established billing method. This may be applicable to services such as: office visits, spinal manipulation, physical medicine, etc. Copayment amounts and applicable covered services differ according to group and product type.

Copayments And Fee-For-Service

For fee-for-service claims, applicable copayment amounts are deducted from the network maximum fee allowance. If the patient is covered by Medical Assistance in addition to a Highmark or network managed care program, the patient is not responsible for paying the copayment amount. The copayment amount may be billed to the Department of Public Welfare in accordance with their reimbursement procedures.

When Office Visit Copayments May Be Charged

Office visit copayments may be charged when an office or home visit is provided. This copayment may also be charged when other services are performed in conjunction with an office visit.

Examples:

- Minor surgery in the office
- Nebulizer treatments
- Diagnostic procedures
- Immunizations
- Therapeutic injections

Continued on next page

3.3 Copayments, Continued

Instances When Charging An Office Visit Copayment Is Not Appropriate

Office visit copayments should not be charged in instances where there would not be a bill for an office visit.

Examples:

- Maintenance allergy injection (unless the group specifies otherwise)
- Blood draw, but no office visit
- Throat culture with no office visit
- Services rendered by office staff such as blood pressure checks.

Collecting The Copayment

Providers are required to make all attempts to collect all member liability, either at the time of service or following adjudication. When a member's benefit design includes multiple copayments, providers should collect all applicable copayments. Providers can verify a Highmark member's eligibility and benefits, including liability information, through NaviNet.

If a copayment is required the provider should collect the copayment at the time of the office visit. If a member does not pay the copayment at the time of the office visit, the PCP or specialist will bill the member for the copayment. Highmark requires PCPs and Specialists to collect all applicable member liabilities including copayments, deductibles and coinsurance as required by the member's plan document, except where such collection is prohibited or restricted by applicable laws.

Members Who Refuse To Pay Copayments

If members refuse to pay the copayment, the practice should use its routine collection process. If this process is unsuccessful, the practice may use standard collection methods (such as engaging a collection agency). Neither Highmark nor the network is responsible for assisting the provider in the collection of debt.

If the methods above are unsuccessful, the practice may choose to remove the member from the practice.

3.3 Deductibles and Coinsurance

Definitions Of Deductibles And Coinsurance

A deductible is a specific, fixed dollar amount of charges for which the member is responsible. The deductible amount must be met before health insurance benefits can be paid. Coinsurance is a percentage of the allowed amount related to any or all services, for which the member is responsible.

Providers will collect deductibles and coinsurance as required by the member's plan document.

What Region Am I?

To Which Programs Do They Apply?

Deductibles and coinsurance currently can apply to many of Highmark's products. Please check individual benefit structures to determine potential deductible and coinsurance amounts.

Example: Deductibles And Coinsurance

For a PPOBlue member:
In this example, the member's group has a $250 annual deductible and a 20% coinsurance rate for out-of-network care. (Deductibles and coinsurance rates may vary for other groups.)

This PPOBlue member has chosen to go out-of-network. The member has not yet met the annual deductible. Under PPOBlue, deductibles and coinsurance would apply.

- If the provider charges $100 for services rendered, and that charge is equal to the allowance, the member would be responsible for the entire amount.
- If the provider charges $300 for services rendered, and $300 is equal to the allowance, the member would be responsible for $250 (deductible), and PPOBlue would pay 80% of the remaining $50 balance. 80% of $50 is $40. So the member would pay another $10 (coinsurance) and PPOBlue would pay $40. The total member liability is $260.
- A provider should not bill members for any coinsurance or deductible amounts until they receive an Explanation of Benefits (EOB) that clearly indicates the member liability.

In What Instances Do They Apply?

It is difficult to give a general answer because coinsurance and deductibles vary from group to group and program to program. Members may find their group coinsurance and deductible information in their member handbooks or by calling the Member Service number on their ID cards. Providers who want to determine benefits in advance of services can check NaviNet.

Continued on next page

3.3 Deductibles and Coinsurance, Continued

In What Instances Do They Apply?

By using NaviNet's Member Responsibility Calculator via the Benefit Accumulator function under Eligibility and Benefits Inquiry, providers can obtain an estimated value of the member's financial responsibility for services. This enables providers to collect payment from the member at the point of services, if they wish to do so. Note: this is only an estimate. You may need to later refund money to the member or bill the member for additional amounts once the claim is processed.

Those practices that do not have NaviNet may call: What Region Am I?

Western Region: 1-800-547-3627, option 2
Central Region: 1-866-731-8080
Eastern Region: 1-866-975-9270
Northeastern Region: 1-888-827-7117

3.3 Coordination of Benefits

Where To Find Information Regarding Coordination Of Benefits

The Highmark Blue Shield Office Manual (HBSOM) includes other helpful information about Highmark's products and related policies and procedures. Detailed information about Coordination of Benefits, Subrogation and Worker's Compensation can be found in Chapter 6, Unit 1 of the Office Manual.

3.3 Income Based Fee Schedule Program Payment

Income Based Fee Schedule Program Payment

Fee schedules are tables of maximum allowances that Highmark Blue Shield pays. They are not intended to necessarily represent the actual value of services performed.

If the member's income falls within the specified income limits of the agreement, a network provider must accept the Highmark Blue Shield allowance as payment-in-full for covered services.

Highmark Blue Shield's fee schedule agreements have the following income limits:

Program	Income limits
Plan 1800S	$6,000 for an individual $12,000 for a family
Plan C	$12,000 for an individual $24,000 for a family
Plan 5000S	$18,000 for an individual $36,000 for a family

Network providers initially determine whether a member is of "low income" or "over income" – for Plans 1800S, Plan C and Plan 5000S.

This rule applies except for members of Highmark's social mission programs: CHIP (Children's Health Insurance Program), adultBasic and Special Care. It is not necessary to verify the member's income. Highmark reviews applications and income documents for these social mission programs to determine eligibility for these programs annually.

Providers who suspect member fraud or abuse should notify Highmark for investigation.

Continued on next page

3.3 Income Based Fee Schedule Program Payment, Continued

Income Based Fee Schedule Program Payment, continued

The member's income is based on the year previous to the date of service. If there is a dispute concerning the member's income status, Highmark Blue Shield will make the final determination. (See the Social Mission Programs' payment section on the following page for information regarding adultBasic, CHIP, and Special Care).

In summary, if the patient has fee schedule coverage:

And the provider is:	And the member's income is:	Then the member is Responsible for:
Participating	1. Less than the limits 2. Above the limits	1. 0 2. Any unpaid balance
Non-participating*	1. Less than the limits 2. Above the limits	1. Any unpaid balance 2. Any unpaid balance

*Special Care does not have coverage for members who visit non-participating providers.

By setting provider reimbursement equal to the fee schedule amounts, these programs remain affordable to low-income individuals. By agreeing to accept this reimbursement as payment-in-full for eligible individuals, Highmark Blue Shield network providers help Highmark Blue Shield provide programs and services for lower income individuals and families who need healthcare. Highmark also subsidizes the member premiums for many of these individuals.

3.3 PremierBlue Shield's Fee Structure

Overview

PremierBlue Shield is Highmark Blue Shield's statewide selectively contracted network of preferred providers. It is not tied to a specific benefits program, but supports a variety of Highmark Blue Shield programs.

Payment Structure

PremierBlue Shield allowances are based on a fee schedule that emphasizes evaluation and management services.

Adjustments to the PremierBlue Shield fee schedule are made, as needed, to assure providers are receiving fair reimbursement – and to assure that members have adequate access to primary care and specialty services.

PremierBlue Shield providers agree to accept Highmark Blue Shield's allowances as payment-in-full for covered services. Members are responsible for any copayments or coinsurances.

3.3 Payments for Members Over 65

Medicare Advantage Programs	Refer to Chapter 3, Unit 1 of the Highmark Blue Shield Office Manual for information about payment under the Medicare Advantage Program.
Medigap Programs	Refer to Chapter 3, Unit 1 of the Highmark Blue Shield Office Manual for information about payment under the Medigap Program.

3.3 Payment for Social Mission Programs

What Region Am I?

In The Western Region Only: The table below shows payment levels for Highmark's Social Mission Programs in the Western Region.

Program	Covered preventive services	Covered medical visits	Other covered, medical-surgical services
CHIP	HMO	HMO	HMO
adultBasic	HMO	HMO	HMO
Special Care – Tier One*	UCR	Plan C	Plan C
Special Care – Tier Two**	UCR	UCR	UCR

Special Care does not cover services provided at non-participating facility providers (non-emergency).

For CHIP And adultBasic Only: Participating Providers accept Highmark's reimbursement for services as payment in full without balance billing the members. There is no additional discount applied to provider reimbursement rates due to income level (providers receive the full Highmark reimbursement rate). The HMO in the Western Region does not provide benefits for Non-Participating HMO Providers unless the care was preauthorized by Highmark.

In The Central Region Only: The table below shows payment levels for Highmark Blue Shield's Social Mission Programs in the Central Region.

Program	Covered preventive services	Covered medical visits	Other covered, medical-surgical services
CHIP	PPO	PPO	PPO
adultBasic	PPO	PPO	PPO
Special Care – Tier One*	UCR	Plan C	Plan C
Special Care – Tier Two**	UCR	UCR	UCR

Special Care does not cover services provided at non-participating facility providers (non-emergency).

Continued on next page

3.3 Payment for Social Mission Programs, Continued

For CHIP And adultBasic Only:

Network providers accept Highmark's reimbursement for services as payment in full without balance billing the members. There is no additional discount applied to provider reimbursement rates due to income level (providers receive the full Highmark reimbursement rate). Non-network providers in the PPO (Central Region) may bill the member for the difference between the indemnity fee for a given procedure and the actual charge made for that procedure.

*Special Care Tier One is designed for new and ongoing members whose income does not exceed 200% of the federal poverty guidelines.

**Special Care Tier Two is for those members who have been in Special Care one or more years and who exceed 200% of the federal poverty guidelines. Benefits remain the same; however reimbursement is determined at the UCR rate for all services. Providers may balance bill Special Care Tier Two members who are over income. However, for Special Care Tier One members (those members with qualifying income at 200% of the Federal Poverty Level), covered services are reimbursed at the Plan C fee schedule.

Chapter 3

Products, Networks, and Payment

Unit 4: Pharmacy and Formulary

In This Unit

Topic	See Page
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Drug Management	4

NOTE: This section provides a brief overview of the Highmark Pharmacy Benefit. To access all policies and updates, please refer to the Pharmacy/Formulary section, located on the home page of the Provider Resource Center.

3.4 Pharmaceutical Overview

Medco Health Program

Highmark Blue Shield administers prescription benefits for many of its members. The Medco Health Program logo appears on the member's identification card if the member utilizes Highmark's prescription drug benefit.

Pharmacy Networks

The prescription drug program offers a wide network of pharmacies that includes most national chains and many local, independent pharmacies. Drug benefits may vary slightly, depending upon the member's group program. Pharmacies have point-of-sale technology that confirms a member's eligibility, benefit design and copayment information at the time of dispensing.

Under most prescription drug programs, members must use one of the participating pharmacies in Highmark Blue Shield's Premier Pharmacy networks. Members may consult their pharmacy directory by visiting www.highmark.com or calling Customer Service at the number shown on their identification cards to find a network pharmacy that is conveniently located for them.

Highmark also offers a Home Delivery (Mail Service) option to most members. Under this option, members can get a 90-day supply of medication through the mail. For most prescriptions, the member can save on the cost of the medication when it is obtained via the mail service pharmacy.

How To Use Highmark's Formulary List

The Drug Formulary is a list of FDA-approved prescription drug medications reviewed by our Pharmacy and Therapeutics (P&T) Committee. The formulary is designed to assist in maintaining the quality of patient care and containing cost for the patient's drug benefit plan. Our P&T Committee approves revisions to the drug formulary on a quarterly basis; updates will be provided to reflect such additions.

Products are removed from the formulary twice a year, January 1st and July 1st after a minimum of 30 days notification is given to providers.

Physicians are requested to prescribe medications included in the formulary whenever possible. Our Medical and Pharmacy Affairs department will monitor provider-specific formulary prescribing and communicate with providers to encourage use of formulary products.

The drug formulary is divided into major therapeutic categories for easy use. Products that are approved for more than one therapeutic indication may be included in more than one category. Drugs are listed by brand and generic names.

To access Highmark's Formulary list, please refer to the Pharmacy/Formulary section, located on the home page of the Provider Resource Center.

3.4 Pharmaceutical Home Delivery

Mail Service	Home delivery service is a standard component of our prescription drug benefit. Members may call the Member Service telephone number on their identification card to obtain a home delivery order form.
Advantages Of Home Delivery	Members may prefer to use the home delivery prescription service. This service enables members to obtain up to a 90-day supply at a discounted copayment compared to the 30-day retail prescriptions.
How To Assist Members With Home Delivery	If a member must begin taking a new maintenance drug immediately, you may need to write two prescriptions. The member can have one of the prescriptions filled at a local pharmacy to begin taking the medication immediately. The member can send the other prescription to the home delivery service for up to a 90-day supply.
How Members Can Enroll In Home Delivery	Members can obtain home delivery forms for maintenance drugs by calling the Member Service telephone number on their identification card or by visiting our Web site at www.highmark.com. Once a member places an order, the member's information remains on file. Any subsequent refills do not require an order form. For refills, the member can call the toll-free number, send in the refill form with the applicable copayment, or visit Highmark Blue Shield's Web site at www.highmark.com. As a convenience to patients, physicians may fax new prescriptions directly to Medco Health. Call 1-888-EasyRxl for details regarding how to fax a prescription to the mail order pharmacy.

3.4 Drug Management

Prescription Drug Management (Pharmaceutical Management) Programs

Management (Pharmaceutical Management) programs are designed to safeguard patients from potentially harmful drug interactions and side effects, optimize clinically appropriate therapy, promote appropriate prescription drug utilization and promote compliance with recommended drug quantity, dosage and intended use of product. These programs bring together every individual or entity involved in the management and delivery of pharmaceutical care: plan sponsor, physicians, members, and pharmacists. The programs are administered across all lines of business and are seamless across both retail and home delivery prescription drug benefit programs. These programs achieve this by:

- Identifying specific prescribing situations that may represent inappropriate utilization based on nationally-recognized clinical practice guidelines or manufacturer's recommended dosages.

- Providing the appropriate clinical interventions and follow up necessary with physicians and patients to foster more appropriate and effective use of prescription therapy.

Pharmaceutical Management Programs

Highmark's pharmaceutical management programs include the following:

- Drug Utilization Review
- Quantity Level Limit Program*
- Prior Authorization Program
- Managed Prescription Drug Coverage (MRxC) Program
- Formulary Management

Highmark Blue Shield's Pharmacy and Therapeutics Committee has approved all of these program policies. This Committee is composed of network physicians and pharmacists who consider the safety, efficacy and appropriate use of medications when reviewing these policies. Changes and updates to these criteria are distributed quarterly to all network providers via a formulary update.

To access all policies and updates, please refer to the Pharmacy/Formulary section, located on the home page of the Provider Resource Center.

***NOTE: Beginning January 1, 2007, this program does not apply to Highmark's Medicare Advantage plans or the BlueRx prescription drug plans.**

Continued on next page

3.4 Drug Management, Continued

Medical Necessity Criteria For Drug Management

Except where any applicable law, regulation, or government body requires a different definition (i.e., the Federal Employees Health Benefits Program, CMS as to the Medicare Advantage program, etc.), Highmark Blue Shield has adopted a universal definition of medical necessity. The term "Medically Necessary," "Medical Necessity" or such other comparable term in any provider contract shall mean health care services (or such similar term as contained in the applicable benefit agreement or plan document to include, but not be limited to, "health services and supplies," "services and supplies" and/or "medications and supplies") that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- *in accordance with generally accepted standards of medical practice;*
- *clinically appropriate, in terms of type, frequency, extent, site and duration, and*
- *considered effective for the patient's illness, injury or disease; and not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.*

Chapter 3

The BlueCard® Program

Unit 5: Program Overview

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3.5 Introduction

Introduction

This unit describes the advantages of the program, and provides information to make filing claims easy. This manual offers helpful information about:

- Identifying members
- Verifying eligibility
- Obtaining pre-certifications/pre-authorizations
- Filing claims
- Who to contact with questions

For more information on BlueCard participation, please visit the BlueCard section of Chapter 3.1 in the Highmark Blue Shield Office Manual by hovering over Administrative Reference Materials on the Provider Resource Center.

BlueCard Participation

As a participating provider of Highmark Blue Shield you may render services to patients who are national account members of other Blue Plans, and who travel or live in Pennsylvania.

In Pennsylvania, the BlueCard networks include:

- Participating Provider network (supports all Blue Card programs for members that usually live outside their Blue Plan's service area with traditional, POS and HMO coverage.
- PremierBlue Shield network (supports the BlueCard PPO programs for members that usually live outside their Blue Plan's service area in a PPO plan).

3.5 What Is The BlueCard Program?

Definition

BlueCard is a national program that enables members of one Blue Plan to obtain healthcare service benefits while traveling or living in another Blue Plan's service area. The program links participating healthcare providers with the independent Blue Cross and Blue Shield Plans across the country and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

The program lets you submit claims for patients from other Blue Plans, domestic and international, to your local Blue Plan.

Highmark Blue Shield is your sole contact for claims submission, payment, problem resolution and adjustments.

BlueCard Program Advantages To Providers

The BlueCard Program lets you conveniently submit claims for members from other Blue Plans, including international Blue Plans, directly to Highmark Blue Shield. Highmark Blue Shield will be your one point of contact for all of your claims-related questions.

Highmark Blue Shield continues to experience growth in out-of-area membership because of our partnership with you. That is why we are committed to meeting your needs and expectations. In doing so, your patients will have a positive experience with each visit.

Accounts Exempt From The BlueCard Program

The following claims are excluded from the BlueCard Program:

- Stand-alone dental
- Prescription drugs and
- The Federal Employee Program (FEP)

***Please visit Chapter 5, Unit 2 of the Highmark Blue Shield Office Manual for more information on FEP.*

Please follow Highmark Blue Shield billing guidelines.

3.5 How The BlueCard Program Works

Member ID Cards

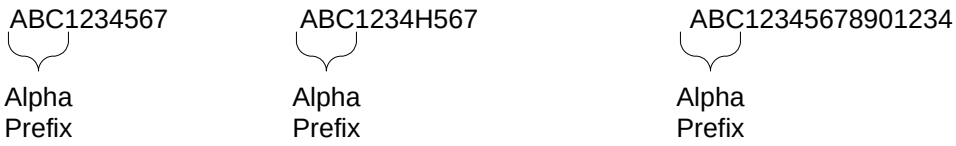
When members of Blue Plans arrive at your office, be sure to ask them for their current Blue Plan membership identification card.

The main identifier for out-of-area members is the alpha prefix. The ID cards may also have:

- PPO in a suitcase logo, for eligible PPO members
- Blank suitcase logo
- Important facts concerning member IDs:
  - A correct member ID number includes the alpha prefix (first three positions) and all subsequent characters, up to 17 positions total. This means that you may see cards with ID numbers between 6 and 14 numbers/letters following the alpha prefix.
  - Do not add/delete characters or numbers within the member ID.
  - Do not change the sequence of the characters following the alpha prefix.
  - The alpha prefix is critical for the electronic routing of specific HIPAA transactions to the appropriate Blue Plan.

Members who are part of the Federal Employee Program (FEP) will have the letter "R" in front of their member ID number.

Examples of ID numbers:



As a provider servicing out-of-area members, you may find the following tips helpful:

- Ask the member for the most current ID card at every visit. Since new ID cards may be issued to members throughout the year, this will ensure that you have the most up-to-date information in your patient's file.
- Verify with the member that the ID number on the card is not his/her Social Security Number. If it is, call the BlueCard Eligibility line 1.800.676.BLUE to verify the ID number.
- Make copies of the front and back of the member's ID card and pass this key information on to your billing staff.

Remember: Member ID numbers must be reported exactly as shown on the ID card and must not be changed or altered. Do not add or omit any characters from the member ID numbers.

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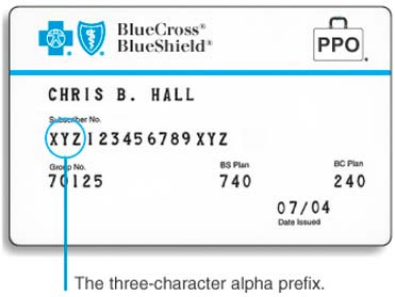
3.5 How The BlueCard Program Works, continued

Alpha Prefix

The three-character alpha prefix at the beginning of the member's identification number is the key element used to identify and correctly route claims. The alpha prefix identifies the Blue Plan or national account to which the member belongs. It is critical for confirming a patient's membership and coverage.

To ensure accurate claim processing, it is critical to capture all ID card data. If the information is not captured correctly, you may experience a delay with the claim processing. Please make copies of the front and back of the ID card, and pass this key information to your billing staff.

Do not make up alpha prefixes. Do not assume that the member's ID number is the social security number. As of 2006, nearly all Blue Plans have replaced Social Security numbers on member ID cards with an alternate, unique identifier.



The "suitcase" logo may appear anywhere on the front of the card.





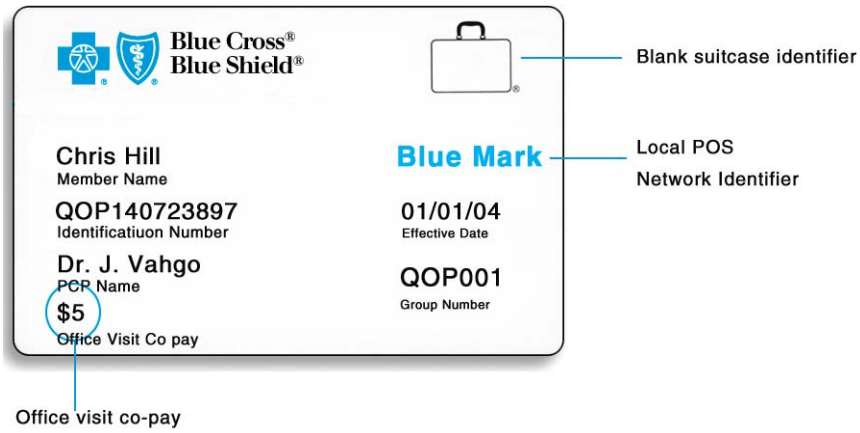
3.5 How to Identify BlueCard Managed Care/POS Members

How To Identify BlueCard Managed Care/POS Members

The BlueCard Managed Care/POS program is for members who reside outside their Blue Plan's service area. Unlike in the BlueCard PPO Program, in the BlueCard Managed Care/POS members are enrolled in Highmark Blue Shield network and have a primary care physician (PCP). You can recognize BlueCard Managed Care/POS members who are enrolled in the Highmark Blue Shield network through the member ID card as you do for all other BlueCard members.

The ID cards will include:

- The three-character alpha prefix at the beginning the member's ID number.
- A local network identifier and
- The blank suitcase logo



3.5 How To Identify International Members

Foreign Identification Cards

Occasionally, you may see identification cards from foreign Blue members. These ID cards will also contain three-character alpha prefixes. Please treat these members the same as domestic Blue Plan members.

NOTE: The Canadian Association of Blue Cross Plans and its members are separate and distinct from the Blue Cross and Blue Shield Association and its members in the U.S. Claims for members of the Canadian Blue Cross Plans are not processed through the BlueCard Program. Please follow the instructions of these Plans and those, if any, on their ID cards for servicing their members.

The Blue Cross Plans in Canada are:

Alberta Blue Cross	Atlantic Blue Cross Care	Saskatchewan Blue Cross
Manitoba Blue Cross	Quebec Blue Cross	Pacific Blue Cross

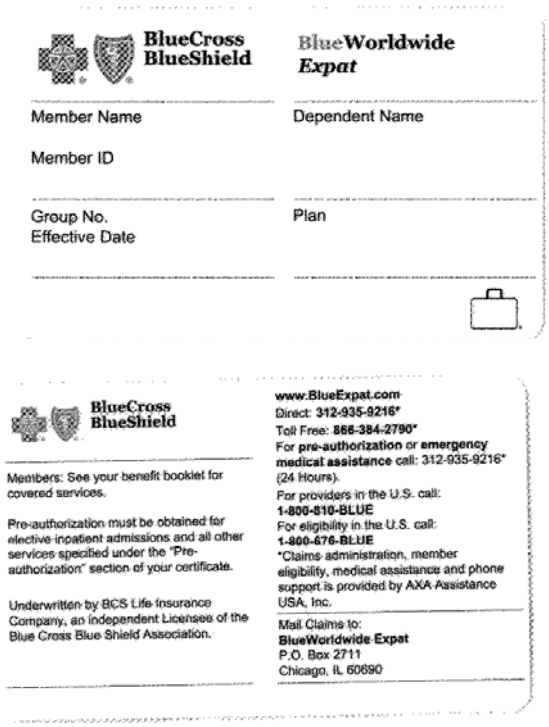
Sample Foreign Identification Card



Continued on next page

3.5 How To Identify International Members, Continued

Sample image of the U.S. Blue member's residing abroad card:



If you are unsure about your participation status, call Highmark Blue Shield.

3.5 Consumer Directed Health Care and Health Care Debit Cards

Overview

Consumer Directed Healthcare (CDHC) is a broad umbrella term that refers to a movement in the healthcare industry to empower members, reduce employer costs, and change consumer healthcare purchasing behavior.

Health plans that offer CDHC provide the member with additional information to make an informed and appropriate healthcare decision through the use of member support tools, provider and network information, and financial incentives.

Members who have CDHC plans often carry healthcare debit cards that allow them to pay for out-of-pocket costs using funds from their Health Reimbursement Arrangement (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA).

Some cards are "stand-alone" debit cards to cover out-of-pocket costs, while others also serve as a member ID card with the member ID number. These debit cards can help you simplify your administration process and can potentially help:

- Reduce bad debt
- Reduce paper work for billing statements
- Minimize bookkeeping and patient-account functions for handling cash and checks
- Avoid unnecessary claim payment delays

The card will have the nationally recognized Blue logos, along with the logo from a major debit card logo such as MasterCard® or Visa®.









3.5 Consumer Directed Health Care and Health Care Debit Cards, Continued

Card Details

The cards include a magnetic strip so that providers can swipe the card at the point of service to collect the member cost-sharing amount (i.e. copayment, deductible, etc.). With health debit cards, members can pay for other out-of-pocket expenses by swiping the card though any debit card swipe terminal. The funds will be deducted automatically from the member's appropriate HRA, HSA or FSA account.

Combining a health insurance ID card with a source of payment is an added convenience to members and providers. Members can use their cards to pay outstanding balances on billing statements. They can also use their cards via phone in order to process payments. In addition, members are more likely to carry their current ID cards, because of the payment capabilities.

If your office currently accepts credit card payments, there is no additional cost or equipment necessary. The cost to you is the same as the current cost you pay to swipe any other signature debit card.

Helpful Tips

- Carefully determine the member's financial responsibility before processing payment. You can access the member's accumulated deductible by using online electronic capabilities services or by contacting the BlueCard Eligibility line at 1.800.676.BLUE (2583).
- Ask members for their current member ID card and regularly obtain new photocopies (front and back) of the member ID card. Having the current card will enable you to submit claims with the appropriate member information (including alpha prefix) and avoid unnecessary claims payment delays.
- If the member presents a debit card (stand-alone or combined), be sure to verify the out of pocket amounts before processing payment:
  - Many plans offer well care services that are payable under the basic healthcare program. If you have any questions about the member's benefits or to request accumulated deductible information use electronic capabilities or, contact 1.800.676.BLUE (2583).
  - You may use the debit card for member responsibility for medical services provided in your office.
  - You may choose to forego using the debit card and submit the claims to Highmark Blue Shield for processing. The Remittance Advice will inform you of member responsibilities.
  - All services, regardless of whether or not you've collected the member responsibility at the time of service, must be billed to the local Plan for proper benefit determination, and to update the member's claim history.

Continued on next page

3.5 Consumer Directed Health Care and Health Care Debit Cards, Continued

Helpful Tips, continued

- If you have any questions about the member's benefits, check eligibility and benefits electronically or contact 1.800.676.BLUE (2583). For questions about the health care debit card processing instructions or payment issues, please contact the toll-free debit card administrator's number on the back of the card.

Coverage and Eligibility Verification

For other Blue Plans' members, submit an electronic inquiry to Highmark Blue Shield or call BlueCard Eligibility (1.800.676.BLUE) to verify the patient's eligibility and coverage:

- Electronic options:
  – Initiate a Blue Exchange inquiry from within NaviNet

- Submit a HIPAA 270 transaction (eligibility) to Highmark Blue Shield.

  You can receive real-time responses to your eligibility requests for out-of-area members between 7:00am and 1:00 a.m., Eastern Standard Time, Monday through Saturday.

- Phone—Call BlueCard Eligibility 1.800.676.BLUE (2583)
  - English and Spanish speaking phone operators are available to assist you.
  - Keep in mind that Blue Plans are located throughout the country and may operate on a different time schedule than Highmark Blue Shield. You may be transferred to a voice response system linked to customer enrollment and benefits.
  - The BlueCard Eligibility line is for eligibility, benefit and pre-certification/referral authorization inquiries only. It should not be used for claim status. See the Claim Filing section for claim filing information.

3.5 Utilization Review

Utilization Review

You should remind patients that they are responsible for obtaining pre-certification/ preauthorization for their services from their Blue Plan.

When the length of an inpatient hospital stay extends past the previously approved length of stay, any additional days must be approved. Failure to obtain approval for the additional days may result in claims processing delays and potential payment denials.

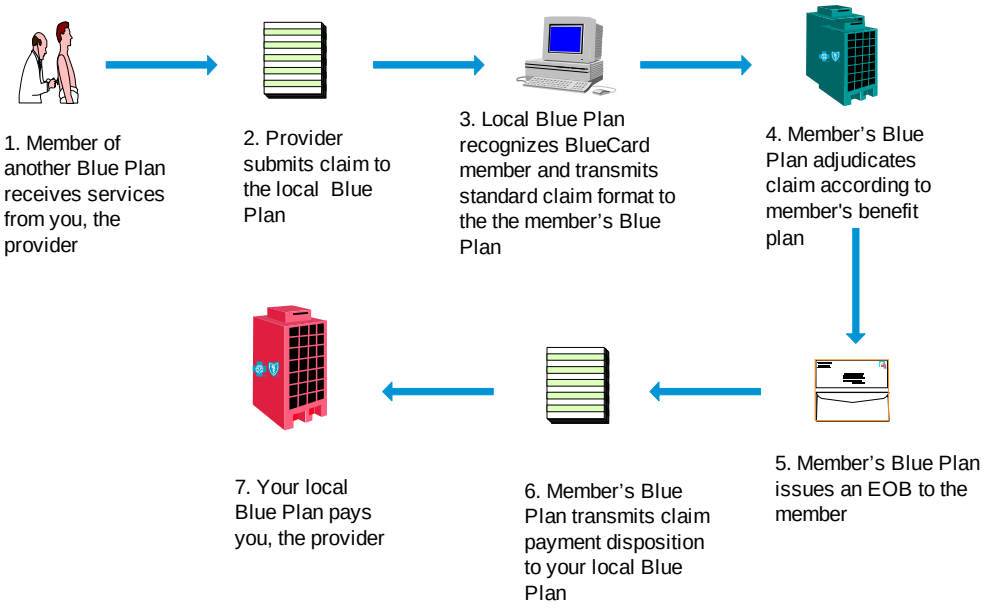
**You may also contact the member's Plan on the member's behalf for authorization. See pages 28-29 for more details.

The member's Blue Plan may contact you directly related to clinical information and medical records prior to treatment or for concurrent review or disease management for a specific member.

3.5 Claim Filing

How Claims Flow Through BlueCard

Below is an example of how claims flow through BlueCard.



NOTE: You should always submit claims to Highmark Blue Shield and use NAIC code 54771 as the payer code in the 837 Health Care Claim transaction.

Helpful Tips

Following these helpful tips will improve your claim experience:

- Ask members for their current member ID card and regularly obtain new photocopies of it (front and back). Having the current card enables you to submit claims with the appropriate member information (including alpha prefix) and avoid unnecessary claims payment delays.
- Check eligibility and benefits. See pages 28-29 for more details.
- Verify the member's cost sharing amount before processing payment.

Continued on next page

3.5 Claim Filing, Continued

Helpful Tips, continued

- Indicate on the claim any payment you collected from the patient.
  - On the 837 electronic claim submission form, check field AMT01=**F5** patient paid amount;
  - On the CMS1500 locator Box **29** amount paid; this is the total of patient and other payer(s) prior paid, not just patient prior paid.
- Submit all Blue claims to Highmark Blue Shield. Be sure to include the member's complete identification number when you submit the claim. This includes the three-character alpha prefix. Submit claims with only valid alpha-prefixes; claims with incorrect or missing alpha prefixes and member identification numbers cannot be processed.

International Claims

The claim submission process for international Blue Plan members is the same as for domestic Blue members. You should submit the claim directly to Highmark Blue Shield. See section on 'How to Identify Members' in this unit on servicing members of the Canadian Blue Cross Plans.

Coding

Code claims as you would for Highmark Blue Shield claims.

Adjustments

Contact Highmark Blue Shield if an adjustment is required. We will work with the member's Blue Plan for adjustments; however, your workflow should not be different.

- Search for the claim in question via the Claims Status Inquiry within NaviNet and then initiate an adjustment request via the Claims Investigation section.
- Non-NaviNet enabled providers should submit adjustments electronically via the HIPAA 837 transaction if your office system is capable.

Appeals

Appeals for all claims are handled through Highmark Blue Shield. We will coordinate the appeal process with the member's Blue Plan, if needed.

Appeals for out-of-area Medicare Advantage members are handled by the member's Blue Plan. Initiate your appeal by contacting the Customer Service phone number on the member's identification card.

Continued on next page

3.5 Claim Filing, Continued

Coordination Of Benefits

Coordination of benefits (COB) refers to how we ensure members receive full benefits and prevent double payment for services when a member has coverage from two or more sources. The member's contract language explains the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

If you discover the member is covered by more that one health plan, and:

- Highmark Blue Shield or any other Blue Plan is the primary payer, submit other carrier's name and address with the claim to Highmark Blue Shield. If you do not include the COB information with the claim, the member's Blue Plan will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your volume of bookkeeping.
- Other non-Blue health plan is primary and Highmark Blue Shield or any other Blue Plan is secondary, submit the claim to Highmark Blue Shield only after receiving payment from the primary payor, including the explanation of payment from the primary carrier. If you do not include the COB information with the claim, the member's Blue Plan will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your volume of bookkeeping.
- If you have not received payment for a claim, do not resubmit the claim because it will be denied as a duplicate. This also causes member confusion because of multiple Explanations of Benefits (EOBs). Highmark Blue Shield standard time for claims processing is Highmark Blue Shield's standard or policy. However, claim processing times at various Blue Plans vary.
- If you do not receive your payment or a response regarding your payment, please visit NaviNet or call Highmark Blue Shield Provider Service to check the status of your claim.

In some cases, a member's Blue Plan may pend a claim because medical review or additional information is necessary. When resolution of a pended claim requires additional information from you, Highmark Blue Shield may either ask you for the information or give the member's Plan permission to contact you directly.

Continued on next page

3.5 Claim Filing, Continued

Claim Status Inquiry

Highmark Blue Shield is your single point of contact for all claim inquiries. See pages 28-29 for details.

Calls From Members And Others With Claim Questions

If members contact you about a claim resolution, advise them to contact their Blue Plan and refer them to their ID card for a customer service number.

The member's Plan should not contact you directly regarding claims issues, but if the member's Plan contacts you and asks you to submit the claim to them, refer them to Highmark Blue Shield.

Key Contacts

For more information:

- Visit the Blue Card Information Center within the Provider Resource Center Web site
- Call Highmark Blue Shield
- Contact your provider relations representative

3.5 Special Considerations for Claims Filing

Claims Filing Tips for Border County Providers

Do you practice in a county bordering another state and have contracts with Blue Plans in your home state (based on your physical location) and the neighboring state? If so, you should file all claims with Highmark Blue Shield, based on where you provided the service, except when a member has coverage with the neighboring state's Blue Plan.

Below please find examples using various Plans that border our state. The examples would be the same regardless of which state you may border with.

Examples #1 of Border Plans

Example 1:

Provider has contracts with Blue Plans in two bordering states.

A provider is located in a Georgia county that borders Alabama and has contracts with Blue Plans in both states.

- When this provider renders a service to an Alabama member, the claim is filed with Alabama.
- All other claims are filed with Georgia.

Example #2 of Border Plans

Example 2:

Provider has a contract only with the local Plan in the home state.

A provider is located in a Georgia county that borders Alabama and has a contract only with Georgia.

- All claims are filed with Georgia.

3.5 Special Considerations for Claims Filing, Continued

Example #3 of Border Plans

Example 3:

Provider does not have a contract with the local Blue Plan in the home state, but has a contract with the Blue Plan in a neighboring state.

A provider is located in a Georgia county that borders Alabama. The provider doesn't have a contract with Georgia, but has a contract with Alabama.

- When this provider renders a service to an Alabama member, the claim is filed with Alabama.
- All other claims are filed with Georgia.

3.5 Medicare Advantage Claims

Overview

"Medicare Advantage" (MA) is the program alternative to standard Medicare Part A and Part B fee-for-service coverage (generally referred to as "traditional Medicare").

It offers Medicare beneficiaries several product options (similar to those available in the commercial market), including health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) and private fee-for-service (PFFS) plans.

All Medicare Advantage plans must offer beneficiaries at least the standard Medicare Part A and B benefits, but many offer additional covered services as well (e.g., enhanced vision and dental benefits).

In addition to these products, Medicare Advantage organizations may also offer a Special Needs Plan (SNP) which can limit enrollment to subgroups of the Medicare population in order to focus on ensuring that their special needs are met as effectively as possible.

Medicare Advantage plans may allow in-and out-of-network benefits, depending on the type of product selected. Providers should confirm the level of coverage by submitting an electronic inquiry or calling 1.800.676.BLUE (2583) for all Medicare Advantage members prior to providing service since the level of benefits, and coverage rules, may vary depending on the Medicare Advantage plan.

Types of Medicare Advantage Plans – Medicare Advantage HMO

Medicare Advantage HMO

A Medicare Advantage HMO is a Medicare managed care option in which members typically receive a set of predetermined and prepaid services provided by a network of physicians and hospitals. Generally (except in urgent or emergency care situations), medical services are only covered when provided by in-network providers. The level of benefits, and the coverage rules, may vary by Medicare Advantage plan.

Types of Medicare Advantage Plans – Medicare Advantage POS

Medicare Advantage POS

A Medicare Advantage POS program is an option available through some Medicare HMO programs. It allows members to determine—at the point of service—whether they want to receive certain designated services within the HMO system, or seek such services outside the HMO's provider network (usually at greater cost to the member). The Medicare Advantage POS plan may specify which services will be available outside of the HMO's provider network.

Continued on next page

3.5 Medicare Advantage Claims, Continued

Types of Medicare Advantage Plans – Medicare Advantage PPO

A Medicare Advantage PPO is a plan that has a network of providers, but unlike traditional HMO products, it allows members who enroll access to services provided outside the contracted network of providers. Required member cost-sharing may be greater when covered services are obtained out-of-network. Medicare Advantage PPO plans may be offered on a local or regional (frequently multi-state) basis. Special payment and other rules apply to regional PPOs.

Types of Medicare Advantage Plans – Medicare Advantage MSA

A Medicare Advantage MSA is a Medical Savings Account. This plan has two parts. The first part is a high-deductible Medicare Advantage MSA Health Plan. This health plan won't begin to pay covered costs until you have met the annual deductible, which varies by plan. The second part is a Medical Savings Account into which Medicare deposits money that the beneficiary may use to pay health care costs.

Types of Medicare Advantage Plans – Medicare Advantage PFFS

A Medicare Advantage PFFS plan is a plan in which the member may go to any Medicare-approved doctor or hospital that accepts the plan's terms and conditions of participation. Acceptance is "deemed" to occur where the provider is aware, in advance of furnishing services, that the member is enrolled in a PFFS product and where the provider has reasonable access to the terms and conditions of participation. The provider is considered by CMS to be 'deemed' when the provider has reviewed the Terms & Conditions for the member's plan and/or treated the member. *To view the PFFS Terms and Conditions, please select Medicare Advantage PFFS from the Administrative Reference Materials menu on the Provider Resource Center or visit the Appendix of the Highmark Blue Shield Office Manual.*

The Medicare Advantage organization, rather than the Medicare program, pays physicians and providers on a fee-for-services basis for services rendered to such members. Members are responsible for cost-sharing, as specified in the plan, and balance billing may be permitted in limited instances. The applicable instances are plan-specific.

Medicare Advantage PFFS varies from the other Blue products you might currently participate in:

- *You can see and treat any Medicare Advantage PFFS member without having a contract with Highmark.*
- *If you do provide services, you will do so under the Terms and Conditions of that member's Blue Plan.*

Continued on next page

3.5 Medicare Advantage Claims, Continued

Types of Medicare Advantage Plans – Medicare Advantage PFFS, *continued*

- *Please refer to the back of the member's ID card for information on accessing the Plan's Terms and Conditions. You may choose to render services to a MA PFFS member on an episode of care (claim-by-claim) basis.*
- *MA PFFS Terms and Conditions might vary for each Blue Cross and/or Blue Shield Plan and we advise that you review them before servicing MA PFFS members.*
- *For your convenience, effective January 1, 2008, you will find MA PFFS Terms and Conditions for all Blue Plans on the Provider Resource Center under Administrative Reference Materials by providing the member's three-letter alpha prefix*
- *Submit your MA PFFS claims to Highmark Blue Shield.*

Medicare Advantage Medical Savings Account (MSA)

Medicare Advantage Medical Savings Account (MSA) is a Medicare health plan option made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible. The other part is a special savings account where Medicare deposits money to help members pay their medical bills.

How To Recognize Medicare Advantage Members

Members will not have a standard Medicare card; instead, a Blue Cross and/or Blue Shield logo will be visible on the ID card. The following examples illustrate how the different products associated with the Medicare Advantage program will be designated on the front of the member ID cards:

MEDICARE ADVANTAGE | PPO

MEDICARE ADVANTAGE | MSA

MEDICARE ADVANTAGE | PFFS

MEDICARE ADVANTAGE | HMO

MEDICARE ADVANTAGE | POS

Continued on next page

3.5 Medicare Advantage Claims, Continued

Eligibility Verification	Verify eligibility by initiating a BlueExchange via NaviNet, submitting an electronic inquiry via HIPAA 270/271 transaction or by contacting 1.800.676.BLUE (2583) and providing an alpha prefix. Be sure to ask if Medicare Advantage benefits apply. If you experience difficulty obtaining eligibility information, please record the alpha prefix and report it to your Provider Relations Representative.
Medicare Advantage Claims Submission	Submit all Medicare Advantage claims to Highmark Blue Shield. Do not bill Medicare directly for any services rendered to a Medicare Advantage member. Payment will be made directly by a Blue Plan.
Reimbursement For Medicare Advantage PPO, HMO, POS	**No Plan Contract: Services for out-of-area and local Medicare Advantage members** [Situation below is where the provider does not have a contract with local Plan for MA and provides service to a local or out-of-area MA member.] Based upon the Centers for Medicare and Medicaid Services (CMS) regulations, if you are a Medicare participating professional provider who accepts Medicare assignment and you render services to a Medicare Advantage member for whom you have no obligation to provide services under your contract with a Blue Plan, you will generally be considered a non-contracted provider and CMS regulations require payment be made at the Medicare equivalent amount for covered services, (i.e. the amount you would collect if the beneficiary were enrolled in traditional Medicare). Special payment rules apply to hospitals and certain other entities (such as skilled nursing facilities) that are non-contracted providers. Providers should make sure they understand the applicable Medicare Advantage reimbursement rules. Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Plan or its branded affiliate. In general, you may collect only the applicable cost sharing (e.g., co-payment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member. **NOTE:** Enrollee payment responsibilities can include more than copayments (e.g., deductibles). Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility, and balance billing limitations.

Continued on next page

3.5 Medicare Advantage Claims, Continued

Plan Contract: Services For Local Blue Medicare Advantage Members

[Situation below is where the provider has a contract with the local Plan for MA and provides service to a local Blue MA member.]

If you are a provider who accepts Medicare assignment and you render services to a local Medicare Advantage member for whom you have an obligation to provide services under your contract with a Blue Plan, you will be considered a contracted provider and be reimbursed per the contractual agreement.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules and their individual Plan contractual arrangements.

Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Plan. In general, you may collect only the applicable cost sharing (e.g., co-payment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility, and balance billing limitations.

Plan Contract: Services For Out-Of-Area Medicare Advantage Blue Members

[Situation below is where the provider has a contract with the local Plan for MA and provides services for out-of-area Blue MA members.]

If you are a Medicare participating provider and have a Blue Plan contract to provide services for local Medicare Advantage enrollees only, and you render services to out-of-area Blue Medicare Advantage members, PPO, HMO, and POS members, you will be reimbursed for covered services according to the Medicare fee schedule at the Medicare allowed amount (i.e., the amount you would collect if the beneficiary were enrolled in traditional Medicare). Providers should make sure they understand the applicable Medicare Advantage reimbursement rules and their individual Plan contractual arrangements.

NOTE: Out-of-area Medicare Advantage HMO members are covered only for emergency services.

Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Plan. In general, you may collect only the applicable cost sharing (e.g. co-payment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility and balance billing limitations.

Continued on next page

3.5 Medicare Advantage Claims, Continued

Services For Out-Of-Area Blue Medicare Advantage PFFS Members

[Situation below is where the provider renders services for out-of-area MA PFFS members.]

If you have rendered services for a Blue out-of-area Medicare Advantage PFFS member, you will be reimbursed for covered services according to the Medicare fee schedule at the Medicare allowed amount (i.e., the amount you would collect if the beneficiary were enrolled in traditional Medicare). Providers should make sure they understand the applicable Medicare Advantage reimbursement rules.

Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Plan. In general, you may collect only the applicable cost sharing (e.g.. co-payment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility and balance billing limitations.

3.5 Traditional Medicare Related Claims

Traditional Medicare Related Claims

The following are guidelines for the processing of traditional Medicare-related claims:

- When Medicare is primary payor, submit claims to your local Medicare carrier or intermediary.
- It is not necessary for you to file the secondary claim to Highmark Blue Shield because Highmark has established a nationally standard contract with CMS that defines the criteria for transmitting enrollee eligibility data and Medicare adjudicated claim data. CMS will transfer the claims crossover functions from individual Medicare contractors to a national claims crossover contractor, the Coordination of Benefits Contractor (COBC). This consolidation will allow for the establishment of unique identifiers (COBA IDs) to be associated with each contract and create a national repository for COBA information
- If you use Other Carrier Name and Address (OCNA) number on a Medicare claim, ensure it is correct for the member's Blue Plan. Do not automatically use the OCNA number for Highmark Blue Shield or create an OCNA number of your own. In addition, do not create alpha prefixes. For an electronic HIPAA 835 (Remittance Advice) request on Medicare-related claims, contact Highmark Blue Shield.
- Do not send duplicate claims.

3.5 Medical Records Requests

Medical Records Requests

There are times when the member's Blue Plan will require medical records to review the claim. These requests should come from Highmark Blue Shield. Please forward all requested medical records to Highmark Blue Shield and we will coordinate with the member's Blue Plan. Please direct any questions or inquiries regarding medical records *to Highmark Customer Service at 1-866-731-8080.*

IMPORTANT: Please do not proactively send medical records with the claim, unless requested. Unsolicited claim attachments may cause claim payment delays.

3.5 BlueCard Quick Tips

BlueCard Quick Tips

The BlueCard Program provides a valuable service that lets you file all claims for members from other Blue Cross and/or Blue Shield Plans with your local Plan.

Here are some key points to remember:

- Make a copy of the front and back of the member's ID card.
- Look for the three-character alpha prefix that precedes the member's ID number on the ID card.
- Consider electronic means first for eligibility inquiries:
    - Submit a BlueExchange inquiry via NaviNet
    - Submit a HIPAA 270 transaction to Highmark
- Or, call 1-800-676-BLUE
    - English and Spanish operators are available
    - Because of the time zone difference coast to coast, you may sometimes reach a voice response system linked to enrollment and benefits
- Submit the claim to Highmark Blue Shield using NAIC code 54771. Always report the patient's complete identification number, which includes the three-character alpha prefix.

Consider electronic means first for claims inquiries:

- BlueCard claims can often be found within the claims status inquiry transaction within NaviNet (remember to enter the entire identification number including the alpha prefix)
- Submit a BlueExchange inquiry via NaviNet.
- Initiate a HIPAA 276 transaction to Highmark

Consider electronic means first for utilization review inquiries:

- Submit a BlueExchange inquiry via NaviNet.
- Submit a HIPAA 278 transaction to Highmark
- Or, call 1-800-676-BLUE

Ask to be transferred to the Utilization Review area

3.5 How to Inquire About Eligibility, Benefits, Claims and Submit Authorization Requests for BlueCard Members

Highmark Blue Shield Is Your One-Stop Shop

Provider satisfaction is our top priority. We understand you need the right tools and resources to provide the best care to Blue members, so to help you obtain information for both our members and out-of-area Blue members there are several options available to assist you with administrative processes. Always look to Highmark Blue Shield first when you need help with information about out-of-area members.

Electronic Transactions Preferred

Because of the inherent speed and cost-effectiveness, electronic transactions and online communications are integral to today's business world. Electronic transactions between health care professionals and insurers are essential to maintain efficiency and are, in fact, encouraged by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

NaviNet

To view out-of-area claims electronically you must use the alpha-prefix in addition to the member's identification number.

Electronic eligibility, benefits, and authorizations for out-of-area members are available only via the Blue Exchange transactions initiated within NaviNet.

BlueExchange

BlueExchange simplifies your exchanges for out-of-area members using HIPAA-compliant transactions. The Blue Cross Blue Shield Association developed BlueExchange as a gateway for routing inquiries about out-of-area members between providers and the member's Blue Plan. BlueExchange transactions submitted through Highmark Blue Shield are routed to the member's Blue Plan based on the alpha prefix.

There are three primary types of inquiries that can be routed via BlueExchange: Eligibility and Benefits, Claim Status, and Authorization Requests. Each of these transactions can be initiated within NaviNet. Look for the "BlueExchange (Out-Of-Area) selections from the dropdown menu; you will see a fly-out with each individual selection.

Use Blue Exchange claims status inquiry to search for out-of-area Medicare cross-over claims or those filed directly to the home plan.

Continued on next page

3.5 How to Inquire About Eligibility, Benefits, Claims and Submit Authorization Requests for BlueCard Members,
Continued

HIPAA Transactions

The following transactions can be submitted to Highmark Blue Shield for out-of-area members via your practice management software if your office has this capability:

- 270 for eligibility and benefits
- 276 for claim status
- 278 for utilization review

Highmark Blue Shield will route both the inquiry and response transactions between you and the member's Blue Plan via BlueExchange.

Toll-Free Number Also Available

Call BlueCard Eligibility 1-800-676-BLUE (2583).

- English and Spanish speaking phone operators are available to assist you.
- Keep in mind that Blue Plans are located throughout the country and may operate on a different time schedule that Highmark Blue Shield. You may be transferred to a voice response system linked to customer enrollment and benefits.

The BlueCard Eligibility line is only for:

- Eligibility
- Benefit
- Pre-certification/referral authorization inquiries

This number should not, however, be used for claim status.

3.5 BlueCard Provider Surveys

Tell Us What You Think!

One of our top goals is to keep Blue members and providers satisfied with the service we provide. To help us evaluate our performance and assess your satisfaction with the BlueCard Program, two provider surveys are conducted each year. If your office is contacted by the research vendor, we encourage you to participate. The vendor will ask to speak with a staff member who has broad knowledge of BlueCard claims filing and/or billing.

Your feedback helps us focus on the initiatives that make a difference to you.

Chapter 3

Products, Networks, and Payment

Unit 6: Medicare Advantage HMO, PPO and PFFS Products

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3.6 Medicare Advantage Overview

Introduction

In an effort to make broader and more cost-effective coverage options available to people eligible for Medicare, the Centers for Medicare and Medicaid Services (CMS), formerly known as Health Care Financing Administration (HCFA), created "Medicare Part C."

This term includes a wide variety of delivery models – including Preferred Provider Organizations (PPOs) –, which serve as replacements for Traditional Medicare. All of these models are funded through a combination of payments from the Medicare program and the member's premium. Such plans were originally known as "Medicare+Choice" plans but now are called "Medicare Advantage" programs.

The cornerstone of the program is the network:

- When members receive covered services from **network** providers, those services are paid at the higher level defined in the benefit contract. (Some services require a copayment or coinsurance even when rendered by a network provider.)

- PPO members can still receive most covered services from non-network providers, but if they choose to do so, they are responsible for a greater share of the financial responsibility for the services. Coverage is generally at the lower level of coverage as defined in the benefit contract after the member has met his or her annual non-network deductible. The HMO product requires use of in-network providers – except for urgent/emergent care out of network.

To be included in a Medicare Advantage provider network, a provider must participate in the Medicare program itself.

Medicare Advantage Benefits

At a minimum, Medicare Advantage programs such as FreedomBlue PPO are required to provide coverage for the services covered by Traditional Medicare. They may also provide additional services and benefits.

Highmark offers three Medicare Advantage products.
For more information on Medicare Advantage Products, please visit Members section of www.highmark.com.

1. Western Region Medicare Advantage HMO
   Central and Northeastern Medicare Advantage PPO

2. Western Region Medicare Advantage HMO Product Description

3. Western Region FreedomBlue Private Fee-for-Service (PFFS)
   Central and Northeastern FreedomBlue Private Fee-for-Service (PFFS)

Continued on next page

3.6 Medicare Advantage Overview, Continued

FreedomBlue PPO

FreedomBlue PPO offers its members additional benefits and services beyond those covered by the Medicare program. These include preventive services, routine dental and vision care and prescription drugs.

To enroll in FreedomBlue PPO, a member must have both Medicare Part A and B and must reside in the 40-county service area. Effective January 1, 2008 however, Highmark FreedomBlue PPO will be expanded to 62 counties including all Pennsylvania counties excluding Bucks, Chester, Delaware, Montgomery, and Philadelphia. Additionally, the member cannot have end stage renal disease at the time of enrollment, unless he or she is a current member of a Highmark commercial product.

What Region Am I?

Out-Of-Service Area Benefit

An out-of-area benefit applies to the FreedomBlue PPO product. Members have access to covered services out-of-network, both in area and out-of-area. Members are responsible for paying any applicable cost sharing for covered services. Renal dialysis services are covered at 100%, on a temporary basis, while outside the 40-county service area. Effective January 1, 2008 this service area will be expanded to a 62-county service area, including all Pennsylvania counties excluding Bucks, Chester, Delaware, Montgomery, and Philadelphia.

Western Region Medicare Advantage PPO *(Western Region Only)*

Western Region Only:
Western Region Medicare Advantage HMO coverage replaces Medicare coverage; however, Western Region Medicare Advantage HMO members may retain their Medicare card while they are covered under the Western Region Medicare Advantage HMO. To enroll in Highmark's Western Region Medicare Advantage HMO, a member must have both Medicare Part A and B and must reside in the 17-county Western Region service area.

A Western Region Medicare Advantage HMO member must show his or her identification card to receive services. Services cannot be paid by traditional Medicare while the person is a member of a Western Region Medicare Advantage HMO, except for services incurred during a hospice election period and routine costs associated with clinical trails paid by Medicare.

Continued on next page

3.6 Medicare Advantage Overview, Continued

FreedomBlue Private Fee-For-Service

Effective January 1, 2008, Highmark Blue Shield began offering another Medicare Advantage plan option – Private Fee-for-Service. FreedomBlue PFFS provides Medicare Parts A and B benefits, as well as routine vision/hearing and SilverSneakers®. As a non-network plan, FreedomBlue PFFS does not require a contract making it different than Highmark's FreedomBlue PPO product.

Members can:

- see any licensed professional provider that has or is eligible for a Medicare billing number, has not opted out of the original Medicare program, and accepts FreedomBlue's PFFS terms and conditions of participation.

- be treated at any Medicare-certified facility that accepts FreedomBlue PFFS terms and conditions of participation

Providers are not required to see FreedomBlue PFFS and elect to do so on a per service basis. If you do provide services, you do so under the terms and conditions of that member's plan.

Becoming A Deemed Provider Under FreedomBlue FFS

Providers, both Medicare participating and nonparticipating, are considered deemed when they meet the following conditions:

1. Are aware in advance that the patient is a FreedomBlue PFFS member. All FreedomBlue PFFS members receive an identification card that includes the FreedomBlue PFFS logo to help identify them as PFFS members.

2. Have a copy of or reasonable access to FreedomBlue PFFS's terms and conditions of participation.

3. Provide services covered by FreedomBlue to a FreedomBlue PFFS member.

Continued on next page

3.6 Medicare Advantage Overview, Continued

Highmark's Compliance Commitment To CMS Regulations

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

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

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

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

3.6 Medicare Advantage Medical Policy

Medical Policy Overview

CMS requires that Medicare Advantage plans utilize Medicare medical policy or local Highmark policy when Medicare national or local policy does not exist.

Therefore, Highmark developed Medicare Advantage medical policies which are used to process Medicare Advantage claims. Processing guidelines may be added to the Medicare Advantage medical policy.

When appropriate, Highmark's medical policy guidelines are used for the Medicare Advantage products and are referred to as gap-fill policies. Gap-fill policies are generally used in the following instances:

- Where CMS or Highmark Medicare Services do not have a medical policy for a particular service, or,
- The existing CMS or Highmark Medicare Services policy is not appropriate for the Medicare Advantage products

Both Medicare Advantage and Highmark's medical policy guidelines have been integrated into the claims processing system, allowing for cost effective claims processing and ensuring consistent, accurate administration of our customers' health care benefits.

Medicare Advantage medical policies are located on the Provider Resource Center.

Required Terms For Medicare Advantage Plans

The Appendix of the Highmark Blue Shield Office Manual contains a complete listing of the required Medicare Advantage compliance terms that may be included in Highmark's policies and procedures. Highmark's providers are required to comply with all such provisions, including, but not limited to, taking all necessary actions as may be specifically noted or such actions as may be required and requested by Highmark Inc. or Highmark's networks as applicable.

Please select Medicare Advantage Compliance Language from the Office Manual's Table Of Contents, and then select the appropriate region for your line of business.

3.6 Identifying Medicare Advantage Members with End Stage Renal Disease (ESRD)

Definition

End stage renal disease (ESRD) is permanent kidney failure that requires kidney dialysis or a transplant to maintain life. Medicare beneficiaries generally cannot join FreedomBlue PPO if they have this condition. However, if they develop this condition while they are FreedomBlue PPO members, they will continue to be enrolled. It is important to identify all members with ESRD as soon as possible to ensure adequate treatment. Your role in identifying members with ESRD is crucial.

Policy

When a FreedomBlue PPO or Western Region Medicare Advantage HMO patient is determined to have chronic kidney failure and receives treatment in a Medicare-approved dialysis center or receives a kidney transplant, the attending physician should help the dialysis center complete an *ESRD Medical Evidence Report*, CMS-2728-U3. It takes approximately four months for the CMS-2728-U3 forms to be processed through all systems in order to set up the initial record and pay appropriate reimbursement rates for members with ESRD. **However, it is the responsibility of the patient's dialysis center to send completed CMS-2728-U3 forms to the ESRD Networks in a timely manner.**

Procedure

Step	Action
1	The physician ordering dialysis contacts the dialysis center.
2	The dialysis center is responsible for submitting the original copy of the completed CMS-2728-US to the servicing Social Security office. The dialysis center also submits copies of and is responsible for verifying the information on the form and resolving any questionable items before sending the information to the ESRD networks who transmit the information to CMS.
3	The information that CMS receives from the ESRD Networks is documented in CMS's Group Health Plan system (GHP), which is responsible for assigning ESRD status.

3.6 Advising Medicare Advantage Members Of Their Rights As Inpatients At Discharge

Update To Policy

Effective July 2, 2007, the policy for notifying Medicare Advantage inpatients of their rights at discharge has changed. Under the new notification process, acute care facilities are required to give all Medicare and Medicare Advantage inpatients a revised "Important Message From Medicare" no later than two days after admission to the inpatient level of care. The member will need to sign and date the Important Message to indicate that he or she received and understood it. The hospital must then provide the member with the signed Important Message and retain a copy of the signed document in the member's medical record.

Definition

Medicare Advantage plans must notify their members of their Medicare appeal rights at or near the time of a hospital or facility discharge

Procedure

Step	Action
1	Give all Medicare Advantage inpatients the 'Important Message From Medicare at or near the time of admission, but no later than two days after admission to the inpatient level of care.
2	Provide a follow-up signed copy of the Important Message From Medicare to all Medicare Advantage patients (or, if necessary, to their representative) prior to discharge, but no more than 2 days before discharge and retain a copy of the signed document in the member's medical record or in some other location/format, in order to be able to demonstrate that the requirement was met.

Continued on next page

3.6 Advising Medicare Advantage Members Of Their Rights As Inpatients At Discharge, Continued

Additional Steps For Patients Requesting an Expedited Review

This component of the procedure applies only to patients who wish to initiate an expedited review of the discharge decision.

Step	Action
1	Member must call Quality Improvement Organization (QIO) as directed on the 'Important Message From Medicare.'
2	QIO will notify the facility to forward relevant records and complete and deliver the Detailed Notice. The QIO will also notify Highmark that the request was received.
3	The facility will deliver the Detailed Notice to the member no later than noon of the day after the facility is notified of the review request. This notice provides the member with the clinical and coverage reasons why the member's physician has determined that the level of care is no longer reasonable or medically necessary. The member is not required to sign this document.

If the member decides to accept the discharge, he or she leaves the facility and goes home or to an alternative level of care.

If the member disagrees with the discharge decision, he or she has until midnight on the day of the scheduled discharge (while he or she is still an inpatient) to decide to pursue an appeal (reconsideration). If the member decides to pursue the appeal additional steps would take place.

Continued on next page

3.6 Advising Medicare Advantage Members Of Their Rights As Inpatients At Discharge, Continued

Definition Of Medically Necessary

Services or supplies that are: proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for your convenience of that of your doctor.

If The Member Disagrees With The Appeal Decision

This component of the procedure applies only to patients who disagree with the discharge decision.

Step	Action
1	If the patient disagrees with the discharge decision, no later than midnight on the day of discharge the patient or authorized representative contacts the QIO.
2	The QIO notifies the facility and Highmark of the request to review.
3	No later than noon of the day after the QIO notification, the facility forwards all the information the QIO needs for the review. The facility also prepares and delivers to the patient or representative and the QIO a completed 'Detailed Notice of Discharge'.
4	No later than 1 day after receiving all the necessary information the QIO completed its review and communicates its decision to the member, facility and the health plan.

If The Member Disagrees With The Appeal Decision

The member must be able to understand the purpose and contents of the notice in order to be able to sign indicating receipt. The member may also appeal this discharge decision.

For More Information

Please contact Pennsylvania QIO at www.qipa.org or call Provider Service at:

Western Region Medicare Advantage HMO: 1-800-517-8585
FreedomBlue: 1-866-588-6967

Where Can I Get Forms?

A current copy of the Important Message From Medicare is available on CMS' website at:

http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp

3.6 Advance Directives

Definition

An advance directive is a written document prepared by a patient that indicates how they would want future health care decisions to be made if they are unable to make decisions. An advance directive can tell physicians and family members what life-sustaining treatments one does or does not want at some future time if one becomes incapable of making or communicating treatment decisions.

An essential component of the advance directive is the selection of a person to make health and personal care decisions for one who lacks sufficient capacity to make or communicate choices.

Policy

PCPs must ask Medicare Advantage program members whether they have executed an advance directive and selected a surrogate. PCPs must then review the advance directive and determine their role as described in the procedure below. Advance directive discussions must be documented in a prominent place in the medical record. A copy of the executed advance directive must be placed in a prominent part of the medical record.

Monitoring

During an office site visit, a nurse from the Quality Management department will review medical records to determine whether:

- Discussion of the advance directive with the member is documented in a prominent part of the medical record.
- A copy of the advance directive, signed by the member and physician, is on file, if applicable.

Clinical studies may also be conducted to evaluate ongoing use and discussion of advance directives.

Procedure

Step	Action
1	Ask the member whether he or she has executed an advance directive. Document the response in the member's chart. If the member *has completed* an advance directive, go to step 2. If the member *has not completed* an advance directive, initiate a discussion about completing an advance directive and selecting a surrogate decision-maker. Document the discussion in the member's chart. Process complete.

Continued on next page

3.6 Advising Medicare Advantage Members Of Their Rights As Inpatients At Discharge, Continued

Step	Action
2	Review the advance directive. If you *are willing* to honor the request as it is written, document the discussion and place a copy of the advance directive in a prominent part of the member's medical record. Process complete. If you *are not willing* to honor the request as it is written, document the discussion in a prominent part of the member's chart and go to step 3.
3	If possible, notify the member of the decision not to honor the advance directive. Member Services will make every effort possible to place the member with another provider who is able to honor the member's wishes.

3.6 Expedited Review of Initial Determination and Appeals Policy

Policy

Physicians should be knowledgeable about the expedited review of initial determination and appeals processes for FreedomBlue and Highmark's Western Region Medicare Advantage HMO products. Although these processes are largely member-driven, the physician may represent the member and initiate the expedited review. Also, the physician is responsible for the crucial role of providing requested medical records on a timely basis.

When asking for an expedited review, the enrollee or the physician must submit either an oral or written request directly to the organization responsible for making the determination. The physician may also provide oral or written support for an enrollee's own request for an expedited determination.

Background

The Centers for Medicare and Medicaid Services (CMS) requires all Medicare Advantage programs to implement processes for member-initiated expedited review of initial determination and appeal processes. As a Medicare Advantage program, FreedomBlue and Highmark's Western Region Medicare Advantage HMO have implemented expedited review of initial determination and appeal processes for members.

Highmark must automatically provide an expedited determination to any request made or supported by a physician. The physician must indicate either orally, or in writing, that applying the standard time for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. The physician need not be appointed as the enrollee's authorized representative in order to make the request.

Expedited Review Rights

Members of Medicare Advantage programs, or their representatives, may request a 72-hour expedited review of a service if they believe the member's health, life or ability to regain maximum function may be jeopardized by waiting for the standard review process.

In accordance with CMS guidelines, members may request the initial expedited review without speaking to the PCP first.

What These Processes Do Not Apply To...

The expedited review of initial determination and appeal process does not apply to claim denials if services have already been received. Members or providers may appeal claims denials through their respective standard appeal processes.

Continued on next page

3.6 Expedited Review of Initial Determination and Appeals Policy, Continued

Your Role	You may be contacted by an HMS care manager or physician advisor to supply a copy of the member's medical records in the case of an expedited review. If so, you must supply the records immediately. Additionally, if you are contacted for information by a physician advisor about an expedited appeal, you must return his or her call by 8 a.m. the following day. Failure to do so could result in corrective action and/or sanctioning.
Appealing On Behalf Of A Member	You or a treating physician may wish to initiate an appeal on behalf of a Medicare Advantage member if you believe services are medically necessary and covered under the member's benefit plan. If you choose to initiate the appeal on behalf of the member, then the appeal is automatically considered an expedited appeal.
If A Denial Decision Is Upheld	If a denial decision is upheld, the network is required to forward the case to the CMS appeals contractor within 24 hours of the decision. The appeals contractor may request additional information. In such cases, a Medicare Advantage appeals administrator may contact your office for additional information. If you are contacted, please respond to the request immediately.

3.6 Expedited Review of Initial Determinations and Appeals Procedure

Introduction

The information below is intended to help you understand the expedited review process for Medicare Advantage members.

Note: Appeal administrators will automatically forward member appeals that do not meet expedited review criteria through the standard appeal process.

Expedited Review Process

The table below explains how the expedited review process for Medicare Advantage members works:

Step	Who does it	What happens
1	Member or treating physician	Decides to pursue an expedited initial determination or expedited appeal.
2	Member	Does member want to pursue the review or the appeal or appoint someone as a representative? If the member is pursuing the review, go to step 4. If the member is appointing a representative, go to step 3.
3a OR 3b	Member Or Physician An appointed representative	3a. For expedited appeals the member or the physician does not require a representative statement to make a request. Members or physicians may request an expedited appeal by phone, fax or by mail. If the request does not meet expedited criteria, it will be processed as a standard appeal and then a representative statement will be requested for a physician or other appointed representative request only. 3b. The appointed representative may submit a Representative Statement Document by following instructions located on the form directly or sending a written equivalent. Both member and representative must sign the document. Fax or mail the signed document to the contact information in step 4.
4	Member or appointed representative	Contacts the Expedited Review department at: 1-800-485-9610 May send a physician's statement supporting the urgent need for services to: Fax: 1-800-894-7947 Mail: Expedited Review Department P.O. Box 535073 Pittsburgh, PA 15253-5073

Continued on next page

3.6 Expedited Review of Initial Determinations and Appeals Procedure Procedure, Continued

Expedited Review Process **(continued)**

Stage	Who does it	What happens
5	HMS care manager and/or physician advisor	Investigates the review. (The 72-hour period begins upon receipt of this request.) Is there enough information to render a decision? If yes, go to step 7. If no, request additional information from provider of care and go to step 6.
6	Care provider	Forwards member's medical records to care manager or physician advisor.
7	HMS care manager and/or physician advisor	Renders decision. Notifies member by telephone and letter. Notifies physician.

Where Can I Get Forms

A current copy of the Representative Statement Form is available under the CMS' forms section of the CMS website at:

http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf

3.6 DME/Respiratory Supplies Management Program

Overview

The DME/Respiratory Supplies Management Program requires that specific items be authorized for all Medicare Advantage program members by DMEnsion, Inc. (formerly Wright & Filippis), a nationally recognized DME company that supports Highmark's efforts by administrating utilization management, claims processing and provider support.

DME Not Requiring Authorization

DME that does not require authorization simply requires a prescription written by the ordering physician.

DME Requiring Authorization

Physicians should contact DMEnsion, Inc. (formerly Wright & Filippis) or HMS to request authorization for DME and supplies furnished through a stand-alone, Highmark Ancillary DME, prosthetics and orthotics supplier for the items listed in the Procedures/DME that Require Authorization list. The Procedures/DME that require authorization can be found on the Provider Resource Center under Administrative Reference Materials.

Authorization Requirements Vary By Product

The DME/Respiratory Supplies Management Program requires that specific items be authorized for all HMO and Medicare Advantage HMO and PPO program members by DMEnsion, Inc. (formerly Wright & Filippis), a nationally recognized DME company that supports the network's efforts by administrating utilization management, claims processing and provider support. For all other members, these items should be authorized through HMS Care Management.

What Region Am I?

For these products…	Authorization is through…
Western Region HMO Medicare Advantage HMO (Western Region Only) FreedomBlue PPO	**DMEnsion, Inc. (formerly Wright & Filippis)**
DirectBlue (group)	**HMS Care Management**
DirectBlue (individual) PreferredBlue PPOBlue EPOBlue	**No authorization required**

3.6 Authorizing DME, Prosthetics, Orthotics, and Respiratory Supplies for Medicare Advantage HMO and PPO Products

Applicable Products

This program applies to all HMO and Medicare Advantage HMO and PPO Products.

Process

The steps listed below describe the process to obtain authorization for durable medical equipment, prosthetics, orthotics, and respiratory equipment.

Step	Action
1	The ordering physician determines whether the request must be sent to DMEnsion, Inc. (formerly Wright & Filippis).
2	If required, the ordering physician submits the request for authorization to DMEnsion, Inc. (formerly Wright & Filippis) through one of the following methods: • Submit the request through NaviNet℠. • Fax an authorization request form to 1-248-844-8614. • Mail an authorization request form to: DMEnsion, Inc. P.O. Box 81460 Rochester Hills, MI 48308-1460 • Call DMEnsion, Inc. (formerly Wright & Filippis) at 1-877-345-4774.
3	DMEnsion, Inc. (formerly Wright & Filippis) will review the request for benefits, eligibility, prior utilization, diagnosis, etc. • If benefits are not available, go to step 4. • If medical appropriateness cannot be determined, go to step 5. • If the request is approved, go to step 8.
4	If benefits are not available for the requested item or service, DMEnsion, Inc. (formerly Wright & Filippis) will deny the authorization request and an explanation letter from Highmark will be sent to the ordering physician and the member. Proceed to Step 9.

Continued on next page

3.6 Authorizing DME, Prosthetics, Orthotics, and Respiratory Supplies for Medicare Advantage HMO and PPO Products,
Continued

Process, (continued)

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>5</td><td>If medical appropriateness cannot be determined from the documentation provided by the ordering physician, DMEnsion, Inc. (formerly Wright & Filippis) will contact the ordering physician for additional information. This information must be returned to DMEnsion, Inc. (formerly Wright & Filippis) within 48 hours or the request may be voided and must be resubmitted. Proceed to step 6.</td></tr>
<tr><td>6</td><td>If the documentation does not substantiate the request, the authorization request is denied and an explanation from Highmark will be sent to the ordering physician and member. If medical necessity cannot be determined, the authorization request is pended and sent to the Highmark Physician Advisor Office for review. Proceed to step 7.

If the documentation substantiates the request, proceed to step 8.</td></tr>
<tr><td>7</td><td>If the Highmark Physician Advisor Office determines that the authorization
<table>
<tr><th>Is medically appropriate</th><th>Is not medically appropriate</th></tr>
<tr><td>DMEnsion, Inc. (formerly Wright & Filippis) will approve the pended authorization
Proceed to step 8</td><td>Highmark will send a denial letter to the PCP and the member and instruct DMEnsion, Inc. (formerly Wright & Filippis) to deny the pended authorization.
Proceed to step 9</td></tr>
</table></td></tr>
<tr><td>8</td><td>DMEnsion, Inc. (formerly Wright & Filippis) gives the ordering physician the appropriate HCPCS codes and the authorization number.</td></tr>
</table>

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3.6 Authorizing DME, Prosthetics, Orthotics, and Respiratory Supplies for Medicare Advantage HMO and PPO Products, Continued

Process (continued)

Step	Action
9	The ordering physician receives the completed authorization (approved or denied) and communicates the information to the DME, respiratory, prosthetic, or orthotic network participating supplier.
10	If the supplier believes that the equipment or supplies authorized by the ordering physician are inadequate, the supplier must contact the PCP to correct the previous authorization. The supplier may contact DMEnsion, Inc. (formerly Wright & Filippis) to make adjustments to the original request or provide additional information as long as the authorized benefits do not change. This can be done through one of the following methods: • Fax an authorization request form to 1-248-844-8614. • Call DMEnsion, Inc. (formerly Wright & Filippis) at 1-877-345-4774 (1-877-FILIPPI). The supplier must provide patient information and the reason the original order is inappropriate.

3.6 Submitting Claims for DME, Prosthetics, Orthotics, and Respiratory Equipment Authorized through DMEnsion, Inc.

Submitting Claims

The steps listed below describe the process for submitting claims.

Step	Action
1	The DME supplier submits the claim to DMEnsion, Inc. (formerly Wright & Filippis) on a CMS-1500 form by mailing it to: DMEnsion, Inc. P.O. Box 81460 Rochester Hills, MI 48308-1460
2	DMEnsion, Inc. (formerly Wright & Filippis) verifies benefits eligibility and authorization and processes the claim.
3	The check and remittance are sent to the supplier (or member, if appropriate).
4	Claim information is sent to Highmark for administrative purposes and historical record.

3.6 Pre-Service Denials for Medicare Advantage Products

Definition

A pre-service denial occurs when a physician tells a member that a specific requested service cannot be provided or continued due to lack of medical necessity or because the service is a non-covered benefit.

If the member accepts the physician's decision, this is not a pre-service denial. However, if the member continues to request the service, a pre-service denial has occurred.

Background

The Centers for Medicare & Medicaid Services (CMS) requires all contracting Medicare Advantage programs and their physicians to advise members of their right to appeal any denial of a service to which they believe they are entitled.

Policy

All Medicare Advantage HMO and Medicare Advantage PPO members have the right to appeal a pre-service denial and to be informed in a timely manner of their right to appeal an adverse decision. CMS requires that all Medicare Advantage programs must comply with pre-service denial regulations.

Pre-Service Denials After The Member Leaves The Office

If the member agrees with the physician's decision not to supply the service at the time of the visit, **but later reconsiders** and decides that he or she wants to have the service, this is a pre-service denial.

If the member calls the physician's office to communicate this disagreement, the physician's office must send a pre-service denial notice generated from the practice and a statement of member appeal rights to the member within one business day. However, if the member calls Member Services instead, a Highmark representative will issue a statement of member appeal rights to the member.

New Members Who Have Never Been Seen At The Office

If a Medicare Advantage HMO or PPO member, who has never been examined by the physician, telephones and requests a service, the physician has the right to ask the member to come for an office visit. If the member refuses, this does not constitute a pre-service denial because the member is not following the plan's rule that members must coordinate all non-urgent, non-emergent care. If the member is not in agreement, the physician should advise the member to contact their Member Service Department.

3.6 Medicare Advantage Home Oxygen Therapy

Introduction

Medicare Advantage HMO and PPO products provide coverage for medically necessary home oxygen therapy and the equipment necessary for the safe, effective delivery of that therapy.

Equipment Included

The equipment necessary for delivery of home oxygen therapy includes the following:

- Oxygen furnishing system
- Oxygen storage vessels
- Tubing
- Administration sets

Supplies	Codes
Stationary oxygen delivery system only ***(One code per patient per month)***	E0424 E0439 E1390
Portable oxygen delivery system only ***(One code per patient per month)***	E0431 E0434 E0443 contents payable only when stationary liquid is used with portable gaseous (E0431)
Patient owned equipment	E0425 E0430 E0435 E0440 E0441 E0442 A4615 (cannula) A4616 (tubing) E0550 (humidifier) E0555 (humidifier) E0560 (humidifier)

Continued on next page

3.6 Medicare Advantage Home Oxygen Therapy, Continued

Conditions For Which Coverage Is Available

Home oxygen therapy coverage is available for rented, not purchased, oxygen equipment for members with significant hypoxemia in the chronic stable state provided all of the following conditions are met:

1. The attending or consulting physician has determined that the patient suffers a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy.
2. The patient's blood gas levels indicate the need for oxygen therapy
3. Alternative treatment measures have been tried or considered and have been deemed clinically ineffective.

Conditions For Which Coverage Is Unavailable

Coverage for oxygen therapy for Medicare Advantage members is not available for the following conditions:

1. Angina pectoris in the absence of hypoxemia. This condition is generally not the result of a low oxygen level in the blood, and there are other preferred treatments.
2. Dyspnea without cor pulmonale or evidence of hypoxemia.
3. Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities. There is no evidence that increased PO_2 will improve the oxygenation of tissues with impaired circulation.
4. Terminal illnesses that do not affect the respiratory system.

Portable Oxygen Systems

Coverage of a portable oxygen system alone or to complement a stationary oxygen system may be allowed if the patient is mobile within the home. When submitting an authorization request, check both boxes, "portable" and "stationary."

Spare Tanks Or Emergency Inhalators

Spare tanks of oxygen or emergency oxygen inhalators are considered not medically necessary since these items are precautionary and not therapeutic in nature.

Continued on next page

3.6 Medicare Advantage Home Oxygen Therapy, Continued

Blood Oxygen Determinations

Initial orders for oxygen therapy must also include the results of a blood gas study, usually a measurement of the partial pressure of oxygen (PO_2) in arterial blood. **The study must be performed within 30 days before the date of service.**

The study should be performed under one of the following circumstances:

- Ordered and evaluated by the attending or consulting physician
- Ordered and evaluated by the attending physician and performed under his or her supervision
- Performed by a qualified provider or supplier of laboratory services

Note: Medicare does not recognize DME suppliers as qualified to provide or supply blood oxygen determinations.

Conditions Of Blood Gas Studies

The conditions under which the blood gas study was performed must be specified in writing and submitted on the *Certificate of Medical Necessity* (CMN) form. Examples of this documentation may include the following:

- At rest
- While sleeping
- While exercising
- On room air
- On oxygen

Note: If the study is performed while the patient is receiving oxygen, indicate the following:

- Amount
- Body position during testing
- Additional information required for interpretation

Continued on next page

3.6 Medicare Advantage Home Oxygen Therapy, Continued

Blood Gas Level Criteria

The table below describes three groups of blood gas levels for which coverage is provided.

Group	Blood gas level criteria
Group 1 *Medically necessary*	Arterial PO_2 is at or below 55 mm Hg, or arterial oxygen saturation is at or below 88% taken at rest. OR Arterial PO_2 is at or below 55 mm Hg, or arterial oxygen saturation is at or below 88% taken during sleep for a patient who demonstrates arterial PO_2 at or above 56 mm Hg or arterial oxygen saturation at or above 89% while awake. OR A greater than normal fall in oxygen level during sleep (arterial PO_2 decreases more than 10 mm Hg, or arterial oxygen saturation decreases more than 5%) associated with symptoms or signs reasonably attributable to hypoxemia (e.g., cor pulmonale, "P" pulmonale on EKG, documented pulmonary hypertension and erythrocytosis). OR Arterial PO_2 is at or below 55 mm Hg or arterial oxygen saturation at or below 88%, taken during activity for a patient who demonstrates arterial PO_2 at or above 56 mm Hg or arterial oxygen saturation at or above 89%, during the day while at rest. In this case, supplemental oxygen is provided during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the patient was breathing room air.

Continued on next page

3.6 Medicare Advantage Home Oxygen Therapy, Continued

Blood Gas Level Criteria, continued

Group	Blood gas level criteria
Group 2 *Medically necessary*	Arterial PO_2 is 56 to 59 mm Hg or arterial blood oxygen saturation is 89% if any of the following are documented: • Dependent edema suggesting congestive heart failure • Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale of EKG (P wave is greater than 3 mm in Standard Leads II, III, or AVF) • Erythrocythemia with a hematocrit greater than 56%
Group 3 ***Not*** *medically necessary*	Home use of oxygen is not medically necessary for members with PO_2 levels at or above 60 mm Hg, or arterial blood oxygen saturation at or above 90%.

Additional Studies

Retesting between the 61st and 90th day of home oxygen therapy is required in order to establish continued medical necessity when a patient's initial certification for oxygen is approved based on one of the following criteria:

- Arterial PO_2 was 56 mm Hg or greater
- Oxygen saturation was 89% or greater

Certificate Of Medical Necessity

A *Certificate of Medical Necessity* (CMN) form for home oxygen is necessary for the following:

- Initial certification
- Recertification
- Changes in the oxygen prescription

The CMN must be completed, signed, and dated by the ordering physician.

Continued on next page

3.6 Medicare Advantage Home Oxygen Therapy, Continued

Obtaining Authorization

DMEnsion, Inc. (formerly Wright & Filippis) must authorize all home oxygen therapy for Medicare Advantage members. Follow the steps listed below to obtain authorization.

Step	Action
1	The physician enters a request for oxygen into NaviNet[SM]. The physician should also fax a CMN form to DMEnsion, Inc. at 1-248-844-8614 at the same time.
2	The electronically submitted request is automatically sent to DMEnsion, Inc. (formerly Wright & Filippis). Fax paper referral forms to DMEnsion, Inc. at 1-248-844-8614.
3	If the physician has not included a CMN form, DMEnsion, Inc. will send or fax a CMN form to the physician for completion.
4	Physician returns completed CMN form to DMEnsion, Inc.
5	DMEnsion, Inc. sends an authorization approval through ROAR or by fax.
6	The physician sends the approved request to a DME supplier.
7	The DME supplier provides services to the patient.

Recertification

Recertification must include the results of a recently performed arterial blood gas (ABG) or oximetry test; and it is required one to three months after initial certification under the following circumstances:

- If the patient's arterial PO_2 was 56 mm HG or greater at the initial certification
- If the patient's oxygen saturation was 89% or greater at the initial certification
- If the physician initially estimated that oxygen was needed for one to three months

Note: Once recertification establishes medical necessity for continued therapy, subsequent recertification is not required except when there is a change in the oxygen prescription or the attending physician.

3.6 Diabetic Testing Devices for Medicare Advantage HMO and PPO Members

Changes Effective January 1, 2006

Medicare Advantage HMO and PPO products provide coverage for medically necessary diabetic testing devices including glucometers, test strips and lancets effective January 1, 2006. Insulin pens and insulin pumps are also being covered under DME. Insulin and syringes will not be covered as DME, but will be covered under the Medicare Part D Prescription Drug Benefit.

Purchasing Diabetic Testing Devices

Members are now able to purchase these items from any participating, in-network DME vendor with applicable member cost-sharing under Medicare Advantage.

Part B Drugs are covered in full after a copayment when they are obtained from an in-network specialty pharmacy, DME vendor, or furnished in a physician's office. Any out of network supplies, are subject to additional copayments and coinsurance.

Although FreedomBlue PPO members have out-of network benefits, those members who elect to go out-of-network to purchase DME supplies will incur additional out-of-pocket expenses. Please review the patient's specific benefit design to determine possible authorization requirements and/or coinsurance amounts and maximum annual coinsurance amounts.

Prescriptions For Multiple, Daily Diabetic Testing

If a patient is instructed to test multiple times in the same day for diabetes, treatment prescriptions for DME diabetic supplies should be written to clearly state the correct frequency of testing (Ex. To be tested three times daily). This will ensure that the correct amount of supplies are ordered and submitted for DME coverage under a Medicare Advantage product.

Many of the in-network DME vendors can supply increased supplies in a timely manner. If a patient requires additional supplies the treating physician will need to provide the patient with a new prescription detailing the testing frequency. After receiving the new prescription, the patient will need to contact the DME vendor to indicate that their testing needs have increased and that their physician wrote a new prescription detailing the change.

Mail Order Diabetic Testing Supplies

Members are still able to order 90-day supplies of diabetic supplies via mail order. The physician must write the prescription to reflect the long term supply so that the member is able to submit the prescription to the mail order DME vendor and receive accurate long term supplies.

For More Information

If you have specific questions about diabetic testing devices for Medicare Advantage members, please contact Provider Service.

3.6 Medicare Prescription Drug Coverage under Medicare Advantage

Prescription Drug Coverage

Medicare Advantage HMO and PPO products provide Part B prescription drug coverage (MA-only plans). Some Medicare Advantage plans may also include Medicare Part D Prescription Drug Coverage benefits (MA-PD plans). Effective January 1, 2006, Medicare Advantage members can obtain the following Part B drugs from the following providers/suppliers:

- oral medication for cancer from specialty pharmacies including Medmark and
- nebulizer solution from approved Durable Medical Equipment (DME) vendors.

Medicare Advantage HMO and PPO members are **not** able to purchase any Part B drugs, including those listed above, at a retail pharmacy.

Medicare Advantage HMO and PPO members can obtain oral medication for cancer from a specialty pharmacy when it is covered under their Part D benefit, but are not required to do so.

Coverage Levels for In And Out Of Network Purchases

Part B drugs are covered in full after a co-payment when they are obtained from an in-network specialty pharmacy or a DME vendor.

If FreedomBlue PPO members purchase these drugs at an out-of-network specialty pharmacy or DME vendor, in addition to a co-payment, they are responsible for 20-30% coinsurance on the lesser of the out-of-network charge or network allowed amount as well as any difference between the out-of-network charge and network amount. Highmark's Western Region Medicare Advantage HMO product does not have an out-of network benefit.

Members Can Buy Supplies From A Listing Of Vendors And Pharmacies

There are several network specialty pharmacies and DME vendors from which members can choose. A listing of specialty pharmacy providers and DME vendors are now available on NaviNet℠ and via www.highmark.com.

For More Information

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

3.6 DME Supplies Provided in the Physician Office

Simple DME Supplies Can Be Provided In The Office Setting

Minor DME items, prosthetics, orthotics, and supplies *incidental to a physician or facility that do not require authorization* can be furnished to members for their convenience in the physician office setting.

What Region Am I?

Applicable Products

The supplies listed below can be provided in the office setting for Medicare Advantage HMO and PPO members as well as other Highmark managed care members enrolled in many Highmark Blue Shield products.

Submit A Claim For The Appropriate Charge

Under no circumstances should a member be charged for such items or supplies. Include the charge for the item/supply on a claim and submit to Highmark following normal billing protocols.

Eligible Supplies/Items

Following is a list of those items that can be supplied to members in the office setting and billed to Highmark for reimbursement at fee-for-service. *These supply items do not require authorization.*

Item	Code
Crutches, underarm, wood, adjustable or fixed, pair with pads, tips and handgrips	E0112
Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips and handgrips	E0114
Cervical, Flexible, non-adjustable (foam collar)	L0120
Knee orthosis, immobilizer, canvas longitudinal, prefabricated, includes fitting and adjustment	L1830
Plastazote sandal-each	L3265
Wrist hand Orthosis, wrist extension control cock-up, non molded, prefabricated, includes fitting and adjustment	L3908
Ankle control orthosis, stirrup style, rigid, includes any type interface (e.g., pneumatic, gel) prefabricated, includes fitting and adjustment	L4350
Pneumatic knee splint, prefabricated, includes fitting and adjustment	L4380
Peak Expiratory Flow Rate Meter, Hand Held (Effective 03/01/06)	A4614
Spacer, Bag or Reservoir, with or without mask, for use with metered dose inhaler (Effective 03/01/06)	A4627

IMPORTANT! All Other DME And Supplies

Requests for all other DME, prosthetic and orthotic supplies must be directed to a network DME, prosthetic and orthotic provider. Search in NaviNet[SM] for eligible providers within each managed care product.

3.6 Record Retention Procedures For Medicare Advantage

Overview

Highmark complies, and requires its contracted providers to comply, with Centers for Medicare and Medicaid Services polices and procedures including inspection of records.

Record retention is required to ensure efficient availability in case of immediate need. Compliance with CMS' requirements is paramount for continuing participation in the Medicare Advantage (M.A.) program and the ability services our M.A. members.

Policy

CMS has revised its regulations with respect to records retention and access to records, increasing the period from six to ten years. Therefore, network providers must maintain records and information in an accurate and timely manner in accordance with 42CFR §422.504(d) and provide access to such records in accordance with 42CFR §422.504(e)(2).

42CFR §422.504(d) states M.A. organizations are to maintain records and allow CMS access to them, for 10 years from the termination date of the contract or the date of the completion of any audit.

42CFR §422.504(e)(2) states,

"HHS, the Comptroller General, or their designees may audit evaluate, or inspect any books, contracts, medical records, patient care documentation, and other records of the Medicare Advantage (M.A.) organization, related entity, contractor, subcontractor, or its transferee that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce the contract."

If you wish to read the entire context of the requirement please visit The Code of Federal Regulations, Title 42, Volume 2, Chapter 1V – Centers for Medicare and Medicaid Services, Department of Health and Human Services, Part 422, Medicare Advantage Program, Subpart K, Contracts with Medicare Advantage Organizations.

Previous Record Retention Regulations

Previous record retention regulations specified that records must be maintained for six years. This period is now ten years.

Chapter 4

Health Care Management

Unit 1: Care Management

In This Unit

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4.1 Care Management

Healthcare Management Services

Healthcare Management Services (HMS), Highmark Blue Shield's medical management division, is responsible for all the care management services provided to Highmark Blue Shield members, including utilization management, case management and disease/condition management. These services are provided either directly by HMS staff or through contracted relationships managed through HMS to ensure that all health care management services received by Highmark Blue Shield members are coordinated and integrated.

Goal Of HMS Care Management

To deliver a comprehensive and integrated care management program which positively impacts both members' health and medical benefit costs.

How Care Management Services Are Requested

Medical management services are requested in the following ways:

- Electronically
- Telephonically
- Fax

Medical Record Review

Highmark reserves the right to request and review medical records for visits whether or not preauthorization is required. If such review determines that any or all treatments were not medically necessary, were not billed appropriately, or were not performed, a refund will be requested. If a refund is requested, the practitioner may not bill the member for the services.

Utilization Decision Making

Highmark makes utilization review decisions based only on appropriateness of care and service and the existence of coverage. They do not reward practitioners, providers, Highmark employees or other individuals conducting utilization review for issuing denials of coverage or service, nor do they provide any financial incentives to utilization management decision makers to encourage denials of coverage.

Continued on next page

4.1 Care Management, Continued

Criteria Used

Highmark uses McKesson Health Solution's InterQual® criteria in its processes for assessing the medical necessity and appropriateness of health care services. The Interqual® criteria are applied to assessment of acute adult, acute pediatric, acute rehabilitative, long-term acute, skilled nursing and home health services. These criteria are applied in conjunction with applicable Highmark Medical Policy, Medicare Advantage Policy, and Highmark Government Services Administrative Policy.

Note: If you would like more information about the criteria used for determinations, please contact HMS at 1-866-731-8080.

Medical Necessity Criteria

Except where any applicable law, regulation, or government body requires a different definition (i.e., the Federal Employees Health Benefits Program, CMS as to the Medicare Advantage program, etc.), Highmark Blue Shield has adopted a universal definition of medical necessity. The term "Medically Necessary," "Medical Necessity" or such other comparable term in any provider contract shall mean health care services (or such similar term as contained in the applicable benefit agreement or plan document to include, but not be limited to, "health services and supplies," "services and supplies" and/or "medications and supplies") that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

National Criteria And Corporate Medical Policy

Highmark Blue Shield uses nationally recognized evidence-based criteria and/or corporate medical policy in making its determinations of medical necessity and clinical appropriateness. Physicians review and approve both criteria sets and recommend changes that incorporate regional and local variations in medical practice. In addition to the criteria, clinical and peer reviewers also consider individual member needs such as age, co-morbidities, etc. when making medical necessity decisions.

Continued on next page

4.1 Care Management, Continued

InterQual®

InterQual® Level of Care criteria is a nationally recognized criteria set used by Healthcare Management Services clinical staff in reviewing the medical necessity and appropriateness of services.

Highmark Blue Shield Medical Policy

Highmark Blue Shield's medical policies are developed to clarify and support the benefit language present in member benefit documentation. These policies are based on extensive medical research and input from professional consultants and actively practicing physicians.

The medical policies address issues such as the following:

- Anesthesia services
- Consultation
- Durable medical equipment and supplies
- Pathology
- Diagnostic medical services
- Radiology
- Nuclear medicine
- Surgery
- Cosmetic and reconstructive surgery
- Maternity services
- Therapies
- Evaluation and management services

Medical policy also addresses services considered to be experimental or investigative and those judged to be "of current questionable usefulness." It addresses the relationship among services on a claim and provides guidance on which services should be combined for billing purposes.

Continued on next page

4.1 Care Management, Continued

Availability Of Criteria

InterQual® Level of Care guidelines specific to the case being reviewed are available upon request by contacting Healthcare Management Services at 1-866-731-8080 from 8:30 a.m. through 7:00 p.m., Monday through Friday. For urgent care, HMS is also available between the hours of 8:30 a.m. and 4:30 p.m. on Saturday and Sunday. Behavioral Health criteria can be obtained by calling 1-800-628-0816.

Highmark Blue Shield medical policy is available to participating providers through our region-specific Web sites by accessing www.highmark.com. If for any reason this resource is not available, you may request a policy from Healthcare Management Services at 1-866-731-8080 between the hours of 8:30 a.m. and 7:00 p.m., Monday through Friday.

4.1 Case Management

Case Management

Case management is a systematic, proactive and collaborative approach to effective assessment, monitoring and evaluation of options and services required to meet an individual member's health needs. Case Management is a collaborative process involving the physician, the patient and support system, the case manager, and other healthcare service providers to encourage and assist patients to achieve their optimum level of wellness, self-management, and functional capability.

Identifying Members For Case Management

Highmark Blue Shield's case management staff use clinical and utilization indicators to identify members who could benefit from case management. The indicators include but are not limited to the following:

- *High risk diagnoses*
- *Situation and discharge planning needs*
- *Psycho-social issues*
- *Financial issues*
- *Complex care coordination needs*
- *Multiple admissions*
- *Health risk assessment screening*

Case Management Services

Highmark case managers are licensed, experienced healthcare professionals able to assist your patient by providing the following services, including but not limited to:

- *Assessment of knowledge deficits regarding their condition, treatment, or benefit issues*
- *Reinforcement of educational information as directed by the physician or service provider*
- *Evaluation and reinforcement of medication use and adherence which is particularly important in polypharmacy situations*
- *Evaluation and reinforcement of adherence with treatment regime*
- *Intervention to assist with obtaining medical supplies or equipment*
- *Coordination of service providers*
- *Communication of adverse situations to the physician or service provider*
- *Evaluation and assistance with financial concerns*
- *Assessment and assistance with advance care planning*

Continued on next page

4.1 Case Management, Continued

Case Management Processes

If it is determined that a member would benefit from case management and the member accepts case management, his or her case is assigned to a Highmark Blue Shield case manager. Case management is a voluntary program and is free to Highmark members. The case manager is responsible for the following processes:

- *Contacting the member and his or her providers*
- *Comprehensive assessment of the member's needs*
- *Identifying the issues and/or barriers affecting the member's care.*
- *Developing, implementing, coordinating and evaluating a plan of care in collaboration with the member and his or her providers*

Provider Referrals For Case Management

Highmark encourages providers to identify members who could benefit from coordinated case management services, please contact the Healthcare Management Services case management staff at 1-800-596-9443 to discuss your patient's needs.

*Please consider the following conditions for **Case Management referral**:*

- *Patients with multiple medical or behavioral health concerns or services*
- *Patients who lack a consistent caregiver, have financial concerns and require community resources*
- *Patients with a life-altering diagnosis or condition such as brain trauma, cancer, or debilitating neurological condition*
- *Patients with difficulty achieving self management resulting in frequent emergency room visits or hospital admissions*

4.1 Emergency Services

Emergency Services

An emergency service is any health care service provided to a member after sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the enrollee, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy
- Serious impairment to bodily functions, or
- Serious dysfunction of any body organ or part.

Definition of Prudent Layperson

A prudent layperson is one who is without medical training and who draws on his or her practical experience when deciding whether emergency medical treatment is needed.

Reimbursement Of Emergency Services

Emergency services are reimbursed without authorization in cases where a prudent layperson believed that an emergency medical condition existed. If the emergency condition results in an inpatient admission, authorization is required within 48 hours of the admission.

Emergency Transportation And Emergency Services

Emergency transportation and the related medical emergency services provided by a licensed ambulance service are considered to be emergency care, and therefore, are covered **without** authorization.

Chapter 4

Health Care Management

Unit 2: Introduction to Authorizations

In This Unit

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Remember: Highmark has eliminated referral requirements; however, authorization requirements continue to exist.

Note: The processes discussed in this unit do not pertain to pharmaceutical authorizations or prior authorizations for certain outpatient, advanced imaging services under the Radiology Management Program.

For more information about pharmacy policies please visit the Pharmacy/Formulary Information section of the Provider Resource Center.

Certain outpatient and advanced imaging services need to be authorized. For more information about the Radiology Management Program, please visit the Radiology Management Program section of the Provider Resource Center.

4.2 Introduction to Authorizations

Definition

Authorization (preauthorization) is the process whereby the health care practitioner must contact Highmark to determine the benefit coverage for and/or the medical necessity or appropriateness of health care services.

Overview

Throughout the year, Highmark Blue Shield adds and/or deletes procedures/DME that require authorizations under the commercial HMO and POS products, as well as Medicare Advantage, and communicates these changes to the provider community. To view the all-inclusive and most up-to-date list, please visit the Provider Resource Center and select, Procedures Requiring Authorization under Administrative Reference Materials.

Products Requiring Authorization

What Region Am I?

The following products require authorizations:

- Medicare Advantage PPO, Medicare Advantage HMO
- DirectBlue (group)
- ClassicBlue
- Western Region HMO
- *ShortTermBlue*
- DirectBlue*
- PPOBlue*
- EPOBlue*

*Has limited authorization requirements: generally, only for inpatient care depending on the benefit design.

Responsibility For Requesting Authorization

Authorization can be requested by the following parties:

- A member's PCP
- A member's Specialist
- The facility to which the member has been admitted

Continued on next page

4.2 Introduction to Authorizations, Continued

When An Authorization Is Required

The following circumstances are representative of those that require an authorization. **This is not an all-inclusive list.** A list of procedures and DME that require authorization can be found on the Provider Resource Center by hovering over Administrative Reference Materials and clicking Procedures Requiring Authorization.

- All hospital admissions
- Cosmetic vs. reconstructive procedures
- Non-standard issue DME
- Experimental/investigational procedures or treatments
- Nutritional Counseling
- Selected injectable drugs
- Home health care
- Diabetic education
- Out-of-network care
- Alternative medicine
- Home Health
- Oxygen (For All Medicare Advantage Members)
- All Therapies (For Medicare Advantage HMO and Medicare Advantage PPO out-of network)

NOTE: The authorization requirement associated with spinal manipulation for Medicare Advantage members was eliminated as of June 1, 2005.

NaviNet Benefit Verification

For NaviNet users:

Step	Action
1	Click on Eligibility and Benefits Inquiry
2	Enter the Member Information
3	Click Select beside the correct patient name
4	The Patient Eligibility and Benefits Detail Screen will appear. This screen displays current benefits for the member.

Continued on next page

4.2 Introduction to Authorizations, Continued

NaviNet Benefit Verification (continued)

Step	Action
5	Review member benefits within the categories.

Phone Benefit Verification

Certain procedures require benefit verification prior to performing the procedure. NaviNet is the required method for benefit verification.

What Region Am I?

However, if you are not a NaviNet enabled provider, please call the appropriate number below for benefit verification:

Western Region: 1-800-547-3627, Option 2
Central Region: 1-866-731-8080, Option 2, then Option 2

For Medicare Advantage Members call 1-866-517-8585.

If you have specific questions about authorization or benefit verification please contact your Provider Relations Representative.

Authorization Is Not A Guarantee Of Payment

When an authorization number is provided, it serves as a statement about medical necessity and appropriateness; it is not a guarantee of payment. Payment is dependent upon the member's having coverage at the time the service is rendered and the type of coverage available under the member's benefit plan. Some benefit plans may also impose deductibles, coinsurance, co-payments and/or maximums that may impact the payment. Providers may consult NaviNet, InfoFax, or OASIS or to obtain benefit information.

Failure To Obtain And Authorization

Failure to pre-authorize or pre-certify a service or admission may result in a retrospective review. Highmark Blue Shield has the right to review the service retrospectively for medical necessity and appropriateness, and to deny payment when necessary. If a retrospective review is performed, and

- HMS determines that the service was medically necessary and appropriate, the claim will be paid.

Continued on next page

4.2 Introduction to Authorizations, Continued

Failure To Obtain And Authorization (continued)

HMS determines that the service was not medically necessary and appropriate, no payment will be made for the claim. In this situation, the network provider must write off the entire cost of the claim and may not bill the member (except for any non-covered services).

If The Member Still Wants A Service For Which Authorization Can Not Be Obtained

If an authorization has not been obtained because it has been determined that the care is either not medically necessary/appropriate or a non-covered service, the member may still want to receive the service. In such cases, the provider can have the member acknowledge the financial responsibility, in writing, for the specific service to be received.

If The Authorization Is Not In Place At The Time Of Service

Ordinarily, the member's attending physician should have requested any required authorization prior to the member receiving the services. However, if a Highmark Blue Shield member presents him or herself for non-emergency services and the required authorization does not appear to be in place, the provider has the following options:

- Perform an authorization inquiry in NaviNet
- Contact HMS directly to request an authorization at 1-866-731-8080 between the hours of 8:30 a.m. and 7:00 p.m. Monday through Friday. For urgent care, HMS is also available between the hours of 8:30 a.m. and 4:30 p.m. on Saturday and Sunday.
- For Behavioral Health Management authorization requests, call 1-800-628-0816.

Chapter 4

Health Care Management

Unit 3: Requesting an Authorization

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4.3 Overview

Authorizing Services In The Appropriate Network	When requesting an authorization, be sure that the member receives care from a provider who participates in the network associated with the member's program.
Electronic Authorization System	Authorizations may be requested through NaviNet or by submitting a HIPAA 278 transaction through your practice's software. Electronic authorization requests are the preferred method and are quick and easy to perform. To learn more about how to request authorizations electronically access the Customer Care page on NaviNet. For a HIPAA 278 transaction, refer to the Provdier EDI Reference Guide on the Provider Resource Center.
Medical Record Review	Highmark reserves the right to request and review medical records for visits whether or not preauthorization is required. If such review determines that any or all treatments were not medically necessary, were not billed appropriately, or were not performed, a refund will be requested. If a refund is requested, the practitioner may not bill the member for the services.
Utilization Decision Making	Highmark makes utilization review decisions based only on appropriateness of care and service and the existence of coverage. They do not reward practitioners, providers, Highmark employees or other individuals conducting utilization review for issuing denials of coverage or service, nor do they provide any financial incentives to utilization management decision makers to encourage denials of coverage.
Criteria Used	Highmark uses McKesson Health Solution's InterQual® criteria in its processes for assessing the medical necessity and appropriateness of health care services. The Interqual® criteria are applied to assessment of acute adult, acute pediatric, acute rehabilitative, long-term acute, skilled nursing and home health services. These criteria are applied in conjunction with applicable Highmark Medical Policy, Medicare Advantage Policy, and Highmark Medicare Services Administrative Policy. Note: If you would like more information about the criteria used for determinations, please contact HMS at 1-866-731-8080.

Continued on next page

4.3 Requesting an Authorization

How to Request An Authorization Follow these steps to request an authorization.

Step	Action	What Region Am I?
1	**Electronic Submissions**	**Non-Electronic submissions**
	Use NaviNet or HIPAA 278: NaviNet guides the user through the steps. For information about using the 278 transaction, refer to the Provider EDI Reference Guide in the Provider Resource Center.	Call HMS at one of the following telephone numbers to request an authorization: Western Region: 1-800-547-3627, option *2* Erie 1-800-227-0215, option 3 Johnstown 1-800-429-0401, option 3 Central Eastern and Northeastern Region: 1-866-731-8080 Central, Eastern and Northeastern Region Specialists should continue to call 1-866-731-8080. Western Region Specialists *should call 1-800-547-3627, Option 2.* For behavioral health services, contact Highmark Blue Shield's Behavioral Health Unit at 1-800-258-9808. Provide HMS the following information about the patient: • General information (name, age, gender, etc.) • Member identification number • Medical history • Any comorbidity • All pertinent medical information (test results, prior treatment, etc.) • Presenting symptoms • Acuity • Diagnosis • Service to be performed, including admission or procedure dates and location • Names of any other health care providers involved in the care • Proposed length of stay and frequency or duration of services • Treatment plan and goals • Psycho-social issues impacting care • Discharge plan Note: The HMS reviewer may request additional information. Requests may be denied for lack of information.

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4.3 Requesting an Authorization Continued

How to Request An Authorization (continued)

<table>
<tr><th>Step</th><th colspan="4">Action</th></tr>
<tr><td rowspan="5">2</td><td colspan="4">HMS reviews the information. The decision-making period begins once HMS has received the request.</td></tr>
<tr><td></td><td>If the request is for a…</td><td>A decision is made within…</td><td></td></tr>
<tr><td></td><td>Pre-certification authorization</td><td>1 calendar day for urgent care
2 business days for non-urgent care</td><td></td></tr>
<tr><td></td><td>Concurrent inpatient authorization</td><td>No later than 1 business day</td><td></td></tr>
<tr><td colspan="4">Note: If you would like more information about the criteria used for determinations, please contact HMS at 1-866-731-8080.</td></tr>
<tr><td rowspan="3">3</td><td colspan="4">Following review, HMS either authorizes or denies coverage for the request.</td></tr>
<tr><td></td><td>If the request is approved…</td><td>If the request is denied…</td><td></td></tr>
<tr><td></td><td>You will be notified through Referral/Authorization Inquiry in NaviNet or through your practice’s software. If you do not have access to NaviNet, you will receive a paper report through the mail.</td><td>You will be advised of your appeal rights and the option of requesting a peer-to-peer conversation with the physician advisor who made the decision.</td><td></td></tr>
</table>

4.3 Treatment Plan Submissions - Requesting Outpatient Therapy Services Authorization for Medicare Advantage Members

The Process

The following services require authorization from the initial visit, and a subsequent treatment plan after the 12th visit:

- Physical therapy
- Occupational therapy
- Speech therapy

There are two ways a request may be submitted for physical or occupational therapy: via NaviNet, or by phone.

NaviNet Submissions: Physical Therapy and Occupational Therapy

Step	Action
1	Hover over the Referral/Auth Submission button on Plan Central
2	Select the Treatment Plan fly out button
3	On the Request Form, the instructions are printed at the top. • Providers reporting for 12 visits or less within the current calendar, year should complete Part 1 only • Providers reporting for greater than 12 visits within the current calendar year should complete both Part 1 & 2. When visits since the beginning of the year are in question, always complete both Part 1 & 2.
4	If you need additional training on how to submit a Treatment Plan request, contact NaviMedix Customer Care at 1-888-482-8057.

Phone Requests

Call the HMS Care Management automated telephone system: What Region Am I?

Pittsburgh Region: 1-800-547-3627, option *2*
When prompted, select the therapy pathway.
Erie Region: 1-800-227-0215
Johnstown/Altoona Region: 1-800-429-0401
Central, Eastern, and Northeastern Regions: 1-866-731-8080

Continued on next page

4.3 Treatment Plan Submissions - Requesting Outpatient Therapy Services Authorization for Medicare Advantage Members, continued

NaviNet Submissions: Speech Therapy

Step	Action
1	The authorization request to begin treatment must be initiated by the member's physician who is requesting the therapy services.
2	Hover over the Referral/Auth Submission button on Plan Central
3	Select the Auth Submission fly out button
4	On the Selection Form, select the Category of "Outpatient" and "Service of Speech Therapy" from the dropdowns
5	If a plan of treatment has already been developed by the speech therapist, that information can be entered into the Request Form comment block titled "Treatment Plan."
6	Submit the request to HMS
7	Beginning with the 12th visit, an additional treatment plan will be necessary. HMS will contact the speech therapist with a request for information about the member's treatment plan.

Telephonic Submissions: Speech Therapy

Step	Action
1	The authorization request to begin treatment must be initiated by the member's physician who is requesting the therapy services.
2	Call the HMS Care Management automated telephone system: Pittsburgh Region: 1-800-547-3627, option *2* When prompted, select the therapy pathway. Erie Region: 1-800-227-0215 Johnstown/Altoona Region: 1-800-429-0401 Central, Eastern and Northeastern Regions: 1-866-731-8080 Hover over the Referral/Auth Submission button on Plan Central
3	Beginning with the 12th visit, an additional treatment plan will be necessary. HMS will contact the speech therapist with a request for information about the member's treatment plan.

What Region Am I?

Chapter 4

Health Care Management

Unit 4: Denials, *Grievances and* Appeals

In This Unit

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4.4 Filing A *Grievance On The Member's Behalf (Act 68)*

Overview

Any Highmark Blue Shield or western region network member has the right to file a grievance or a complaint, as applicable if they are not satisfied with decisions made by Highmark Blue Shield or the western region network regarding medical necessity issues.

What Region Am I?

This process applies to the following Highmark products:

- *Western Region HMO*
- *Western Region POS*
- *adultbasic*
- *CHIP*
- *Central Region PPO*

Denial Decisions

The decision to deny a service, admission or item on the basis of medical necessity is one that can only be made by a physician reviewer.

Definition Of A Member *Grievance /Appeal*

A process by which a member or member's authorized representative (or provider on behalf of member) with the written consent of the member may file a written grievance regarding the denial of payment of a health care service on the basis of medical necessity and appropriateness. A grievance may be filed regarding a decision that:

1. *disapproves full or partial payment for a requested health care service*
2. *approves the provision of a requested health care service for a lesser scope or duration than requested or*
3. *disapproves payment for the provision of a requested health care service but approves payment for the provision of an alternative health care service.*

Provider-Initiated *Grievances* On The Member's Behalf

The grievance must be submitted in writing with supporting documentation regarding the request. A Designation of an Authorized Representative form, that can be found on the Provider Resource Center under the Provider Forms selection, must be completed (including page 3) and include, but not be limited to:

- *the member's name*
- *the member's address*
- *member's identification number*
- *if the member is a minor or legally incompetent, the name, address and relationship to the member of the person who consents for the member;*
- *the name, address and identification number of the provider to whom the member is granting consent;*
- *the name and address of the plan to whom the member is providing consent;*
- *an explanation of the specific service for which coverage was provided and/or denied to which the consent applies.*

4.4 Filing A *Grievance On The Member's Behalf (Act 68),*
Continued

Provider-Initiated *Grievances* On The Member's Behalf, *continued*

The member may not submit a grievance concerning the services listed in the consent form without rescinding the consent in writing. The member may rescind consent at anytime during the process.

The provider, having obtained consent from the member or the member's legal representative to file a grievance, shall have 10 days from receipt of the standard written UR denial and any decision letter from a first, second or external review upholding the plan's decision to notify the enrollee or the enrollee's legal representative of its intention not to pursue a grievance.

The grievance must be filed within one hundred and eighty (180) days from the denial to:

What Region Am I?

In the Western Region: *Member Grievance and Appeals Department*
P.O. Box 2717
Pittsburgh, PA 15230-2717

In the Central Region: *Highmark Blue Shield*
P.O. Box 890174
Camp Hill, PA 17089-0174

**For member appeals and reconsiderations for the Federal Employees Program, please contact FEP Customer Service at 1-866-763-3608.

An acknowledgement letter will be sent to you and to the member within five (5) business days from receipt of the grievance request.

The acknowledgement letter will include the following information:

- *The plan considers the matter to be a grievance rather than a complaint. The enrollee, enrollee's representative, or provider on behalf of member may question the classification of complaints and grievances by contacting the Pennsylvania Department of Health*
- *That the enrollee may appoint a representative to act on the member's behalf at any time during the internal grievance process.*
- *That the enrollee, enrollee's representative, or the provider on behalf of member may review information related to the grievance upon request and submit additional material to be considered by the plan.*
- *That the enrollee or the enrollee's representative may request the aid of a plan employee who has not participated in the utilization management decision to assist in preparing the enrollee's first level grievance.)*

Continued on next page

4.4 Filing A *Grievance On The Member's Behalf (Act 68),*
Continued

Grievance Review Process, – *First Level*

The First Level Grievance Committee will consist of a practitioner in the same or similar specialty that typically treats the medical condition, performs the procedure or provides the treatment. The physician will not be an individual who was involved in any previous adverse benefit determination regarding the grievance or a subordinate of any individual involved. You and the member will be notified of the decision within thirty (30) days from receipt of the grievance request. The decision letter will contain a statement of the issue under review, the basis for the decision, the specific reasons for the decision, the scientific and clinical rational for making the decision applying the terms of the plan to the enrollee's medical circumstances, specific references to the plan provisions on which the decision is based or instructions on how to obtain the specific plan provisions, and an explanation of how to file a request for a second level review of the decision and the time frames for requesting a second level review.

It is not necessary for written consent for each level of the grievance process. The second level grievance request must be submitted within forty-five (45) days from receipt of the first level grievance decision. Upon the plan's receipt of a second level grievance review request, an acknowledgement letter will be sent to the enrollee, enrollee's representative, and the provider, if the provider filed the grievance on behalf of the member. The acknowledgement letter will include an explanation of the procedures to be followed during the second level review, including, how the enrollee or the enrollee's representative may request the aid of a plan employee at no charge, who has not participated in previous decisions to deny coverage for the issue in dispute, in preparing the enrollee's second level grievance; the enrollee, enrollee's representative, and provider if the provider filed the appeal on the enrollee's behalf, have the right to appear before the second level review committee and that the plan will provide the enrollee and the enrollee's representative, and the provider with 15 days advance written notice of the time scheduled for the review. A hearing notification will be sent to you and the member at least fifteen (15) days prior to the hearing explaining that you and/or the member may attend the hearing or participate via phone.

Continued on next page

4.4 Filing A *Grievance On The Member's Behalf (Act 68),*
Continued

Grievance Review Process – *Second Level*

The second level grievance committee will consist of a director/manager of customer service, a customer service supervisor and a medical director who will interpret the written report prepared by the practitioner of the same or similar specialty, who typically treats the medical condition, performs the procedure, or provides the treatment, for consideration by the Committee. You and the member will be notified of the decision within thirty (30) days from receipt of the grievance request.

The decision letter will include the basis for the decision and the procedures and timeframes for the enrollee, enrollee's representative, or the provider on behalf of enrollee to file a request for an external grievance review, a statement of the issue reviewed by the second level review committee, the specific reasons for the decision, references to the specific plan provisions on which the decision is based, instructions on how to obtain the internal rule, guideline, protocol, or criterion used to make the decision, an explanation of the scientific or clinical rationale for the decision, applying the terms of the plan to the enrollee's medical circumstances.

Grievance Review Process – *Third Level*

Third level requests must be submitted to the plan within fifteen (15) days from receipt of the second level grievance decision. Within 5 business days of receiving the external grievance request from the enrollee or the provider on behalf of the member, the plan will notify the Pennsylvania Department of Health (DOH) and request an assignment of an IRO. The plan, within 15 days of request for an external review, forward the case file to the assigned IRO. If the external grievance is being requested by a provider, the plan and the provider must each establish escrow accounts in the amount of half the anticipated cost of the review. The PA Department of Health will randomly select an IRO to review the case and will notify the enrollee, enrollee's representative, and provider on behalf of member of assigned IRO. The plan, within 15 days of the request, will forward the case file to the IRO. The Plan will send the provider or enrollee a listing of all documents forwarded to the IRO.

Additional information must be submitted within fifteen (15) days of receipt of the notice that the external grievance was filed. The IRO will assign a practitioner in the same or similar specialty, who treats the medical condition, performs the procedure, or provides the treatment and who was not involved in the previous decisions. Highmark will implement the IRO's decision within the time frame specified by the IRO.

Continued on next page

4.4 Filing A *Grievance On The Member's Behalf (Act 68),* Continued

Grievance Review Process – *Third Level,* *continued*	*If the IRO's decision in an external grievance review filed by a provider is against the provider in full, the provider shall pay the fees and costs associated with the external grievance. If the IRO's decision is against the plan in full or in part, the plan will pay the fees and costs associated with the external grievance review. The assigned IRO will review and issue a written decision within 60 days of the filing of the request for an external grievance review. The decision will be sent to the enrollee, the enrollee's representative, the provider, the plan, and the DOH.*

4.4 Filing An *Expedited Grievance On The Member's Behalf (Act 68)*

An Expedited Grievance

A request for an expedited review of an initial adverse benefit determination for medical, pharmaceutical, or behavioral health services based on medical necessity and appropriateness when; 1) a delay in decision making might jeopardize the member's life, health or ability to regain maximum functions based on a prudent layperson's judgment and confirmed by the treating practitioner; or 2) in the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request; 3) concerning the admission, continued stay or other health care services for a member who has received emergency services, but has not been discharged from a facility; or 4) concerning a concurrent review.

Requests from providers may be received either verbally or in a written format. Provider requests will be accepted as expedited requests, however if a member submits the same type of request Highmark requires the provider to submit a Physician Certification Form. The form will be sent directly to the member's requesting provider and should be returned to Highmark immediately.

Expedited appeals will follow the second level review process with verbal and written notification of the decision to you and the member within 48 hours from receipt of the request. The hearing may be held telephonically if the enrollee and/or provider on behalf of enrollee cannot be present in the short time frame. All information presented at the hearing is read into the record. If the plan cannot provide a copy of the report of the same or similar specialist to the enrollee/provider prior to the expedited hearing, the plan may read the report into the record at the hearing, and shall provide the member/provider with a copy of the report at that time. It is the responsibility of the enrollee, enrollee's representative, or the provider to provide information to the plan in an expedited manner to allow the plan to conform to the requirements of this section.

Continued on next page

4.4 Filing An *Expedited Grievance On The Member's Behalf (Act 68)*, Continued

An Expedited Grievance, *continued*	*The written decision to the enrollee, enrollee's representative, or provider on behalf of member will state the basis for the decision, including any clinical rationale, and the procedure for obtaining an expedited external review. The enrollee, enrollee's representative, or provider on behalf of member has 2 business days from the receipt of the expedited grievance decision to request an expedited external review. If the Independent Review Organization's (IRO's) decision in an external grievance review filed by a health care provider is against the health care provider in full, the health care provider shall pay the fees and costs associated with the external grievance. If the IRO's decision is against the plan in full or in part, the plan will pay the fees and costs associated with the external grievance review. For expedited external review requests, the plan will submit a request for an expedited external review to the DOH within 24 hours of the receipt of the request. The DOH will assign an IRO within 1 business day of receiving the request for an expedited review. The IRO will have 2 business days following the receipt of the case file to make a decision.*
Services That Are Potentially Cosmetic Or Experimental/ Investigational	A Highmark Blue Shield physician *of the same or similar specialty as the request or who was not previously involved in the denial,* evaluates the medical necessity and appropriateness of services that may potentially be cosmetic or experimental/investigational. If the review indicates that medical necessity or appropriateness does not exist for the service, an experimental/investigational/cosmetic denial will be issued. *The Act 68 appeal process for services that are potentially cosmetic or experimental/investigational are the same. Please review the above language for appeal information related to these services.*

4.4 Filing An Appeal On The Member's Behalf

Overview

Any Highmark Blue Shield member has the right to appeal if they are not satisfied with decisions made by Highmark Blue Shield regarding the coverage of service(s). There are specific regulations in place for handling member appeals.

This process applies to the following Highmark products:

- *Indemnity Products*
- *PPOBlue*
- *EPOBlue*

Definition Of A Member Appeal

A request from a member or member's authorized representative to review an adverse benefit determination. This includes services related to coverage, which includes contract exclusions, non-covered benefits and decisions related to the medical necessity and/or appropriateness of a health care service. This also includes full or partial adverse benefit determinations involving a requested health care service or claim.

Provider-Initiated Appeals On The Member's Behalf

The appeal must be submitted in writing with supporting documentation regarding the request. A Designation of an Authorized Representative form, which can be found on the Provider Resource Center under Provider Forms in the Miscellaneous Forms category or by clicking on the link above must be completed and include:

- *the member's name*
- *the member's address*
- *member's identification number*
- *if the member is a minor or legally incompetent, the name, address and relationship to the member of the person who consents for the member;*
- *the name, address and identification number of the provider to whom the member is granting consent;*
- *the name and address of the plan to whom the member is providing consent;*
- *an explanation of the specific service for which coverage was provided and/or denied to which the consent applies.*

The member may not submit an appeal concerning the services listed in the consent form without rescinding the consent in writing. The member may rescind consent at anytime during the process.

Continued on next page

4.4 Filing An Appeal On The Member's Behalf, Continued

Provider-Initiated Appeals On The Member's Behalf, *continued*

The appeal must be filed within one hundred and eighty (180) days from the denial to:

What Region Am I?

In the Western Region: *Member Grievance and Appeals*
Attention: Review Committee
P.O. Box 535095
Pittsburgh, PA 15253-5095

In the Central Region: *Highmark Blue Shield*
Attention: Review Committee
P.O. Box 890178-0178

***For member appeals and reconsiderations for the Federal Employees Program, please contact FEP Customer Service at 1-866-763-3608.*

An acknowledgement letter will be sent to you and to the member within five (5) business days from receipt of the appeal request.

Any appeals related to medical necessity issues are reviewed by a licensed practitioner in the same or similar specialty that typically treats the medical condition, performs the procedure or provides the treatment of the service being appeals. The practitioner will not have been involved in any previous decision to deny coverage or the subordinate of any individual that was involved in the adverse determination. Appeals related to benefit issues will be reviewed by an Appeals Administrator who was not involved in the initial determination.

For pre and post service appeals, you and the member will be notified of the decision in writing within thirty (30) days from receipt of the request.

Urgent Appeals

A request for an urgent review of a previous adverse benefit determination for medical, pharmaceutical, or behavioral health services based on medical necessity and appropriateness, filed by a member, member's authorized representative or a provider with the members written consent, when: 1) a delay in decision making might jeopardize the member's life, health, or ability to regain maximum function or when supported by a physician with knowledge of the claimants medical condition; 2) concerning the admission, continued stay or other health care services for a member who has received emergency services, but has not been discharged from a facility; or 3) concerning a concurrent review.

Verbal and written notification will be made to you and the member within seventy-two (72) hours from receipt of the request.

Continued on next page

4.4 Filing An Appeal On The Member's Behalf, Continued

Urgent Appeals, *continued*

Requests from providers may be received either verbally or in a written format. Provider requests will be accepted as expedited requests, however if a member submits the same type of request Highmark requires the provider to submit a Physician Certification Form. The form will be sent directly to the member's requesting provider and should be returned to Highmark immediately.

4.4 Provider *Appeals*

Types of Provider Appeals

There are two types of provider appeals to be used under differing circumstances:

*An **expedited** appeal is used when a member is receiving an ongoing service or is scheduled to receive a service for which coverage has been denied and the seriousness of the circumstances require that the appeal be reviewed quickly because the physician believes that the lack of service will adversely affect the member's health. This process may be used when any of the following circumstances exist:*

- *A delay in decision making might jeopardize the member's life, health or ability to regain maximum functions based on a prudent layperson's judgment and confirmed by the treating practitioner; or*
- *In the opinion of the practitioner with knowledge of the member's medical condition would subject the member to sever pain that cannot be adequately managed without the care or treatment that is the subject of the request.*
- *Concerning the admission, continued stay or other health care services for a member who has received emergency services, but has not been discharged from a facility; or*
- *Concerning a concurrent review.*

- *A **standard appeal** is used under all other circumstances, including denials resulting from retrospective reviews of services rendered without the required authorization.*

Explicit directions for filing appeals appear in the written denial notification, which is sent to the member or the member's representative, the physician and the facility, when appropriate. This process involves a telephonic or written request initiated by the provider to review a determination that denied payment of a health care service. A clinical peer reviewer who was not involved in the original denial must conduct the review.

Length Of Time To Request An Appeal

A provider has 180 days from the date of the initial denial of coverage in which to file the appeal.

Continued on next page

4.4 Provider Appeals, Continued

Peer-To-Peer Review

Peer-to-peer contact is a process that offers the member's attending physician the opportunity to present additional pertinent clinical information to support the authorization of a requested service *prior to initiating a formal appeal*. It is provided when a medical necessity denial has been rendered without a peer-to-peer conversation about the request or when additional information has become available. The physician who made the initial denial decision, or a designee, will be available within one Highmark Blue Shield business day to discuss the determination with the requesting physician. To request a Peer-to-Peer contact, call 1-866-634-6468.

Requirements In Processing *Appeals*

Highmark Blue Shield's process for reviewing *appeals* follows all applicable accreditation requirements. These include the following components:

- Review by a clinical peer reviewer who is board certified and holds an unrestricted license and is in the same or similar specialty that typically manages the medical condition, procedure or treatment under review.
- *Are neither the individual who made the original denial decision, nor the subordinate of such an individual*
- Review of the *appeal* within timeframes established by the applicable regulations and standards
- Verbal (as applicable) and written communication of the decision within timeframes established by the applicable regulations and standards.

Responsibility For Medical Treatment And Decisions

Under all circumstances, the member and the physician bear ultimate responsibility for the medical treatment and the decisions made regarding medical care.

Providers and Highmark Blue Shield employees involved in utilization management decisions are not compensated for denying coverage, nor are there any financial incentives to encourage denials of coverage.

4.4 The Expedited Provider *Appeal* Process

Steps To Request An Expedited *Appeal* For A Highmark Member

What Region Am I?

Step	Action
1	Call HMS. In the Central, Eastern and Northeastern Regions call 1-866-731-8080. In the Western Region call 1-800-547-3627, option *2* For Western Region Medicare Advantage HMO, call 1-800-485-9610.
2	An HMS care or case manager will inform the practitioner if additional information is necessary for review. The practitioner gathers the information and forwards it to the HMS care or case manager.
3	A clinical peer reviewer who was not involved in the original decision reviews the case and renders a decision to uphold or reverse the original denial.
4	The appropriate parties will be notified of the determination by telephone. The *written* notification will include, but not be limited to, the following information: • The reason/clinical rationale for the adverse determination. • The source of the screening criteria used to make the determination, if applicable. • The right to file a standard *appeal (except Medicare Advantage).* • The procedure to initiate a standard *appeal.* *Note: This does not apply to provider appeals.*
5	Within one working day of the decision (not to exceed 72 hours of receipt of the *appeal* request), a letter containing the information in step 4 will be sent to the: • *Appealing physician/provider* • Member, member's representative, *if applicable* • Primary care physician and/or specialist • Facility or ancillary provider, if appropriate

4.4 The Standard *Appeal* Process

Steps To Request A Standard *Appeal* For A Highmark Member

Step	Action
1	**In the Western Region, mail information to:** What Region Am I? **Prospective/Concurrent Appeals** Healthcare Management Services 120 Fifth Avenue Place Suite P4301 Pittsburgh, PA 15222 **Retrospective Appeals** Highmark Medical Review P.O. Box 890392 Camp Hill, PA 17089-0392 In all other Western Region cases, call: 1-800-547-3627, Option *2* **In the Central, Eastern and Northeastern Regions mail information to:** Highmark Blue Shield P.O.Box 890035 Camp Hill, PA 17089-0035 Attention: Appeals In all other Central, Eastern and Northeastern Region cases, call 1-866-731-8080.
2	HMS care or case manager communicates any additional information necessary *to conduct the* review. The provider gathers the information and forwards it to the HMS care or case manager.
3	*Within 30 calendar days of receipt of all pertinent information,* a clinical peer reviewer who was not involved in the original decision reviews the case and communicates the decision to the care or case manager by telephone.
4	HMS sends written notification of the decision to the: • Appealing physician or provider • Primary care physician, if appropriate • Facility, if appropriate • Member, member's representative
5	The communication includes: • The decision on the case • Principal reasons and clinical rationale • If applicable, a description of the source of screening criteria used to make the decision.

Chapter 4

Health Care Management

Unit 5: Quality Management

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4.5 Quality Management Program

Purpose of the Quality Management Program

The purpose of the Highmark Quality Management (QM) Program is to provide the framework and the formal processes within which the organization continually assesses and improves the quality of clinical care, safety and service provided to members. This includes the ongoing and systematic monitoring, analysis and evaluation of the accessibility, availability and continuity of medical and behavioral health care and services provided to members in the applicable products. This approach enables the organization to focus on opportunities for improving operational performance, health outcomes and member/practitioner/provider satisfaction, as well as to change perceptions.

Overall Goals Of The QM Program

- Improve the health status of the population within our service area through delivery of quality, cost effective and accessible health care service
- Anticipate the health-related needs of members and their families, and proactively match these needs with high-value programs and services
- Ensure that the right support and care is given at the right time, in the right place and for the right price
- Lead and support the advance of safe, effective patient-centered care
- Measure outcomes of care and service, and apply interventions that continuously improve the level of care and service provided to members
- Build effective partnerships with internal and external customers
- Develop and implement systems and processes within the QM Department that will function seamlessly across program components

Overall Objectives Of The QM Program

- Maintain updated and comprehensive documentation of plan patient safety activities
- Ensure ongoing compliance oversight of entities performing functions on behalf of the plan in either a delegation or other business related capacity
- Continue to develop and refine the QM Department's electronic prescribing (eRx) and electronic health record (eHR) implementation assistance program that will be designed to facilitate practitioner office transition to this new technology
- Ensure ongoing compliance and continuous audit preparedness for all applicable accrediting and regulatory bodies, for all applicable products. Specific focus will be placed on compliance activities related to the Medicare Modernization Act
- Select the Quality Improvement Project(s) (QIPs) for the FreedomBlue PPO product and ensure that data collection is initiated
- Address potential health care disparity issues in clinical and service quality through continued participation in the National Health Plan Learning Collaborative to Reduce Disparities and Improve Quality and the implementation of the Highmark Health Care Disparities/Culturally and Linguistically Appropriate Services (HCD/CLAS) Committee

Continued on next page

4.5 Quality Management Program, Continued

What Region Am I?

Overall Objectives Of The QM Program, continued

- Ensure the implementation of the statewide Hospital Quality
  - Performance Report to provide network hospitals with comparative reports of member satisfaction, patient safety activities, compliance ratings with defined clinical indicators, and various clinical measures provided through the Pennsylvania Health Care Cost Containment Council (PHC4)
- Annually evaluate the continuity and coordination of medical and behavioral health care, as well as medical care across settings or transitions in care.
- **Western Region Only:** Continue to coordinate the implementation of the Risk Adjustment Data Validation (RADV) Western Region Medicare Advantage HMO initiative that is consistent with the focus on timely submission of all relevant medical record documentation and CMS guidelines
- Demonstrate improvements in the clinical outcomes, processes and quality of health care provided to members as a result of quality improvement initiatives, based on demographic and epidemiologic characteristics of the membership
- Facilitate the collaborative efforts of various departments within Highmark towards the development of strategic clinical initiatives through the Executive/Large Clinical Planning Committee
- Establish practice guidelines for preventive health, acute and chronic care, including behavioral health, that are pertinent to the membership and measure performance against at least two important aspects of four clinical practice guidelines, two of which relate to behavioral health
- Measure availability and accessibility to care and service, including behavioral health care, at least annually to meet the specific health care needs of the Highmark membership
- Measure member satisfaction to identify and address sources of dissatisfaction through analysis of member complaint and grievance data, and analysis of annual member satisfaction surveys
- Demonstrate quality improvements that positively affect the service that members receive
- Maintain an ongoing, up-to-date credentialing and recredentialing system that is compliant with all state/federal regulations, as well as accreditation standards. Conduct regular file and directory audits at defined intervals to ensure compliance, identify opportunities for improvement and identify best practices
- Promote safety and quality in practitioner offices through office site reviews and measurement of conformance to medical record standards. Consult with practitioners regarding opportunities for improvement with record documentation and best practices to ensure that members are accessing the system appropriately for prevention and wellness, as well as chronic conditions
- Provide input and support to new corporate initiatives/programs, such as Lifestyle Returns, Pay for Performance, and Transparency
- Evaluate new technologies available to continuously improve the level of care and service provided to members (e.g., Eliza, etc.) and be a leader in promoting adoption of the new technologies to enhance corporate goals and efficiency.

Continued on next page

4.5 Prevention and Wellness

Preventive Health Guidelines

Preventive services are available for the entire plan membership which include:

- Adults over 65
- Adults ages 19-64
- Pediatrics 0-18
- Prenatal/Perinatal

Preventive health guidelines are reviewed and approved by the Quality Improvement Committee annually and revised as needed in accordance with medical evidence based on national health maintenance guidelines.

All preventive health guidelines, both new and existing, are communicated to network providers and members through written communication and/or one of Highmark's Regional Web sites accessible through www.highmark.com.

Behavioral Health

The coordination of behavioral health programs is based on an analysis of the demographic, cultural, clinical and risk characteristics of Highmark members who utilize behavioral health services.

Highmark developed a Quality Improvement Program Description that outlines in greater detail activities to monitor and improve the quality and safety of behavioral health care and the quality of service provided to members. The document outlines the behavioral health aspects of the Quality Improvement Program and is reviewed and approved annually by Highmark and related Quality Improvement Committees.

Highmark manages the inpatient utilization of behavioral health services for all members who have behavioral health care coverage through Highmark. Outpatient behavioral health services are authorized in accordance with the behavioral health benefits available for each product.

Behavioral Health Activities that Have Been Implemented Include:

- Access to care and service availability for behavioral health services.
- Communication standards to improve communication between behavioral health practitioners and primary care physicians to enhance continuity and coordination of care.
- Adoption and dissemination of clinical practice guidelines for the treatment of depression.
- Development of preventive behavioral health clinical initiatives.
- Implementation of a Depression Condition Management Program.

Continued on next page

4.5 Clinical Quality

Clinical Practice Guidelines

On an annual basis, the Quality Management Department, along with participating network physicians, review and update the Clinical Practice Guidelines. These guidelines are distributed to the provider community via NaviNet or Highmark's Regional Web sites accessible via www.highmark.com as a reference tool to encourage and assist you in planning your patients' care.

Condition Management Program

The condition management program creates an integrated approach that will concentrate on the total health care needs of members instead of focusing on one specific disease. Highmark Blue Shield will work closely with providers and members and, through provider input, will offer members the kind of services and support they need, between office visits, to more effectively follow providers' treatment plans. Examples could include support with patient-monitoring issues like medications or blood sugar levels.

Providers will play a crucial role in helping to develop specific components of the new program. Highmark Blue Shield is seeking input and suggestions from the provider community on how to:

- Better educate patients on how to help themselves when they have diseases and other medical conditions.
- Help Highmark Blue Shield tailor activities that best support the provider-patient relationship to the most positive impact on the patient.
- Streamline the program to be more patient-centered and easier to use.

Continuity and Coordination of Care

Highmark recognizes the importance of coordination of care as part of the quality continuum. There are programs and policies in place to ensure coordination of medical, behavioral health or other community support for members. This process enables Highmark to inform the membership of health care needs that require follow-up, receive training in self-care and other measures to promote their health.

The QM Department facilitates the continuity and coordination of medical care across the delivery system and also collaborates with behavioral health practitioners to monitor and improve coordination between medical and behavioral health care. The communication between PCPs and specialists is regularly monitored as part of Highmark's Quality Management Program, specifically through the medical record review program and as part of the provider satisfaction survey. During medical record review, representatives will check for the practitioner's initials on the patient's chart and ensure that any necessary follow-up actions are addressed.

Continued on next page

4.5 Clinical Quality, Continued

Continuity and Coordination of Care, continued

Network organizational providers, such as hospitals, emergency facilities, ambulatory surgery centers, home health agencies, and skilled nursing facilities must promote continuity and coordination of care for network members by communicating with PCPs when care is delivered to their patients. PCPs should expect a written description of the care given to their patients any time services have been rendered by these providers.

Patient Safety Program Activities

Highmark recognizes the importance of patient safety programs; therefore, Highmark's Patient Safety Program focuses on the development of activities which assess and improve the plan's patient safety efforts.

Many activities have been developed to enhance patient safety, including:

- Collaboration with other departmental areas to catalog the plan's various patient safety activities
- Facilitation of a Patient Safety Committee that is responsible for assessing, monitoring and reporting of the plan's patient safety activities in an effort to enhance patient safety and setting a strategic direction for the organization
- Development of a written patient safety plan for collecting and providing information on provider and practitioner safety and quality that includes:
  - Activities to collect information on provider's actions to improve patient safety
  - Activities to make performance data publicly available for members and practitioners
- Development of an electronic prescribing (eRx) and electronic health record (eHR) implementation assistance program

Quality of Care Case Reviews

The Quality Management Department is responsible for evaluating member dissatisfactions, concerns and issues related to quality of care and initiating appropriate action in response to them. The Quality Management Department becomes aware of quality of care dissatisfactions through information received from a number of sources, including providers and members as well as internal Highmark departments. Tracking mechanisms enable the Quality Management Department to monitor the information received over time.

Continued on next page

4.5 Clinical Quality Continued

Quality of Care Case Reviews, continued

Step	Who Does It?	What is Done?
1	Registered Nurse from Quality Management	Performs a preliminary review to determine whether there is potential for a quality issue. • IF NO, the case is closed. • IF YES, accepts the case for review.
2	Registered Nurse from Quality Management	Without the review of medical records, tracks the accepted case in a database for similar issues involving the provider; or Requests and reviews medical records according to Quality Management department policy. • IF medical record review indicates no potential for an adverse outcome, closes the case but maintains a record of it to track the provider for similar issues. • IF potential for an adverse outcome is identified or the provider may have contributed to an adverse outcome, passes the case to a Medical Director for review.

Continued on next page

4.5 Clinical Quality, Continued

Quality of Care Case Reviews, continued

Step	Who Does It?	What is Done?
3	A Highmark Medical Director	Reviews the case. • IF this review indicates there is no quality issue, the case is closed by the RN but maintained in the records so the provider can be tracked for similar issues. IF this review indicates that a quality issue may be present, sends a written request for a provider/practitioner response.
4	Provider/ Practitioner	Responds to the Medical Director's request for information
5	A Highmark Medical Director	Reviews the case with the additional information provided. • IF this information satisfies the concern, the case is closed by the RN and a record of the case is maintained so that the provider can be tracked for similar issues. • IF the review still indicates the presence of a quality concern, a corrective action may be initiated, depending on the severity of the issue.
6	Provider/ Practitioner	May choose to appeal these actions before a subcommittee of the Credentialing Committee.
7	Quality Management Staff	Documents the outcome of the case via the Member Dissatisfaction Tracking Database. Tracks the incident(s) and providers for similar trending patterns. Generates confidential reports from this database on a quarterly basis for the Quality Management Medical Director to take further action if needed.

4.5 Network Quality

Office Site and Medical Record Documentation Reviews

Office site and medical record documentation reviews are conducted for all initial, new and relocated PCPs, ob/gyns, independently practicing certified registered nurse practitioners and nurse midwives, and for all high-volume behavioral health sites. In lieu of performing a review, we will accept practitioners that have been recognized by the National Committee for Quality Assurance's (NCQA's) Physician Practice Connections Program. The office must provide a copy of NCQA's recognition letter as evidence. Reviews will continue to be conducted triennially for all dual-credentialed practitioners.

General Elements Assessed During a Review

CPR Certification

Office Site Evaluation

- Handicapped parking
- Adequate waiting rooms
- Physical appearance of the office
- Adequate exam rooms
- Fire extinguishers
- Emergency/evacuation plan
- Handicapped accessibility
- Secure medical/treatment records
- Marked exits
- Proper handling of biohazardous waste
- Proper sterilization of equipment
- Properly secured medication and prescription pads
- Emergency drugs and airway equipment availability
- Proper storage of medications and lab specimens
- Confidentiality

Office Accessibility

- Physician availability at least 20 hours per week
- Availability of emergent, urgent, routine and preventive appointments
- Guidelines for phone triage, advance directives, disclosure of confidential information
- Coverage availability 24 hours a day, seven days per week

Continued on next page

4.5 Network Quality, Continued

General Elements Assessed During a Review, continued

Medical Records Documentation

- Personal biographical data
- Problem lists
- Preventive services flow sheet
- All entries dated
- Past medical history
- Vital signs at each visit
- Coordination of care and notation of follow-up plans
- History & Physical identifies pertinent subjective and objective data
- Immunizations as recommended for age
- Preventive health services as recommended for age and sex
- Medication flow sheet
- Medication allergies and adverse reactions
- All entries contain author identification
- Use of cigarettes, alcohol and substance abuse
- Discussion of advance directives
- Growth and development appropriate for age
- The Plan's Primary Medical Record Standards shall reflect:
  - ➢ all services provided directly by a PCP
  - ➢ all ancillary services and diagnostic tests ordered by a practitioner
  - ➢ all diagnostic and therapeutic services for which a member was referred by practitioners, such as:
    - home health nursing reports
    - specialty physician reports
    - hospital discharge reports
    - physical therapy reports

Treatment Record Documentation (for behavioral health practitioners)

Personal biographical data

- Psychiatric history
- Developmental history
- Mental status exam
- Risk factors
- Identification of DSM-IV diagnoses
- Treatment plan and goals

Continued on next page

4.5 Network Quality, Continued

General Elements Assessed During a Review, continued continued

Other indicators are also reviewed. A detailed list is available by calling 717-302-3353. All office site reviews will be scored in the aggregate for each component of the comprehensive site visit tool used by Highmark: Environmental Assessment, Medical/Treatment Record Documentation and Preventive Services Review. A score of at least 80 percent on the Environmental Assessment, Medical Record Documentation and Preventive Services evaluation must be met.

Assessments may also be conducted in response to information obtained from quality improvement activities, including member complaints. To monitor the network for ongoing compliance, a statistically valid random sample of practice sites will undergo an evaluation using selected components of the elements listed on this page. These evaluations require an aggregate visit score of 80 percent.

Practices not meeting PremierBlue Shield compliance standards on office site, medical/treatment record or preventive services evaluations are expected to correct the deficiencies and will be re-evaluated within six months. The re-evaluation will be a reassessment of the non-compliant elements from the previous site review. (Practices failing to correct deficiencies may be sanctioned and become ineligible for QualityBLUE bonus payments. Practices with office deficiencies on repeated re-evaluations may be terminated from network participation.)

Partners In Quality Toolkit

Highmark's Quality Management Department staff has a selection of resource materials that network providers may find useful. NaviNet-enabled providers can find the Partners in Quality Toolkit on NaviNet under the Clinical Reference Materials link in the Provider Resource Center. Non-NaviNet providers may obtain a CD of the Partners in Quality Toolkit by faxing a request to 1-412-544-2619.

4.5 Service Quality

Member Satisfaction Monitoring	Annual member satisfaction surveys are conducted, using a statistically valid sample of the membership, to ensure that the plan identifies potential areas for service quality improvements. Results of the survey are reviewed by the Quality Management Department, the Survey Analysis Committee, the Quality Operations Committee, and are reported to the Quality Improvement Committee and Quality Management Council. Member satisfaction is also monitored through review of member dissatisfactions, complaints and appeals.

Chapter 4

Health Care Management

Unit 6: Quality Management

In This Unit

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Prevention and Wellness	4
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Network Quality	9
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4.6 Quality Management Program

Purpose of the Quality Management Program

The purpose of the Highmark Quality Management (QM) Program is to provide the framework and the formal processes within which the organization continually assesses and improves the quality of clinical care, safety and service provided to members. This includes the ongoing and systematic monitoring, analysis and evaluation of the accessibility, availability and continuity of medical and behavioral health care and services provided to members in the applicable products. This approach enables the organization to focus on opportunities for improving operational performance, health outcomes and member/practitioner/provider satisfaction, as well as to change perceptions.

Overall Goals Of The QM Program

- Improve the health status of the population within our service area through delivery of quality, cost effective and accessible health care service
- Anticipate the health-related needs of members and their families, and proactively match these needs with high-value programs and services
- Ensure that the right support and care is given at the right time, in the right place and for the right price
- Lead and support the advance of safe, effective patient-centered care
- Measure outcomes of care and service, and apply interventions that continuously improve the level of care and service provided to members
- Build effective partnerships with internal and external customers
- Develop and implement systems and processes within the QM Department that will function seamlessly across program components

Overall Objectives Of The QM Program

- Maintain updated and comprehensive documentation of plan patient safety activities
- Ensure ongoing compliance oversight of entities performing functions on behalf of the plan in either a delegation or other business related capacity
- Continue to develop and refine the QM Department's electronic prescribing (eRx) and electronic health record (eHR) implementation assistance program that will be designed to facilitate practitioner office transition to this new technology
- Ensure ongoing compliance and continuous audit preparedness for all applicable accrediting and regulatory bodies, for all applicable products. Specific focus will be placed on compliance activities related to the Medicare Modernization Act
- Select the Quality Improvement Project(s) (QIPs) for the FreedomBlue PPO product and ensure that data collection is initiated
- Address potential health care disparity issues in clinical and service quality through continued participation in the National Health Plan Learning Collaborative to Reduce Disparities and Improve Quality and the implementation of the Highmark Health Care Disparities/Culturally and Linguistically Appropriate Services (HCD/CLAS) Committee

Continued on next page

4.6 Quality Management Program, Continued

What Region Am I?

Overall Objectives Of The QM Program, continued

- Ensure the implementation of the statewide Hospital Quality
  - Performance Report to provide network hospitals with comparative reports of member satisfaction, patient safety activities, compliance ratings with defined clinical indicators, and various clinical measures provided through the Pennsylvania Health Care Cost Containment Council (PHC4)
- Annually evaluate the continuity and coordination of medical and behavioral health care, as well as medical care across settings or transitions in care.
- **Western Region Only:** Continue to coordinate the implementation of the Risk Adjustment Data Validation (RADV) Western Region Medicare Advantage HMO initiative that is consistent with the focus on timely submission of all relevant medical record documentation and CMS guidelines
- Demonstrate improvements in the clinical outcomes, processes and quality of health care provided to members as a result of quality improvement initiatives, based on demographic and epidemiologic characteristics of the membership
- Facilitate the collaborative efforts of various departments within Highmark towards the development of strategic clinical initiatives through the Executive/Large Clinical Planning Committee
- Establish practice guidelines for preventive health, acute and chronic care, including behavioral health, that are pertinent to the membership and measure performance against at least two important aspects of four clinical practice guidelines, two of which relate to behavioral health
- Measure availability and accessibility to care and service, including behavioral health care, at least annually to meet the specific health care needs of the Highmark membership
- Measure member satisfaction to identify and address sources of dissatisfaction through analysis of member complaint and grievance data, and analysis of annual member satisfaction surveys
- Demonstrate quality improvements that positively affect the service that members receive
- Maintain an ongoing, up-to-date credentialing and recredentialing system that is compliant with all state/federal regulations, as well as accreditation standards. Conduct regular file and directory audits at defined intervals to ensure compliance, identify opportunities for improvement and identify best practices
- Promote safety and quality in practitioner offices through office site reviews and measurement of conformance to medical record standards. Consult with practitioners regarding opportunities for improvement with record documentation and best practices to ensure that members are accessing the system appropriately for prevention and wellness, as well as chronic conditions
- Provide input and support to new corporate initiatives/programs, such as Lifestyle Returns, Pay for Performance, and Transparency
- Evaluate new technologies available to continuously improve the level of care and service provided to members (e.g., Eliza, etc.) and be a leader in promoting adoption of the new technologies to enhance corporate goals and efficiency.

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4.6 Prevention and Wellness

Preventive Health Guidelines

Preventive services are available for the entire plan membership which include:

- Adults over 65
- Adults ages 19-64
- Pediatrics 0-18
- Prenatal/Perinatal

Preventive health guidelines are reviewed and approved by the Quality Improvement Committee annually and revised as needed in accordance with medical evidence based on national health maintenance guidelines.

All preventive health guidelines, both new and existing, are communicated to network providers and members through written communication and/or one of Highmark's Regional Web sites accessible through www.highmark.com.

Behavioral Health

The coordination of behavioral health programs is based on an analysis of the demographic, cultural, clinical and risk characteristics of Highmark members who utilize behavioral health services.

Highmark developed a Quality Improvement Program Description that outlines in greater detail activities to monitor and improve the quality and safety of behavioral health care and the quality of service provided to members. The document outlines the behavioral health aspects of the Quality Improvement Program and is reviewed and approved annually by Highmark and related Quality Improvement Committees.

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4.6 Clinical Quality, Continued

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Continued on next page

4.6 Clinical Quality Continued

Quality of Care Case Reviews, continued

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Continued on next page

4.6 Clinical Quality, Continued

Quality of Care Case Reviews, continued

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4.6 Network Quality

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General Elements Assessed During a Review

CPR Certification

Office Site Evaluation

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- Adequate exam rooms
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- Proper sterilization of equipment
- Properly secured medication and prescription pads
- Emergency drugs and airway equipment availability
- Proper storage of medications and lab specimens
- Confidentiality

Office Accessibility

- Physician availability at least 20 hours per week
- Availability of emergent, urgent, routine and preventive appointments
- Guidelines for phone triage, advance directives, disclosure of confidential information
- Coverage availability 24 hours a day, seven days per week

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4.6 Network Quality, Continued

General Elements Assessed During a Review, continued

Medical Records Documentation

- Personal biographical data
- Problem lists
- Preventive services flow sheet
- All entries dated
- Past medical history
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- Medication flow sheet
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- All entries contain author identification
- Use of cigarettes, alcohol and substance abuse
- Discussion of advance directives
- Growth and development appropriate for age
- The Plan's Primary Medical Record Standards shall reflect:
  - ➢ all services provided directly by a PCP
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  - ➢ all diagnostic and therapeutic services for which a member was referred by practitioners, such as:
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    - specialty physician reports
    - hospital discharge reports
    - physical therapy reports

Treatment Record Documentation (for behavioral health practitioners)

Personal biographical data

- Psychiatric history
- Developmental history
- Mental status exam
- Risk factors
- Identification of DSM-IV diagnoses
- Treatment plan and goals

Continued on next page

4.6 Network Quality, Continued

General Elements Assessed During a Review, continued continued

Other indicators are also reviewed. A detailed list is available by calling 717-302-3353. All office site reviews will be scored in the aggregate for each component of the comprehensive site visit tool used by Highmark: Environmental Assessment, Medical/Treatment Record Documentation and Preventive Services Review. A score of at least 80 percent on the Environmental Assessment, Medical Record Documentation and Preventive Services evaluation must be met.

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Partners In Quality Toolkit

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4.6 Service Quality

Member Satisfaction Monitoring

Annual member satisfaction surveys are conducted, using a statistically valid sample of the membership, to ensure that the plan identifies potential areas for service quality improvements. Results of the survey are reviewed by the Quality Management Department, the Survey Analysis Committee, the Quality Operations Committee, and are reported to the Quality Improvement Committee and Quality Management Council. Member satisfaction is also monitored through review of member dissatisfactions, complaints and appeals.

Chapter 5

Claims Submission

Unit 1: Benefits of Electronic Communication

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5.1 Electronic Connections

Overview

Highmark Blue Shield provides you the convenience and cost savings of electronic data interchange (EDI) through various means.

This unit will provide information about the *some of the* most common forms of provider electronic exchanges with Highmark: streamlined claims filing, acknowledgement information about your claims, inquiry features, *and information retrieval.*

Learn more about them by visiting Electronic Data Interchange (EDI) Services via the Provider Resource Center or by clicking www.highmark.com/edi to access the site directly. This site provides up to the minute information about transaction specifications, Trading Partner requirements, and enrollment applications.

How to Save Money and Increase Effectiveness Through EDI

Everyone has a stake in health care cost containment. Health care professionals, patients, insurance companies and state and federal government are all affected by the high price of maintaining good health.

Fortunately, technology can help simplify business operations and thus, cut costs. EDI makes electronic communications a viable method of streamlining claims processing and eliminating wasted time and money.

EDI is the computer-to-computer delivery of information. This technology is not new. Each time you make an ATM deposit or withdrawal or make a purchase with a bank or department store credit card, an EDI transaction takes place. EDI transactions provide convenience, efficiency and transactional record management.

Because of the inherent speed and cost-effectiveness, electronic transactions and online communications are integral to today's business world. Electronic transactions between health care professionals and insurers are essential to maintain efficiency and are, in fact, encouraged by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Highmark Offers Electronic Services

Highmark Blue Shield supports a variety of HIPAA compliant electronic claims and inquiry transactions. To find out more about the EDI services available to Highmark Trading Partners in support of their electronic business activities, visit the EDI Services Web site via either the Resource Center or www.highmark.com/edi.

Continued on next page

5.1 Electronic Connections, Continued

Highmark Offers Electronic Services, continued

The Provider Resource Center includes a link to Highmark Blue Shield's HIPAA site that provides a broad range of information requested daily by health care professionals and health care software vendors.

5.1 Electronic Claim Submission Benefits

How Electronic Claims Submission Works	All it takes is a desktop PC, the proper software and an Internet connection. Instead of printing, bundling and sending paper claims through the mail, you simply enter and store claim data in your office computer, through a practice management system. Then, as often as you wish, you either connect to the internet or dial a toll-free number and transmit the claim information to your clearinghouse, billing service or directly to Highmark Blue Shield.
Faster Claim Payment	Electronic claims are convenient and confidential and operational around the clock. Highmark Blue Shield's claim processing system places a higher priority on claims filed electronically. Electronic claims will typically process in 7 to 14 calendar days, whereas paper claims will process in 21 to 27 calendar days. These payment targets are in compliance with timely claims payment regulations defined by Act 68 of 1998 (Article II: the Provision For Quality Health Care Accountability and Protection) and reflect processing of claims that do not require manual intervention or investigation.
Cost Effective	Electronic claim submission increases staff productivity by speeding claim preparation and delivery. Many of the paper claim processes are eliminated such as form printing, bundling, postage and mailing. Many errors experienced in the keying and processing of paper claim forms are reduced or eliminated. Electronic claim submission means greater claim acceptance rates and reduced staff time in claim research and resubmissions.
Convenient and Confidential	Electronic submission provides the added benefit of both claim preparation and delivery at your convenience. Postal service hours of operation or delays do not limit your productivity. Electronic claims can be submitted 24 hours a day, seven days a week, 365 days a year. It is safe, immediate and direct to Highmark Blue Shield. EDI security standards are in place to ensure your claim data remains confidential and secure.
For More Information On EDI	Learn more about the benefits of electronic claims submission by visiting Electronic Data Interchange (EDI) Services via the Provider Resource Center or by clicking www.highmark.com/edi to access the site directly.

5.1 About Trading Partners

What is a Trading Partner?

A trading partner is an entity that conducts business electronically with Highmark.

Providers, clearinghouse/billing services and software vendors are the most common types of trading partners who enter into agreements with Highmark.

The Trading Partner Agreement

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

To view the Provider Trading Partner Agreement in its entirety, visit the EDI Services Web site at www.highmark.com/edi and select Enrollment Application from the fly out. You can also reach the site from the Provider Resource Center.

Trading Partner Types

A Provider is a Highmark assigned professional or institutional provider or organization in whose name the bill is submitted and to whom payment should be made.

- Billing Providers doing their own electronic billing using a vendor software package must apply for their own Trading Partner number.
- Billing Providers using a billing service or clearinghouse to conduct electronic billing must be affiliated with the Trading Partner number of the billing service or clearinghouse.
- Providers doing their own electronic billing using a vendor software package must apply for their own Trading Partner number.
- Providers using a billing service or clearinghouse to conduct electronic billing must be affiliated with the Trading Partner number of the billing service or clearinghouse.
- A Clearinghouse/Billing Service is an entity who submits claims, or other transactions on behalf of professional or institutional providers.
- Billing Services and Clearinghouses must obtain their own Trading Partner numbers for conducting electronic business with Highmark. In addition, customers (providers) must be affiliated to their Trading Partner number(s).

Continued on the next page

5.1 About Trading Partners, Continued

EDI Transaction Application

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

To complete an application visit Electronic Data Interchange (EDI) Services Web site via either the Provider Resource Center or www.highmark.com/edi

HIPAA Production Ready Entities

The EDI Services Web site maintains a list of, Clearinghouses, Billing Services and Software Vendors who have executed a Trading Partner Agreement with Highmark Blue Shield and have conducted successful testing of both their software, and connectivity with EDI Operations.

The list can be found under the Helpful Links section of the Electronic Data Interchange (EDI) Services Web site.

5.1 Getting Started with Electronic Claims Submission

Considerations Before Making The Transition From Paper To EDI

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

There are numerous things to consider when selecting an EDI vendor or clearinghouse. List your needs, determine your budget and talk to others in your specialty who are using EDI.

Selecting The Right EDI Option

Practice Management System Vendor

Purchase a complete system from a reputable vendor. Complete system solutions typically include the hardware (personal computer, monitor, modem and printer) and the software, which includes electronic claims submission and possibly accounts receivable posting capabilities. Terms and conditions of each system vary from vendor to vendor.

Clearinghouse or Billing Service

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

Selecting A Practice Management Vendor

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

- Do they offer electronic claims submission of Highmark Blue Shield claims? Is the transmission direct, or through an intermediary such as a clearinghouse? Is this capability offered with the basic electronic claims submission module at no additional charge?
- Can they support the submission of secondary claims and additional documentation electronically?
- Does the software capture and print the electronic reports provided by Highmark?
- Do they offer clearinghouse capabilities?
- How is installation performed?
- Ask about training on the software and if there on-going education provided. Is system help available (online or through paper manuals)?
- How much additional office software is included (word processing, e-mail)?
- Do they offer Internet access?

Continued on next page

5.1 Getting Started with Electronic Claims Submission,
Continued

Selecting A Practice Management Vendor, continued

- Can you get a list of their clients in your specialty? What is the average turnaround time for a service call?
- What is the cost of the system? What features are standard with the system?
- When there are changes in Highmark Blue Shield reporting requirements, how long will it take to update your software and how is it updated? What is the cost of normal updates, customization requests and annual maintenance fees?
- What hardware is included (PC configurations, modems, terminals)?
- Are you getting color monitors or black and white?
- Is the workstation a "dumb terminal" or a PC?
- Will the system automatically bill for co-insurance, copayment or deductible after the primary insurance pays you?
- What other services do they offer (free conversion, loaner hardware)?
- Do they provide remittance advice information? Is there a fee for this package?
- What computer operating systems do they support?

Selecting A Clearinghouse/ Billing Service

Questions for a billing service:

- How frequently do they submit your claims to the carriers involved?
- What kind of tracking reports do they offer to their clients?
- Do they provide credit and collection services?
- What is the cost per transaction?

5.1 Claim Record Management

Claims Record Management

Highmark Blue Shield provides electronic acknowledgements, enhancing your ability to track and monitor your claim transactions. The Administrative Simplification Electronic Transactions and Code Sets rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), named the 'ASC X12N 837 Health Care Claim: Professional' transaction as the mandated standard to be used for electronic submission of professional claims and encounters.

Transactions Associated With Electronic Claims Submission

Electronic claims can be submitted via the 837 Professional Health Care Claim Transaction. Upon receipt of the 837 transaction, there are several acknowledgement transactions available for tracking electronic claim submissions and payment depending on the capabilities of your software.

- 997 – Functional Acknowledgement
- 277CA– Claim Acknowledgement
- 835– Electronic Remittance Advice ERA

997 – Functional Acknowledgement Overview

This transaction is available after transmission of the claim(s) file on the same day you transmit your claim(s). It verifies that Highmark Blue Shield received your claim(s) file and indicates the file was "accepted" or "rejected" for further claim editing. The 997 Functional Acknowledgement should be reviewed after every 837 file submission to ensure you know the status of the file submission.

277CA – Claim Acknowledgement Overview, continued

This transaction is available approximately 24 hours after an accepted/accepted with errors 997 Functional Acknowledgement report is accepted. After the EDI claim editing process is complete, you are able to verify through the 277CA (Claim Acknowledgement) transaction that your claims were accepted and forwarded for claim processing. The 277CA also identifies claims that did not pass or were rejected by the editing process due to data errors. The 277 CA's should be reviewed after every accepted/accepted with errors claim file transmission because they provide a valuable and detailed analysis of your claim file. Claims that were accepted should not be resubmitted. *Highmark will no longer attempt to correct or retrieve missing information, this* **rejected claim data must be corrected and the claim resubmitted electronically.**

For electronic claim submitters that are not able to interpret the 277CA Transaction, a text format Claim Acknowledgement Report has been developed. Electronic submitters must work with their software vendor to determine which report works best with their practice management system.

Continued on next page

5.1 Claim Record Management, Continued

Tip Sheet - New!

New Edit Checks Reported on 277 Report

Effective April 11, 2008 Highmark added new up front edit checks to its claims processing in an effort to streamline the process and increase provider satisfaction. The checks review incomplete and inaccurate electronic claims to prevented them from entering the system.

When a claim rejects, it is important for your billing staff and/or vendor to understand exactly what was wrong and what is needed to correct it.

For claims submitted using the HIPAA 837 transaction, you may encounter the following error codes and descriptions on your 277 CA report:

Claim Status Code	***Claim Status Category Code***	***Claim Status Code Description***	***Claim Status Category Code Description***
454 and 145 with Entity code 85	*A8*	*Procedure code for services rendered Entity's specialty/taxonomy code (Entity code 85 = Billing Provider*	*Acknowledgement/ Rejected for relational field in error*
475	*A3*	*Procedure code not valid for patient's age*	*Acknowledgement/ Returned as unprocessable claim*

835– Electronic Remittance Advice ERA

This transaction contains finalized claim payment information including payment when issued, used for automated account posting.

Continued on next page

5.1 Claim Record Management, Continued

835– Electronic Remittance Advice (ERA) Health Care Claim Payment/ Advice (ASC X12 835)

The Health Care Claim Payment Advice (835) is essentially an electronic version of a paper Explanation of Benefits notice. When 835 (ERA) information is combined with an Accounts Receivable System (ARS), it provides an efficient method of reconciling your patients' accounts by providing financial information relating to your claim payments and denials. Your software vendor can advise you on your system's ERA and ARS capabilities. Highmark's ERA (835 transactions) are created on a weekly or daily basis to correspond with our weekly or daily payment cycles. Contact your software vendor to determine if your software is ERA capable. This transaction can help you reduce costs and improve office efficiency.

Its benefits are:

- **Eliminates posting errors**
  Little to no manual intervention, depending on the AR system, is necessary with electronic 835 posting. Errors associated with manual keying of payment data are eliminated.

- **Reduces posting time**
  The 835 information allows you to electronically post payments to your AR system in a matter of minutes or hours instead of days. Actual posting time is dependent on the practice size and AR system. Electronic posting allows your staff more time to attend to patient needs, instead of administrative tasks.

- **Accelerates payment process**
  Electronic posting accelerates your ability to perform secondary billing of non-contractual financial liabilities. 835 information is available online Monday through Friday and can generally be retrieved before the paper EOB arrives in the mail. This means you can start your posting and subsequent secondary billing processes upon receipt of the electronic file.

For More Information On Claims Record Management

To learn more about claims record management transactions please visit the Electronic Data Interchange (EDI) Services Web site via the Provider Resource Center or by clicking www.highmark.com/edi to access the site directly.

5.1 Next Steps: Electronic Claims Submission

Enrollment

Whether you select a practice management system or a billing service, the next step is to enroll as an EDI Trading Partner.

Enroll online by visiting the Electronic Data Interchange (EDI) Services Web site via the Provider Resource Center or by clicking www.highmark.com/edi to access the site directly.

Upon receiving your completed application, EDI Operations will process your request, verify that you have a valid Highmark Blue Shield billing provider record, identified by a Highmark provider ID and/or a National provider Identifier (NPI). A Trading Partner ID will then be assigned to you.

Within 5 to 10 business days you should receive an authorization letter in the mail listing your assigned electronic Trading Partner number, login identification and the toll-free transmission telephone number.

Testing

Although testing is not required, we strongly recommend that new electronic billers transmit test claims before submitting production electronic claims. If you decide to test, a test file with a minimum of 10 test claims is recommended.

Where To Find Support

The EDI Web site at www.highmark.com/edi has the most up to the date information about doing business electronically with Highmark. Highmark recommends that you bookmark this site and consider it your first source when you have a problem or question.

The Highmark Blue Shield EDI Operations support staff is comprised of trained personnel dedicated to supporting electronic communications. They provide information and assistance with questions or problems you encounter with any aspect of your EDI transactions. Support is free and staff is available Monday through Friday from 8 a.m. to 5 p.m. EST.

To contact a support analyst by phone, call 1-800-992-0246. To save time when calling, be prepared to provide your Trading Partner number, billing provider number (NPI or Highmark provider number) and log-on identification to the support analyst.

Continued on next page

5.1 Next Steps: Electronic Claims Submission, Continued

Accessible 24 Hours A Day, 7 Days A Week

Electronic transactions can be sent and retrieved seven days a week, 24 hours a day. Electronic transactions can be submitted once or multiple times per day or week. Claim transmittal and report retrieval schedules are controlled by each office.

Information on EDI Claim Submission can be found on the EDI Web site by visiting the Electronic Data Interchange (EDI) Services Web site via the Provider Resource Center or by clicking www.highmark.com/edi to access the site directly. The EDI Web site contains information on:

- Getting Started with Electronic Claims Submission
- Selecting a Practice Management Vendor
- Health Care Claim Payment/Advice
- Where to Enroll for Electronic Claims Submission
- Where to find support
- Technical specification EDI Reference Guide

5.1 Getting Started with EDI/ Making Changes to your Practice Information

Background

Your Provider Profile at Highmark Blue Shield includes many facts about your practice such as:

- Practice name
- Address (both practice locations and where checks should be sent)
- Billing Provider Identification Number, e.g. NPI, Highmark Assignment Account number, and/or Highmark Individual Provider Identifier
- Individual Practitioners who submit claims under this Billing Provider Number
- NPI or Highmark Provider Identification number for each Practitioner

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

When To Notify EDI

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

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

Continued on next page

5.1 Getting Started with EDI/ Making Changes to your Practice Information, Continued

Report Changes Immediately

The Provider Information Change transaction within NaviNet allows you to make several types of changes to your Provider Profile. The two that could directly affect your claims payment are:

- Edit an existing address
- Add a new address

* Consider using NaviNet to report these changes.

As an electronic biller, you will need to notify Highmark EDI Operations of some changes that take place at your office as soon as possible.

Address Change

If your practice does their own billing (the Trading Partner Agreement is in the practice name), it will be necessary to report address changes to EDI Operations.

Additionally, address changes for your provider number must be reported to Provider Information Management. Please send all updates to:

What Region Am I?

Provider Information Management
P.O. Box 898842
Camp Hill, PA 17089-8842

Western Region Fax: 1-800-236-8641
Central Region Fax: 1-866-731-2896
Northeastern Pennsylvania:
If your main practice is located in one of the counties located in the 13 county area serviced by Blue Cross of Northeastern Pennsylvania (Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan Susquehanna, Tioga, Wayne, and Wyoming) please call 1-800-451-4447.

Changes in Physician Staff
Please complete the EDI Trading Partner Update form if you need to add or remove a new provider to your Trading Partner number (but only if the new provider will receive checks directly from Highmark Blue Shield).

5.1 Getting Started with EDI/ Making Changes to your Practice Information, Continued

View Your Trading Partner Profile Online	Highmark Blue Shield has created a secure online service to view your Trading Partner Profile as often as needed. Visit the EDI Services site at www.highmark.com/edi or via the Provider Resource Center. After logging in you will be able to view the basic demographics of the Trading Partner, affiliated providers, contact information and status of HIPAA setup.
Reporting Changes To Your Trading Partner Profile	If after viewing your Trading Partner Profile you need to report changes to Highmark Blue Shield a new EDI Transaction Enrollment Application must be submitted. The application can be found on the Enrollment Application page of the EDI Web site.
If you Obtain A New Assignment Account Number	You will receive a letter from Provider Information Management if a new Assignment Account (Group Practice) number has been assigned to your practice, along with the effective date of the new number. **IMPORTANT!** Do not submit any claims to Highmark Blue Shield using the Account name and number prior to the effective date, otherwise incorrect payments and/or rejections of your claims could result. Attaching the new Assignment number to your current Trading Partner Number is not an automated process. If you would like to add your new number for electronic billing or inquiry purposes you will need to complete an EDI Transaction Application for claims and inquiry. The application is available through the EDI Services Web site at www.highmark.com/edi. You can also reach this Web site from the Provider Resource Center.
Provider Profile Questions?	If after visiting the EDI Web site you still have questions about your Trading Partner Profile, call EDI Operations at (800) 992-0246.
Enrollment	Whether you select a practice management systems or a billing service, the next stop is to enroll as an EDI Trading Partner.

5.1 Claim Submission Formats

Required Formats

Use the following table to determine the required format for submitting claims:

If you submit	Use one of these formats
Electronically	ASC X12N 837 Health Care Claim: Professional version 004010A1 (HIPAA mandated version)
On paper	CMS-1500 (08/05)(Formerly the HCFA-1500) Note: If you are using paper forms, please submit the original claim form. Submitting a photocopy delays processing.

Electronic Billing and EDI Assistance

For assistance with electronic submission of claims and encounters and other EDI transactions, visit the Electronic Data Interchange (EDI) Services section of the Provider Resource Center. Through the website you will be able to:

- Sign-Up to perform EDI transactions
- Obtain technical companion specifications (Provider EDI Reference Guide)
- Obtain a listing of software vendors, clearinghouses and billing services that are 'HIPAA Transaction Ready' with Highmark

Where Payments Will Be Sent

The check and the Explanation of Benefits (EOB) are sent to the address on our files at the time of payment. Remember to report any address changes as identified previously.

5.1 The Top Ten Billing Errors—And How to Avoid Them

Common Claims Reporting Errors

Claims processing experts identified the top ten common errors that cause claims to process incorrectly. Please review the Trading Partner Portal for documentation on Highmark's transition to the National Provider Identifier to identify providers.

Tip Sheet

Some Practices Make These Errors	Correction
Incorrect provider number listed	If practices are unsure which number to use (assignment account/group or individual practitioner/group member), they should seek advice from their Provider Relations representative. Generally, the billing provider number is the assignment account, while the performing provider number is the individual practitioner.
Performing provider name and number	The performing practitioner name and practitioner identification number should be reported on the claim when it is different than the billing provider identification number.
Invalid place of service codes submitted and/or the facility name and number is not listed	Ensure the correct place of service code is being used. Ensure a facility name and identification number are reported when the place of service is different than the billing provider's service location (ex. Hospital or SNF).
NOC (not otherwise classified) codes listed without descriptions	Descriptions of the service provided must be reported on the claim for NOC codes.
Applicable coordination of benefits/other insurance information and/or documentation is not accompanying the claim	Please make an effort to report electronically or attach coordination of benefits/other insurance information
Member identification numbers are incomplete	List the complete member identification number including any alpha prefix.
Zero charges or adjustments are being reported	Unless the claim is an encounter, zero dollars or blank charges are not acceptable.
Claims are range dated, but the number of services do not clearly correspond with the date range (e.g., indication that services were performed 01-01-04 through 01-10-04, but list only 5 services)	When services span over a period of days, the number of services should correspond on a one-on-one basis if you are range dating (indicating that services span from one date through another date). If they do not correspond on a one-on-one basis, you should itemize the services.
Submit HCPCS codes that are not valid for the time the service was rendered (e.g., billing for a service performed in 2006 with a code that wasn't in place until 2007 or vice versa)	Report correct and valid procedure codes that reflect the correct date of service.
Invalid diagnosis code	Report diagnosis codes that are the highest degree of specificity and valid for the date of service.

5.1 The Provider Resource Center

What Region Am I?

The Provider Resource Center

The Provider Resource Center (PRC) is a repository of pertinent reference materials. This special section of our Web site is specifically dedicated to Highmark providers and contains lots of helpful information and resources to help in your daily interactions with Highmark members and with Highmark.

We encourage you to bookmark the site and take advantage of this convenient reference tool. Click the links below to access the PRC applicable to your region.

- *Central, Eastern and Northeastern Region Provider Resource Center*
- *Western Region Provider Resource Center*

The Resource Centers also contain information, including but not limited to:

- *Current and Archived Newsletters, Recent Mailings*
- *The Highmark Blue Shield Office Manual & Tip Sheets*
- *Radiology Management Program*
- *BlueCard*
- *Clinical Reference Materials*
- *Quick Links To Provider Manuals*
- *The QualityBlue Program*
- *Medical & Claim Payment Guidelines*
- *Pharmacy/Formulary Information*
- *EDI Services*

How To Access The Provider Resource Center

The main page of the Provider Resource Center can be accessed two ways:

Public PRCs can be accessed through our public member sites by clicking the provider tab in the upper right hand corner.

The second way you can access the PRC is by securely logging in to NaviNet and clicking on the Resource Center button from the left navigation bar.

5.1 Highmark's Member Web sites

Highmark's Informational Member Web Sites

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

What Region Am I?

Highmark has two region specific sites for member information.

- *Central, Eastern and Northeastern Region Member Site*
- *Western Region Member Site*

The Member Web sites contain information, including but not limited to:

- *Benefit Information – Highmark Individual Benefits and Highmark Group Benefits – provides information on Highmark's full-service health insurance programs. This information is included to assist your office in directing Highmark members when they have these types of questions. Benefit information can be found under the 'Members' section of Highmark's informational member sites.*
- *Find a doctor, hospital or other medical provider, even network vision providers*
- *Locate a Pharmacy – this site allows members to find a pharmacy near their home. Pharmacy information can be found under the 'Find a Pharmacy' selection on Highmark's informational member sites.*
- *Billing Information*
- *Detailed Information for Medicare beneficiaries*
- *Health Savings Accounts*

How To Use Highmark's Member Web Sites

Tip Sheet – New!

Highmark's member sites provide hundreds of topics for you and our members. Whether our members are looking for a health care provider or managing claim or want to make informed health care decisions on treatment options or lead a healthier lifestyle, Highmark can help with easy-to-use online tools and resources. Our web sites have everything you need to help our members have a greater hand in your health.

Members should take advantage of our online resources especially when preparing for their office visits. Please click the tip sheet above for more information on how to use our member web site.

Chapter 5

Claims Submission

Unit 2: Claims Submission and Billing Information

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5.2 Verifying Eligibility

Overview

Highmark Blue Shield processes over 326,000 medical claims per day. During 2006, it processed over 81 million medical claims. The Company could not have accomplished this without the cooperation of providers, office and medical assistants who prepare and submit claims to Highmark Blue Shield.

Verifying Eligibility

There are several ways to verify eligibility of Highmark Blue Shield members: member identification cards, NaviNet, the EDI 270/271 transaction, InfoFax, and OASIS.

To verify eligibility for BlueCard members, please use NaviNet or call 1-800-676-BLUE. For additional information about BlueCard, refer to the BlueCard Information Center located on the Provider Resource Center of NaviNet or the Highmark Web site.

Member Identification Cards

Highmark Blue Shield issues members a variety of identification cards, depending upon the type of program and the location of the Blue Plan through which members are enrolled. Practices with the fewest claim submission errors generally require the member to show the current ID card with each visit and verify eligibility on every visit/service. This is why it is important that you check the member's identification card prior to each visit or service you provide. Generally, the identification card includes the following information:

- Subscriber's name; dependent's name;
- Identification number – alpha numeric* characters used to identify the member (the member's Unique Member Identifier [UMI]);
- Group number – a series of alphabetical and numeric characters assigned to employment groups, professional associations and direct payment programs;
- Plan code – three digits that identify the Blue Plan through which the member is enrolled;
- Type of agreement – a brief description of the type of agreements and coverage of the member. Not all identification cards have this information;
- BlueCard – all BlueCard members can be identified by a three-digit alphabetical prefix preceding the member identification number on their identification card. Always report the three-digit alpha prefix from any ID card.

*Alphabetical prefixes are used in conjunction with the identification number to identify the member's coverage. Members may have more than one identification card, depending on the type(s) of coverage in which members are enrolled. Please verify the correct alpha prefix is billed for the type of service reported.

Continued on next page

5.2 Verifying Eligibility, Continued

Member Identification Cards, continued

Examples of some identification cards are included in Chapter 3, Unit 2. Since the Blue Plans periodically update the format of the identification cards, the information provided on the sample identification cards may change without prior notice.

NaviNet

NaviNet is our primary resource for providers to obtain their data on Highmark Blue Shield patients. This Internet-based service enables you to access enrollment and benefits information, claims status, program allowances, accounts receivable management as well as many other sources that will help you find information about your Highmark Blue Shield patients. This time-saving service is provided free of charge to providers who have a large volume of Highmark Blue Shield members and will utilize the service.

InfoFax

InfoFax is a free service that allows you access to enrollment and limited benefits information and claims status through the use of your touch-tone telephone. The information is sent to your fax machine.

InfoFax is similar to OASIS in that you enter the patient's information into the system through your touch-tone telephone. Instead of the information being read back to you, the response is faxed to you in minutes.

Please refer to Chapter 1, Unit 2, "Highmark's Informational Resources," for more information about InfoFax.

OASIS

OASIS (Office Assistance Information System) is Highmark Blue Shield's fully-automated telephone response service. Providers may call OASIS on a touch-tone telephone to obtain enrollment and claim status information.

OASIS is easy to use and provides clear and concise information about Highmark Blue Shield's Medical-Surgical, Medicare Supplemental and Major Medical programs. The service is available 7 a.m. to 11 p.m., Monday through Friday, and 7 a.m. to 5 p.m., Saturday and Sunday. It allows for unlimited inquiries on multiple patients per telephone call. Two specific areas of information are available through OASIS: *Enrollment inquiry and status of claim inquiry.*

To access OASIS, call 1-800-462-7474, or in the Harrisburg area, 1-717-302-5125 on your touch-tone telephone.

Please refer to Chapter 1, Unit 2 "Highmark's Informational Resources" for more information about OASIS.

5.2 General Guidelines for Submitting Claims

Overview

In today's business world, there are no requirements to submit claims on paper. Electronic transactions and online communications are integral to health care. In fact, Highmark Blue Shield's claim system places higher priority on processing and payment of claims filed electronically. If you are not already billing electronically, please refer to Chapter 5, Unit 1, "Benefits of Electronic Communication," for information on how to take advantage of the electronic solutions available to you.

For Paper Claims

If you must submit paper claims, always print or type all information on the claim form. Clear, concise reporting on the form helps us to interpret the information correctly.

Complete the claim form in its entirety. Our claims examiners code each claim individually. If you submit several claim forms for the same member, but fill in only essential details on one form, Highmark Blue Shield will reject the claim forms.

In cases where you must use several claim forms to report multiple services for the same patient, total the charges on each form separately. Treat each form as a separate and complete request for payment. Do not carry balances forward. It also is important that you report all other essential information on each claim form.

Mail the claim forms to the appropriate PO Box address. A complete listing of addresses can be found in Chapter 1, Unit 1 "Quick Reference Directory."

Timely Filing

Timely filing is a Highmark Blue Shield requirement whereby a claim must be filed within a certain time period after the last date of service relating to such claim or the payment/denial of the primary payor, or it will be denied by Highmark. Per the timely filing policy, any claim not received within **365 days** of the last date of service will be denied for untimeliness. This policy applies to all Highmark Blue Shield providers. Claims submitted with an attached EOB are to be received within the 365 days of the primary payor's finalized or payment date, as depicted on the claim attachment.

Avoid Form 1099-Misc Errors

How you complete your claim form affects how your income is reported to the Internal Revenue Service (IRS). Highmark Blue Shield must notify the IRS of payments of $600 or more it makes to a provider or practice within a calendar year. If you received payments of $600 or more from Highmark Blue Shield in any calendar year, Highmark Blue Shield will send you a miscellaneous income statement (form 1099-Misc) at the end of January of the following year.

So that Highmark Blue Shield reports your correct income to the IRS, please follow these guidelines:

Continued on next page

5.2 General Guidelines for Submitting Claims, Continued

Avoid Form 1099-Misc Errors, continued

If the income is to be reported under the practice's name (group name) and tax identification number (TIN), please enter the Highmark Blue Shield group provider number or NPI number in the billing provider box on the claim form. Highmark Blue Shield will then issue all checks payable to the group's name. The 1099-Misc form will also be issued under the group's name.

If the income is to be reported under an individual's name and Social Security Number, (in the case of a sole proprietor), please enter the Highmark Blue Shield individual provider number or NPI number in the billing provider box on the claim form. Highmark Blue Shield will issue all checks payable to the individual provider's name. The 1099-Misc form will also be issued under the individual's name.

Note: Highmark Blue Shield will not make changes to form 1099 if the claims (paper or electronic) were submitted with the performing provider incorrectly listed as the billing provider.

For Central, Eastern, and Western Region Providers:
If you have any questions about form 1099-Misc issues, please call 1-866-425-8275. You can also e-mail 1099inquiry@highmark.com**.**

For Northeastern Region Providers:
For providers located within the 13 counties of Northeastern Pennsylvania, (Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne and Wyoming), please call 1-800-451-4447.

5.2 Concurrent Major Medical Processing

Overview

Concurrent Major Medical processing is a feature included with our ClassicBlue Traditional product. ClassicBlue Traditional offers basic medical-surgical, hospital and major medical coverage as one benefit package. For processing and payment purposes, the major medical benefits are incorporated into the traditional benefits.

This process simplifies the billing process for providers, who can report **all** professional services on one claim form and send it either electronically or on paper to Highmark Blue Shield. The services will process for basic coverage first and then automatically process for major medical coverage. One Explanation of Benefits shows you the details of both the basic and major medical processing. Please refer to pages 56-57 for an example of a Concurrent Major Medical Explanation of Benefits.

You will receive the standard Explanation of Benefits for members who do not have concurrent major medical processing.

5.2 OCR Scanning of Paper Claims

OCR Scanner Improves Paper Claims Processing Time

Highmark Blue Shield uses an OCR (Optical Character Recognition) scanner for direct entry of paper claims and encounters into its claims processing system, OSCAR (Optimum System for Claims Adjudication and Reporting). OCR technology is an automated alternative to manually entering claims data. The OCR equipment scans the claim form, recognizes and "reads" the printed data then translates it into a format for direct entry into OSCAR. The scanner can "read" both computer-prepared and typewritten claim forms but **only if the data is within the borders of each box.**

Direct entry of claims by the OCR scanner is an advantage to you because it requires less human intervention in preparing and entering your claims. The scanner reads, numbers, and images your paper claims in one step. OCR scanning reduces claim entry time as well as entry errors. However, OCR claims do not receive the same priority processing as do electronically submitted claims.

For the most efficient processing, please use the CMS-1500 (08/05) red, claim form. The OCR scanner is programmed to read this form. To obtain a supply of the CMS-1500 (08/05) claim form, please contact your current forms distributor. If your forms distributor needs a negative or PDF of the claim form, they should e-mail or call:

- TFP Data Systems, e-mail: **1500form@tfpdata.com** or 1-800-482-9367, extension 1770
  OR
- Government Printing Office at 1-202-512-0455.

If you use computer billing software to complete the CMS-1500 (08/05) paper claim forms, please do not use your software for the previous CMS-1500 (12/90) version of the claim form. If this is used, it causes information to be aligned incorrectly and the OCR equipment cannot properly scan the form.

5.2 Tips for Submitting Paper Claims

Tips for Submitting Paper Claims

To ensure your claims are scanned as quickly as possible, processed accurately and paid without delay, please follow these guidelines when completing the claim form:

- Use computer-printed forms or type the data within the boundaries of the boxes provided. **DO NOT HAND WRITE.**
- The claim form can only accommodate six lines of service. The top area of the six service lines is shaded and is the location for reporting supplemental information. Supplemental information can only be entered with a corresponding, completed service line. It is not intended to allow the billing of 12 lines of service.
- Fill in the information requested. We must have complete information before we can process the claim. If details are missing, Highmark Blue Shield will reject the claim.
- If using a rubber stamp, do not stamp information in or over boxes one through 33 or in the upper right hand corner of the claim form. Any stamps used should be in black ink only.
- Regularly change your print ribbon to ensure print readability. Light print cannot be read by the scanner.
- Always provide Highmark Blue Shield with the original claim form. Do not send copies of claims – they cannot be scanned. If you use a two-part form, send the original claim (red fields - top form) rather than the copy (black and white - bottom form).
- Avoid using special characters such as dollar signs, hyphens, slashes or periods.
- Avoid extra labeling in boxes on claim form.
- Use X's for marking Yes or No blocks. Do not use other alphabetical indicators such as Y for Yes, N for No, F for Female or M for Male.
- Use black ink. **Do not use red ink.** The OCR image scanner cannot read red ink.
- Do not use correction fluid on the claims.
- Use flat envelopes for mailing claims. Do not fold claim forms. Folded or wrinkled claim forms cannot be effectively read by the scanner.
- The OCR scanner is designed to read computer prepared or typewritten claim forms. Claims with superbill attachments cannot process through the OCR scanner. Type data from the superbill directly onto the claim form. Do not attach superbills for the same services you have reported on the claim form.
- Leave the upper right-hand corner of the claim form blank for internal purposes. If you need to print information at the top of the form, use the open space in the center.

Continued on next page

5.2 Tips for Submitting Paper Claims, Continued

Tips for Submitting Paper Claims, continued

- Report all information about a service on one line. If the service dates, diagnosis code, charge, etc., are reported on separate lines, the scanner "creates" an extra line. This may cause the claim to be returned to you for correction and re-submission.
- Printing Specifications:
  - Use 10-pitch PICA type.
  - Submit all claims on 20 pound paper.
- Use the procedure code that most closely describes the service. Written descriptions are only necessary if using NOC codes or when no procedure code is available. Unnecessary descriptions are problematic for OCR scanned claims.
- Not Otherwise Classified (NOC) Codes – When reporting NOC procedure codes, provide a written description of the item or service above the code in the shaded area of the service line on the claim form. When more than one NOC is submitted, provide an individual description and charge for each item.
- **Do not** fill in blank fields or space with unnecessary data. For example, if hospitalization dates are not required, leave the field blank rather than entering 00/00/00 or XX/XX/XX.
- **Do not** use highlighters to emphasize information on the claim form or attachments. Highlighted information becomes blackened out when imaged and is not legible.
- In cases where you must use several claim forms to report multiple services for the same patient, total the charges on each form separately. Treat each form as a separate and complete request for payment. Do not carry balances forward. It also is important that you report all other essential information on each claim form.
- Verify patient and member information, via NaviNet before completing the claim form. Make sure that the member's contract number is correctly reported on the claim form (including the alphabetical prefix) in the Insured's I.D. Number box. Do not submit a photocopy of the member's identification card.
- Submit a separate claim for each patient, even when they are members of the same family. When a patient has had multiple hospital admissions, submit separate claim forms for each hospital admission.
- Include the date each service was provided in 6-digit format (MMDDYY).

Continued on next page

5.2 Tips for Submitting Paper Claims, Continued

Tips for Submitting Paper Claims, continued

- Include HCPCS codes to identify the service or services rendered. Other coding manuals may use the same code number to describe a different service.
- Avoid routinely submitting copies of your payment records or ledgers. They often omit vital information and it may be difficult to determine what services are to be considered for payment. Again, using the CMS-1500 (08/05) claim form will reduce the risk of error and expedite payment.
- Do not routinely send "Release of Information" forms signed by the patient. Our member agreements give us the right to receive the information without additional release forms.
- Be certain the total charge equals the service line charges.
- Be sure to include your 10-digit NPI or Highmark provider number (The provider number includes two alphabetical or numeric characters plus one to nine numeric characters) in the Billing Provider Info & PH # box.
- Include coordination of benefits or Medicare information on the claim form when the patient qualifies.
- Claims and other documents (inquiries, referrals, etc.) should never be taped or glued in any way. Staples should be avoided unless absolutely necessary.
- Avoid the use of Post-it Notes on claims or inquiries. (Full sheets of paper are preferable.)
- Avoid routinely attaching hospital notes (progress notes and order sheets) to claims. We will request this information if it is necessary to process the claim.
- Surgical procedures do not require operative notes unless:
    - An "individual consideration" (IC) or "unlisted procedure" code is reported.
    - The service performed is a new procedure.
    - The service performed is potentially cosmetic.
    - Multiple primary surgeons participated in a surgical procedure.
    - The terminology for the reported code indicates, "by report" (BR).
    - A pre-authorization letter advised you to submit specific reports.
    - The service involves unusual circumstances. Remember to also report modifier 22. If this modifier is not reported, the special circumstances will not be considered.
- When reporting circumcision for a baby boy, report the service on the baby's claim, not the mother's.
- When reporting services involving a multiple birth, report the services under the babies' names, not as Baby A, Baby B, etc.

Continued on next page

5.2 Tips for Submitting Paper Claims, Continued

Tips for Submitting Paper Claims, continued (continued)

- Anytime you have a question about how to complete a claim form, contact Highmark Blue Shield's Provider Service department.

Examples Of How To Submit Claims Correctly

Insured's ID number	
Correct	**Incorrect**
YYZ1094657692001	YYZ-109-465-7692001
	ID # YYZ1094657692001
Charges	
Correct	**Incorrect**
20 00	$20.00
Dates	
Correct	**Incorrect**
Date of Birth (use 8-digit format): 12271949	12/27/49 12-27-1949
All Other Dates, e.g., Dates of Service (use 6-digit format): 122749	12/27/49 12-27-49
Insured's policy group number	
Correct	**Incorrect**
123456	GRP # 123456
NAS123	GRP # NAS123

5.2 Tips for Submitting Paper Claims, Continued

Clean Claim Definitions and Requirements

The Prompt Payment Provision of Pennsylvania's Act 68 of 1998, which became effective on January 1, 1999, stipulates that health insurers pay "clean claims" within 45 days of receipt. A "clean claim" is defined as a claim with no defect or impropriety and one that includes all the substantiating documentation required to process the claim in a timely manner. The core data required on a claim to make it clean are outlined in this section.

"Unclean" claims are those claims where an investigation takes place outside of the corporation to verify or find missing core data. An example of this is when a request is sent to the member for information regarding coordination of benefits. This may require obtaining a copy of an Explanation of Benefits (EOB) from the member's other carrier. Claims are also considered unclean if a request is made to the health care professional for medical records. Claim investigations can delay the processing of the claim. The 45-day requirement only begins once all of the information needed to process the claim is obtained.

Highmark Blue Shield consistently processes claims well within the 45-day requirement. In fact, clean claims submitted electronically receive priority processing and are finalized within 7 to 14 days. With this in mind, we encourage you to submit all claims electronically to take advantage of the faster processing. For instructions on how to begin to submit claims electronically, please call EDI Operations at 1-800-992-0246.

You must provide us with the following information in order for the claim to be eligible for consideration as a "clean claim." If changes are made to the required data elements, this information shall be provided to network providers at least 30 days before the effective data of the changes. Please refer to the following section for more detailed explanations of these fields.

5.2 CMS-1500 (08/05) Claim Form Completion Instructions

Overview

The National Uniform Claim Committee (NUCC) released a new version of the 1500 Health Insurance Claim Form. The CMS-1500 (08/05) claim form replaced the 12/90 version on October 1, 2006. The instructions for completing the claim form are below. "New" is indicated in the boxes that were not on the 12/90 version. Please refer to Page 26 in this section for an example of a completed CMS-1500 (08/05) claim form.

Instructions for Completing the CMS-1500 (08/05) Form

The data, e.g., diagnosis codes, charges, NPIs, etc., used in the sample claim form is for the purpose of illustration only. Note: Please refer to pp. 29-46 for additional information about specific claim reporting situations.

Box #	Item Description	Instructions
TOP	Carrier Name Block	Report name and address in the center of the open space. Do not report above box 1a, as this is where Highmark prints the claim number.
1	Program Blocks	For Highmark products, you may place an X in the "Other" box.
1a	Insured's ID Number	Enter insured's identification number exactly as shown on the insured's identification card. Be sure to include any alpha prefixes.
2	Patient's Name	Enter the patient's full last name, first name, and middle initial. If the patient uses a last name suffix (e.g., Jr, Sr), enter it after the last name, and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.
3	Patient's Birth Date	Enter the patient's 8-digit birth date (MMDDCCYY). Enter an X in the correct box to indicate sex of the patient. Only one box can be marked. If gender is unknown, leave blank.
4	Insured's Name	Enter the insured's full last name, first name, and middle initial. If the insured uses a last name suffix (e.g., Jr, Sr), enter it after the last name, and before the first name. Titles (e.g., Sister, Cpt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.
5	Patient's Address	Enter the patient's mailing address and telephone number. The first line is for the street address; the second line, the city and state; the third line, the ZIP code and telephone number.

Continued on next page

5.2 CMS-1500 (08/05) Claim Form Completion Instructions, Continued

Instructions for Completing the CMS-1500 Form, continued

Box #	Item Description	Instructions
6	Patient Relationship to Insured	Enter an X in the correct box to indicate the patient's relationship to insured. Only one box can be marked.
7	Insured's Address	Enter the insured's address and telephone number. If box 4 is completed, then this box should also be completed. The first line is for the street address; the second line, the city and state; the third line, the ZIP code and telephone number.
8	Patient Status	Highmark does not need this information to adjudicate the claim.
9	Other Insured's Name	If box 11d is marked, complete boxes 9 and 9a-d, otherwise leave blank. When additional group health coverage exists, enter other insured's full last name, first name, and middle initial of the enrollee in another health plan if it is different from that shown in Item Number 2. If the insured uses a last name suffix (e.g., Jr, Sr), enter it after the last name, and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.
9a	Other Insured's Policy or Group Number	Enter the policy or group number of the other insured.
9b	Other Insured's Date of Birth	Highmark does not need this information to adjudicate the claim.
9c	Employer's Name or School Name	Highmark does not need this information to adjudicate the claim.
9d	Insurance Plan Name or Program Name	Enter the other insured's insurance plan or program name.
10a - 10c	Is Patient's Condition Related to:	When appropriate, enter an X in the correct box to indicate whether one or more of the services described in box 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Only one box on each line can be marked. The state postal code must be shown if "YES" is marked in box 10b for "Auto Accident." Any item marked "YES" indicates there may be other applicable insurance coverage that would be primary, such as automobile liability insurance.

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5.2 CMS-1500 (08/05) Claim Form Completion Instructions, Continued

Instructions for Completing the CMS-1500 Form, continued

Box #	Item Description	Instructions
10d	Reserved for Local Use	Highmark requires the sub-set of Condition Codes approved by the NUCC in this field, when applicable. The Condition Codes approved for use on the 1500 Claim Form are available at http://www.nucc.org under Code Sets.
11	Insured's Policy Group or FECA Number	Enter the insured's policy or group number as it appears on the insured's health care identification card. If box 4 is completed, then this box should also be completed.
11a	Insured's Date of Birth	Enter the 8-digit date of birth (MMDDCCYY) of the insured and an X to indicate the sex of the insured. Only one box can be marked. If gender is unknown, leave blank.
11b	Employer's Name or School Name	Enter the name of the insured's employer or school.
11c	Insurance Plan Name or Program Name	Enter the insurance plan or program name of the insured.
11d	Is There Another Health Benefit Plan?	When appropriate, enter an X in the correct box. If marked "YES," complete boxes 9 and 9a-d. Only one box can be marked.
12	Patient's or Authorized Person's Signature	Highmark does not need this information to adjudicate the claim. You may report "Signature on File," "SOF," or a legal signature in this block. If you obtain a legal signature, (1) be sure the name is contained inside this box so it does not interfere with data you report in other boxes and (2) enter the date signed in 6-digit format (MMDDYY). If there is no signature on file, leave blank or enter "No Signature on File."
13	Insured's or Authorized Person's Signature	Highmark does not need this information to adjudicate the claim. You may report "Signature on File," "SOF," or a legal signature in this box. If you obtain a legal signature, (1) be sure the name is contained inside this box so it does not interfere with data you report in other boxes and (2) enter the date signed in 6-digit format (MMDDYY). If there is no signature on file, leave blank or enter "No Signature on File."

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5.2 CMS-1500 (08/05) Claim Form Completion Instructions, Continued

Instructions for Completing the CMS-1500 Form, continued

Box #	Item Description	Instructions
14	Date of Current: Illness, Injury, Pregnancy	Enter the 6-digit (MMDDYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Be sure to complete this box when services were performed as a result of accident or injury.
15	If Patient Has Had Same or Similar Illness	Enter the first date the patient had the same or a similar illness. Enter the date in the 6-digit format (MMDDYY). Previous pregnancies are not a similar illness. Leave blank if unknown.
16	Dates Patient Unable to Work in Current Occupation	If the patient is employed and is unable to work in current occupation, an 6-digit (MMDDYY) date must be shown for the "from-to" dates that the patient is unable to work. An entry in this box may indicate employment-related insurance coverage.
17	Name of Referring Provider or Other Source	Enter the name (First Name, Middle Initial, Last Name) and credentials of the professional who referred or ordered the service(s) or supply(s) on the claim.
17a	Other ID #	The Other ID number of the referring provider, ordering provider, or other source is reported in 17a in the shaded area. The two-digit qualifier indicating what the non-NPI number represents is reported in the qualifier field to the immediate right of box 17a. The NUCC defines many qualifiers, which also are used in the electronic 837 Professional 4010A1. For paper claims submitted to Highmark, use one of the following: **1B** Highmark Blue Shield Provider Number **ZZ** Provider Taxonomy Note: If you report an NPI number in box 17b, after May 23, 2007, you must report the taxonomy in this box. Prior to May 23, 2007, report the Highmark Blue Shield provider number in box 17a.

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5.2 CMS-1500 (08/05) Claim Form Completion Instructions, Continued

Instructions for Completing the CMS-1500 Form, continued

Box #	Item Description	Instructions
17b	NPI	Enter the NPI number of the referring provider, ordering provider, or other source in box 17b. When reporting an NPI, you must report the taxonomy (not the Highmark Blue Shield Provider Number) in box17a.
18	Hospitalization Dates Related to Current Services	Enter the inpatient 6-digit (MMDDYY) hospital admission date followed by the discharge date (if discharge has occurred). If not discharged, leave discharge date blank. This date is when a medical service is furnished as a result of, or subsequent to, a related hospitalization (inpatient services only).
19	Reserved for Local Use	Highmark does not need this information to adjudicate the claim.
20	Outside Lab	Highmark does not need this information to adjudicate the claim.
21	Diagnosis or Nature of Illness or Injury	Enter the patient's diagnosis/condition. List up to four ICD-9-CM diagnosis codes. Relate lines 1,2,3,4 to the lines of service in 24E by line number. Use the highest level of specificity. Do not provide narrative description in this box. When entering the number, include a space (accommodated by the period) between the two sets of numbers. If entering a code with more than 3 beginning digits (e.g., E codes), enter the fourth digit to the right of the period. Please see page 31 for instructions regarding claims for FEP members and page 41 for reporting tips.
22	Medicaid Resubmission Code/Original Reference Number	The left portion of this box is for Medicaid resubmissions only. The right portion, "Original Ref. No.," should be used to report the original Highmark claim number when this is a resubmitted claim.

Continued on next page

5.2 CMS-1500 (08/05) Claim Form Completion Instructions, Continued

Instructions for Completing the CMS-1500 Form, continued

Box #	Item Description	Instructions
23	Prior Authorization Number	For ambulance services, use this block to report the ZIP code of the Point of Origin. Ambulance providers who submit paper claims for non-emergent ambulance transports must attach a PMNC (Physician's Medical Necessity Certification) form to the claim.
24		Supplemental information can only be entered with a corresponding, completed service line. The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and another/proprietary identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service. **The top area of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service.** The following are types of supplemental information, and their qualifier, that can be entered in the shaded lines of box 24: **Qualifier** / **Type of Information** **7** Anesthesia information — Anesthesia duration in hours and/or minutes with start and end times **ZZ** Narrative description of unspecified code — Narrative description of unspecified code **N4** National Drug Codes (NDC) — National Drug Codes (NDC) for drugs To enter supplemental information, begin at box 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code.

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5.2 CMS-1500 (08/05) Claim Form Completion Instructions, Continued

Instructions for Completing the CMS-1500 Form, continued

Box #	Item Description	Instructions
24A	Dates of Service	Enter date(s) of service, from and to, in 6-digit format (MMDDYY). If one date of service only, enter that date under "From." Leave "To" blank. If grouping services, you may range date if the place of service, procedure code, charges, and individual provider for each line is identical for that service line. Grouping is allowed only for services on consecutive days. The number of days must correspond to the number of units in box 24G. **An exception to this is prolonged detention care. Do not range date these services even when performed on consecutive days.**
24B	Place of Service	Enter the appropriate two-digit code from the Place of Service Code list for each item used or service performed. The Place of Service Codes are available at: http://www.cms.hhs.gov/MedHCPCSGenInfo/Downloads/Place_of_Service.pdf
24C	EMG	Highmark does not need this information to adjudicate the claim.
24D	Procedures, Services, or Supplies	Enter the CPT or HCPCS code(s) and modifier(s) (if applicable) from the appropriate code set in effect on the date of service. This field accommodates the entry of one procedure code and up to four, two-digit modifiers. The specific procedure code(s) must be shown without a narrative description. Please see pp. 31-35 for additional reporting tips.
24E	Diagnosis Pointer	Enter the diagnosis code reference number (pointer) as shown in box 21 to relate the date of service and procedures performed to the primary diagnosis. When multiple services are performed, the primary reference number for each service should be listed first, other applicable services should follow. The reference number(s) should be a 1, or a 2, or a 3, or a 4; or multiple numbers as explained. If multiple numbers are used, do not use hyphens between the diagnosis pointers, e.g., 1-4 or 1, 3-5. (ICD-9-CM diagnosis codes must be entered in box 21 only. Do not enter them in box 24E.)

5.2 CMS-1500 (08/05) Claim Form Completion Instructions,

Instructions for Completing the CMS-1500 Form, continued

Box #	Item Description	Instructions
24F	Charges	Enter the charge for each listed service. Enter the number right-justified in the dollar area of the box. Do not use commas or dollar signs when reporting the dollar amount. Do not report negative dollar amounts. Enter 00 in the cents area if the amount is a whole number.
24G	Days or Units	Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered. When required by payers to provide the NDC units in addition to the HCPCS units, enter the applicable NDC units' qualifier and related units in the shaded line following the NDC qualifier and code. The following qualifiers are to be used when reporting NDC: **F2** International Unit — **ML** Milliliter **GR** Gram — **UN** Unit
24H	EPSDT Family Plan	Highmark does not need this information to adjudicate the claim.
24I	ID Qual.	In the shaded area, enter the two-digit qualifier identifying the non-NPI number you report in box 24J. The Other ID# of the rendering provider is reported in box 24J in the shaded area. The NUCC defines many qualifiers, which are the same as those used in the electronic 837 Professional 4010A1. For paper claims submitted to Highmark, use one of the following qualifiers. **1B** Highmark Blue Shield Provider Number **ZZ** Provider Taxonomy The Rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care. In the case where a substitute provider (locum tenens) was used, enter that provider's information here. Report the provider's Identification Number in boxes 24I and 24J only when different from data recorded in boxes 33a and 33b. In other words, when you report a billing provider (e.g., assignment account) in box 33, you must report the rendering/performing provider information in boxes 24I and 24J.

5.2 CMS-1500 (08/05) Claim Form Completion Instructions, Continued

Instructions for Completing the CMS-1500 Form, continued

Box #	Item Description	Instructions
24J	Rendering Provider ID #	The individual rendering the service is reported in box 24J. Enter the non-NPI ID number in the shaded area of the field. Enter the NPI number in the unshaded area of the field. The Rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care. In the case where a substitute provider (locum tenens) was used, enter that provider's information here. Report the provider's Identification Number in boxes 24I and 24J only when different from data recorded in boxes 33a and 33b. In other words, when you report a billing provider (e.g., assignment account) in box 33, you must report the rendering/performing provider information in boxes 24I and 24J.
25	Federal Tax ID Number	Enter the federal tax ID (employer identification number) or Social Security Number. Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked. This must be the tax ID which correlates to the billing provider reported in box 33.
26	Patient's Account Number	Optional. Highmark cannot provide this back to you on an Explanation of Benefits for paper claims. However, Highmark can reference this number when contacting your office for additional information.
27	Accept Assignment?	Enter an X in the correct box. Only one box can be marked. Note: this box is required for government claims only.

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5.2 CMS-1500 (08/05) Claim Form Completion Instructions, Continued

Instructions for Completing the CMS-1500 Form, continued

Box #	Item Description	Instructions
28	Total Charge	Enter total charges for the services (i.e., total of all charges in column 24F). Enter number right justified in the dollar area of the field. Do not use commas or dollar signs when reporting dollar amounts. Do not report negative dollar amounts. Enter 00 in the cents area if the amount is a whole number.
29	Amount Paid	Enter total amount the patient or other payers paid on the covered services only. Enter number right justified in the dollar area of the field. Do not use commas or dollar signs when reporting dollar amounts. Do not report negative dollar amounts. Enter 00 in the cents area if the amount is a whole number.
30	Balance Due	Enter total amount due. Enter number right justified in the dollar area of the field. Do not use commas or dollar signs when reporting dollar amounts. Do not report negative dollar amounts. Enter 00 in the cents area if the amount is a whole number.
31	Signature of Physician or Supplier including Degrees or Credentials	This box must be completed on all claims to affirm that the reported services were performed by the provider, or performed under the provider's personal supervision. The name of the individual performing the service on the claim must be entered. The name may be computer printed or typed. Simply reporting the name of the group is insufficient.

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5.2 CMS-1500 (08/05) Claim Form Completion Instructions, Continued

Instructions for Completing the CMS-1500 Form, continued

Box #	Item Description	Instructions
32	Service Facility Location Information	Enter the name, address, city, state, and ZIP code of the location where the services were rendered. Enter the name and address information in the following format: 1st Line – Name 2nd Line – Address 3rd Line - City, State and ZIP Code NOTE: Using the 9-digit ZIP + 4 code will result in faster and more accurate processing when the provider does not obtain an NPI for each Highmark provider ID number. Highmark requires the Service Facility Location when the service was performed at a secondary location and the provider's primary location was reported in box 33. Highmark always requires the Service Facility Location when the Place of Service reported in box 24B is one of the following: 21 - Inpatient Hospital 22 - Outpatient Hospital 23 - Emergency Room – Hospital 31 - Skilled Nursing Facility 32 - Nursing Facility 51 - Inpatient Psychiatric Facility 61 - Comprehensive Inpatient Rehabilitation Facility
32a (new)	NPI	Enter the NPI number of the service facility location

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5.2 CMS-1500 (08/05) Claim Form Completion Instructions, Continued

Instructions for Completing the CMS-1500 Form, continued

Box #	Item Description	Instructions
32b (new)		Enter the two-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number. The NUCC defines many qualifiers which are used in the electronic 837 Professional 4010A1. For paper claims submitted to Highmark, use one of the following qualifiers: **1B** Highmark Blue Shield Provider Number **ZZ** Provider Taxonomy NOTE: If you do not report an NPI number in box 32a, then report the Highmark Blue Shield Provider Number in this box, preceded by qualifier "1B." If you report an NPI number in box 32a, after May 23, 2007, you must report the taxonomy preceded by the two-digit qualifier ZZ in this box.
33	Billing Provider Info & Ph #	Box 33 identifies the provider that is requesting to be paid for the services rendered and should always be completed. Enter the provider's or supplier's billing name, address, ZIP code, and telephone number. The telephone number is to be entered in the area to the right of the box title. Enter the name and address information in the following format: 1st Line - Name 2nd Line – Address 3rd Line - City, State and ZIP Code
33a (new)	NPI	Enter the NPI number of the billing provider reported in box 33.

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5.2 CMS-1500 (08/05) Claim Form Completion Instructions, Continued

Instructions for Completing the CMS-1500 Form, continued

Box #	Item Description	Instructions
33b (new)	Other	Enter the two-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number. The NUCC defines many qualifiers which are used in the electronic 837 Professional 4010A1. For paper claims submitted to Highmark, use one of the following: **1B** Highmark Blue Shield Provider Number **ZZ** Provider Taxonomy NOTE: If you do not report an NPI Number in 33a, then report the Highmark provider number in this box preceded by qualifier "1B." If you report an NPI number in box 33a, after May 23, 2007, you must report the taxonomy preceded by the two-digit qualifier ZZ in this box.

Additional Edit Checks For Paper Billers

Tip Sheet

Effective April 11, 2008 Highmark will no longer attempt to correct Or retrieve missing information for the situations listed below. Instead, these situations will result in a rejection of the claim, and you will be required to resubmit a new claim with the corrected data.

When a claim rejects, it is important for your billing staff and/or vendor to understand exactly what was wrong and what is needed to correct it.

Continued on next page

5.2 CMS-1500 (08/05) Claim Form Completion Instructions, Continued

Additional Edit Checks For Paper Billers

If you submit paper claims, you may encounter the following denial codes and descriptions on your explanation of benefits notices.

Rejection Code	Rejection Code Description
B5606	In order to process the claim, additional information is required. Please resubmit the claim with a prescription for this service. Electronically enabled providers should resubmit electronically.
P5039	In order to process this claim, additional information is required. The claim should be resubmitted with a valid modifier and associated number of services rendered. Electronically enabled providers should resubmit electronically.
P5040	The patient's coverage does not provide for this service in the place of treatment reported. Therefore, no payment can be made.
P5010	The procedure code reported is not appropriate for the patient's age. Please resubmit claim with verification of the patient's age and/or a corrected procedure code. Electronically enabled providers should resubmit electronically.
P5011	The procedure code reported is not appropriate for the patient's age. Please resubmit claim with verification of the patient's age and/or a corrected procedure code. Electronically enabled providers should resubmit electronically.
P5012	The patient's sex is invalid for the reported procedure. Please resubmit the claim with verification of the patient's sex and/or a corrected procedure code or a complete description of service. Electronically enabled providers should resubmit electronically.

Printing Standards

Use 10 pitch PICA. All paper claim submissions should be printed on the original CMS-1500 (08/05) claim form. Do not use photocopied forms or forms printed in black ink on a on a laser printer.

5.2 Example CMS-1500 (08/05) Claim Form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Highmark Blue Shield
P.O. Box 890173
Camp Hill, PA 17089-0173

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)	OTHER [X] (ID)
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	ABC123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Doe Jr, John J
3. PATIENT'S BIRTH DATE MM DD YY / SEX	01 01 1987 / M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	Doe, John J
5. PATIENT'S ADDRESS (No., Street)	123 Main Street
6. PATIENT RELATIONSHIP TO INSURED	Self [ ] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street)	123 Main Street
CITY / STATE	Anytown / PA
8. PATIENT STATUS	Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
CITY / STATE	Anytown / PA
ZIP CODE / TELEPHONE (Include Area Code)	17011 / (717) 5551212
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Doe, Mary A
10. IS PATIENT'S CONDITION RELATED TO:	
11. INSURED'S POLICY GROUP OR FECA NUMBER	HIM378
a. OTHER INSURED'S POLICY OR GROUP NUMBER	DEF9876543210
a. EMPLOYMENT? (Current or Previous)	YES [ ] NO [X]
a. INSURED'S DATE OF BIRTH MM DD YY / SEX	01 01 1958 / M [X] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX	12 31 1960 / M [ ] F [X]
b. AUTO ACCIDENT? PLACE (State)	YES [ ] NO [X]
b. EMPLOYER'S NAME OR SCHOOL NAME	FGH Company
c. EMPLOYER'S NAME OR SCHOOL NAME	
c. OTHER ACCIDENT?	YES [ ] NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME	Highmark Blue Shield
d. INSURANCE PLAN NAME OR PROGRAM NAME	XYZ Insurance Company
10d. RESERVED FOR LOCAL USE	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	YES [X] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY / ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	09 30 06
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	09 25 06
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY	FROM 09 25 06 TO 10 28 06
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Jane A Smith MD
17a.	ZZ 193400000X
17b. NPI	5123456789
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY	FROM TO
19. RESERVED FOR LOCAL USE	
20. OUTSIDE LAB? $ CHARGES	YES [ ] NO [ ]
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)	1. 98859 2. 78060 3. V180 4. E8788
22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.	06123456789
23. PRIOR AUTHORIZATION NUMBER	

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
										ZZ	193400000X
09 30 06		11		99241	25	1234	50 00	1		NPI	5876543210
N400026064871 Immune Globulin Intravenous					UN2					ZZ	193400000X
10 01 06	10 01 06	11		J1563		13	50 00	20		NPI	5876543210
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER / SSN EIN	123498765 / EIN [X]	26. PATIENT'S ACCOUNT NO.	12341234
27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	YES [ ] NO [ ]	28. TOTAL CHARGE	$ 550 00
29. AMOUNT PAID	$ 00 00	30. BALANCE DUE	$ 550 00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	Joseph Jones MD 093006 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION	Big Facility Hospital 123 Facility Road Facility, PA 17000
a.	1164535423	b.	
33. BILLING PROVIDER INFO & PH #	(717) 555-2222	Physician Practice Inc 1234 Healthcare Street Anytown PA 17011	
a.	5321043210	b.	ZZ193200000X

5.2 Claim Inquiries

Choices

There are several choices available to check the status of a claim.
Offices may use:

- NaviNet
- 276/277 Health Care Claim Status Request and Response Transaction (HIPAA mandated version)
- Telephone
- InfoFax
- OASIS

NaviNet

NaviNet uses the Internet to link physician offices with Highmark computer systems. Claim-related functions available on NaviNet include:

- Claims status inquiries
- Claim investigations
- Codes and allowances inquiries

NaviNet is the required method over telephone inquiries to check routine eligibility, benefits, and/or claims status for NaviNet enabled offices. Providers who are NaviNet enabled may also use the 276/277 Health Care Claim Status Request and Response or InfoFax, but not the telephone.

NaviNet is a service provided free of charge to providers who have a compatible computer system in their office and who will utilize the service. With NaviNet, providers can avoid the hassle of telephone inquiries for routine claims status or enrollment/benefit verification. To learn more about NaviNet or to become a NaviNet enabled office, please call the Provider Service Center at

What Region Am I?

Western Region: 1-800-547-3627, option 2.
Central Region: 1-800-345-3805, option 3.

Hours are from 9:00 a.m. to 4:30 p.m., Monday through Friday.

276/277 Health Care Claim Status Request and Response Transaction

Information about the Health Care Claim Status Request and Response (267/277) can be found in the Provider EDI Reference Guide or by contacting Highmark EDI Operations at 1-800-992-0246, option 2.

Continued on next page

5.2 Claim Inquiries, Continued

Telephone

Only those providers who do not have Highmark-hosted NaviNet, or who have non-routine inquiries that require analysis and/or research may contact the Provider Service Center at the following numbers:

What Region Am I?

- Western Region Medicare Advantage HMO claims: 1-866-517-8585
- Western Region: 1-800-547-3627, option 2
- Central Region: 1-866-731-8080
- Western & Central Region Medicare Advantage PPO Claims: 1-866-588-6967
- Eastern Region: 1-866-975-7290
- Northeastern Region (Traditional Participating Providers): 1-888-827-7117
- Northeastern Region BlueCare PPO (formerly AccessCare II):1-866-262-5635

Before calling with an inquiry, please have the following information available so that the service representative may readily assist you:

- Patient name
- Member Identification Number
- Date of service
- Charge in question
- Your provider number or National Provider Identifier (NPI)
- Reason for your inquiry

InfoFax

InfoFax is an option for your office to receive information on enrollment, the status of claims, and limited benefits information and enrollment through your fax machine. After entering the patient's information into the system via your touch-tone phone, the information is faxed to you within minutes of your request.

Benefit information is also available for Medicare Supplemental contracts. You must use the patient's HIC (Medicare ID #) for information regarding this program.

InfoFax is available from:

- 7:00 a.m. to 9:00 p.m. (Weekdays)
- 7:00 a.m. to 2:00 p.m. (Saturday)

Continued on next page

5.2 Claim Inquiries, Continued

How To Gain Access To InfoFax

Simply call 1-800-891-1856 and enter your fax number including area code when prompted. An authorization form will be sent to your fax machine. Complete the authorization form and fax it to 1-800-985-6275. Once authorized to use InfoFax, a User Guide with complete instructions will be faxed to you. This process takes approximately 24-48 hours to complete.

If you would like any additional information about InfoFax, please contact the InfoFax Helpline at 1-800-985-2032.

OASIS (Office Assistance Information System)

OASIS is Highmark Blue Shield's automated voice-response system that gives you quick, direct inquiry access to enrollment and claim status information. OASIS provides concise and accurate information promptly for Highmark Blue Shield's medical-surgical and Medicare supplemental programs.

OASIS

The OASIS system allows you to access our data files through your touch-tone telephone. Because we have a toll-free number and extended hours, you can reduce administrative costs by calling OASIS. Any provider who has a valid Highmark Blue Shield provider number or National Provider Identifier (NPI) may call OASIS.

When you call OASIS, the system leads you through the information-gathering process with pre-recorded messages. Press the buttons on your telephone to access desired information.

To access OASIS, call:

Toll-free: 1-800-462-7474
In the Harrisburg area: 1-717-302-5125

Hours of operation:
Weekdays: 7:00 a.m. to 9:00 p.m.
Weekends: 7:00 a.m. to 5:00 p.m.

NOTE: OASIS can not provide status of a claim to a network provider if the claim processed through BlueCard and the member's coverage is through a plan outside of Pennsylvania.

When To Check Claim Status

Claim status questions should not be submitted until 30 days after the claim has been submitted.

5.2 Federal Employee Program (FEP) Processing

FEP Claim Tips

To ensure that your claims are accurately processed and paid without delay, please follow these guidelines in completing the claim form:

- When submitting claims for ambulance services, please include a completed trip report and detailed information concerning the medical necessity of the transport.
- FEP Durable Medical Equipment (DME) claims: Claims submitted via paper or electronic method must be sent with a Certificate of Medical Necessity (CMN) the **first time** you submit a claim for the rental or purchase of a particular DME item. Paper claims and paper CMNs that are an attachment to an already electronically submitted claim should be sent to: FEP Claims, P.O. Box 898854, Camp Hill, PA 17089-8854.
  You can submit subsequent claims electronically for the same DME item, while the CMN is in effect – without submitting another copy of the CMN. To order the Highmark Blue Shield CMN form (No. CL328 G 7.03), call 717-302-5105.
- Do not range date services.
- Medications – When providing information about medication, be sure to include the name, the dosage and the individual charge for each drug. Be sure that this information is legible.
- Use the appropriate address, P.O. Box 898854, when submitting claims.
- When reporting inpatient services, also report the service facility name and address.
- Submit FEP claims to the state where the services were rendered.

Special Notes On Diagnosis Coding For FEP Members

- Use special "V" *ICD-9-CM* diagnosis codes for FEP member claims. (The "V" codes are related to circumstances other than the specific diseases or injuries that are classified under categories 001.0 -999.9.) Following are specific "V" *ICD-9-CM* diagnosis codes that are valid for FEP claims: V40.0 – V40.9; V61.0 – V61.9; and V71.0 – V71.9. The codes must be used for claims for mental illness and should be reported to the highest level of specificity.
- Diagnosis codes 290.0 to 319 may also be used for claims for mental illness and must be reported to the highest level of specificity.
- When codes fall within 800.0 to 999.9, a condition must be reported for any accident or injury along with reporting the diagnosis to the highest level of specificity.

Please access the *ICD-9-CM* coding manual for the above-noted diagnosis codes.

5.2 Medicare Part B Supplemental Claims

Overview

For patients with Highmark Blue Shield Medicare Part B supplemental coverage, it is not necessary to submit a claim for payment after you submit one to Medicare Part B. The supplemental payment by Highmark Blue Shield should automatically follow the Medicare Part B payment. The Centers for Medicare & Medicaid Services consolidated its claim crossover process under a special Coordination of Benefits Contractor (COBC) by means of the Coordination of Benefits Agreement. Under this program, the COBC automatically forwards Medicare claims to the secondary payer, eliminating the need for providers to separately bill the secondary payer.

The claims you submit to the Medicare carrier will cross over to the Blue Plan only after the Medicare carrier has processed them. The Medicare carrier automatically advises the Blue plan of Medicare's approved amount and payment for the billed services. Then, the Blue plan determines its liability and makes payment to the provider. This one-step process means that you do not need to submit a separate claim and copy of the Explanation of Medicare Benefits (EOMB) statement to the Blue plan after you receive the Medicare carrier's payment. Whether you submit electronic or paper claims, it is not necessary to send a separate claim and EOMB statement for the purpose of obtaining payment on a secondary claim.

Please allow 30 days for the secondary claim to process. If you haven't received notification of the processing of the secondary payment, please do not automatically submit another claim. Rather, you should check the claim status via NaviNet before resubmitting. To streamline the claim submission process to save your practice time and money, consider revising the time frame for the automated resubmission cycle of your system to accommodate the processing times of these secondary claims. If there is not indication of a payment after checking the claim status, you can submit electronically using the PWK segment to fax the Explanation of Medicare Benefits (EOMB) statement or mail the EOMB with a completed CMS-1500 (08/05) claim form to:

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

or

Highmark Blue Shield
(for ClassicBlue, PPOBlue, Medigap, and DirectBlue)
P.O. Box 890052
Camp Hill, PA 17089-0052

Please be sure to submit the entire Explanation of Medicare Benefits statement. Do not highlight the Medicare payments in question. Either circle or place an asterisk (*) next to the information you want to bring to our attention. Provide the patient's Highmark Blue Shield identification number and their complete name and address.

5.2 Anesthesia Reporting Tips – Areas of Special Interest

Anesthesia Reporting Tips

For the most efficient processing of anesthesia services, submit claims electronically. If you bill electronically, please refer to the Highmark Provider EDI Reference Guide on the Provider Resource Center under Electronic Data Interchange (EDI) Services for billing instructions.

For more specific information about anesthesia services, please select Medical Policy from the Medical and Claim Payment Guidelines selection on the Provider Resource Center.

Coverage for services may vary for individual members, based on the terms of the benefit contract. Please check Highmark members' benefits via NaviNet or, if not-NaviNet enabled, call Provider Service. The listing of a procedure code and/or terminology in this section does not necessarily indicate coverage.

Anesthesia Procedure Codes

Use the national CPT (Current Procedural Terminology) anesthesia five-digit procedure codes (00100-01999) to report the administration of anesthesia along with national anesthesia modifier codes.

A description of service is required when a national anesthesia CPT code is reported. The best descriptor of the service is the surgical CPT code.

Payment Of Anesthesia Services

The following types of anesthesia qualify for payment as anesthesia services:

- Inhalation
- Regional
  - Spinal (low spinal, saddle block)
  - Epidural (caudal)
  - Nerve block (retrobulbar, brachial plexus block, etc.)
  - Field block
- Intravenous
- Rectal
- Moderate (conscious) sedation

Anesthesia for diagnostic or therapeutic nerve blocks and injections (01991, 01992) (when the block or injection is performed by a different provider) is eligible for payment.

Local anesthesia (A9270) which is direct infiltration of the incision, wound, or lesion is not a covered service.

Payment for anesthesia services is evaluated according to the **base unit** value, plus **time units** reported, plus eligible **modifying units** when appropriate, multiplied by a **monetary conversion factor**.

Continued on next page

5.2 Anesthesia Reporting Tips – Areas of Special Interest,
Continued

Anesthesia Base Units

Base unit values have been assigned to most anesthesia services (procedure codes 00100-01999) by the (ASA) American Society of Anesthesiologists Relative Value Guide and reflect the difficulty of the anesthesia service including the usual preoperative and postoperative care and evaluation.

The base value for anesthesia when multiple surgical procedures are performed is the base value for the procedure with the highest unit value. No payment is allowed for the base unit value of a second, third, etc., procedure.

When a surgical procedure is reported for which no base units have been assigned, a minimum of three base units will be assigned to the anesthesia service.

Anesthesia Time Units

Anesthesia time begins when the anesthesiologist or CRNA is first in attendance with the patient for the purpose of creating the anesthetic state. Anesthesia time ends when the anesthesiologist or CRNA is no longer in personal attendance, that is, when the patient may be safely placed under customary postoperative supervision. You must document this time in the anesthesia record.

Report total anesthesia time as minutes. Time must be indicated on all anesthesia claims. Highmark will convert total minutes to time units. When calculating time units for the time actually spend administering anesthesia, each 15 minute segment or fraction thereof is considered one time unit. Report total anesthesia time as minutes in box 24G, "DAYS or UNITS," on the CMS-1500 (08/05) claim form.

Continued on next page

5.2 Anesthesia Reporting Tips – Areas of Special Interest, Continued

Medical Direction (supervision) Of Anesthesia

Highmark defines the medical direction or supervision of anesthesia as direction, management or instruction of anesthesia by one who is physically present or immediately available in the operating suite. A physician performing medical direction should not actually administer anesthesia.

Highmark limits reimbursement to the medical direction of no more than four anesthesia services being performed concurrently. When the physician is medically directing more than four procedures concurrently, he or she must submit documentation of the medical necessity for directing more than four procedures. Highmark will then review the claim on an individual consideration basis. A physician medically directing four or fewer anesthesia procedures can concurrently:

- address an emergency of short duration in the immediate area;
- administer an epidural or caudal anesthetic to ease labor pain;
- provide periodic, rather than continuous, monitoring of an obstetrical patient;
- receive patients entering the operating suite for the next surgery;
- check or discharge patients in the recovery room; or
- handle scheduling matters.

To identify who performed the anesthesia service, please report the appropriate anesthesia procedure code modifiers in conjunction with codes 00100-01999. Do not report the modifier's description on the claim form.

Modifier	Description
AA	Anesthesia services performed personally by anesthesiologist (The AA modifier is one of several modifiers Highmark requires to identify who is performing an anesthesia service. Although this modifier's terminology states "performed personally by an anesthesiologist," any duly licensed and trained health care professional who is personally performing anesthesia services can report it. The AA modifier is not limited to physicians who specialize in anesthesiology.) Note: Do not report the AA modifier when the anesthesiologist is medically directing one or more anesthetists, regardless of the employment status of the anesthetists.
AD	Medical supervision by a physician: more than four concurrent procedures
GC	This service has been performed in part by a resident under the direction of a teaching physician
QK	Medical direction of two, three, or four concurrent anesthesia procedures

Continued on next page

5.2 Anesthesia Reporting Tips – Areas of Special Interest, Continued

Medical Direction (supervision) Of Anesthesia (continued)

Modifier	Description
QX	CRNA (Certified Registered Nurse Anesthetist) service with medical direction by a physician
QY	Medical direction of one CRNA by an anesthesiologist
QZ	CRNA service without medical direction by a physician
47	Anesthesia by surgeon: **regional** or **general** anesthesia provided by the operating surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) • Report modifier 47 in conjunction with the basic service, for example, the surgery code. • Do not use modifier 47 as a modifier for anesthesia codes 00100-01999. • Do not report modifier 47 for moderate sedation (see information about moderate sedation further in this unit.)

Medical Direction of a physician-in-training (e.g., intern or resident) – 100 percent total payment:

Report modifier GC. Payment will be made in the same manner as for the anesthesiologist's personal performance of the anesthesia service.

Medical Direction of an employed CRNA – 100 percent total payment:

When an anesthesiologist medically directs a CRNA, hired and paid by the anesthesiologist, **two lines on the claim form** are required when reporting the medical direction. Report modifiers QK and QX or QY and QX, as appropriate. Payment is made in the same manner as for the anesthesiologist's personal performance of the anesthesia service.

The employer (anesthesiologist) must be immediately available within the operating suite or within the immediate vicinity to assume primary care of the patient, if needed.

Report the name and Highmark provider ID number including the alpha prefix and/or NPI (National Provider Identifier) of the physician who is medically directing the service in box 24J of the CMS-1500 (08/05) claim form. Report the name of the physician who is medically directing the service in box 31 of the claim form. **Do not include the CRNA's name on the claim form.**

Continued on next page

5.2 Anesthesia Reporting Tips – Areas of Special Interest, Continued

Medical Direction (supervision) Of Anesthesia, continued

Medical Direction of Non-Employed CRNA – 50 percent total payment:

When an anesthesiologist medically directs a CRNA not employed by the anesthesiologist, e.g., hospital compensated, report modifier QK or QY, as appropriate. Payment of 50 percent of the fee allowed for the anesthesiologist's personal performance of the anesthesia services is made to the anesthesiologist.

Medical Direction of Independently Practicing (non-employed) CRNA – 50 percent/50percent total payment:

When an anesthesiologist medically directs a CRNA who directly bills his/her services on a fee-for-service basis, i.e., independently practicing, the anesthesiologist should report modifiers QK or QY, as appropriate. The CRNA should report modifier QX. Payment of 50 percent of the fee that is allowed for the anesthesiologist's personal performance of the anesthesia services is made to the anesthesiologist. The remaining 50 percent is paid to the CRNA who is directly billing his/her services on a fee-for-service basis.

Anesthesia Services Personally Performed by Physician – 100 percent total payment:

Report modifier AA when (1) the physician personally performs the entire service and (2) the physician is present in the operating room for the entire case and is actively participating in the administration of anesthesia, even if an anesthetist assists in the care of the patient.

Modifying Units

Modifying units represent those circumstances that necessitate skills of a physician beyond those usually required. Report modifying units (representative of age, total body hypothermia, controlled hypertension, and emergency) with the following HCPCS procedure codes. These procedure codes are not associated with number of units; therefore, please do not report additional units.

Highmark will pay these HCPCS codes at a flat fee. You must report procedure codes 99100, 99116, 99135 or 99140 on the same claim as the anesthesia service (00100-01999).

Code	Description
99100	Extreme age, under 1 year or 71 years of age or older
99116	Total body hypothermia
99135	Controlled hypertension
99140	Emergency conditions

Continued on next page

5.2 Anesthesia Reporting Tips – Areas of Special Interest, Continued

Modifying Units (continued)

Exception: You can report physical status with the applicable modifier. Report this modifier only in conjunction with the appropriate anesthesia procedure code (00100-01999).

The list of modifiers to report physical status include:

MODIFIER	DESCRIPTION	Modifying Units
P1	Physical status 1	0
P2	Physical statue 2	0
P3	Physical status 3	1
P4	Physical status 4	2
P5	Physical status 5	3
P6	Physical status 6	0

CMS-1500 (08/05) Claim Example

Claim example for anesthesia services personally performed by physician:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan
10	01	06				22		00300	AA	P2				765	00	47	

Continued on next page

5.2 Anesthesia Reporting Tips – Areas of Special Interest, Continued

Administration Of Anesthesia For Surgical And Nonsurgical Procedures, Same Provider

Anesthesia administered for covered services is eligible when rendered by a professional provider other than the operating surgeon, assistant surgeon, or attending professional provider.

When anesthesia is reported by the operating surgeon, assistant surgeon, or attending professional provider, it is not covered. A participating, preferred, or network provider can bill the member for the denied anesthesia service.

A benefit exception is anesthesia administered by the operating surgeon, assistant surgeon, or attending professional provider for covered oral surgical procedures. This anesthesia is eligible for payment in addition to the oral surgery when performed in any place of service other than inpatient.

Use modifier 47 (Anesthesia by surgeon) when general or regional anesthesia has been administered by the operating surgeon.

When moderate sedation, also referred to as conscious sedation, has been administered by the operating surgeon, report codes 99143-99145, as appropriate, and report with the AA modifier.

Modifier 59 is appropriate to use when a nerve block and surgery are reported by the same provider as treatment for two separate and distinct conditions, i.e., the nerve block is not performed as anesthesia for the surgery. In this instance, modifier 59 should be reported in conjunction with the nerve block procedure code.

Note:
When an associate or member of the same practice group (who is other than the operating surgeon, his assistant, or attending provider) administers anesthesia, payment can be made for covered anesthesia services.

Moderate (conscious) Sedation

Moderate sedation, also known as conscious sedation, induces an altered state of consciousness that minimizes pain and discomfort through the use of pain relievers and sedatives. Patients who receive moderate sedation usually are able to speak and respond throughout the procedure.

Continued on next page

5.2 Anesthesia Reporting Tips – Areas of Special Interest, Continued

Moderate (conscious) Sedation, continued

The administration of moderate sedation, also known as conscious sedation, for specified procedures, by the same provider (99143-99145) who is also performing the procedure, regardless of specialty, is not eligible for separate payment. In this instance, report procedure codes 99143-99145. Reimbursement for sedation is included in the global allowance for these procedures and, therefore, is not separately reimbursable. A network provider cannot bill the member for the moderate sedation. See Highmark Medical Policy Bulletin A-17.

Moderate sedation performed with any other surgical procedure by the same provider is not covered. A participating, preferred or network provider can bill the member for the sedation in these cases.

Moderate sedation performed by other than the operating surgeon, assistant surgeon, or attending professional (99148-99150) for a covered surgical service is eligible for separate payment. When moderate sedation has been administered by the operating surgeon, report codes 99143-99145, as appropriate, with the AA modifier (anesthesia services performed personally by anesthesiologist), for example, 99143AA.

Because Highmark uses the anesthesia conversion factor to calculate its reimbursement for moderate sedation services (99143-99150), you must report anesthesia time incurred during "face-time" with the patient. If you do not, your claims may be delayed or may not be paid correctly. Please report total anesthesia time in minutes.

Other Modifiers

If anesthesia must be administered to a patient at two separate and distinct times during the same day, you must identify each anesthesia service performed within the separate session. Report modifier 78 or 79, as appropriate, on each service line of the claim form.

78 – Return to the operating room for a related procedure during the postoperative period
79 – Unrelated procedure or service by the same physician during the postoperative period

Consultation Services By An Anesthesiologist

Highmark will pay for a consultation, preoperative work up, performed by an anesthesiologist prior to surgery, in accordance with the member's benefits. A consultation is defined as a professional service furnished by a second physician at the written or verbal request of the attending physician. It includes a history, examination of the patient, evaluation of tests when applicable, and a written report files with the patient's permanent record.

5.2 Diagnosis Coding Reporting Tips

Overview

Highmark Blue Shield requires you to report the highest level of specificity when reporting diagnosis codes from the *ICD-9-CM* (International Classification of Diseases, 9th Revision Clinical Modification) manual on its medical-surgical claim forms. The *ICD-9-CM* codes are used to assign numeric codes to disease, injuries, impairments, symptoms and causes of death. Since Highmark Blue Shield's claims processing system applies medical payment guidelines based on diagnosis codes, you must report the most appropriate three-, four- or five-digit diagnosis code on every claim. The diagnosis must be valid for the date of service reported.

Be As Accurate As Possible

Highmark Blue Shield will reject your claims for payment if you submit them without complete or accurate diagnosis codes.

NaviNet

NaviNet includes a diagnosis code inquiry that lets you look up diagnosis codes by code, description, start and end dates.

Please Note

For all lines of business:

1. Report diagnosis codes to the highest level of specificity available,
2. Substantiate all member diagnoses in the medical record.
3. Relate the diagnosis code(s) reported in Box 21 (Diagnosis or Nature Illness or Injury) of the CMS-1500 claim form to Box 24E (Diagnosis Pointer) by line of service.

For FreedomBlue PPO Members:

In addition to above, include all *ICD-9-CM* diagnosis codes that impact the patient's evaluation, care and treatment for the current problems.

5.2 Modifiers

Overview

A modifier is a two-character code – either numeric, alphabetical or alpha-numeric – that is placed after the usual procedure code. A modifier permits a provider to indicate whether a service or procedure has been altered by specific circumstances, but not changed its definition or code. Up to four modifiers can be reported for each service.

Essential Modifiers

Some modifiers that are essential to accurate claims processing, and that also must be reported on the claim form (when applicable) are:

Modifier	Definition
LT	Identifies procedures performed on the left side of the body.
RT	Identifies procedures performed on the right side of the body.
50	Identifies bilateral procedures. Unless otherwise identified by a specific code, bilateral procedures should be identified by adding a 50 modifier to the appropriate procedure code.

Our claims processing system is programmed to look for RT or LT modifiers on codes for services that may be performed bilaterally. When reporting a procedure that can be performed on either side of the body, report the appropriate RT or LT modifier. If neither the 50, RT or LT modifiers are reported, one of the services will be rejected as a duplicate.

Modifier	Definition
76	Repeat procedure by same physician. Use this modifier to report all procedures or portions of procedures that are repeated on the same date.

The 76 modifier should be applied to the subsequent or repeat procedure only. Failure to use this modifier when appropriate will result in a rejection, as the service will be read as a duplicate.

Modifier	Definition
22	Unusual Procedural Services: one that is of greater complexity than that usually required for the listed procedure – identify that service by adding a 22 modifier to the standard procedure code.

The 22 modifier distinguishes the procedure performed as an unusual service, including extenuating medical circumstances. When you report a procedure code with a 22 modifier, Highmark Blue Shield recommends that you submit your claim electronically through an 837 transaction and use the Paperwork (PWK) Segment to report the type and transmission of the attachment.

Continued on next page

5.2 Modifiers, Continued

Essential Modifiers, continued

Fax or mail supporting medical documentation to: (717) 302-3686, or mail to: PWK Additional Documentation, PO Box 890176, Camp Hill, PA 17089-0176. **Please do not submit with the claim.**

One of our Professional Consultants will review your claim and supporting documentation. He or she will determine whether or not additional reimbursement is warranted based on the clinical circumstances documented in the medical records, and if so, how much additional reimbursement is appropriate. Claims with a procedure code with a 22 modifier will be adjudicated and will receive one of the following message codes:

- J6056 – unusual procedural services were reported with no supporting documentation, therefore, no additional payment can be considered
- J6057 – unusual procedural services were reported and the supporting documentation was considered, but does not warrant an additional payment
- J6058 – unusual procedural services were reported and the supporting documentation was considered for the additional payment reflected under the allowance

Highmark Blue Shield will conduct a one-time review of the supporting medical documentation that was submitted with the claim. If, after reviewing the claim, Highmark Blue Shield determines that additional payment is not warranted, it will not review the supporting documentation a second time. In this case, Highmark Blue Shield will deny your claim and you will receive message code J6057.

If you submit a claim for a procedure with a 22 modifier and do not send the supporting medical records within 21 days, Highmark Blue Shield will process the claim without considering the 22 modifier and will notify you by including message code J6056 on your Explanation of Benefits form. Highmark Blue Shield will consider the procedure you reported at the standard allowance.

If you send supporting documentation to Highmark Blue Shield after your claim was processed, you should perform a claim investigation through NaviNet. Specific instructions as to where to submit supporting documentation will be included in the response to your claim investigation. If you are not NaviNet-enabled, contact Provider Service for instructions on how to submit your supporting documentation.

5.2 Reporting Bilateral Procedures

Bilateral Procedures

When reporting procedures that were performed bilaterally, you must report the correct number of services to correspond with the modifier(s) you report. There are several ways to report bilateral procedures.

"Right" and "left" modifiers
If you report bilateral services on two lines of service, report an RT modifier on one line and an LT modifier on the other. The number of services on each line should be "1."

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan
10	01	06				22		20610	RT	1234	35 00	1	
10	01	06				22		20610	LT	1234	35 00	1	

If you report bilateral services on one line of service, report RT and LT modifiers. The number of services should be "2."

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER		E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan
10	01	06				22		20610	RT	LT	1234	70 00	2	

"50" modifier – bilateral procedures that are performed at the same operative session. If you report a "50" modifier to indicate bilateral procedures, report only one line of service. The number of services should always be "2."

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan
10	01	06				22		20610	50	1234	70 00	2	

Continued on next page

5.2 Reporting Bilateral Procedures, Continued

Bilateral Procedures (continued)

If you report multiple services performed on the same side of the body (for example, right shoulder, right hip), you may follow either of these examples:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan
10	01	06				22		20610	RT	1234	70 00	2	

OR

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan
10	01	06				22		20610	RT	1234	35 00	1	
10	01	06				22		20610	RT 76	1234	35 00	1	

In this case, the 76 modifier must be reported on the second line that reports the same procedure code for correct payment to be made.

5.2 Range Dating

Overview

Do not range date services, **except** in the following situations:

1. DME monthly rentals
2. End stage renal disease (ESRD) related services, procedure codes 90918-90921
3. In-hospital medical visits may be range dated if the services are identical and the visits were provided on consecutive dates of service within the same calendar month. An **exception to this is prolonged detention care.** Do not range date these services even if rendered on consecutive days.
4. Weekly radiation therapy procedure codes 77427.
   - Five fractions of radiation therapy constitute a week of therapy, whether or not the fractions occur on consecutive days. Since the code represents a week (or five fractions) of therapy management, the number of services reported for each multiple of five fractions should be one unit. Radiation therapy services may be reported weekly or monthly. The number of services reported for a week of five fractions would be "one."
   - A month of 20 fractions would be reported as four services.
   - Date of treatment weeks should not overlap. Rather, reported dates of services should span the range of dates involved.
   - Hyperfractions of radiation therapy occur when two smaller doses are given in one day of treatment. One week of hyperfractions would include 10 hyperfractions or five days. The number of services billed for that week should be "1."
   - When providing radiation therapy services, the notation, "course of treatment ended" should only be used when the final treatment has been administered.

Note: Do not report future dates of service on the claim form. Only report services that have actually been rendered.

5.2 Documentation Requirements

Overview

Highmark Blue Shield requires that patient records document every service submitted for payment. This includes diagnostic tests, medical care, surgery and any other services eligible for payment by Highmark Blue Shield. Regulations issued by the Pennsylvania Board of Medical Education and Licensure support this policy.

You should not submit this documentation with your claims. If documentation is needed, Highmark Blue Shield will request it. Please retain your office records for audit purposes.

Hospital and office records must verify that a service: 1) was actually performed; 2) was performed at the level reported; and 3) was medically necessary. The services billed by the provider must be documented by personal notes and orders in the patient's records.

Criteria For Documentation Submission

Highmark Blue Shield will use this criteria to determine if the provider has met the appropriate documentation requirements:

- Hospital medical visits – The admission and discharge records, doctor's orders and progress notes should clearly reflect the type, level of care and medical necessity of treatment billed by the doctor. The records not only should reflect the doctor's personal involvement in treating the patient, but also should reflect and be co-signed by the interns and residents who write the progress notes and order sheets;
- Surgical services – The operative report should indicate the name of the surgeon who performed the service. Minor surgical procedures not requiring an operative note must be documented in the progress notes. Also, the records should indicate the condition or diagnosis that documents the medical necessity for the surgery;
- Consultation – A consultation includes a history and an examination of the patient by a consultant whose services were requested by the attending physician. There should be a written report signed by the consultant. Additionally, the medical necessity for the consultation must be documented;
- Anesthesia – The anesthesia and/or operative report should indicate the name of the person who actually performed the anesthesia service. Anesthesia time units begin when the doctor begins to prepare the patient for induction and ends when the patient may be safely placed under postoperative supervision and the doctor is no longer in personal attendance. The records should reflect the actual time units reported;

Continued on next page

5.2 Documentation Requirements, Continued

Criteria For Documentation Submission, continued

- Medical reports – Office records should contain the patient's symptoms and/or complaints, diagnoses, tests performed, test results and treatment given or planned. In addition, the copies of hospital records should be clear and readable. In cases involving concurrent medical care, the consulting physician should submit these records with the request for review;
- Emergency medical/accident – Claims for emergency medical and emergency accident services always should include a date of onset and a date of service. Emergency medical services should be reported with the appropriate evaluation and management code, the ET (emergency services) modifier and a diagnosis code that reflects an emergency medical service.

5.2 Defining Inpatient and Outpatient

Overview

When you submit claims to Highmark Blue Shield for diagnostic or therapeutic radiology services or diagnostic medical services provided to hospital inpatients or outpatients, you must report the place of service as inpatient hospital or outpatient hospital, as appropriate. In these cases, you will be reimbursed only the professional component of the service.

Definitions

- **Outpatient** – a patient, other than an inpatient, who is treated in a hospital, on hospital grounds or in a hospital-owned or controlled satellite, when it has been determined that the satellite is an outpatient department of the hospital. This definition does not apply when a treating physician's sole practice is located in a hospital or hospital owned building, if the practice is not affiliated or controlled, in any way, by the hospital or a related entity; or, if the practice has been approved by Provider Data Analysis to be recognized as an office practice.
- **Inpatient** – a patient who is an inpatient of a facility, such as a hospital or skilled nursing facility, at the time the procedure is performed. When an inpatient is taken outside the hospital setting, such as to a physician's office, and is then returned to the hospital, the physician must report services according to the patient's status, in this case, inpatient. Therefore, you must report only "inpatient" as the place of service, rather than the place, such as "office" or "outpatient hospital", where the service actually was performed. For example, if a mobile ultrasound, MRI or CT unit locates on hospital grounds one day each week, all services provided to patients on that day must be reported with inpatient or outpatient, but not office, as the place of service.

For More Information

Please refer to Chapter 6, Unit 5, Outpatient Radiology and Other Diagnostic Services, for additional information on the Highmark Radiology Management Program's requirements for privileging of providers who perform diagnostic imaging and for prior authorization of selected outpatient advanced diagnostic imaging services, such as MRIs, MRAs, CT scans, and PET scans.

5.2 Claim Attachments for Electronic Claims

Electronic Claim Attachments

It isn't necessary or recommended that you submit claims requiring attachments via paper except in certain instances. (See information on when surgical procedures need operative notes under "Tips for Submitting Paper Claims" on page 8 and "Federal Employee Program (FEP) processing" on page 30.) These claims should be sent electronically utilizing the PWK, or paperwork attachment, specifications of the 837 electronic claim transaction. Two PWK option fields are built into the 837 transaction. To review the specifications and PWK process flow, please visit the Provider Resource Center, then Electronic Data Interchange (EDI), finally select, the Provider EDI Reference Guide under the Resources tab of the EDI Trading Partner website.

If you currently work with a trading partner (software vendor and/or clearinghouse) or have an information technology (IT) department within your practice they will be able to assist you with the technical aspects of the specifications. Simply tell your trading partner that you want to begin submitting attachment claims electronically.

Additional Information Requests

If Highmark requires additional documentation to process the claim, you will be contacted after Highmark has started to review it.

Reminder

Highmark Blue Shield's medical-surgical claims processing system places a higher priority on claims filed electronically.

Facility Identification Numbers

To help decrease processing time when reporting inpatient and outpatient services performed at facilities such as hospitals, skilled nursing facilities, nursing homes, etc., Highmark Blue Shield has implemented a facility coding system. You must report an eight-digit alphanumeric facility identification number and/or facility National Provider Identification (NPI) number in addition to the facility name and address in box 32 of the claim form. Claims submitted without the necessary information may result in payment delays.

Continued on next page

5.2 Claim Attachments for Electronic Claims, Continued

Facility Identification Numbers (continued)

For the electronic claims biller, it is important to report the facility identification number without alphabetical characters. The facility identification number is required when you are reporting services that were rendered in an inpatient, outpatient or skilled nursing facility. Please visit NaviNet to find a listing of all licensed facilities under 'Network Facility Inquiry'. You may also refer to Chapter 7, Unit 1 for a listing of all CMS National Provider Identifier (NPI) data. The list will help you report the appropriate facility identification number. It is sorted alphabetically by facility name and includes the address and the eight-digit facility identification number.

5.2 Explanation of Benefits for Medical-Surgical Contracts

For Network Providers

An Explanation of Benefits (EOB) statement is sent to network providers and to members *via postal mail or electronically based on preference*. Along with the claim payments, network providers receive an EOB listing all claims processed each week. This EOB lists each patient's claim separately. Each individual member on the provider's EOB will also receive an EOB listing the services processed. (See example of a provider EOB later in this unit.)

Regardless of your practice location, all Highmark EOBs are available electronically on NaviNet via the 'AR Management' link's 'EOB and Remittance' option.

Electronic EOBs Eliminate Paper Mailing – Central, Eastern and Northeastern Regions

What Region Am I?

In the Central, Eastern and Northeastern Regions, providers also have the option to reduce their administrative costs by choosing to stop paper EOBs. Electronic EOBs are available for those providers who are:

- *electronically enabled to submit claims*
- *enabled with electronic funds transfer (EFT)*
- *NaviNet enabled with Highmark or receive electronic remittance advices, or "ERAs."*

To stop your receipt of paper EOBs, please submit the form 'Request to Eliminate Paper Explanation of Benefits (EOBs) Statements' available on the Provider Resource Center under Provider Forms, then select Miscellaneous forms. If you have any questions, please contact Provider Service at:

Central Region: 1-866-731-8080, Option 2, then Option 6
Eastern Region: 1-866-975-7290, Option 6
If you are located in the 13-county Northeastern Region and want to eliminate paper EOBs, please call your Provider Consultant at 1-800-451-4447.

Electronic EOBs Eliminate Paper Mailing – Western Region Only

Western Region providers may already be taking advantage of electronic EOBs through NaviNet, but effective September 19, 2008, electronic EOBs will replace paper EOBs for EFT-enabled practices. This technological advancement ensures faster delivery, a search capability, easier storage and printability.

If you have specific questions about electronic EOBs, please contact your Provider Relations Representative.

Non-Network Providers

Non-network providers do not receive an EOB. Instead, the member receives the EOB and a check, if applicable. The member is responsible for reimbursing the non-network provider for services performed.

Continued on next page

5.2 Explanation of Benefits for Medical-Surgical Contracts, Continued

Information on EOB

Both the network provider and member EOB contain the following key information:

- Patient's name
- Identification number
- Member's name
- Claim number
- Date of service
- Procedure code
- Doctor's charge
- Highmark Blue Shield's allowance
- Amount applied to deductible
- Amount applied to co-insurance
- Amount deducted for coordination of benefits

If A Provider Identifies An Overpayment

Highmark Blue Shield offers a streamlined process that simplifies how you notify claim overpayment information electronically. Below is how the process works.

If a provider identifies an overpayment

- All Highmark-hosted NaviNet-enabled professional providers must use the Claim Investigation function to notify Highmark Blue Shield of an overpayment. If you are not NaviNet-enabled and an overpayment was made, call Highmark Blue Shield's Provider Service to advise if you want the overpayment offset from a future check.

Continued on next page

5.2 Explanation of Benefits for Medical-Surgical Contracts,
Continued

If a provider identifies an overpayment, (continued)

- If Highmark Blue Shield agrees that an overpayment exists, it will adjust the payment so that the next Explanation of Benefits (EOB) statement and Electronic Remittance Advice (835) transaction (if used) will include details of the changes in the payment. It will also reduce the total payment for that EOB/835 by the amount of the overpayment. The EOB/835 detail, on a line-item basis, is clear and easy to post in your accounts receivable software. If you take advantage of the Electronic Remittance Advice 835 transaction, your office can automatically post the refund.
- While less desirable, if you prefer to refund the amount of overpayment by sending a check, please do not use NaviNet Claim Investigations or call Highmark Blue Shield's Customer Service. Rather, send a check and a copy of the EOB with the overpaid claim circled to:

  Cashier
  P.O. Box 890150
  Camp Hill, PA 17089

Highmark Identifies Overpayments

If Highmark Blue Shield identifies an overpayment:

- Highmark Blue Shield will notify your practice of all overpayments on a separate section of the EOB and Electronic Remittance Advice (835) transaction, if used. Highmark Blue Shield will no longer send notification of overpayment letters to you. The overpayment details in the new section of the EOB (future offset summary) and 835 reference an overpayment that will be withheld from a future check.
- The EOB/835 provides detail as to the reason for the refund request. It serves as notice that unless appealed or paid by check, the overpayment will be deducted from an EOB/835 approximately 60 days following the notification.
- If you agree with the refund request, you should take no action. Highmark Blue Shield will automatically deduct the overpayment from a future check. The deduction will be indicated on your EOB/835. If you do not want the overpayment withheld from a future check but prefer to write a check for the overpayment, send the check and a copy of the EOB with the overpaid claim circled to:

  Cashier
  P.O. Box 890150
  Camp Hill, PA 17089

5.2 Explanation of Benefits for Medicare Part B Supplemental Contracts

Assigned Providers

An EOB statement is sent to assigned providers and to members. Assigned providers will receive an EOB showing all claims processed each week. This EOB lists each patient's claim separately. Each individual member on the provider's EOB also receives an EOB listing the services processed. (See Example of a Medicare Supplemental Provider EOB, on pp. 58-59.)

Non-assigned Providers

Non-assigned providers do not receive an EOB. Instead, the member receives the EOB and a check, if applicable. The member is responsible for reimbursing the non-assigned provider for services performed.

Information on EOB

Both the assigned provider and member EOB contain the following:

- Patient's name
- Medicare health insurance claim (HIC) number
- Claim number
- Date of service
- Procedure code
- Provider's charge
- Medicare approved amount
- Highmark Blue Shield's allowance
- Amount applied to Medicare Part B deductible

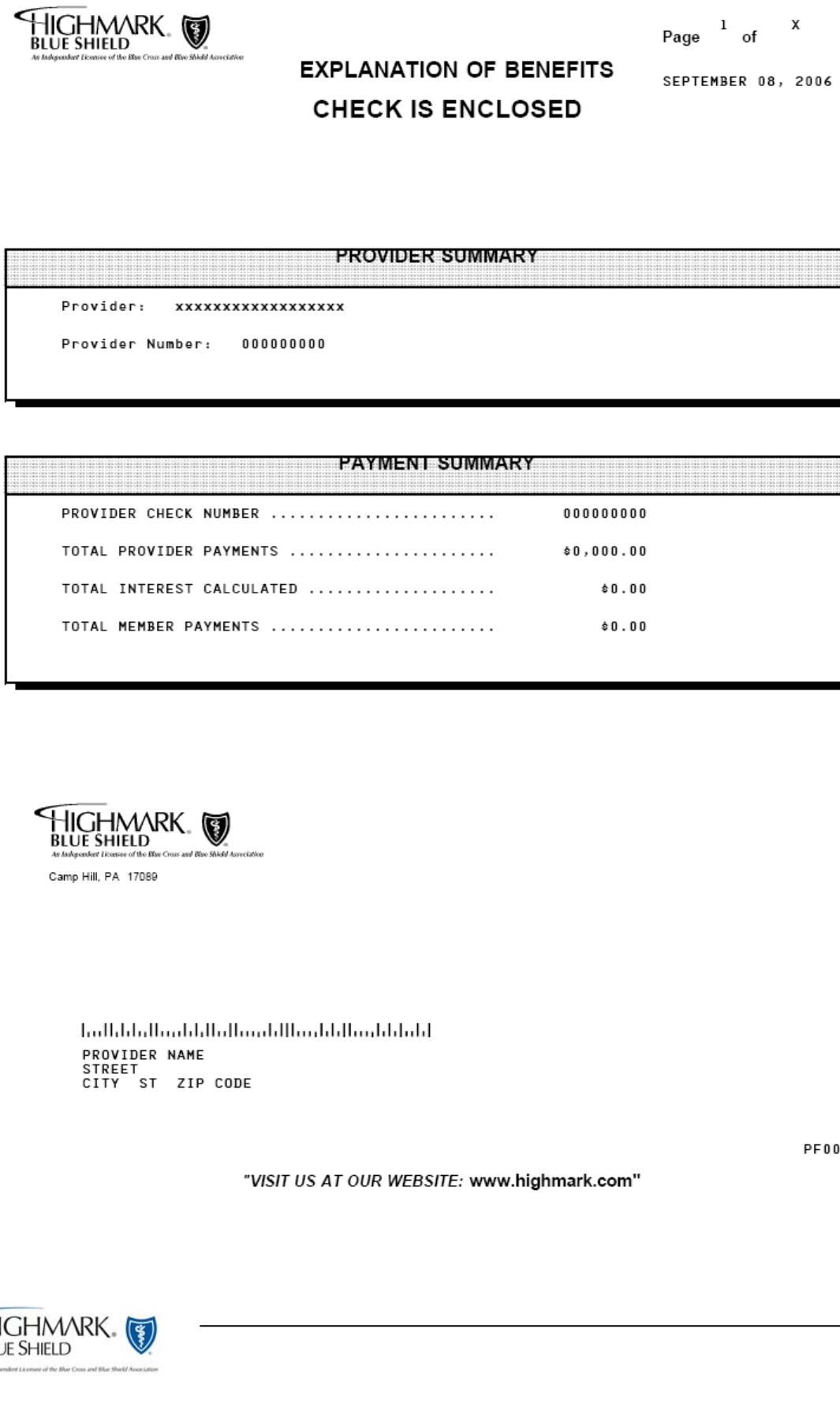
Inquiries About EOBs

Members should direct their questions or comments to the phone number listed on their EOB. Network providers should use NaviNet to contact Highmark Blue Shield's Customer Service department if they have questions about coverage or disagree with the determination of a claim. For more information about inquiries please see Chapter 1, Unit 2, "Highmark's Informational Resources."

Please Note

The EOBs you receive may vary slightly in format from the examples on the following pages.

5.2 Example of Medical-Surgical EOB



HIGHMARK BLUE SHIELD
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EXPLANATION OF BENEFITS

CHECK IS ENCLOSED

SEPTEMBER 08, 2006

PROVIDER SUMMARY

Provider: xxxxxxxxxxxxxxxxx

Provider Number: 000000000

PAYMENT SUMMARY

PROVIDER CHECK NUMBER	000000000
TOTAL PROVIDER PAYMENTS	$0,000.00
TOTAL INTEREST CALCULATED	$0.00
TOTAL MEMBER PAYMENTS	$0.00

HIGHMARK BLUE SHIELD
An Independent Licensee of the Blue Cross and Blue Shield Association

Camp Hill, PA 17089

PROVIDER NAME
STREET
CITY ST ZIP CODE

PF000000

"VISIT US AT OUR WEBSITE: **www.highmark.com"**

Provider Number: 000 0000000

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Provider Name: xxxxxxxxxxxxxxxxxx

SEPTEMBER 08, 2006

DATE(S) OF SVC	NUM OF SVCS	REVENUE/ PROCEDURE CODE	PAY-MENT CODE	PROVIDER CHARGE	OUR ALLOWANCE	NON-CHARGEABLE AMOUNT	NON-CHG CODE	MEMBER LIABILITY AMOUNT	MEM LIAB CODE	OTHER AMOUNT	AMOUNT(S) PAID (* = MEMBER)	MESSAGE CODES
PATIENT ACCT #:				PATIENT: NAME							CLAIM NUMBER:	
MEMBER ID: 000000000000				MEMBER: NAME							00000000000	
07/28/06	1	97012	014	33.00	33.00			6.60	C1		26.40	J9040
07/28/06	1	G0283	014	31.00	31.00			6.20	C1		24.80	J9040
07/28/06	2	97140	014	60.00	60.00			12.00	C1		48.00	J9040
07/21/06	1	G0283	014	31.00	31.00			6.20	C1		24.80	J9040
07/21/06	1	97035	014	30.00	30.00			6.00	C1		24.00	J9040
07/21/06	2	97140	014	60.00	60.00			12.00	C1		48.00	J9040
07/25/06	1	97012	014	33.00	33.00			6.60	C1		26.40	J9040
07/25/06	1	G0283	014	31.00	31.00			6.20	C1		24.80	J9040
07/25/06	2	97140	014	60.00	60.00			12.00	C1		48.00	J9040
			CLAIM TOTALS					73.80			295.20	

CLAIM SPECIFIC MESSAGE(S):

We provide administrative claims payment services only and do not assume any financial risk or obligation regarding claims.

MESSAGE(S):

J9040	If you have any questions, call 1-866-731-8080 or the Western District Office 1-800-547-3627 or the Eastern District Office (215) 564-2131.
X5018	The allowance for this service has been applied to the dollar deductible amount required under the patient's coverage.
J6066	If you have any questions, call 1-866-588-6967.
S5002	Coverage was cancelled prior to the date of service. Therefore, no payment can be made.
J9043	If you have any questions, call 1-800-241-5704.
S0190	We are unable to identify this patient from the information submitted. Please verify the first and last name, alpha prefix, and number indicated on the identification card, along with the patient's sex and date of birth. If the patient is covered by us, please resubmit with corrected information.
VOID	This service has been corrected. Amounts appearing on this line are not included in the totals line, as they were previously processed on the original claim. Please refer to the original Explanation of Benefits or Claim Notice for information on this line.
J0080	If you have questions, please call 1-866-731-8080.
J8060	Our payment was reduced due to a payment made by Medicare. The OTHER AMOUNT may not match Medicare's payment. Since you agreed to accept Medicare's allowance as full payment, our payment combined with Medicare's cannot exceed the Medicare allowance.

PAYMENT CODES:

- 014 = REASONABLE BENEFIT MAX/MAJ MED
- 023 = PREMIERBLUE SHIELD
- 026 = CONTRACTED ALLOWANCE
- 027 = PROGRAM ALLOWANCE

NON-CHARGEABLE AMOUNT CODES:

- 07 = Rejected Non-Billable Services
- 25 = Differential

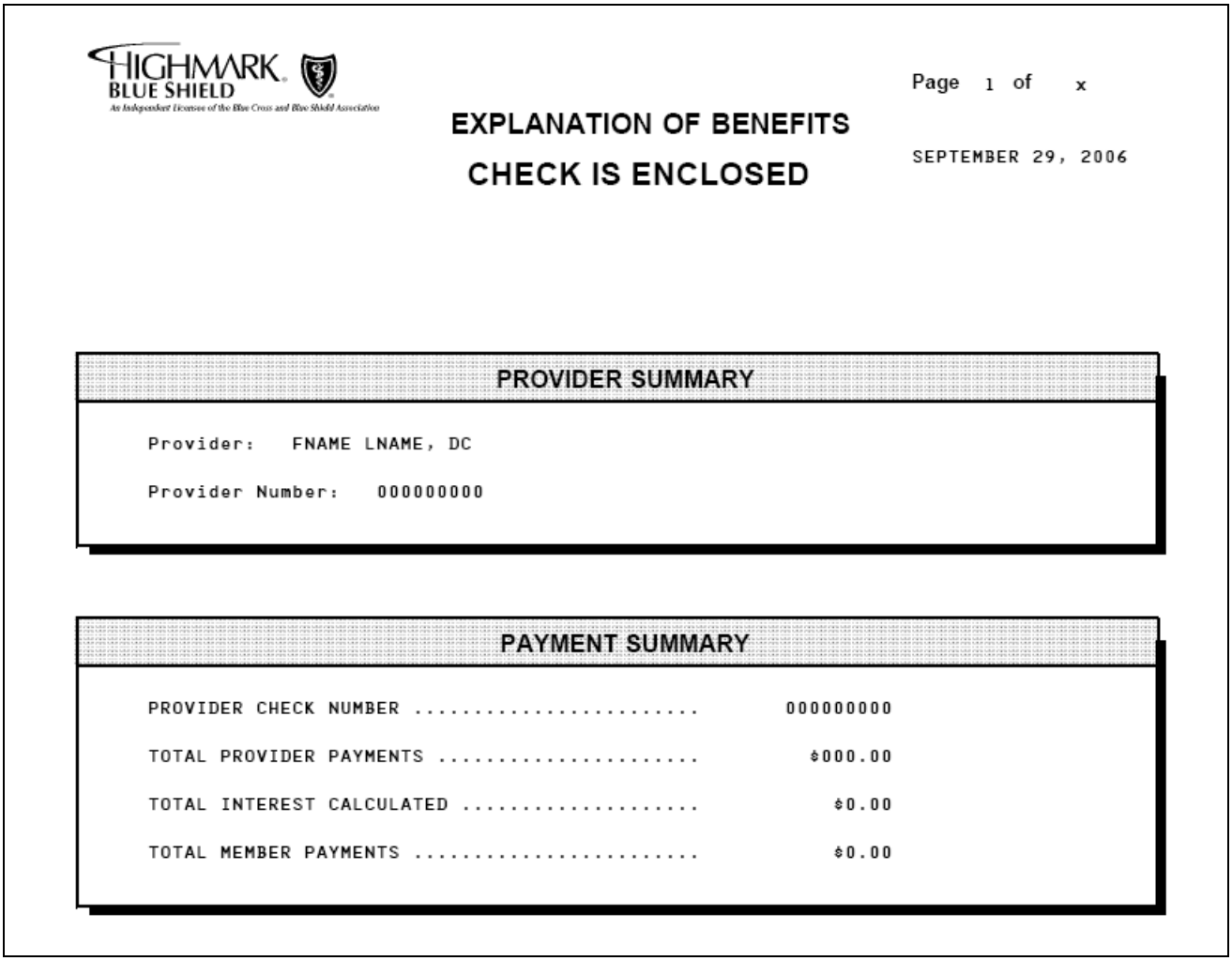
MEMBER LIABILITY CODES:

- A1 = Deductible
- C1 = Coinsurance
- D1 = Copay
- H1 = Rejected Billable Non-Covered

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PF011834

5.2 Example of Concurrent Major Medical EOB



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EXPLANATION OF BENEFITS

CHECK IS ENCLOSED

SEPTEMBER 29, 2006

PROVIDER SUMMARY

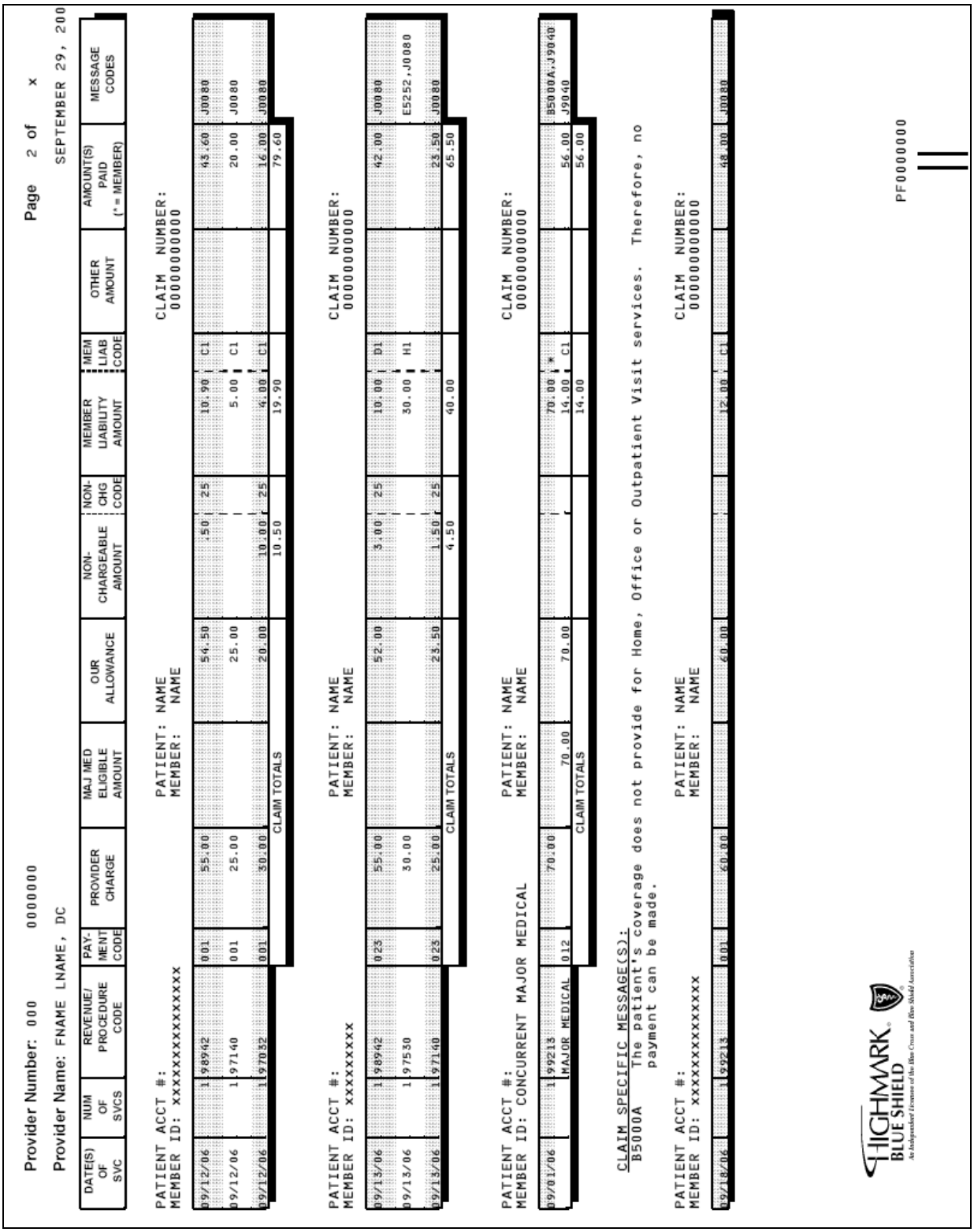
Provider: FNAME LNAME, DC

Provider Number: 000000000

PAYMENT SUMMARY

PROVIDER CHECK NUMBER	000000000
TOTAL PROVIDER PAYMENTS	$000.00
TOTAL INTEREST CALCULATED	$0.00
TOTAL MEMBER PAYMENTS	$0.00

5.2 Example of Concurrent Major Medical EOB, continued



Provider Number: 000 0000000 Page 2 of x

Provider Name: FNAME LNAME, DC SEPTEMBER 29, 200

DATE(S) OF SVC	NUM OF SVCS	REVENUE/ PROCEDURE CODE	PAY-MENT CODE	PROVIDER CHARGE	MAJ MED ELIGIBLE AMOUNT	OUR ALLOWANCE	NON-CHARGEABLE AMOUNT	NON-CHG CODE	MEMBER LIABILITY AMOUNT	MEM LIAB CODE	OTHER AMOUNT	AMOUNT(S) PAID (* = MEMBER)	MESSAGE CODES
PATIENT ACCT #: xxxxxxxxxxxxxxx PATIENT: NAME MEMBER ID: xxxxxxxxxxxxxxx MEMBER: NAME CLAIM NUMBER: 00000000000													
09/12/06	1	98942	001	55.00		54.50	.50	25	10.90	C1		43.60	J0080
09/12/06	1	97140	001	25.00		25.00			5.00	C1		20.00	J0080
09/12/06	1	97032	001	30.00		20.00	10.00	25	4.00	C1		16.00	J0080
CLAIM TOTALS				110.00		99.50	10.50		19.90			79.60	
PATIENT ACCT #: xxxxxxxxxx PATIENT: NAME MEMBER ID: xxxxxxxxxx MEMBER: NAME CLAIM NUMBER: 00000000000													
09/13/06	1	98942	023	55.00		52.00	3.00	25	10.00	D1		42.00	J0080
09/13/06	1	97530		30.00					30.00	H1			E5252,J0080
09/13/06	1	97140	023	25.00		23.50	1.50	25	40.00			23.50	J0080
CLAIM TOTALS				110.00		75.50	4.50		80.00			65.50	
PATIENT ACCT #: CONCURRENT MAJOR MEDICAL PATIENT: NAME MEMBER ID: CONCURRENT MAJOR MEDICAL MEMBER: NAME CLAIM NUMBER: 00000000000													
09/01/06	1	99213		70.00					70.00	*		56.00	B5000A,J9040
MAJOR MEDICAL			012			70.00			14.00	C1			J9040
CLAIM TOTALS				70.00		70.00			14.00			56.00	

CLAIM SPECIFIC MESSAGE(S):

B5000A The patient's coverage does not provide for Home, Office or Outpatient Visit services. Therefore, no payment can be made.

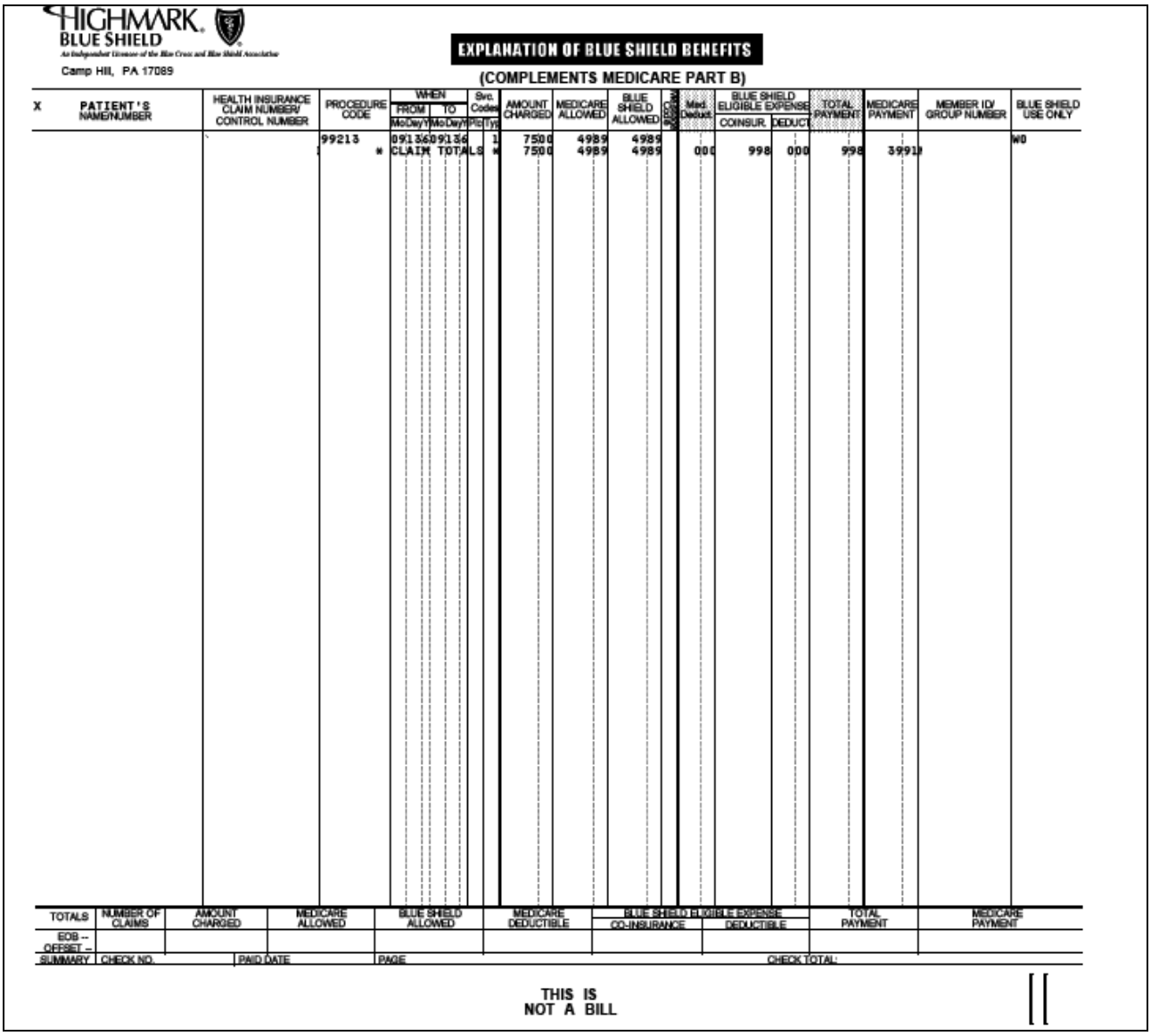
PATIENT ACCT #: xxxxxxxxxxxxxx PATIENT: NAME MEMBER ID: xxxxxxxxxxxxxx MEMBER: NAME CLAIM NUMBER: 00000000000													
09/18/06	1	99213	001	60.00		60.00			12.00	C1		48.00	J0080

HIGHMARK BLUE SHIELD

An Independent Licensee of the Blue Cross and Blue Shield Association

PF0000000

5.2 Example of Medicare Part B Supplemental EOB



HIGHMARK. BLUE SHIELD
An Independent Licensee of the Blue Cross and Blue Shield Association
Camp Hill, PA 17089

EXPLANATION OF BLUE SHIELD BENEFITS

(COMPLEMENTS MEDICARE PART B)

X	PATIENT'S NAME/NUMBER	HEALTH INSURANCE CLAIM NUMBER/ CONTROL NUMBER	PROCEDURE CODE	WHEN FROM Mo Day Yr	WHEN TO Mo Day Yr	Svc. Codes Pla	Svc. Codes Typ	AMOUNT CHARGED	MEDICARE ALLOWED	BLUE SHIELD ALLOWED	COINSURANCE	Med. Deduct.	BLUE SHIELD ELIGIBLE EXPENSE COINSUR.	BLUE SHIELD ELIGIBLE EXPENSE DEDUCT	TOTAL PAYMENT	MEDICARE PAYMENT	MEMBER ID/ GROUP NUMBER	BLUE SHIELD USE ONLY
			99213	09 13 36	09 13 36	1		7500	4989	4989		000	998	000	998	3991		WO
			M	CLAIM TOTALS		M		7500	4989	4989								

TOTALS	NUMBER OF CLAIMS	AMOUNT CHARGED	MEDICARE ALLOWED	BLUE SHIELD ALLOWED	MEDICARE DEDUCTIBLE	BLUE SHIELD ELIGIBLE EXPENSE CO-INSURANCE	BLUE SHIELD ELIGIBLE EXPENSE DEDUCTIBLE	TOTAL PAYMENT	MEDICARE PAYMENT
EOB -- OFFSET --									
SUMMARY	CHECK NO.		PAID DATE	PAGE			CHECK TOTAL:		

THIS IS
NOT A BILL

5.2 Example of Medicare Part B Supplemental EOB, continued

THE ADDRESS FOR FILING MEDIGAP CLAIMS IS:

HIGHMARK BLUE SHIELD
P. O. BOX 898845
CAMP HILL, PA 17089-8845
1-866-763-6695

WHEN QUESTIONING CLAIM STATUS, BENEFITS, OR
ENROLLMENT INFORMATION, PLEASE USE INFOFAX AT
1-800-891-1856 OR OASIS AT 1-800-462-7474.

HIGHMARK BLUE SHIELD
An Independent Licensee of the Blue Cross and Blue Shield Association
Camp Hill, PA 17089

NAME
STE 000
STREET
CITY ST ZIP

13,439

5.2 Highmark's Internal Billing Dispute Process

Billing Dispute Process Overview

Any provider who treats a Highmark member has the right to dispute claims payment decisions made by Highmark. Highmark offers several ways for providers to express dissatisfaction with their claims payment or lack thereof.

Network providers may:

- Call Provider Service
- Submit a NaviNet® Inquiry
- Send Written Correspondence to Customer Service

It is the provider's responsibility to submit all necessary information about the billing dispute and any additional documentation. If Highmark determines there is incomplete information, the provider will be contacted to provide the necessary information.

Once all documentation is received, it is routed to the appropriate department for research and review. A service representative will review the applicable claim(s) and determine whether the claim(s) processed correctly. Individual departments within Highmark have varying levels of review and will notify the provider at various stages of the review, as applicable. In certain instances, internal billing dispute processes are considered final. In cases where eligibility requirements are met, further billing dispute resolution processes may be available.

No matter the outcome, each provider who submits a billing dispute will receive notification advising them of the outcome and the reason for the decision. Actions will be taken to remedy the billing dispute, if the provider's contention was correct.

Medical Review Committee

A dispute with a health services doctor (as defined in 40 Pa. C.S.A. Section 6302) which remains unresolved can be referred to the Medical Review Committee (MRC) for consideration.

This review practice is further discussed in the Introduction of the Highmark Blue Shield Office Manual available on Highmark's Provider Resource Center under Administrative Reference Materials.

Chapter 6

Policies and Procedures

Unit 1: Other Party Liability

In This Unit

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Unit 1: Other Party Liability	
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6.1 Coordination of Benefits

Overview

Highmark Blue Shield employs several processes to ensure the services provided to its members are paid by the proper insurer and the reimbursement for these services does not exceed the actual charge.

Definition – Coordination of Benefits

Coordination Of Benefits allows patients to receive up to 100 percent of the cost of covered services, while ensuring that no one collects more than the actual cost of the covered health expenses.

- When a member is covered by more than one health care plan, one plan is determined to be primary and its benefits are applied to the claim first. Reimbursement of the remaining balance is considered through the secondary policy, subject to benefit provisions.

Definition -- Workers' Compensation Insurance

Workers' Compensation insurance covers medical treatment for work-related injuries or illnesses.

- Federal and State laws require employers to provide this coverage to their employees.
- Employees are entitled to full coverage for all employment-related health care expenses through their Workers' Compensation insurance.
- Highmark Blue Shield is not liable to pay claims under these circumstances unless Worker's Compensation benefits have been exhausted.

Definition -- Subrogation

Subrogation is the contractual and equitable right of Highmark to recover any payments paid for health care expenses which were the result of injuries caused by another person or entity.

- Subrogation helps by crediting the members benefit plan with the recovered monies and controls the cost the customer and his/her employer pay for health care.
- Examples of other party liability include: Product liability, property negligence, auto accident caused by another party or accidental injury on someone else's property.

Continued on next page

6.1 Coordination of Benefits, Continued

Definition – The Motor Vehicle Financial Responsibility Law

The Motor Vehicle Financial Responsibility Law requires anyone who registers a motor vehicle in Pennsylvania to provide for specific levels of medical insurance coverage.

- The law mandates a minimum of $5,000 in medical benefit coverage must be available for each accident victim.
- The victim's motor vehicle accident insurance is always the primary payer for the treatment of injuries sustained in an automobile accident.
- Highmark Blue Shield may pay for covered services after the automobile insurance benefits are exhausted.

Crossover Consolidation Process Automatically Submits Medicare Claims To Secondary Payer

The Centers for Medicare & Medicaid Services (CMS) consolidated its claim crossover process under a special Coordination of Benefits Contractor (COBC) by means of the Coordination of Benefits Agreement. Under this program, the COBS automatically forwards Medicare claims to the secondary payer, eliminating the need to separately bill the secondary payer.

Blue Plans implemented the Medicare crossover consolidation process system-wide. This process provides an increased level of one-step billing for your Medicare primary claims streamlines your claim submissions and reduces your administrative costs.

The claims you submit to the Medicare carrier crossover to the Blue Plan only after the Medicare carrier or intermediary has processed them. The Medicare carrier or intermediary automatically advises the Blue Plan of Medicare's approved amount and payment for the billed services. Then, the Blue Plan determines its liability and makes payment to the provider. This one-step process means that you do not need to submit a separate claim and copy of the Explanation of Benefits (EOMB) statement to the Blue Plan after you receive the Medicare carrier's or intermediary's payment.

Some providers submit paper claims and EOMB statements for secondary payment unnecessarily. Sending a paper claim and EOMB statement for secondary payment, or having your billing agency resubmit automatically, does not speed up the reimbursement of secondary payments. Instead, this costs you money and creates confusion for members. It also increases the volume of claims handled by the secondary payer and can slow down all claim processing, thereby delaying payments.

Continued on next page

6.1 Coordination of Benefits, Continued

Crossover Consolidation Process Automatically Submits Medicare Claims To Secondary Payer, continued

Whether you submit electronic or paper claims, it is no longer necessary to send a separate claim and EOMB statement for the purpose of obtaining payment on a secondary claim.

Please allow at least 30 days for the secondary claim to process. If you haven't received notification of the processing of the secondary payment, please do not automatically submit another claim. Rather, you should check the claim status before resubmitting. To further streamline the claim submission process to save your practice time and money, consider revising the time frame for the automated resubmission cycle of your system to accommodate the processing times of these secondary claims.

6.1 Frequently Asked Questions about COB

When Does COB Apply?

When a patient is covered by two or more health insurance policies.

Why Does COB Apply?

COB allows patients to receive up to 100 percent of the cost of covered services, while ensuring that no one collects more than the actual cost of the covered health expenses.

When a member is covered by more than one health care plan, one plan is determined to be primary and its benefits are applied to the claim first. Reimbursement of the remaining balance is considered through the secondary policy, subject to benefit provisions.

Who Pays First?

Most health insurance carriers, including Highmark Blue Shield, use the following rules to decide who is primary:

1. Typically, the plan where the patient is enrolled as the applicant (or employee) will pay first. The other plan, perhaps through a spouse, will provide secondary coverage.
2. When both parents provide coverage for a dependent child, the plan of the parent whose date of birth (month and day) arrives earlier in the calendar year, is the plan that pays first. For example: if the mother's birthday is March 10 and the father's birthday is March 20, the mother's plan would pay first.

   This is known as the "birthday rule" and applies only when:

- The parents are married, or
- The parents are living together, they are not married to each other or anyone else – and they are not separated from each other, or
- There is a court order for joint custody with no assigned financial responsibility.

If the parents are separated or divorced, then:

- The plan of the parent with whom the child lives pays first.
- The plan of the stepparent with whom the child lives pays second.
- The plan of the parent without custody pays third.
- A court order can establish a different order.

Continued on next page

6.1 Frequently Asked Questions about COB, Continued

Who Pays First?, continued

3. When a person is enrolled in two different plans, the plan that has provided coverage for the longer period of time, will pay first. If that person is covered through an active employment plan and also through a retiree or laid off employee plan, the active employment plan pays first.

How Much Does Highmark Blue Shield Consider Primary?

When Highmark Blue Shield is the primary coverage, the services are considered as though no other coverage is available. A health care professional who participates in our networks agrees to accept the program allowance as payment in full. The only amounts billable to the secondary insurance are for coinsurances, deductibles, amounts exceeding a maximum and those charges denied as non-covered.

How Much Does Highmark Blue Shield Consider Secondary?

Highmark Blue Shield has adopted the *National Association of Insurance Commissioners (NAIC) Model COB Regulation.* This regulation is the most common methodology used for calculating a secondary payment in COB situations.

This model applies to all commercial group products. Highmark Blue Shield's senior products, Medicare Advantage product, direct pay products and the Federal Employee Program are not included. While the majority of commercial business has been moved to the NAIC model, certain national accounts and larger regional accounts will had the option to not participate in this change.

The NAIC model COB regulation applies to institutional claims, professional claims and ancillary claims. It applies to all health care professionals and providers regardless of their participating status with Highmark Blue Shield. The Blue Cross Blue Shield Association supports the NAIC model COB regulation. This is a common industry standard and is consistent with most insurers.

Under the NAIC model COB regulation, Highmark Blue Shield's payment as secondary will be based on the difference between what the other insurer paid and what Highmark Blue Shield would have paid as primary. If the primary payment is less, Highmark Blue Shield will pay the difference.

Continued on next page

6.1 Frequently Asked Questions about COB, Continued

How Much Does Highmark Blue Shield Consider Secondary? (continued)

If the primary payment is greater or equal to the original approved amount, no additional payment will be made. In no case will Highmark Blue Shield, as secondary, pay more than it would have paid if it were primary. Below is an example of the NAIC model COB regulation:

Example	Charge	Blue Shield's Allowance	Primary Carrier's Payment	Blue Shield's Payment	Amount Provider Receives
1	$100	$50	$60	-0-	$60
2	$100	$50	$20	$30	$50

Reminders For Submitting COB Claims:

When submitting COB claims to Highmark Blue Shield when it is the secondary payer, please include all relative information from the primary insurer, including member liability, for example, copayment, coinsurance, and deductible.

When Highmark Blue Shield processes a COB claim as the secondary payer, your Explanation of Benefits (EOB) may or may not show the amount the primary insurer paid. The EOB will also show the member's liability. A network provider cannot balance bill the member when Highmark Blue Shield made payment as secondary payer except for any copayment, coinsurance, deductible or non-covered service under the secondary policy.

What Is Blue On Blue?

In many cases duplicate coverage occurs when both the primary coverage and the secondary coverage are provided through Highmark Blue Shield. In most Blue on Blue cases, the paid-in-full regulations do apply for health care professionals who participate with Highmark Blue Shield networks.

Continued on next page

6.1 Frequently Asked Questions about COB, Continued

How Can Health Care Professionals Assist With The Process?

- When you file COB claims, submit the claims to the primary carrier first.
- When Highmark Blue Shield is the secondary coverage, you must submit information about the primary insurers' claim payment or denial with the claim to Highmark Blue Shield.
- When filing claims electronically, the nationally accepted electronic submission formats accommodate secondary claims submission.
- If you submit paper claim forms, you must also send us a copy of the other plan's Explanation of Benefits payment information.
- If both insurance companies make payments on a claim and the combined payments exceed your charge, notify Highmark Blue Shield's or Blue Cross of Northeastern's Customer Service department at the phone numbers listed below. The Customer Service Department will investigate and advise if a refund is requested.

What Region Am I?

Central and Eastern PA Regions
1-866-731-8080

Northeastern PA Region
Blue Cross of Northeastern PA
BlueCare Traditional: 1-800-827-7117
BlueCare PPO: 1-866-262-5635

Western PA Region
1-866-763-3224, Option 1

Chapter 6

Policies and Procedures

Unit 3: Post-Payment Review

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Techniques Used for Investigation	5
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Highmark's Medical Review Committee (MRC)	9
Special Investigations Unit	10

6.3 Post-Payment Review Process

The Review Process

Post-payment practice pattern review is a key element of the screening process Highmark Blue Shield uses to assure that its members receive health care services that are medically necessary and that the claims for these services are submitted properly.

Which Providers Are Reviewed?

We are required to monitor all providers in our Participating, Preferred and Managed Care networks throughout Pennsylvania and the contiguous states.

Three Phases of Practice Pattern Review

1. Initial claims review - Highmark Blue Shield staff, or Blue Cross of Northeastern Pennsylvania staff if your main practice is located in the 13-county Northeastern Region, audits each claim for easily identifiable errors and services claimed for payment that are not covered in a customer's benefit package. Frequently, Highmark Blue Shield pays for eligible services, even though a more extensive review of the provider's practice pattern may take place at a later time.

2. Pre-payment practice pattern review - staff looks closely at selected claims before the claim is paid in order to determine the medical necessity of the services reported. As in the initial claims review process, Highmark Blue Shield may conduct further review after the provider is paid.

3. Post-payment practice pattern review - staff looks closely at selected claims for multiple years after the claims have been paid in order to determine medical necessity and appropriateness of the services reported. These type cases involve long-term tracking and monitoring of many services rendered by providers.

History of Post-Payment Review

Highmark Blue Shield initiated post-payment practice pattern review in 1962 in cooperation with the Pennsylvania Insurance Department. Since that time, it has increased in importance, not only at Highmark Blue Shield, but in the entire health care industry.

Ultimate Goals of Post Payment Review

Enforce our contracts with all health care professionals.

- Ensure the payments are made consistent with medical policy.
- Educate our provider community on appropriate reporting and "Best Practice" guidelines.
- Identify and stop aberrant reporting.
- Be a deterrent to overutilization, underutilization and misutilization by providing a sentinel role.

Continued on next page

6.3 Post-Payment Review Process, Continued

Ultimate Goals Of Post Payment Review, (continued)

In rare instances of suspected fraud, Highmark Blue Shield's Special Investigations unit, or Blue Cross of Northeastern Pennsylvania if your main practice is located in the 13-county Northeastern Region, tracks claim reporting, collecting information that may become evidence for law enforcement officials or the courts.

Professional consultants support and advise Highmark Blue Shield personnel in these post-payment practice pattern review activities.

When Problems Are Identified

When a problem is identified, what actions are taken to correct the provider's reporting?

- The provider is notified of our findings.
- No matter what the case: overutilization, underutilization or misutilization, through educational efforts, the provider is requested to correct his or her reporting pattern.
- If necessary, at the conclusion of the practice audit, monies may be requested to be refunded.

6.3 Defining the Issues: Overutilization, Misutilization and Underutilization

Defining The Issues

Overtilization is the unnecessary or repetitive performance of an eligible service, which either is not medically necessary, or is not in accordance with the accepted practice of medicine in the community.

Misutilization includes the reporting of services not performed, the reporting of an ineligible service or the upgrading of a service to obtain a higher fee. This may involve fraudulent actions by either a member or provider.

Underutilization is the failure of the provider to furnish care and services when medically necessary in sufficient detail to ensure that members receive needed services to which they are entitled.

6.3 Techniques Used for Investigation

Techniques Used For Investigation

1. Routine surveys of paid claims. Following generally accepted auditing principles, Highmark Blue Shield routinely surveys a percentage of all claims it receives. Our staff verifies the claims' accuracy by gathering information from hospitals' medical records department, providers' offices or members.

2. Special surveys. Surveys are performed as a result of discrepancies uncovered during our reviews. A number of representative claims are selected from all those submitted by a particular provider. Each claim is then verified through member interviews or on-site record reviews.

3. Statistical review of cumulative claims payment data. Highmark Blue Shield has developed a state-of-the art practice pattern review system called ULTRA (Utilization Trends, Reporting and Analysis). ULTRA analyzes claims data and tracks the utilization of services to detect unusual patterns of utilization, charges or payments. ULTRA sorts services in many ways, such as by the number of services performed, the site of service, the region, the specialty, the diagnosis code and more, in many unique ways.

4. Pre-payment review of unusual claims. Conducted before final processing and payment of a claim, these provider-specific reviews are in addition to the usual pre-payment examination of all claims. The criteria for initiating pre-payment focused reviews vary as sophistication in processing claims increases.

Examples of the criteria used are:

- Reports of unusual combinations of multiple services;
- Multiple services by the same provider during one hospitalization;
- In-hospital medical care reported by several providers for the same case;
- Claims from providers whose practices are under review as a result of other post-payment practice pattern monitoring activities.

5. Special research studies. Highmark Blue Shield frequently conducts special studies to identify new areas for review and to assess the adequacy of our present claims systems to ensure cost-effective quality health care for our members.

6. Quality of imaging films. Periodically reviews of imaging films will be conducted to ensure the quality of services provided to members. Films, selected at random, will be reviewed by an appropriate professional consultant.

6.3 When A Case Is Identified

Process: When A Potential Problem Is Identified

When a potential problem is identified a case audit is initiated. This case can be closed at any time if the information developed satisfactorily explains the initial problem detected. Routinely, we review information, including up to two (2) years of reporting. In certain circumstances, however, we may review up to four (4) years which is permitted under the Statute of Limitations in Pennsylvania.

Analysis of claims processed: A statistical analysis of the claims processed for a particular provider will be conducted. This analysis will compare all phases of a provider's post-payment practice patterns to his peers.

If during the audit irregularities are found (for example, the provider is performing more of a particular service than his or her peers), our first action will be to inform the provider of the irregularities through a letter or face to face meetings. In the letter, we will identify possible problems and include a statistical report to demonstrate where the provider may want to alter his, or her, pattern of practice.

On-site review: If warranted, an on-site audit may be conducted. This usually includes obtaining copies of clinical records.

Patients, also, may be interviewed by a staff representative to verify that services were performed as reported. Or, if the patient's age or condition precludes an interview, the representatives may interview the patient's relatives, as appropriate. These interviews usually are necessary only when office or home services are involved.

The interview seeks answers to four basic questions:

1. For what medical problems did you visit the provider?
2. When or approximately how often did you see the provider?
3. What services do you recall that the provider performed?
4. Were there any services for which you made payment yourself?

Our representatives are trained to avoid making any improper comments about the provider or to comment on the quality or appropriateness of treatment the member received. They always clearly identify themselves and present their contact with the member as a routine verification of services which have been paid by Highmark Blue Shield.

Discrepancies between information reported on the claim form and the member's recollection of the services performed are pursued carefully during any interview. Representatives make every effort to assess the reliability of persons interviewed and the accuracy of their statements.

Continued on next page

6.3 When A Case Is Identified, Continued

Post-Payment Practice Pattern Review Specialists

It is the responsibility of the post-payment practice pattern review specialists to examine and summarize hospital and office records and reports of on-site audits. They also review statistical information on payments made and prepare summaries of individual treatment patterns for a random selection of patients covering a period of at least one year.

Review By Professional Consultants

Although not required in every case, a professional consultant may be used to review documentation and provide a written opinion. Sometimes this is done at the request of the provider. Our professional consultant program involves over 250 independent health care professionals who provide their perspective on issues of medical policy, clinical guidelines and unusual claims.

Professional consultants are contracted as Business Affiliates who are actively practicing health care professionals, representing major professional specialties and disciplines. These consultants are required to:

- Provide written medical opinions regarding medical claims,
- Provide written medical opinions regarding medical policy,
- Provide written input for use in the development of reimbursement amounts for medical services, and
- Provide written medical opinions regarding provider practice patterns and utilization.

Referrals to consultants involve two separate and distinct types of audits, pre-payment and post-payment. Pre-payment practice pattern audits are performed on the medical necessity or appropriateness of service(s) or procedure code(s) prior to claims payment. Post-payment practice pattern audits involve utilizing professional consultants to review overall practice patterns. In these situations, we are generally requiring their opinion as to the medical necessity of the services rendered, whether the documentation in the medical records supported the services billed and the level of care. If they don't, we will ask the consultants what services, or level of care, should have been reported.

In order to assure the credibility of these reviews, we always make every effort to use a consultant of the same specialty or subspecialty, similar practice (i.e., a provider in a small office practice would be reviewed by a consultant with a similar practice), different geographic location to attempt to ensure that the provider being reviewed receives a completely unbiased review. Additionally, our consultants are currently in active practice to assure they are aware of the latest developments in their specialties.

Continued on next page

6.3 When A Case Is Identified, Continued

Provider Contact And Education

At this time, the provider is contacted by a Provider Relations representative to discuss several items: the statistical data, the individual treatment patterns, the professional consultant's opinion, provide education on future reporting, and if necessary, obtain a refund of overpaid monies. If Highmark Blue Shield has determined a refund is due, the representative will inform the provider of the amount of the refund request and the provider's options for repayment.

When A Provider Disagrees With The Findings

If the provider disagrees with our audit findings, they have the opportunity to provide additional clinical documentation in support of their position and have this information considered. Or, since the initial review may have been based on a limited sampling, an expanded statistically valid review involving a larger number of records may be requested. Also, the providers are advised that they have the right to appeal their case to the Medical Review Committee (MRC). They are also advised that the determinations made by the MRC are binding on both the provider and Highmark Blue Shield.

6.3 Highmark's Medical Review Committee (MRC)

MRC Process

Any provider audit conducted by the post-payment practice pattern review or higher reimbursement area which remains unresolved can be referred to the Medical Review Committee (MRC) for consideration. The committee is made up of a variety of degree specialties and lay members. The Medical Review Committee, under the Highmark Inc. Bylaws, is charged with the following responsibilities:

- *to consider unresolved matters, disputes or controversies arising out of the relationship between the Corporation and any provider, including any questions involving professional ethics*
- *review any matter affecting the status of a health care professional as a network provider of the Corporation*
- *conduct hearings to resolve disputes involving the status of health care professionals as Participating Providers in accordance with Article IX of the Bylaws of the Corporation.*
- *consider appeals by providers who are rejected or terminated as network providers in any network provider panel operated by the Corporation under Pennsylvania's preferred provider legislation*

For more information on the Medical Review Committee, please visit the Introduction of the Highmark Blue Shield Office Manual.

6.3 Special Investigations Unit

Overview Of The SIU

In addition to conducting post-payment practice pattern reviews, Highmark also investigates potential member and provider fraud and abuse.

The Special Investigations Unit's mission is to maintain the integrity of member and provider claims submitted to Highmark, its subsidiaries, affiliates, and employees through proactive detection and investigation of potential fraud and abuse. When necessary, Special Investigations takes internal and/or external corrective action to assist Highmark in continuing to provide quality, affordable health care to all its clients.

For more information on the Special Investigations Unit, please visit www.highmark.com. Click the tab titled 'About Highmark,' then on the bottom of this page click 'We Fight Fraud'.

Highmark established a Fraud and Abuse Hotline so that members and providers can notify Special Investigations of potential fraud/abuse. The fraud hotline is automated and allows anyone to leave a message 24 hours a day, seven days a week.

The Highmark Fraud and Abuse Hotline telephone number is: 1-800-438-2478.

Chapter 6

Policies and Procedures

Unit 4: Reporting Methods

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6.4 Overview

Functions of Provider Data Analysis

Provider Data Analysis monitors payments for services rendered in a facility, such as a hospital or skilled nursing facility, to ensure that duplicate payments are not being made through both a facility and professional claim submission for the same service.

To do this Provider Data Analysis must monitor and control reimbursements:

- To facility-based providers and to provider-owned and operated free-standing facilities.
- For total charge diagnostic or therapeutic services.

6.4 Reporting Methods

Reporting Anesthesia Services

A professional provider may bill for the medical direction of certified registered nurse anesthetists' (CRNA) services. If the professional provider employs the CRNA, payment is made at the same level as the professional provider's personal performance of the service.

However, if the professional provider does not employ the CRNA, the service will be reimbursed up to 50 percent of the allowance for the full service.
Provider Data Analysis monitors and controls Highmark Blue Shield's payment of medically directed CRNA services. Professional providers are required to provide proof of CRNA employment to Provider Data Analysis prior to billing for their services. All claims for services of CRNAs employed by professional providers must be held until Provider Data Analysis advises the provider that they have been approved to submit them.

Approval for full reimbursement of anesthesia services will be contingent upon meeting employment criteria established in accordance with Highmark Blue Shield policy. Reimbursement will be limited to 50 percent of the full allowance until the approval process is complete.

Reporting services provided in a teaching setting

For a service to be billable as a professional service, it must meet the requirement of being an identifiable physician service to an individual patient.

Services that are furnished by the resident or by the teaching physician for the general benefit of patients, that is, supervising and teaching of residents, are considered to be services to the hospital and are not billable as a professional service on a CMS-1500 claim form.

For additional information concerning services provided in a teaching setting, please visit the Provider Resource Center, choose Administrative Reference Materials then choose 'services provided in a teaching setting.' For additional information or clarification of these materials, you may send or fax a letter listing your questions to:

What Region Am I?

Highmark Blue Shield
Provider Data Analysis
Center Street 1A L4
P.O. Box 890089
Camp Hill, PA 17089-0089

Western Region Fax: 1-800-236-8641
Central, Eastern and Northeastern Region Fax: 1-866-507-6567

Chapter 6

Policies and Procedures

Unit 5: Outpatient Radiology and Other Diagnostic Services

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6.5 Radiology Management Program Overview

Overview

Highmark's Radiology Management Program is designed to improve the quality and appropriateness of services delivered to our members.

Highmark retains the services of an imaging management firm, National Imaging Associates, Inc. (NIA), to assist with the program. NIA is certified in Pennsylvania and compliant with all Department of Health regulations applicable to their services.

The Highmark Radiology Management Program's goal is to ensure that *outpatient* diagnostic imaging providers demonstrate competency in administration of these services, thus improving quality and safety to our members. The initiative will also ensure that selected outpatient advanced imaging services such as MRIs, CT Scans and PET Scans are used only when they are clinically appropriate and that these services are being performed by quality providers.

Program Applies To All Network Products

This program applies to all of Highmark's products, except indemnity products.

Multiple Phases Of Implementation

The Highmark Radiology Management Program was implemented in three phases:

- Privileging,
- Prior Notification, and
- Prior Authorization

6.5 Privileging for Radiology Services

Definition

Privileging is a process that addresses the quality of imaging services performed at an imaging center or in a physician's office. All professional providers who perform imaging services must be privileged. Non-privileged providers are not eligible for reimbursement of imaging services.

Requirements For Privileging

Requirements intended to promote reasonable and consistent quality and safety standards for the provision of imaging services have been developed and can be found on the *Highmark Radiology Management Program* link in the Provider Resource Center via NaviNet or Highmark's Web Site.

Highmark will not reimburse providers for imaging services performed for Highmark members if they do not satisfy the privileging requirements. Any denied services will not be billable to the member.

How To Become A Privileged Provider

Eligible network practitioners who wish to provide imaging services should first consult the Privileging Requirements, and then submit an application. Applications can be completed online by visiting www.RadMD.com. They are also available on the *Highmark Radiology Management Program* link in the Provider Resource Center via NaviNet or Highmark's Web Site or by calling NIA at 1-888-972-9642.

An application must be submitted for each physical location where imaging services are rendered.

Request For Expansion, Additional Services Or Additional Sites

Providers must complete an application for each addition or expansion of services, or when adding additional sites. Practitioners will not be reimbursed for services provided on transferred or new equipment without being privileged.

6.5 Prior Authorization Phase - Radiology

Overview

Prior Authorization is intended to ensure quality and proper use of diagnostic imaging consistent with clinical guidelines. This requires physicians to use NaviNet to request authorizations through NIA prior to ordering any of the selected CT scans, selected MRI and MRA scans and PET scans.

Providers who are not NaviNet-enabled should call the NIA Call Center:

What Region Am I?

In the Central Region Only:
1-866-731-8080, Option 2, then Option 4.

In the Western Region Only:
1-800-547-3627, Option 4

NIA will issue authorization numbers, which will be required for reimbursement. Denials may be issued based on medical necessity and/or appropriateness determinations.

Physicians are advised to recommend Highmark-privileged imaging providers to members who have been approved to receive the selected non-emergency advanced imaging services; a current list is available on our online Provider Resource Center under *Radiology Management Program*.

Authorization Is Not A Guarantee Of Payment

When an authorization number is provided, it serves as a statement about medical necessity and appropriateness; it is not a guarantee of payment. Payment is dependent upon the member's having coverage at the time the service is rendered and the type of coverage available under the member's benefit plan. Some benefit plans may also impose deductibles, coinsurance, co-payments and/or maximums that may impact the payment. Providers may consult NaviNet, InfoFax or OASIS to obtain benefit information.

Services Affected

The prior authorization process applies only to certain outpatient, *non-emergency* advanced imaging services. The prior authorization process does not apply to outpatient *emergency* imaging services, inpatient imaging services or observation stays. Please review member benefits accordingly through NaviNet. If you are not NaviNet enabled you may contact Customer Service.

Continued on next page

6.5 Prior Authorization Phase - Radiology, Continued

Procedures That Require Prior Authorization

The prior authorization process applies to the following imaging procedures. Refer to the *Radiology Management Program* link on the online Provider Resource Center for a complete list of procedure codes (CPT) and descriptions.

-- Select CT scans
-- Select MRI scans
-- Select MRA scans
-- PET scans*

* Not all PET scans are included in this program, as some are not covered due to Highmark's medical policy. Please check medical policy if your PET scan is not include in the procedure code list.

Process Overview

The ordering physician's office staff uses NaviNet to contact NIA for prior authorization before scheduling the test. NIA staff will use nationally accepted clinical standards, or indicators, to determine the medical necessity/appropriateness.

For more detailed information on the prior authorization process, please refer to the *Prior Authorization Reference Guide* available on the Provider Resource Center under the Radiology Management Program link via NaviNet or Highmark's Web Site.

6.5 Reporting Methods

Inpatient Versus Outpatient

When you submit claims to Highmark Blue Shield for diagnostic or therapeutic radiology services or diagnostic medical services provided to hospital inpatients or outpatients, you must report the place of service as inpatient hospital or outpatient hospital, as appropriate. In these cases, you will be reimbursed only the professional component of the service.

- **Inpatient** – a patient who is an inpatient of a facility, such as a hospital or skilled nursing facility, at the time the procedure is performed. When an inpatient is taken outside the hospital setting, such as to a physician's office, and is then returned to the hospital, the physician must report services according to the patient's status, in this case, inpatient. Therefore, you must report only "inpatient" as the place of service, rather than the place, such as "office" or "outpatient hospital", where the service actually was performed.

- **Outpatient** – a patient, other than an inpatient, who is treated in a hospital, on hospital grounds or in a hospital-owned or controlled satellite, when it has been determined that the satellite is an outpatient department of the hospital. This definition does not apply when a treating physician's sole practice is located in a hospital or hospital owned building, if the practice is not affiliated or controlled, in any way, by the hospital or a related entity; or, if the practice has been approved by Provider Data Analysis to be recognized as an office practice.

For example, if a mobile ultrasound, MRI or CT unit locates on hospital grounds one day each week, all services provided to patients on that day must be reported with inpatient or outpatient, but not office, as the place of service.

6.5 Cost Sharing on Outpatient Diagnostic Services

Overview

Effective January 1, 2006, Highmark began offering optional benefit designs that include cost sharing provisions specific to outpatient diagnostic services.

Services Affected

Cost sharing on outpatient diagnostic services will be applied to:

- routine/preventive diagnostic services (with the exception of all mammograms and the annual routine PAP test) and
- non-routine diagnostic services including preadmission testing

Impacted Products

Products that may have a cost sharing benefit design include:

- PPOBlue®
- DirectBlue®
- EPOBlue℠
- FreedomBlue℠

NOTE: Cost sharing provisions will not be noted on Member ID cards. Please review member benefits accordingly through NaviNet or by contacting Customer Service if you are not a NaviNet-enabled provider.

Five Categories Of Outpatient Diagnostic Services

Advanced Imaging Services:

1. **Advanced Imaging Services** – include, but are not limited to, computed tomography (CT), computed tomographic angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET scan), positron emission tomography/computed tomography (PET/CT scan).

Basic Diagnostic Services:

2. **Standard Imaging Services** – procedures such as skeletal x-rays, ultrasound and fluoroscopy.
3. **Diagnostic Medical Services** – procedures such as electrocardiograms (ECG), electroencephalograms (EEG), echocardiograms, pulmonary studies, stress tests, audiology tests.

Continued on next page

6.5 Cost Sharing on Outpatient Diagnostic Services, Continued

Five Categories of Outpatient Diagnostic Services, continued

4. **Laboratory and Pathology Services** – procedures such as non-routine Papanicolaou (PAP) smears, blood tests, urinalysis, biopsies and cultures.
5. **Allergy Testing Services** – allergy testing procedures such as percutaneous tests, intracutaneous tests and patch tests.

How Coinsurance Is Applied

If a member has coinsurance, it is applied to all line items identified as outpatient diagnostic services either on Advanced Imaging only or also on the four categories of Basic Diagnostic Services depending on the benefit design selected.

The coinsurance amount (e.g., 80%) for the four categories of Basic Diagnostic Services is the same.

Coinsurance for outpatient diagnostic services is applicable to the total component, technical component and/or professional component only.

The member may be responsible for both a copayment and coinsurance when a service, such as an office visit or therapy service, and an outpatient diagnostic service are performed on the same date of service.

How Copayments Are Applied

If a member has copayments on outpatient diagnostic services, they are applied per date of service and per type of diagnostic service. If services fall in more than one of the five diagnostic service categories (see above), multiple copayments can be applied. Please review the member's benefit program to determine if a copayment is owed on multiple services. Please note: For FreedomBlue, copayments are applied per date of service, per type of diagnostic service and also per provider.

Copayments may be applicable to only the advanced imaging services or also to all four categories of basic diagnostic services. The copayment amount for the advanced imaging services would usually be a higher amount (e.g., $100). The copayment amount for the four categories of basic diagnostic services is the same (e.g., $25 for each type of service).

Copayments are applied to the total component or technical component claims for outpatient diagnostic services. Copayments are <u>not</u> applied to professional component (26 modifier) only claims.

Continued on next page

6.5 Cost Sharing on Outpatient Diagnostic Services, Continued

Examples of Multiple Copayments And/Or Coinsurance

1. If a PPOBlue member sees his cardiologist and receives an EKG during the visit, he would be responsible for two copayments: an office visit copayment and an outpatient diagnostic service copayment for the EKG (diagnostic medical service).
2. If a PPOBlue member receives an MRI (advanced imaging service), then has a spinal X-ray (standard imaging service) and lab work (laboratory/pathology service) on the same day – all as outpatient services – she would be responsible for three outpatient diagnostic copayments.
3. If an EPOBlue member sees his cardiologist and receives a stress test (diagnostic medical service) while there, he would pay an office visit copayment, and then would be responsible for any applicable coinsurance when the stress test claim is processed.
4. If a FreedomBlue member sees his cardiologist and receives an EKG (diagnostic medical service) while there and on the same day goes to another physician and receives a stress test (also a diagnostic medical service), he would be responsible for two copayments, one for each provider.

Cost Sharing Exception

- All mammograms (routine and medically necessary) and the annual routine PAP tests are generally unaffected by the cost sharing benefit designs.
- Diagnostic services performed in conjunction with an Emergency Room visit would not be impacted in most cases.
- Especially for self-insured employer groups, there may be situations where cost sharing may apply in the above situations. Please be sure to review each service on a case-by-case basis.

Determining If Members Have Cost Sharing

More information on outpatient radiology and other diagnostic services cost sharing can be easily accessed through NaviNet[sm] or by contacting Customer Service if you are not a NaviNet-enabled provider.

Log on to NaviNet and follow these steps:

1. Select *Eligibility and Benefits Inquiry* for a specific patient, then
2. Select *Outpatient Diagnostic Services*.
3. Scroll to the bottom of the benefits page to find any applicable copayment and coinsurance information.

6.5 Outpatient Laboratory Overview

Prescription Necessary

PCPs and specialists need only give their members a prescription for the necessary lab tests and direct them to a network-participating lab.

Communication Between The PCP And Specialist

Specialty practitioners should communicate with a member's PCP after a consultation visit so that laboratory services can be appropriately coordinated.

Designated Outpatient Lab Providers

Network-participating hospitals provide outpatient lab services. In addition, there are several freestanding labs and specialty labs that are designated outpatient lab providers.

NaviNet is the fastest method for accessing real-time lists of network participating providers.

Step	***Action***
1	*Log In to NaviNet by accessing https://navinet.navimedix.com*
2	*From Plan Central, select Network Facility Inquiry*
3	*Use the descriptive fields to narrow your search requirements by network, facility number, specialty description, etc.* *NOTE: Laboratories can be found selecting Laboratory Medicine in the specialty description field.*
4	*Click Search to return requested information.*

NaviNet is the preferred Highmark tool for inquiring about participating providers, however, if you are not NaviNet-enabled, please click the links below for a list of designated outpatient lab providers. Please select the appropriate region-specific link below:

What Region Am I?

Western Region Outpatient Lab Providers

Central Region Outpatient Lab Providers

If you are a provider who participates with Highmark and are interested or want more information about NaviNet, call your Highmark Provider Relations representative.

Continued on next page

6.5 Outpatient Laboratory Overview, Continued

Note For Western Region Medicare Advantage HMO	Laboratory services for members of Western Region Medicare Advantage HMO products may be provided by the appropriate network-participating hospital. In addition, members may also use other network laboratories at their convenience.

Chapter 7

QualityBLUE℠ A Physician Pay-for-Performance Program

Unit 1: Overview - Fee-For-Service Payment

In This Unit

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7.1 Introduction To The QualityBLUE Fee-For-Service Program

Purpose

What Region Am I?

QualityBLUE, A Physician Pay-for-Performance program was developed to encourage physicians to support Highmark's goal of providing accessible, high-quality health care as efficiently as possible. The program is based on the former Quality Incentive Payment System (QIPS) which was available in 29 counties of the Western Region in July 2005 and expanded to an additional 20 counties in April 2006.

Definition

QualityBLUE is an incentive program that offers Primary Care Physicians (PCPs) (family practice, internal medicine, pediatric, and general practitioner specialties) an opportunity to earn an additional reimbursement for providing efficient, high-quality health care.

- The QualityBLUE FFS program is a reward program offered in addition to the fee schedule.
- The QualityBLUE FFS program will focus primarily on quality and efficiency measures.
- There are two components of the program: reports and payments.

Eligibility Requirements

PCPs can qualify for participation in the QualityBLUE FFS program once the provider meets the following eligibility and quality requirements:

- *Required Network Professional Agreements – Please contact your provider representative for region specific networks.*
- Our Network's Professional Agreement
- NaviNet enabled
- A 12-month practice volume of:
  - $40,000 of paid eligible Evaluation & Management (E&M) services.
  - *In the Western Region, 85% of claims submitted electronically.*
  - *In the Central Region, 75% of claims submitted electronically.*
- Achieved a minimum Total Quality Score – this applies only if above requirements are met.

What Region Am I?

Continued on next page

7.1 Introduction To The QualityBLUE Fee-For-Service Program, Continued

Initiation of Quality Scoring and Incentive Payments	*Quality scoring and* incentive payments *(if earned) only* begin when the practice submits a signed agreement and all eligibility requirements are met. Quality scoring or payment will not be calculated *retroactive to the agreement execution date. Claims adjustments will not be made on any E&M services paid retroactive to the agreement execution date. The calculation of the pay for performance quality incentive (if any) will be evaluated quarterly, and will pay concurrently with claims.*
Single Network Participation	Although a physician practice may be credentialed in both the Western Region Network and PremierBlue networks, physician practices may only sign *one* Practitioner Agreement *for QualityBLUE participation* and *may* participate in either the Western Region Network *Incentive* or PremierBlue QualityBLUE incentive *program*. The review of the incentive eligibility and minimum quality requirements will only generate one performance detail report. If you have any questions, please contact your Provider Relations representative.
Practitioner Agreement - Listing of Practitioners	Each practitioner in a physician practice should be credentialed in the Western Region Network or PremierBlue network prior to participation in this quality incentive program. The Western Region Network and/or PremierBlue fee schedule and applicable incentives should be paid to participating physician practices only.

Continued on next page

7.1 Introduction To The QualityBLUE Fee-For-Service Program, Continued

What Products Are Included?

Many of Highmark's products are included in the measurement of the QualityBLUE FFS program including, but not limited to:

- PPOBlue
- EPOBlue
- DirectBlue POS
- DirectBlue PPO
- FreedomBlue Medicare Advantage PPO
- Western Region Medicare Advantage HMO
- Western Region Direct Access Medicare Advantage HMO
- Caring Program HMO
- adultBasic HMO
- adultBasic PPO
- BlueCHIP HMO
- Western Region Individual HMO

Measurement Period

The following table demonstrates the QualityBLUE measurement periods that relate to the Pay-for-Performance incentive payment quarters.

Incentive Payment received in this quarter	**Eligibility Requirements: $40 K (Annual 12 month) Paid Eligible Evaluation and Management Services and Electronic Claims Submissions**	**An additional month is given for remaining claims from prior months**	**Start date for data processing**
January – March	September 1 – August 31	September 30	December 1
April – June	December 1 – November 30	December 31	March 1
July – September	March 1 – February 28	March 31	June 1
October – December	June 1 – May 31	June 30	September 1

Ongoing Changes To The Program

This program continually evolves to meet the needs of Highmark and *participating* network practitioners. Accordingly, this program will be revised from time to time. Notice will be communicated by a separate letter mailed to your practice, and identified in the Special Bulletin or Clinical Views.

7.1 The QualityBLUE Fee-For-Service Detail Report – Quality

The Fee-for-Service Detail Report

The *QualityBLUE FFS Detail Report – Quality*, varies in length based on the type of specialty or detail used for each category and available data, and is generated quarterly based on:

- Clinical Quality Measures
- Generic/Brand Prescribing Patterns
- Member Access
- Best Practice Measure
- Electronic Health Records Implementation (EHR)
- Electronic Prescribing Implementation (eRX)

A sample report is included in this unit. The report is available online via NaviNet.

Performance Profile Graph Pages

The performance profile graph pages of the fee-for-service detail include the key drug utilization indicators, quality trends, Rx trends and costs. *They* provide a visual snapshot of information in the report. Information displayed is practice-specific and based on the current quarter and available previous quarters or year.

The Incentive Trend Report – For Only Fee-For-Service Payments

The Incentive Trend Report for fee-for-service payments is available online through the Provider Resource Center. The Incentive Trend Report/Fee-for-Service provides two separate reports:

- The first report is a Summary, listing the QualityBLUE incentive payment, level and number of select E&M services for a 12 month reporting period.
- The second report is a Claim Detail listing of claim number, procedure code, member ID, DOS, Paid Date, Incentive Level ($3, $6 or $9) based on the number of select E&M services, and the claim payment.

Note: This report will not be mailed. This report should be kept for your records, and be used to review the payment trends for your practice. If your practice is not NaviNet enabled, this report is not applicable.

7.1 The QualityBLUE Fee-for-Service Detail Report – Quality, Continued

QualityBLUE Fee for Service Detail Report - Quality Payment Quarter

Practice Name - 000000000

Region: Western Specialty: Pediatrics

Practice Summary

Incentive Results

Total Quality Score:	103/115
Incentive Level:	High
Quality Incentive Amount:	$9 Per Select E & M Service

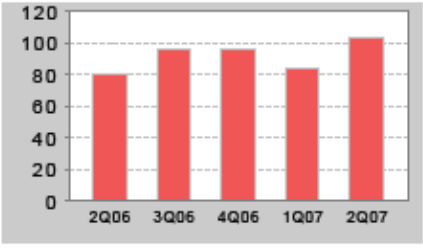
Quality Measure Scores

Quality Measure	Description	Possible Score	Practice Score
Clinical Quality	Expected Quality Guidelines *Uses a 1 - 4 year defined measurement period of claims data*	65	60
Generic / Brand RX	Generic/Brand Prescribing Patterns *Uses 3 months drug claims data in measurement period*	30	30
Member Access	Average Weekly Office Hours and Non-Traditional Hours *Uses current office hours*	5	5
Best Practice	Clinical Improvement Activity *Uses work plan progress documentation*	5	3
Electronic Health Record (EHR)	Electronic Health Record Implementation *Uses evidence of implementation progress*	5	0
Electronic Prescribing	Electronic Prescribing Implementation *Uses evidence of implementation progress*	5	5
Total Quality Score		**115**	**103**

Quality Incentive Level Scoring

Total Quality Score	Incentive Level	Incentive Amount
Over 100	High	$9 Per Select E & M Service
90 - 100	Medium	$6 Per Select E & M Service
65 - 89	Low	$3 Per Select E & M Service
0 - 64	None	$0 No Incentive

Quality Trends for the Practice



Eligibility Requirements

Incentive Bonus Eligibility and Minimum Quality Requirements - Measured and Moved Forward Quarterly

NaviNet Enabled

12-Month Volume of:

A minimum of $40,000 of paid Evaluation & Management (E&M) services

85% of claims submitted electronically

Achieved Minimum Total Quality Score - applies only if above two eligibility requirements are met

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7.1 QualityBLUE Fee-For-Service Payment

When Does Payment Occur?

When your practice submits claims with eligible Evaluation and Management (E&M) services, the QualityBLUE FFS incentive will be calculated at the time the claims are processed. (Incentive payments will be made based on incurred dates, not paid dates.)

How Does Payment Occur?

The incentive *(INC)* amounts will be added to your claims payments, which are included in your reimbursement check. The incentive amounts will be itemized separately on the Provider Explanation Of Benefit (EOB).

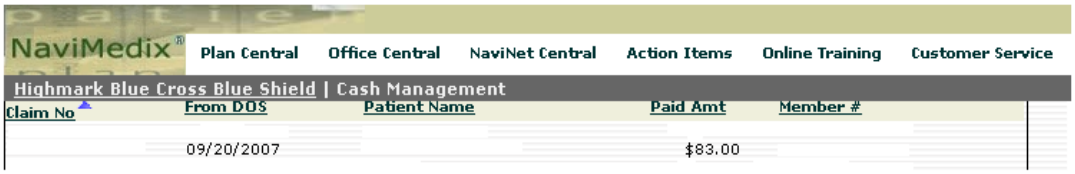
The incentive payments will also be itemized on the Electronic Remittance Advice (ERA (855P)). The allowed amount will show the net of the actual fee schedule and the incentive. There are other segments of the transaction which show "Contractual Obligations (CO)". CO161 will show the amount of the incentive. CO161 will be represented as a negative number. CO161 is a negative number because it actually shows that Highmark is adding back into the payment, the amount of the incentive. Although this seems contrary to logic, anything with a CO remark code is considered a write-off from the provider's charge; thus a negative number adds back to the payment.

Below is an example of the incentive payment displayed on an Explanation of Benefits (EOB) and ERA.

Provider Number: Page of

Provider Name:

DATE(S) OF SVC	NUM OF SVCS	REVENUE/ PROCEDURE CODE	PAY-MENT CODE	PROVIDER CHARGE	OUR ALLOWANCE	NON-CHARGEABLE AMOUNT	NON-CHG CODE	MEMBER LIABILITY AMOUNT	MEM LIAB CODE	OTHER AMOUNT	AMOUNT(S) PAID (* = MEMBER)	MESSAGE CODES
PATIENT ACCT #: MEMBER ID:					PATIENT: MEMBER:						CLAIM NUMBER:	
09/20/07	1	99391	026 INC	104.00	95.00 3.00	6.00	25	15.00	D1		83.00	J5054,J9040
			CLAIM TOTALS			6.00		15.00			83.00	



Continued on next page

7.1 QualityBLUE Fee-For-Service Payment, Continued

Quality Incentive Level Scoring

The quality incentive amount is based on the total quality score. Refer to the Quality Incentive Level Scoring Table below.

Total Quality Score Range	Incentive Level Description	Incentive Amount
Over 100	High	$9 Per E&M Service
90 - 100	Medium	$6 Per E&M Service
65 - 89	Low	$3 Per E&M Service
0 - 64	None	$0 No Incentive

Minimum Quality *Score*

To be eligible for any QualityBLUE incentive, the practice must have a quality score of 65 and above.

7.1 Qualifying For QualityBLUE Fee-for-Service Payment

Reminder: Eligibility Requirements

PCPs can qualify for participation in the QualityBLUE FFS program once the provider meets the following eligibility and quality requirements:

- *Required* Network Professional Agreements. *Please contact your Provider Relations representative for region specific networks.*
- NaviNet enabled
- A 12-month practice volume of:
  - $40,000 of paid eligible Evaluation & Management (E&M) services.
  - *In the Western Region, 85% of claims submitted electronically.*
  - *In the Central Region, 75% of claims submitted electronically.*
- Achieved a minimum Total Quality Score – this applies only if above requirements are met.

What Region Am I?

Eligible E&M Codes

There are 12 Evaluation & Management (E&M) categories, *which include a total of* 106 individual codes *are eligible for the incentive reimbursement.* Please refer to the table below for more information. Please note: the review for eligible codes will be performed annually and as necessary.

E&M Category Description and Range	Number of Codes	Individual Codes
Office/Outpatient 99201 – 99215	10	99201-99205 99211-99215
Office/Preventive 99381 – 99412	20	99381-99387 99391-99397 99401-99404 99411-99412
Hospital Visit 99221 – 99239	11	99221-99223 99231-99236, 99238-99239
Outpatient Consults 99241 – 99245	5	99241-99245
Hospital Consults 99251 – 99255	5	99251-99255
Newborn 99431 – 99440	6	99431-99433, 99435-99436 99440
Observation 99217 – 99220	4	99217-99220
Nursing Home 99304 – 99318	10	99304-99309, 99310, 99315-99316, 99318

Continued on next page

7.1 Qualifying For QualityBLUE Fee-for-Service Payment, Continued

Eligible E&M Codes, continued

E&M Category Description and Range	Number of Codes	Individual Codes
Critical Care – 99289 – 99300	**11**	99289 99290-99296, 99298-99299 99300
ER 99281 – 99288	**6**	99281-99285, 99288
Rest Home 99324 – 99337	**9**	99324-99328 99334-99337
Home Visit 99341 – 99350	**9**	99341-99345, 99347-99350

Composite Quality Performance Measures

The QualityBLUE FFS payments are based on the QualityBLUE quality performance measures shown in the table below.

Measure	Based on…	Max score	Refer to Chapter, Unit, and Page
Clinical Quality	The clinical quality categories specific to each specialty with their corresponding expected quality guidelines	65	7.2 Page 2
Generic/Brand Prescribing Patterns	The percentage of prescriptions that are written for generic drugs	30	7.2 Page 29
Member Access	Average office hours and non-traditional office hours	5	7.2 Page 33
Best Practice	Clinical Improvement Activity	5	7.2 Page 37
EHR	Electronic Health Record Implementation	5	7.2 Page 43
eRX	Electronic Prescribing Implementation	5	7.2 Page 45
Maximum Total Quality Score		**115**	

Continued on next page

7.1 Qualifying For QualityBLUE Fee-for-Service Payment,
Continued

Ineligibility

If any practitioner within a practice has been cited for network non-compliance or is in the sanctioning process, the practice is ineligible to participate in the QualityBLUE Program.

The three categories of non-compliance are:
- Quality of care concerns
- Unacceptable resource utilization
- Administrative non-compliance

The practice is ineligible to participate in QualityBLUE for at least one full quarter immediately following the citation or sanctioning date.

7.1 QualityBLUE Reports Accessible Via NaviNet

Online Resources For PCPs

Network PCPs are encouraged to visit the *QualityBLUE Program selection on the Provider Resource Center, accessible via NaviNet or either of our public member sites. The Provider Resource Center includes many helpful reference materials related to QualityBLUE.*

- The QualityBLUE program is detailed throughout the Highmark Blue Shield Office Manual, Chapter 7.
- Data submission forms for the Best Practice, Electronic Health Record (EHR), and Electronic Prescribing (eRx) quality measures are available for downloading under the **QualityBLUE Physician Pay-for-Performance Submission Forms**.
- The *Fee-for-Service Detail Report*, Clinical Quality Patient Names Report and the Incentive Trend Report/Fee-for-Service *are available on NaviNet under the QualityBLUE section of the Provider Resource Center.*
  - *The Detail Report provides several pages of practice specific information such as: the summary calculation for eligibility and incentive level, graph(s), clinical quality, member access, generic/brand prescribing patterns, best practice, electronic health record and electronic prescribing.*
  - The Clinical Quality Patient Names Report provides a convenient "check list," including patient name, ID number, date of birth and an indicator ("yes" or "no") on whether or not the expected quality guideline was met for each patient. This report can be viewed online or opened as an excel version. It can also be sorted to review and follow up on patients in need of specific care, per the quality guideline.
  - The Incentive Trend Report/Fee-for-Service provides two separate reports. The first report is a Summary, listing the QualityBLUE incentive payment, level and number of select E&M services for a 12 month reporting period. The second report is a Claim Detail listing of claim number, procedure code, member ID, DOS, Paid Date, Incentive Level ($3, $6 or $9) based on the number of select E&M services, and the claim payment.

Chapter 7

QualityBLUE℠ A Physician Pay-for-Performance Program

Unit 2: Quality Performance Measures

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7.2 Clinical Quality

Description

The clinical quality performance measures identify clinical quality categories that are specific to each PCP focus (Internal Medicine, Family Practice, Pediatrics), and directly correspond to an expected quality guideline. This measure compares practitioners to others in their PCP focus. An example is shown below.

QualityBLUE Fee for Service Detail Report - Quality Payment Quarter

Practice Name – 000000000

Administrative reference: Network Practitioner Office Manual (NPOM) (Chapter 7, Reimbursement and Billing)

Clinical Quality

Scoring Summary

Total earned points:	4.50
Total possible points:	9.00
Maximum clinical quality score:	65
Practice clinical quality score:	**23**

*(Total Earned Points/Total Possible Points) * Max Clinical Quality Score*

Clinical Quality Performance Measurement Detail

Clinical Category/Expected Quality Guidelines	Practice Quality %	Specialty Quality %	Practice to Specialty %	Earned Points
Acute Pharyngitis Testing Throat culture or antigen agglutination test for streptococcus completed on the date a sole diagnosis of acute pharyngitis is identified or within 3 days before or 3 days after	74%	75%	99%	0.50
Adolescent Well-Care Visits 1 or more comprehensive well-care visits with a PCP or an OB/GYN	38%	43%	88%	0.00
Appropriate Medications for People with Asthma 1 or more dispensed prescriptions for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers, or methylxanthines	86%	92%	93%	0.50
Beta Blocker Treatment After a Heart Attack 1 dispensed beta-blocker prescription on an ambulatory basis while the patient is hospitalized for AMI through 7 days following hospital discharge	100%	93%	100%	1.00
Breast Cancer Screening 1 or more mammograms in the measurement year or the year prior	69%	73%	95%	0.50
Cervical Cancer Screening 1 or more Pap tests in the measurement year or the prior 2 years	81%	78%	100%	1.00
Cholesterol Management For Patients With Cardiovascular Conditions 1 LDL-C test in the measurement year	75%	85%	88%	0.00
Comprehensive Diabetes Care			90%	0.50
Screening for nephropathy during the measurement year	37%	53%	70%	
1 retinal exam by dilation during the measurement year or prior year	48%	52%	92%	
1 LDL-C test during the measurement year	82%	83%	99%	
At least 1 HbA1c test during the measurement year	85%	86%	99%	
Congestive Heart Failure Annual Care, Advanced Standard				

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7.2 Clinical Quality, Continued

QualityBLUE Fee for Service Detail Report - Quality Payment Quarter

Practice Name - 000000000

Region: Western Specialty: Family Practice

Clinical Category/Expected Quality Guidelines	Practice Quality %	Specialty Quality %	Practice to Specialty %	Earned Points
2 E&M visits, 1 BUN, 1 creatinine, and 1 potassium test, and 1 or more ACE Inhibitor, B-adrenergic beta-blocker, or ARB prescriptions per year	50%	51%	98%	0.50
MMR Vaccination Status Measles, mumps, rubella or combination vaccination from ages 4 to 7	N/A	86%	N/A	
Varicella Vaccination Status Varicella vaccination from ages 12 to 18 months	N/A	74%	N/A	
Well Child Visits in the First 15 Months 5 or more well-child visits	N/A	80%	N/A	
Well Child Visits in the Third, Fourth, Fifth, and Sixth Year At least 1 well-child visit per year	N/A	66%	N/A	

Coding Reminder

Note: THE LEVEL OF CLAIMS CODING CAN IMPACT YOUR QUALITYBLUE SCORE AND CORRESPONDING INCENTIVE PAYMENT.

REMEMBER to use the highest degree of specificity and report all diagnoses relating to a member's evaluation, care and treatment, including the main reason for the visit, and co-existing, chronic and pertinent past conditions, as well as applicable procedures.

Earned Points Table

Practice to Specialty %	Earned Points
100% or more	1.00
90 - 99%	0.50
0 - 89%	0.00

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7.2 Clinical Quality, Continued

Quality Score

The maximum quality score for this measure is 65.

Product Inclusion

Managed care and Medicare Advantage products are included for eligibility and payment. Indemnity products, as well as Managed care and Medicare Advantage products can be included in the measurement and scoring of clinical quality. *For further product information, see HBSOM Chapter 7,Unit 1, page 4.*

Measurement Year

The measurement year encompasses a moving 12 month span of demographic and/or illness occurrence data that may not correspond to a calendar or fiscal year. In general, the span will move by three months every measurement quarter. The span used is the same for all indicators. For information pertaining to specific clinical quality categories, refer to pages 10 through 28.

Payment Quarters' Measurement Years

Refer to the following chart to determine the Clinical Quality measurement year span that corresponds to a particular payment quarter.

Payment Quarter	Measurement year
1st quarter – January through March	October 1 through September 30
2nd quarter – April through June	January 1 through December 31
3rd quarter – July through September	April 1 through March 31
4th quarter – October through December	July 1 through June 30

Measurement Period

The measurement period ends on the last day of the measurement year and may begin one to four years earlier depending on the "look back" period for each specific measure. For information pertaining to specific clinical quality categories, refer to pages 10 through 28.

Continued on next page

7.2 Clinical Quality, Continued

Measurement Method

The method used to measure clinical quality is called the Clinical Quality Tool. The Clinical Quality Tool uses historical inpatient, outpatient, professional and pharmacy claims and encounter data for valid ICD-9-CM procedure and diagnostic codes, CPT-4/HCPCS procedure codes, revenue codes, DRGs and NDC numbers for drugs that reflect services that were performed, documented, and reported for applicable Highmark members

ICD-9-CM, CPT or HCPCS codes that have been previously listed as valid for the numerator or denominator may be deleted from the coding manuals for 2006. Deleted codes may not appear in the code listings of the clinical category descriptions. However, because QualityBLUE uses historical claims data for some clinical quality measures, these codes are retained and captured when necessary to obtain past claims.

Expected Quality Guidelines

The expected quality guidelines are based on nationally accepted standards of preventive and disease oriented basic clinical care. The majority of these expected quality guidelines mirror HEDIS as closely as possible. To measure the expected quality guideline for the inclusion in the numerator[1], a set of unique criteria must be met for each of the clinical categories. To assess what is included in the denominator[2], the review consists of unique enrollment and/or diagnostic requirements for each of the clinical categories.

[1]*The numerator can be defined as the patient population that met the expected quality guideline.*
[2]*The denominator describes the total patient population evaluated for the inclusion of the expected quality guideline.*
For information pertaining to specific clinical quality categories, refer to pages 10 through 28.

Calculating the Practice Quality %

The practice quality percentage is based on the claims assigned members in the practice treated per quality guidelines out of the total patients in the category.

Calculating the Specialty Quality %

The specialty quality percentage is based on the claims assigned members in the specialty (Family Practice, Internal Medicine, Pediatrics) who were treated according to the quality guidelines out of the total patients in the category.

Calculating the Practice % to Specialty %

This result is a comparison of the practice quality % to specialty quality % and is reported at a maximum of 100%.

7.2 Clinical Quality

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Calculating The Clinical Quality Score

There are three steps to calculate clinical quality:

Step	Action
1	Divide the practice quality percentage by the specialty quality percentage.
2	Compare the result to the earned points table to determine points earned for each clinical category. (Refer to the table below.) The total possible points for each specialty is as follows: a. Internal Medicine – 8 b. Family Medicine – 13 c. Pediatrics – 7
3	Multiply by the Maximum Clinical Quality score (65) to determine the Clinical Quality score.

Earned Points Table

Refer to the following table to determine points earned for each clinical category.

Practice to specialty quality percentage	Points earned
Greater than or equal to 100% of specialty average	1.00
Greater than or equal to 90% but less than 100%	0.50
Less than 90%	0.00

Continued on next page

7.2 Clinical Quality, Continued

Categories And Criteria

The following table shows:

- Each clinical quality category
- The requirement that must be met to earn a point
- The specialty for which the measure is intended
- Page number reference

Category	Standard	Family Practice	Internal Medicine	Pediatrics	See Page
Acute Pharyngitis Testing	Throat culture or antigen agglutination test for streptococcus completed on the date a sole diagnosis of acute pharyngitis is identified or within 3 days before or 3 days after	✓	✓	✓	10
Adolescent Well Care	One or more comprehensive well-care visits with a PCP or an OB/GYN	✓		✓	12
Appropriate Medications for People with Asthma	One or more dispensed prescriptions for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers, or methylxanthines	✓	✓	✓	13
Beta Blocker Treatment After MI	One dispensed beta blocker prescription on an ambulatory basis while the patient is hospitalized for AMI through 7 days following hospital discharge	✓	✓		15

Continued on next page

7.2 Clinical Quality, Continued

Category	Standard	Family Practice	Internal Medicine	Pediatrics	See Page
Breast Cancer Screening	One or more mammograms in measurement year or the year prior	✓	✓		16
Cervical Cancer Screening	One or more PAP tests in the measurement year or the 2 preceding years	✓	✓		17
Cholesterol Management For Patients With Cardiovascular Conditions	One LDL-C test in the measurement year	✓	✓		18
Comprehensive Diabetes Care	• At least one HbA1c during the measurement year • One LDL-C test during the measurement year • Screening for nephropathy during the measurement year • One retinal exam by dilation during the measurement year or prior year	✓	✓		20
Congestive Heart Failure Annual Care, Advanced Standard	• Two E/M visits • 1 BUN (blood urea nitrogen) • One creatinine • One potassium test • One or more ACE inhibitor/beta blocker/ARB prescriptions per year	✓	✓		23
MMR Vaccination Status	Measles, mumps or rubella or combination from ages 4 to 7	✓		✓	25

Continued on next page

7.2 Clinical Quality, Continued

Category	Standard	Family Practice	Internal Medicine	Pediatrics	See Page
Varicella Vaccination Status	Varicella vaccination from ages 12 to 18 months	✓		✓	26
Well Child Visits in the First 15 Months	Five or more well-child visits	✓		✓	27
Well Child Visits in the Third, Fourth, Fifth and Sixth Year	At least one well-child visit per year	✓		✓	28

Future Category Additions Or Modifications

Please remember that upon review of the QualityBLUE program, Highmark may add or delete clinical indicators as deemed appropriate. *Advance notice will be given.*

7.2 Acute Pharyngitis Testing

Description	Identifies members with the sole diagnosis of acute pharyngitis who had appropriate testing done prior to antibiotics being prescribed
Applies To	Applies to the following specialties: • Family practice • Internal medicine • Pediatrics
Measurement Period	The measurement period is the current measurement year.
Enrollment Requirements	The member must be continuously enrolled 30 days preceding and 7 days following each time the diagnosis is documented during the measurement year.
Diagnostic Requirements	The member must be identified with the sole diagnosis of acute pharyngitis in the measurement year and have an antibiotic dispensed within 7 days of diagnosis.
Numerator	The numerator consists of those in the denominator who have a throat culture or an antigen agglutination test for streptococcus (rapid screening test) on the date of diagnosis or in the period 3 days before or 3 days after.
Denominator	The denominator consists of the population that met the enrollment and diagnostic requirements. **Note**: A member is counted in the denominator each time the requirements are met in the measurement year.

Continued on next page

7.2 Acute Pharyngitis Testing, Continued

Numerator Codes

Codes that may be valid for the numerator are shown in the following table.

CPT Codes		
87070	87430	87652
87071	87650	87880
87081	87651	

Denominator Codes

Codes that may be valid for the denominator are shown in the following table.

ICD-9 CM Codes	
034.0	462
034.1	

Note: National Drug Code (NDC) numbers are also used in the denominator to identify antibiotics.

7.2 Adolescent Well Care

Description

Identifies adolescents who received comprehensive well care visits.

Applies To

Applies to the following specialties:

- Family practice
- Pediatrics

Measurement Period

The measurement period is the current measurement year.

Enrollment Requirements

The member enrollment requirements are as follows:

- Age — 12-21 by the end of the measurement year
- Enrollment — Continuously enrolled through the measurement year - no more than one break of up to 45 days in enrollment
- Membership — Member of the plan at the end of the measurement year

Numerator

The numerator consists of those in the denominator who have had one or more adolescent well care visits in the measurement year.

Denominator

The denominator consists of the population that met the enrollment requirements.

Numerator Codes

Codes that may be valid for the numerator are shown in the following table.

ICD-9 CM Codes		*CPT Codes*
V20.2	V70.5	99383-99385
V70.0	V70.6	99393-99395
V70.3	V70.8-V70.9	

Denominator Codes

ICD-9, CPT, or revenue codes are not required for the denominator.

7.2 Appropriate Asthma Medications

Description

Identifies members with persistent asthma who received appropriate asthma medications.

Applies To

Applies to the following specialties:

- Family practice
- Internal medicine
- Pediatrics

Measurement Period

The measurement period is the current measurement year and the preceding year.

Enrollment And Diagnostic Requirements

The member enrollment and diagnostic requirements are as follows:

- Age — 5-56 by the end of the measurement year
- Enrollment — Continuously enrolled in the measurement year and the preceding year – no more than one break of up to 45 days in enrollment each year
- Membership — Member of the plan at the end of the measurement year
- Diagnosis — Identified with persistent asthma in **both** the year preceding the measurement year and the measurement year

Numerator

The numerator consists of those in the denominator who were dispensed one or more prescriptions for appropriate asthma medications in the measurement year.

Denominator

The denominator consists of the population that met the enrollment and diagnostic requirements.

Numerator Codes

Codes that may be valid for the numerator are those as indicated by NDC numbers for the following:

- Inhaled corticosteroids
- Nedocromil
- Cromolyn sodium
- Leukotriene modifiers
- Methylxanthines

Continued on next page

7.2 Appropriate Asthma Medications, Continued

Denominator Codes To be included in the denominator, the coding combination listed below or a drug combination may be required on one or more claims.

Combination Codes (ICD-9 CM codes must be used with a revenue code or a CPT code)

ICD-9 CM Codes	CPT Codes		Revenue Codes	
493.00-493.92	99201-99205	99291	0100-0109	0459
	99211-99215	99341-99345	0110-0114	0510-0519
	99217-99223	99347-99350	0119-0124	0520-0523
	99231-99233	99382-99386	0129-0134	0526-0529
	99238-99239	99392-99396	0139-0144	0570-0599
	99241-99245	99401-99404	0149-0154	0720-0729
	99251-99255	99411-99412	0159-0169	0770-0771
	99261-99263	99420, 99429	0200-0229	0779
	99281-99285	99499	0450-0452	0981-0983
			0456	0987

Note: NDC (National Drug Code) numbers may also be used in the denominator

7.2 Beta-Blocker Treatment After AMI

Description

Identifies members who received beta-blocker prescriptions after hospitalization for AMI (acute myocardial infarction).

Applies To

Applies to the following specialties:

- Family practice
- Internal medicine

Measurement Period

The measurement period is the current measurement year.

Enrollment And Diagnostic Requirements

The member enrollment and diagnostic requirements are as follows:

• Age	35 and older by the end of the measurement year
• Enrollment	Continuously enrolled for 7 days after discharge for AMI– no breaks in enrollment
• Membership	Member of the plan in the measurement year
• Diagnosis	Identified as being hospitalized with AMI and discharged alive

Numerator

The numerator consists of those in the denominator who had a beta-blocker prescription filled on an ambulatory basis while hospitalized for AMI or within 7 days of discharge.

Denominator

The denominator consists of the population that met the enrollment and diagnostic requirements.

Numerator Codes

Codes that may be valid for the numerator are NDC Numbers for specified beta-blockers.

Denominator Codes

Codes that may be valid for the denominator are shown in the following table.

ICD-9 CM Codes			*DRG*
410.01	410.31	410.61	121
410.11	410.41	410.71	122
410.21	410.51	410.81	516
		410.91	526

7.2 Breast Cancer Screening

Description

Identifies women members who had mammograms for breast cancer screening.

Applies To

Applies to the following specialties:

- Family practice
- Internal medicine

Measurement Period

The measurement period is the current measurement year and the preceding year.

Enrollment Requirements

The member enrollment requirements are as follows:

- Age — 42-69 by the end of the measurement year
- Enrollment — Continuously enrolled in the measurement period – no more than one break of up to 45 days in enrollment each year
- Membership — Member of the plan at the end of the measurement year

Numerator

The numerator consists of those in denominator who had one or more mammograms within the measurement period.

Denominator

The denominator consists of the population that met the enrollment requirements.

Numerator Codes

Codes that may be valid for the numerator are shown in the following table.

ICD-9 Codes		*CPT/HCPCS Codes*	*Revenue Codes*
Procedure	V76.11	76090-76092	0403
	V76.12	77055-77057	
	87.36	G0202	
	87.37	G0204	
		G0206	

Denominator Codes

ICD-9, CPT, or revenue codes are not required for the denominator.

7.2 Cervical Cancer Screening

Description

Identifies women members who were screened for cervical cancer with Pap tests.

Applies To

Applies to the following specialties:

- Family practice
- Internal medicine

Measurement Period

The measurement period is the current measurement year and the two preceding years.

Enrollment Requirements

The member enrollment requirements are as follows:

- Age 24-64 in the measurement year
- Enrollment Continuously enrolled in the measurement period– no more than one break of up to 45 days in enrollment each year
- Membership Member of the plan at the end of the measurement year

Numerator

The numerator consists of those in the denominator who received a Pap test within the measurement period.

Denominator

The denominator consists of the population that met the enrollment requirements.

Numerator Codes

Codes that may be valid for the numerator are shown in the following table.

ICD-9 Codes	*CPT/HCPCS codes*		*Revenue Codes*
V72.31	88141-88145	G0101, G0123-G0124	0923
V72.32	88147-88148	G0141, G0143-G0145	
V76.2	88150, 88152-88155	G0147-G0148	
91.46	88164-88167	P3000-P3001	
	88174-88175	Q0091	

Denominator Codes

ICD-9, CPT, or revenue codes are not required for the denominator.

7.2 Cholesterol Management For Patients With Cardiovascular Conditions

Description

Identifies members with an acute cardiovascular event or a diagnosis of ischemic vascular disease that were tested for cholesterol. A cardiovascular event is one of the following:

- AMI – acute myocardial infarction
- PTCA – percutaneous transluminal coronary angioplasty
- CABG – coronary artery bypass graft

Applies To

Applies to the following specialties:

- Family practice
- Internal medicine

Measurement Period

The measurement period is the current measurement year and the preceding year.

Enrollment And Diagnostic Requirements

The member enrollment and diagnostic requirements are as follows:

• Age	18-75 by the end of the measurement year
• Enrollment	Continuously enrolled during the measurement year and the preceding year with no more then one break in enrollment of up to 45 days per year
• Diagnosis	Identified as hospitalized & discharged alive after CV event in the year prior to the measurement year **or** with ischemic vascular disease in **both** the measurement year and the prior year

Numerator

The numerator consists of those in the denominator who received an LDL-C (low-density lipoprotein cholesterol) test in the measurement year.

Denominator

The denominator consists of the population that met the enrollment and diagnostic requirements.

Continued on next page

7.2 Cholesterol Management For Patients With Cardiovascular Conditions, Continued

Numerator Codes

Codes that may be valid for the numerator are shown in the following table.

CPT Codes	
80061	83704
83700-83701	83721

Denominator Codes

Codes that may be valid for the denominator for AMI, PTCA or CABG are shown in the following table.

ICD-9 CM Diagnosis Codes		*/Procedure Codes*	*CPT /HCPCS*	*Codes*	*DRG*
410.01	410.51	00.66	33140	35600	106-107, 109
410.11	410.61	36.06-36.07	33510-33514	92980-92982	**121-122**
410.21	410.71	36.09	33516-33519	92984	516-517
410.31	410.81	36.10-36.19	33521-33523	92995	526-527
410.41	410.91	36.2	33533-33536	92996	547-550
			33572	S2205-S2209	555-558

Denominator Codes

Codes that may be valid for the denominator for ischemic vascular disease are shown in the following table.

Combination Codes (ICD-9 codes must be combined with a CPT or Revenue Code)

ICD-9 Codes		CPT Codes		Revenue Codes		DRG
411.0-411.1	434.90-434.91	99201-99205	99341-99350	0100-0109	0510-0523	140
411.81	440.1	99211-99215	99384-99387	0110-0114	0526-0529	559
411.89	440.20-440.24	99217-99223	99394-99397	0119-0124	0570-0599	
413.0-413.1	440.29	99231-99233	99401-99404	0129-0134	0720-0729	
413.9	444.0-444.1	99238-99239	99411-99412	0139-0144	0770-0779	
414.00-414.07	444.21-444.22	99241-99245	99420	0149-0154	0982-0983	
414.8-414.89	444.81	99251-99255	99429	0159-0169	0987	
414.9-414.99	444.89	99261-99263	99455-99456	0200-0229		
429.2	445.01-445-02	99291	99499			
433.00-433.91	445.81					
434.00-434.11	445.89					

7.2 Comprehensive Diabetes Care

Description

Identifies adult members who received annual comprehensive care for diabetes.

Applies To

Applies to the following specialties:

- Family practice
- Internal medicine

Measurement Period

The measurement period is the current measurement year and the preceding year.

Enrollment And Diagnostic Requirements

The member enrollment and diagnostic requirements are as follows:

• Age	18-75 by the end of the measurement year
• Enrollment	Continuously enrolled through the measurement year – no more than one break of up to 45 days in enrollment
• Membership	Member of the plan at the end of the measurement year
• Diagnosis	Identified as diabetic in the measurement period

Numerator

This category has 4 numerators with the same common denominator.

1. Those in the denominator who received one HbA1c (glycosylated hemoglobin) in the measurement year.
2. Those in the denominator who received one LDL-C (low-density liproprotein cholesterol) test in the measurement year.
3. Those in the denominator who had evidence of nephropathy, or who were screened for it within the measurement year.
4. Those in the denominator who had a retinal eye examination by an eye care professional in the measurement year or the preceding year.

Denominator

The denominator consists of the population that met the enrollment and diagnostic requirements. This denominator applies to each of the four numerators.

Continued on next page

7.2 Comprehensive Diabetes Care, Continued

Numerator Codes Codes that may be valid for the numerators are shown in the following tables.

Codes that may be valid for the first three numerators

Numerator #	ICD-9 CM Diagnosis	ICD-9 Procedure Codes	CPT/HCPCS Codes	Revenue Codes	DRG
1-HbA1c Test			83036, 83037		
2-LDL-C Test			80061 83700-83701 83704 **83721**		
3-Nephropathy Screening*	250.40-250.43 403.00-404.93 405.01 405.11 405.91 581.81 582.9 583.81 584.5-586 588-588.99 753.0-753.19 791.0-791.09 V42.0 V45.1 V56.0-V56.8	38.95 39.27 39.42-39.43 39.53 39.93-39.95 54.98 55.4-55.69	36145 36800 36810, 36815 36818-36821 36831-36833 50300, 50320 50340, 50360 50365, 50370 50380 82042-82044 84156 90920-90921 90924-90925 90935, 90937 90939-90940 90945, 90947 90989, 90993 90997, 90999 99512 G0257 G0314-G0319 G0322-G0323 G0326-G0327 S9339	0367 0800-0804 0809 0820-0825 0829-0835 0839-0845 0849-0855 0859-0882 0889	316 317

***Note**: Compliance for nephropathy screening can also be met by one of the following**:**

1. A nephrologist visit identified by specialty code.
2. Claim for an ACE/ARB prescription dispensed on an ambulatory basis.

7.2 Comprehensive Diabetes Care, Continued

Numerator Codes, continued

Codes that may be valid for the numerators are shown in the following tables.

Codes that may be valid for the fourth numerator

Numerator #	ICD-9 CM Procedure Codes	CPT Codes		
4 – Eye exam **Must be completed by an eye care professional**	14.11-14.59	67028	67210	92226
	14.9	67038-67040	67218	92230
	95.02-95.04	67101	67227	92235
	95.11-95.12	67105	67228	92240
	95.16	67107	92002	92250
	V72.0	67108	92004	92260
		67110	92012	99203-99205
		67112	92014	99213-99215
		67141	92018	99242-99245
		67145	92019	S0620-S0621
		67208	92225	S0625, S3000

Denominator Codes

The coding combination shown on the table below may be required on one or more claims for denominator inclusion.

Combination Codes (ICD-9 code must be combined with CPT or Revenue Code or DRG)

ICD-9 Codes	CPT Codes		Revenue Codes		DRG
250.00-250.93	92002-92014	99318	0100-0114	0510-0529	294
357.2	99201-99205	99324-99328	0119-0124	0550-0559	295
362.01-362.07	99211-99215	99334-99337	0129-0134	0570-0599	
366.41	99217-99223	99341-99345	0139-0144	0660-0669	
648.00-648.04	99231-99233	99347-99350	0149-0154	0720-0729	
	99238-99239	99384-99387	0159-0169	0770-0779	
	99241-99245	99394-99397	0190-0199	0800-0809	
	99251-99255	99401-99404	0200-0229	0820-0859	
	99261-99263	99411-99412	0450-0452	0880-0889	
	99281-99285	99420-99429	0456	0981-0983	
	99291	99455-99456	0459	0987	
	99304-99310	99499			
	99315-99316				

Note: NDC numbers may also be used to identify insulin and hypoglycemic drugs.

7.2 Congestive Heart Failure Annual Care, Advanced Standard

Description

Identifies members with congestive heart failure who received advanced annual care.

Applies To

Applies to the following specialties:

- Family practice
- Internal medicine

Measurement Period

The measurement period is the current measurement year and the preceding year.

Enrollment And Diagnostic Requirements

The member enrollment and diagnostic requirements are as follows:

• Enrollment	Continuously enrolled in the measurement year and enrolled the preceding year – no more than one break of up to 45 days in enrollment
• Membership	Member of the plan in the measurement year
• Diagnosis	Identified with CHF in the year preceding the measurement year

Numerator

The numerator consists of those in denominator who received advanced standard annual care for CHF:

- 2 evaluation/management visits
- 1 BUN (blood urea nitrogen) test
- 1 Potassium test
- 1 Creatinine test
- One or more defined prescriptions

Denominator

The denominator consists of the population that met the enrollment and diagnostic requirements.

Continued on next page

7.2 Congestive Heart Failure Annual Care, Advanced Standard, Continued

Numerator Codes

Codes that may be valid for the numerator are shown in the following table.

CPT Codes			
80048	82565	99211-99215	99334-99337
80050-80051	84132	99304-99310	99341-99350
80053	84520	99318	99381-99397
80069	99201-99205	99324-99328	99401-99404

Note: Also ACE inhibitors/beta blockers/ARBs as indicated by NDC numbers.

Denominator Codes

Codes that may be valid for the denominator are shown in the following table.

ICD-9 CM Codes			
398.91	404.01	404.91	428.40-428.43
402.01	404.03	428.0-428.1	428.9
402.11	404.11	428.20-428.23	
402.91	404.13	428.30-428.33	

7.2 MMR Vaccination Status

Description

Identifies members 7 years of age that received MMR (measles, mumps or rubella) vaccination from ages 4 to 7.

Applies To

Applies to the following specialties:

- Family practice
- Pediatrics

Measurement Period

The measurement period is the current measurement year and the three preceding years.

Enrollment Requirements

The member enrollment requirements are as follows:

- Age — Turned 7 years of age during the measurement year
- Enrollment — Continuously enrolled through the measurement year and the three preceding years– no more than one break of up to 45 days in enrollment each year
- Membership — Member of the plan at the end of the measurement year

Numerator

The numerator consists of those in the denominator who have had a mumps, measles, or rubella vaccination or any combination of the three.

Denominator

The denominator consists of the population that met the enrollment requirements.

Numerator Codes

Codes that may be valid for the numerator are shown in the following table.

CPT Codes	
90704	90708
90705	90709
90706	90710
90707	

7.2 Varicella Vaccination Status

Description

Identifies members 18 months of age that received a varicella vaccination between the ages of 12 to 18 months.

Applies To

Applies to the following specialties:

- Family practice
- Pediatrics

Measurement Period

The measurement period is the current measurement year and the preceding six months.

Enrollment Requirements

The member enrollment requirements are as follows:

- Age — Turned 18 months of age during the measurement year
- Enrollment — Continuously enrolled through the measurement year and the prior six months – no more than one break of up to 45 days in enrollment
- Membership — Member of the plan at the end of the measurement year

Numerator

The numerator consists of those in the denominator who had a varicella vaccination from 12-18 months of age.

Denominator

The denominator consists of the population that met the enrollment requirements.

Numerator Codes

Codes that may be valid for the numerator are shown in the following table.

CPT Codes
90710
90716

7.2 Well Child Care Visits – First 15 Months

Description

Identifies children who received well child visits in the first 15 months of life.

Applies To

Applies to the following specialties:

- Family practice
- Pediatrics

Measurement Period

The measurement period is the current measurement year and the preceding 15 months.

Enrollment Requirements

The member enrollment requirements are as follows:

• Age	15 months of age reached by the end of the measurement year
• Enrollment	Continuously enrolled in the plan from 31 days to 15 months old– no more than one break of up to 45 days in enrollment.
• Membership	Member of the plan at reaching 15 months

Numerator

The numerator consists of those in the denominator who had 5 well child PCP visits in the first 15 months of life.

Denominator

The denominator consists of the population that met the enrollment requirements.

Numerator Codes

Codes that may be valid for the numerator are shown in the following table.

ICD-9 CM Codes		*CPT Codes*
V20.2	V70.6	99381-99382
V70.0	V70.8	99391-99392
V70.3	V70.9	99432
V70.5		

7.2 Well Child Care Visits – Third, Fourth, Fifth and Sixth Year

Description

Identifies 3, 4, 5, and 6-year-old children who received annual well child visits.

Applies To

Applies to the following specialties:

- Family practice
- Pediatrics

Measurement Period

The measurement period is the current measurement year.

Enrollment Requirements

The member enrollment requirements are as follows:

- Age — 3, 4, 5, or 6 by the end of the measurement year
- Enrollment — Continuously enrolled through the measurement year – no more than one break of up to 45 days in enrollment
- Membership — Member of the plan at the end of the measurement year

Numerator

The numerator consists of those in the denominator who received one or more well child visits in the measurement year.

Denominator

The denominator consists of the population that met the enrollment requirements.

Numerator Codes

Codes that may be valid for the numerator are shown in the following table.

ICD-9 CM Codes		*CPT Codes*
V20.2	V70.6	99382-99383
V70.0	V70.8	99392-99393
V70.3	V70.9	
V70.5		

7.2 Generic/Brand Prescribing Patterns

Description

The generic/brand prescribing quality performance measurement is based on the percentage of generic drugs prescribed compared to the total number of drugs prescribed. A sample report is shown below:

QualityBLUE Fee for Service Detail Report - Quality Payment Quarter

Practice Name – 000000000

Region: Western Specialty: Family Practice

Rx Generic/Brand

Scoring Summary

Total Earned Points:	8
Total possible points:	30
Practice Rx generic/brand score:	**8/30**

Rx Generic/Brand Prescribing Patterns

Generic Tier

Quarterly Practice Average %:	58 %
Quarterly Speciality Average %:	65 %
Practice % compared to Speciality Average:	-7 %

Earned Points Table

Generic Drug Percentage Performance Level Earned Points +/- Network Average	Earned Points
+8% or more	30
+6 to +7%	27
+4 to +5%	24
+2 to +3%	22
-1 to +1%	20
-4 to -2%	16
-6 to -5%	12
-8 to -7%	8
Less than -8%	0

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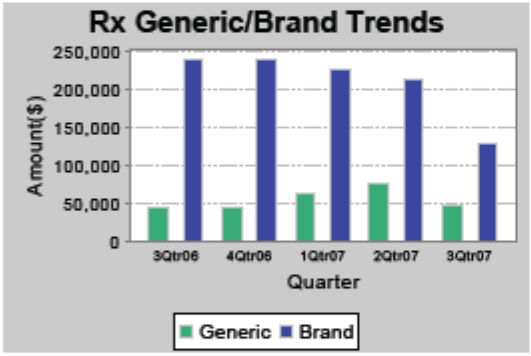
7.2 Generic/Brand Prescribing Patterns, Continued

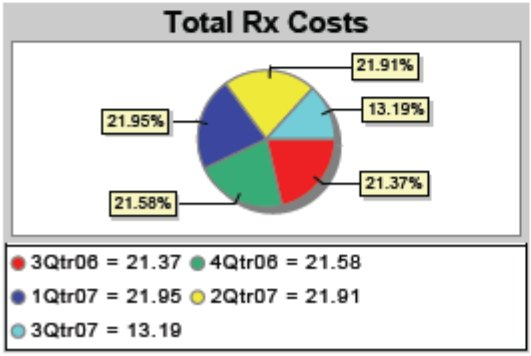
QualitvBLUE Fee for Service Detail Report - Quality Payment Quarter
Practice Name - 000000000
Region: Western Specialty: Family Practice

Rx Generic/Brand Utilization Trends

Drug	Current Quarter	Last Quarter	% Chng	Current Quarter Specialty Avg
Rx Total Costs	$ 174,293.00	$ 0.00	0.00 %	$ 64,818.08
Rx Generic Costs	$ 46,527.00	$ 0.00	0.00 %	$ 18,460.22
Rx Brand Costs	$ 127,766.00	$ 0.00	0.00 %	$ 46,357.86

Drug	Current Quarter	Last Quarter	% Chng	Current Quarter Specialty Avg
Rx Total Scripts	2,366	0	0.00 %	$ 1,076.00
Rx Generic Scripts	1,361	0	0.00 %	$ 695.00
Rx Brand Scripts	1,005	0	0.00 %	$ 381.00





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7.2 Generic/Brand Prescribing Patterns, Continued

Description

The generic/brand prescribing quality performance measurement is based on the percentage of generic drugs prescribed compared to the total number of drugs prescribed.

- Points will be awarded to practices in which physicians prescribe generic medications.

Maximum Quality Score

The maximum quality score is 30 for this indicator.

Network Specialty Average

The practice is compared to other practices in the same specialty to ensure equivalent measurement. The specialty averages are calculated on a quarterly basis for each primary care specialty: Family Practice, Internal Medicine and Pediatrics using a three month measurement period (see payment quarter and measurement period shown below).

Points Vary

The points earned vary by specialty and by program. Refer to the earned points table on the next page.

Measurement Period

Network averages and practice scores will be based on three months of data. See table below for further information.

Payment Quarter	Measurement Period
1st quarter – January through March	July 1 through September 30
2nd quarter – April through June	October 1 through December 31
3rd quarter – July through September	January 1 through March 31
4th quarter – October through December	April 1 through June 30

Continued on next page

7.2 Generic/Brand Prescribing Patterns, Continued

Measurement Method

The measurement method is shown in the following table.

Step	Action
1	Total the number of prescriptions written for any eligible member for each PCP within a practice.
2	Separate the number of all prescriptions into either the brand or generic category.
3	Calculate the percentage of generic prescriptions by dividing total generic prescriptions by the total prescriptions.
4	Compare the percentage to the PCP specialty average. Refer to the earned points table to determine the score.

Earned Points Tables

Refer to the table below which is for each primary care specialty: Family Practice, Internal Medicine and Pediatrics.

Generic Drug Percentage Performance Level Earned Points +/- Network Average	Earned Points
+8% or more	30
+6 to +7%	27
+4 to +5%	24
+2 to +3%	22
-1 to +1%	20
-4 to -2%	16
-6 to -5%	12
-8 to -7%	8
Less than -8%	0

7.2 Member Access

Description The member access measure is based on the practice's office hours and non-traditional hours. A sample report is shown below.

QualityBLUE Fee for Service Detail Report - Quality Payment Quarter
Practice Name – 000000000
Region: Western Specialty: Family Practice

Member Access

Scoring Summary

Earned points for average weekly hours:	3
Earned points for average weekly non-traditional hours:	0
Practice Member access score:	3/5

Member Access Measurement Detail

Average Weekly Hours		Avg. Weekly Non-Traditional Hours *Before 9 a.m., after 5 p.m., weekends*	
Practice average:	43.00	Practice average:	4.00
Group specialty average:	42.35	Group average required:	6.00
Earned Points:	3	Earned Points:	0
Total Possible Points:	3	Total Possible Points:	2

Average Weekly Hours - Earned Points Table

Performance Level	Earned Points
Meets or Exceeds the specialty average hours	3
Does not meet the specialty average hours	0

Average Weekly Non-Traditional Hours - Earned Points Table

Performance Level	Earned Points
Non-Traditional (before 9.a.m, after 5 p.m., weekends)	2
Does not meet required non-traditional hours	0

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7.2 Member Access, Continued

Criteria

This table outlines the criteria for measuring access.

If the practice:	The practice earns:
Meets or exceeds the specialty average	3 points
Offers weekly non-traditional hours	2 points (in addition)
Does not meet specialty average hours or Does not meet required non-traditional hours	0 points
Total Possible Points	**5 Points**

Maximum Quality Score

The maximum quality score for this measure is 5.

Measurement Period

Accessibility is measured quarterly. Averages are derived at the start of each calendar year.

Measurement Method

The number of office hours that a practice is available to see patients are derived from an internal database containing information reported by each practice. The table on page 34 shows how office hours are calculated for solo and group practices.

Specialty Average

The practice is compared to other practices in the same specialty and type (group or solo) to ensure equivalent measurement. The specialty averages are derived at the start of each calendar year.

Non-Traditional Hours: A Definition

Non-traditional hours are those hours offered either before or after Monday through Friday 9 a.m. through 5 p.m. They are any hours offered:

- Before 9 a.m. Monday through Friday
- After 5 p.m. Monday through Friday
- Anytime on Saturday or Sunday

Continued on next page

7.2 Member Access, Continued

Points Earned For Non-Traditional Hours

The requirement to earn points for offering non-traditional office hours differs according whether you are a solo or group practice.

- Group practices must offer 6 or more non-traditional office hours
- Solo practices must offer 4 or more non-traditional office hours

Important!

Our data is based on information that you provide, so if your practice office hours change, it's important to let us know.

Update your information via NaviNet

or

On practice letterhead, state:

- Your Practice name
- Practice number
- Previous office hours at all locations
- New office hours at all locations

Fax to:
1-800-236-8641

or

Mail to:
Provider Information Management
P.O. Box 898842
Camp Hill, PA 17089-8842

Note: Please contact your Provider Relations representative in addition to sending us the new information.

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7.2 Member Access, Continued

Calculating Member Access

This table shows how to determine office hours for solo and group practices.

Solo practice	Group practice
Add the number of office hours reported at all of the solo practitioner's offices each week to determine the weekly total. If any practice location's office hours overlap with another location, only the non-overlapping hours will be counted. Any locations with the same office hours will not be counted twice. If the solo practice has more than 4 non-traditional hours within a week, the practice will receive additional points.	Add the number of office hours reported at all of the group's offices each week to determine the weekly total. If any practice location's office hours overlap with another location, only the non-overlapping hours will be counted. Any locations with the same office hours will not be counted twice. If the group practice has more than 6 non-traditional hours within a week, the practice will receive additional points.
Example: *Dr. X - solo practitioner* Dr. X's Elm Street location is open Monday through Friday from 9am to 4 pm and is closed one hour for lunch. (6 hrs/day x 5 days) = 30 hrs Dr. X's Oak Street location is open Monday through Friday from 5:30pm to 7pm (1.5 hrs/day x 5 days) = 7.5 hrs Dr. X offers a total of 37.5 weekly hours that include 7.5 non-traditional hours.	Example: *Doctors Inc. - group practice* Doctors Inc.'s Maple Avenue location is open Monday through Thursday from 9am to 5pm. Doctors Inc.'s Aspen Avenue location is open Monday through Thursday from 12pm to 8pm and Friday from 9am to 7pm. Maple Ave- (8 hrs/day x 4 days) = 32 hrs Aspen Ave- (3 hrs/day x 4 days) = 12 hrs* (10 hrs/day x 1 day) =10 hrs* *Only non-overlapping hours are counted at the Aspen Avenue location. Doctors Inc. offers a total of 54 weekly hours that include 14 non-traditional hours.

7.2 Best Practice – Clinical Improvement Activity

Description

The Best Practice indicator awards points to practices that have created a clinical quality initiative to improve care offered in the office setting. The initiative must be different than the clinical quality indicators in the QualityBLUE program. A work plan must be submitted to Highmark for approval prior to implementation. A Highmark Medical Management Consultant or Provider Relations Representative can assist you with the process.

Highmark may also accept professional organization based certification or recognition activities as meeting the Best Practice requirement. A practice may complete either an office based or professional organization based activity.

An example report is shown on the next page.

Continued on next page

7.2 Best Practice – Clinical Improvement Activity, Continued

QualityBLUE Fee for Service Detail Report - Quality Payment Quarter

Practice Name - 000000000

Region: Western Specialty: Family Practice

Best Practice

Scoring Summary

Initiative Subject:	N/A
Tier:	N/A
Best practice score:	**0/5**

Best Practice Clinical Improvement Initiative Measurement Detail

Initiative Subject:	N/A
Earned Points:	0
Total Possible Points:	5

Earned Points Table

Tier	Elements or Certification/ Recognition Activities Completed	Timelines	Earned Points
Tier One	Elements 1-3	Once approved, you have 3 months to complete Element 4 and move to Tier Two.	0
Tier Two	Elements 1-4	Once approved, you have 1 year to complete Elements 5 & 6 and move to Tier Four.	3
Tier Three	Elements 1-5	If you skipped to Tier Three, you have 1 year to complete Element 6 and move to Tier Four. If you were approved for Tier Two previously, you have 1 year from the date you were approved for Tier Two.	4
Tier Four *	Elements 1-6 or Physician Certification/Recognition Activity	Once approved, you will retain your 5 points for 1 year.	5

Work Plan Elements That Must be Approved

Element	Description
1	Definition and scope of specific problem being addressed, impact on patient care and why this problem was chosen as a quality initiative. Description of the specific issue the work plan should improve.
2	Baseline level of performance/ measurement relative to the problem identified in element #1 with the method of calculation, source of performance data, and timeframe that applies to the baseline measurement.
3	Specific goal and achievable results expected, including a time line/target date to reach the performance goal.
4	Detailed descriptive list of action items/interventions with a target date for implementation and the person responsible.
5	Specific results or outcome measures relative to the targeted performance level in element #3, including a cost impact analysis of the change in performance. Quantify change in performance from beginning to end of initiative.

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7.2 Best Practice - Clinical Improvement Activity, Continued

QualityBLUE Fee for Service Detail Report - Quality Payment Quarter
Practice Name – 000000000
Region: Western Specialty: Family Practice

Element	Description
6	The overall summary of the clinical initiative, including issues identified, lessons learned, barriers to implementation, an analysis of the impact on patient care and success of the activity undertaken.

*Tier Four may be obtained by completion and committee approval of either of the following:

1. Six work plan elements related to an office based Best Practice activity.
2. Documentation of an accepted Professional Organization based Best Practice certification/recognition activity.

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7.2 Best Practice – Clinical Improvement Activity, Continued

Criteria-Office Based Activity

All work plans submitted must be documented and include the following elements:

1. The work plan should define the specific problem being addressed. It should also describe the scope of the problem, the impact on patient care and why this specific problem was chosen as a quality initiative.
   A description of the specific issues the work plan will improve should also be included.

2. A baseline measurement of performance/measurement relative to the problem identified in element number one should be provided. The method of calculation, source of performance data, and timeframe that applies to the baseline measurement should be included.

3. A specific goal and achievable results expected must be provided. A timeline/target date to reach the stated performance goal must also be included.

4. A detailed descriptive list of action items/interventions must be provided. Each action item is to have a target date for implementation and a person responsible for implementation identified.

5. Specific results or outcome measures relative to the targeted performance level in element number three must be provided. A cost impact analysis of the change in performance should be included. Change in performance from beginning to end of the initiative must be quantified.

6. The overall summary of the clinical initiative should include a description of lessons learned, barriers to implementation, an analysis of the impact on patient care, and success of the activity undertaken. Finally, the summary should indicate how the process changes implemented or improvements achieved will be sustained.

Continued on next page

7.2 Best Practice – Clinical Improvement Activity, Continued

Measurement Method-Office Based Activity

Less than 4 work plan elements deemed to be complete earns 0 points.

4 work plan elements deemed to be complete earns 3 points
5 work plan elements deemed to be complete earns 4 points
6 work plan elements deemed to be complete earns 5 points

The practice improvement activity has one year for completion from the start date, which begins when 3 points are earned. The maximum score of 5 points obtained by the completion date is retained for one year.

Criteria-Professional Organization Based Activity

In order for a practice to be eligible to receive five points using this method, all physicians in a practice must participate in the certification/recognition activity and each physician who participated in the activity must submit proof documentation. Certification/recognition activities accepted by Highmark for consideration as meeting the Best Practice requirement include the following:

1. Performance in Practice (PIP) modules from the American Board of Family Medicine (ABFM)
2. Performance in Practice (PIP) activities from the American Board of Pediatrics (ABP)
3. Maintenance of Certification Practice Improvement Modules (PIMs) from the American Board of Internal Medicine (ABIM)
4. METRIC modules from the American Academy of Family Physicians(AAFP)
5. National Committee for Quality Assurance (NCQA) Physician Recognition Programs

Practices cannot receive partial credit for incomplete certification/recognition activities. Submit only final proof documentation from one of the above.

Measurement Method-Professional Organization Activity

Certification/ recognition activities approved as complete earn 5 points for the Best Practice initiative.

Points awarded are retained for one year. To maintain the points for a Best Practice initiative, updated documentation of a new activity completed must be received and approved prior to the end of the 12 month period for which the previously awarded points were applicable.

Continued on next page

7.2 Best Practice – Clinical Improvement Activity, Continued

Measurement Period

Data work plans and certification/ recognition program documentation will be reviewed quarterly.

The documentation submission deadlines are as follows:

1st Quarter	November 10
2nd Quarter	February 10
3rd Quarter	May 10
4th Quarter	August 10

Data Submission Forms

For Best Practice Data Submission Forms, look in the Provider Resource Center, QualityBLUE Program in NaviNet via www.highmarkblueshield.com.

7.2 Electronic Health Record Implementation

Description The Electronic Health Record Implementation (EHR) indicator awards points to practices that have initiated the implementation of an electronic health record system (EHR). The EHR must include, at a minimum, a point-of-patient-contact, electronic documentation component. A sample report is shown below.

QualityBLUE Fee for Service Detail Report - Quality Payment Quarter

Practice Name – 000000000

Region: Western Specialty: Family Practice

Electronic Health Record

Scoring Summary

Tier awarded: Tier One

Practice Electronic Health Record (EHR) score: **0/5**

Electronic Health Record (EHR) Initiative Measurement Detail

Initiative Start Date: N/A

Based on date committee approved
3 points awarded

Initiative Completion Date: N/A

Completion required 2 years from start date

Earned Points: 0

Total Possible Points: 5

Earned Points Table

Tier	Implementation Activities Completed	Earned Points
Tier One	No EHR Implementation Activities Completed	0
Tier Two	1 of the 2 Following Activities Documented & Verified Documented commitment to purchase EHR Initiated implementation of EHR in at least 1 practice site	3
Tier Three	EHR Implementation in 50% of Total Primary Care Practice Sites	5

All implementation activities must be documented and committee verified and approved for scoring. Acceptable forms of proof are as follows:

Commitment to Purchase	*Verification of Installation*
A copy of signed practice contract	Practice letter acknowledging implementation
A copy of a purchase order	Letter from practice verifying implementation by practice site
A copy of a paid invoice or receipt	

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7.2 Electronic Health Record Implementation, continued

Criteria

Acceptable forms of proof include the Commitment to Purchase and Verification of Installation as follows:
Copy of a signed vendor contract
Copy of a purchase order
Copy of cancelled check
Vendor letter acknowledging implementation
Letter from practice verifying implementation by practice site

Maximum Quality Score

The maximum quality score for this indicator is 5 points.

Measurement Method

The practice has not initiated any activity relative to the implementation of an EHR. 0 points are earned.

If any of these elements are documented and verified the practice will earn 3 points. The practice has:

- Documented the commitment to purchase an EHR.
- Initiated the implementation of an EHR in at least one practice site.

This element will earn the practice 5 points:

- The implementation of an EHR in at least 50% of practice sites.

The implementation activity has two years for completion from the start date, which begins when 3 points are earned.

Measurement Period

Implementation activities will be reviewed quarterly.

The documentation submission deadlines are as follows:

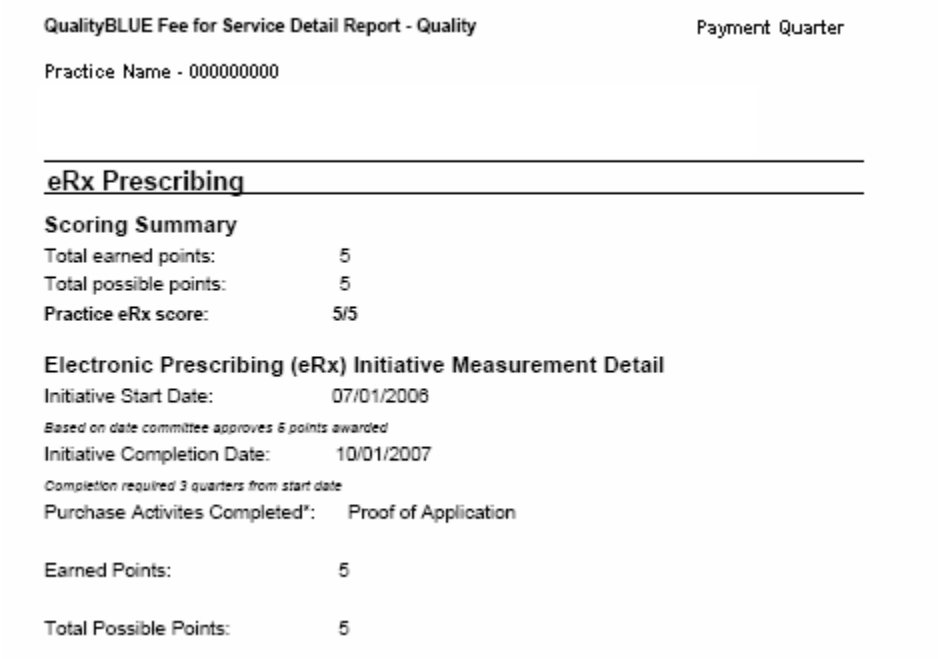
1st Quarter	November 10
2nd Quarter	February 10
3rd Quarter	May 10
4th Quarter	August 10

Data Submission Forms

For Electronic Health Record Data Submission Forms, look in the Provider Resource Center, QualityBLUE Program in NaviNet or via www.highmarkblueshield.com.

7.2 Electronic Prescribing (eRx)

Description The practice has initiated the implementation of an Electronic Prescribing (eRx) record. The intention of this indicator is to reward practices not only for the purchase of an eRx system, but also to guide practices toward maximum functionality and utilization. A sample report is shown below.



QualityBLUE Fee for Service Detail Report - Quality Payment Quarter

Practice Name - 000000000

eRx Prescribing

Scoring Summary

Total earned points: 5
Total possible points: 5
Practice eRx score: 5/5

Electronic Prescribing (eRx) Initiative Measurement Detail

Initiative Start Date: 07/01/2006
Based on date committee approves 6 points awarded
Initiative Completion Date: 10/01/2007
Completion required 3 quarters from start date
Purchase Activites Completed*: Proof of Application

Earned Points: 5

Total Possible Points: 5

eRx Purchase Activity	Earned Points
Proof of existing eRx system with minimum functionality (functional elements 1-4), which is **not** upgraded with full functionality/bidirectional elements 1-7.	3
Proof of commitment to purchase or proof of purchased eRx system with minimum functionality (functional elements 1-4).	3
Proof of purchased eRx system with full functionality including bidirectional (functional elements 1-7).	5

7.2 Electronic Prescribing (eRx), Continued

*All activities must be documented and committee verified and approved for scoring.
Acceptable forms of proof are as follows:

Commitment to Purchase	*Verification of approved eRx*
Acknowledging receipt of application	Meets required functionality, communications and
Copy of signed vendor contract	interoperability with EHR
Copy of a purchase order	

Continued on next page

7.2 Electronic Prescribing (eRx), continued

QualityBLUE Fee for Service Detail Report - Quality Payment Quarter

Practice Name - 000000000

eRx Prescribing

Scoring Summary

Total earned points: 5
Total possible points: 5
Practice eRx score: 5/5

Electronic Prescribing (eRx) Initiative Measurement Detail

Initiative Start Date: 07/01/2006
Based on date committee approves 6 points awarded
Initiative Completion Date: 10/01/2007
Completion required 3 quarters from start date
Purchase Activites Completed*: Proof of Application

Earned Points: 5

Total Possible Points: 5

Earned Points Table

eRx Purchase Activity	Earned Points
Proof of application to eHealth Collaborative	5
Proof of existing eRx system with minimum functionality (if Other, elements 1-4)	5
Proof of Commitment to Purchase an eRx system	5
Proof of an existing eRx system from an acceptable vendor with all functionality	5

*All activities must be documented and committee verified and approved for scoring.
Acceptable forms of proof are as follows:

Commitment to Purchase	*Verification of approved eRx*
Acknowledging receipt of application	Meets required functionality, communications and
Copy of signed vendor contract	interoperability with EHR
Copy of a purchase order	

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7.2 Electronic Prescribing (eRx), continued continued

Criteria

Practices can earn 5 points if the selected vendor , software and version have been approved by the eHealth Collaborative. A complete listing of approved vendors and software solutions can be found at www.highmarkehealth.org.

If the practice selects a vendor not approved by the eHealth Collaborative, the software must meet all 7 requirements listed below to earn 5 points. If the software meets fewer than the 7 requirements, but meets at least elements 1-4, the practice will be awarded 3 points.

If a vendor other than those listed on the highmarkehealth website is used, verification of functionality is required. The practice must check all functional elements that apply to the existing or purchased eRx system. These include:

1. Electronically order medications from the patient's pharmacy of choice, record and maintain medical history
2. Identify drug-to-drug interactions at the point-of-care
3. Protect confidential patient information
4. Direct electronic connections with majority of pharmacies in the 49-county area to place prescription orders (faxing capabilities acceptable)
5. Communication with Highmark's Pharmacy Benefits Manager to show benefits and formulary information at the point-of-care
6. Communication with Highmark's Pharmacy Benefits Manager to display dispensed medications prescribed by other physicians
7. Bi-direction electronic communications with pharmacies to respond to Pharmacy-initiated refill requests.

Maximum Quality Score

The maximum quality score for this indicator is 5 points.

Continued on next page

7.2 Electronic Prescribing (eRx), continued

Measurement Method	Acceptable forms of documentation include: • A signed contract or purchase order, • A monthly invoice from the vendor if the system has been long-standing
Measurement Period	Implementation activities will be reviewed quarterly. The documentation submission deadlines are as follows: 1st Quarter November 10 2nd Quarter February 10 3rd Quarter May 10 4th Quarter August 10
Data Submission Forms	For Electronic Prescribing (eRx) Data Submission Forms, look in the Provider Resource Center, QualityBLUE Program in NaviNet or via www.highmarkblueshield.com.

7.2 QualityBLUE *2008* Provider Information Submission Schedule

How To Use The QualityBLUE Calendar *2008*

Please use this *2008* calendar as a guideline for the timely submission of practice data changes impacting the QualityBLUE Physician Pay for Performance Program. The highlighted dates identify when this practice information needs to be received by Highmark for the corresponding QualityBLUE quarter.

Continued on next page

7.2 QualityBLUE *2008* Provider Information Submission Schedule

DATA/INFORMATION	SUBMISSION DEADLINE	PAYMENT PERIOD
The following information is collected on a quarterly basis. Submission form(s) and documentation must be received by Highmark on or before the submission deadline. • *Best Practice Form* • *Electronic Health Record Form* • *Electronic Prescribing Form*	*11/10/2007* *02/10/2008* *05/10/2008* *08/10/2008* *11/10/2008*	*1st Qtr 2008* *2nd Qtr 2008* *3rd Qtr 2008* *4th Qtr 2008* *1st Qtr 2009*
The following information is collected and evaluated on a monthly basis. Documentation must be received by Highmark on or before the submission deadline. ***Certain changes may affect the practice's ability to receive or be eligible for an incentive:*** • *Eligibility Requirements:* o *NaviNet enabled status* • *Performance Measures:* o *Member Access office hours* • *General:* o *All information related to any billing provider number changes.* o *Specialty changes* ***Please contact your provider relations representative or medical management consultant for advice.***	*12/10/2007* *01/10/2008* *02/10/2008*	*1st Qtr 2008*
	03/10/2008 *04/10/2008* *05/10/2008*	*2nd Qtr 2008*
	06/10/2008 *07/10/2008* *08/10/2008*	*3rd Qtr 2008*
	09/10/2008 *10/10/2008* *11/10/2008*	*4th Qtr 2008*
	12/10/2008	*1st Qtr 2009*

2008

January

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

February

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	

March

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

April

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

May

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

June

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

July

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

August

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

September

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

October

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

November

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	29	20	21	22
23	24	25	26	27	28	29
30						

December

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

HIGHMARK. BLUE SHIELD

Chapter 7

QualityBLUE℠ A Physician Pay-for-Performance Program

Unit 3: Clinical Quality Updates

In This Unit

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7.3 Clinical Quality Updates

How To Use This Document

This document lists modifications made to the QualityBLUE program effective April 1, 2007. The modifications were made to incorporate HEDIS and coding manual (ICD-9, CPT, HCPCS, etc.) changes. The coding changes are displayed in the tables below. Codes were added and deleted. Any code deleted, has been retained in the programming to capture past claims data when necessary for measures which "look back" beyond the measurement year.

Updates To Prescription Drugs Used In Clinical Quality

Applied NDC updates pertaining to any of the following categories:

- Acute Pharyngitis Testing
- Appropriate Asthma Medications
- Beta Blocker Treatment After AMI
- Comprehensive Diabetes Care
- CHF Annual Care, Advanced Standard

Appropriate Asthma Medications

Asthma Denominator Codes Added

CPT Codes	Revenue Codes
99341-99345	0511-0514
99347-99350	0522
99382-99386	0527-0529
99392-99396	0570-0599
99401-99404	0771
99411-99412	
99420, 99429, 99499	

Continued on next page

7.3 Clinical Quality Updates, Continued

Appropriate Asthma Medications, continued

Asthma Denominator Codes Removed

CPT Codes	Revenue Codes
99271-99275	0115-0118
99292	0125-0128
99356	0135-0138
99357	0145-0148
	0155-0158
	0760-0769
	0800-0809
	0988

Breast Cancer Screening

The age requirement for breast cancer screening was changed from ages 50 through 69 and lowered to ages 40 through 69.

Breast Cancer Screening Numerator

Added CPT codes 77055-77057
Removed-Revenue Code 0401

Breast Cancer Screening Exclusions

Added CPT codes 19303, 19305-19307 for mastectomy. Exclusion applies if bilateral codes or two separate occurrences on two different dates are identified.

Cervical Cancer Screening

The age requirement for cervical cancer screening was changed from ages 18 through 64 and increased to ages 21 through 64.

Cervical Cancer Screening Numerator

Added HCPCS codes G0101, G0141, G0147-G0148, Q0091

Continued on next page

7.3 Clinical Quality Updates, Continued

Cholesterol Management After Acute Cardiovascular Event

Numerator for AMI, PTCA, CABG and Ischemic Vascular Disease (IVD)
Added CPT codes 83700-83701, 83704

Denominator for AMI, PTCA, and CABG
Added HCPCS Codes S2205-S2209 for CABG
ICD-9 procedure codes 00.66, 36.06, 36.07 for PTCA

Denominator for Ischemic Vascular Disease
The period for identifying the ischemic vascular disease diagnosis has changed. Currently, IVD is captured in the year prior to the measurement year. With this update, the diagnosis must now be identified in both the measurement year **and** the prior year for denominator inclusion. Additional codes specific to IVD were added as below:

Added ICD-9 codes 414.8, 414.9
CPT codes 99455-99456

Ischemic Vascular Disease Denominator Codes Removed

ICD-9 Codes	CPT Codes	Revenue Codes	DRG
435.0-435.9	92002-92014	0115- 0118	524
437.0-437.1	99271-99275	0125- 0128	
438.0-438.89	99281-99285	0135- 0138	
441.00-441.9	99292	0145- 0148	
443.9	99301-99313	0155- 0158	
	99315-99316, 99318	0190-0199	
	99321-99328	0450-0459	
	99331-99337	0490-0499	
	99351-99357	0500-0509	
		0524-0525	
		0530-0539	
		0550-0559	
		0560-0569	
		0650-0659	
		0660-0669	
		0760-0769	
		0800-0809	
		0820-0859	
		0880-0889	

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7.3 Clinical Quality Updates, Continued

Cholesterol Management After Acute Cardiovascular Event, continued

Ischemic Vascular Disease Denominator Codes Removed, continued

ICD-9 Codes	CPT Codes	Revenue Codes	DRG
		0920-0929	
		0940-0949	
		0960-0969	
		0972-0979	
		0981	
		0984-0986	
		0988-0989	

Comprehensive Diabetes Care

Numerators

Nephropathy Screening Numerator

An additional component was added that allows the practice to meet the quality guidelines for the numerator. With this update, a practice can be considered numerator compliant if an ACE/ARB prescription dispensed on an ambulatory basis is identified during the measurement year.

Nephropathy Screening Numerator Codes Added

ICD-9 Diagnosis Codes	ICD-9 Procedure Codes	CPT/HCPCS Codes	Revenue Codes
791.0-791.09	38.95	36145	0367
		36831-36833	
		90939-90940	
		G0257	
		G0314-G0319	
		G0322-G0323	
		G0326-G0327	
		S9339	

Nephropathy Screening Numerator Codes Removed

CPT Codes 81050, 83518, 84160, 84165-84166

Continued on next page

7.3 Clinical Quality Updates, Continued

Comprehensive Diabetes Care, continued

Retinal Eye Exam Numerator
The time frame for identifying a retinal eye exam to meet *numerator requirements* was expanded to include the measurement year *or* the preceding year. The change was effective on January 1, 2007.

Retinal Eye Exam Numerator Codes Added
CPT/HCPCS Codes 67028, 67038-67040, S0620-S0621, S0625

Retinal Eye Exam Numerator Codes Removed
CPT Code 92287

LDL-C Screening Numerator
The time frame for identifying LDL-C testing to meet the numerator requirement is changed to the measurement year only.

LDL-C Screening Numerator Codes Added
CPT codes 83700-83701, 83704

HbA1c Test Numerator

Added CPT code 83037

Comprehensive Diabetes Care Denominator for all four measures

The time frame for identifying exclusions for steroid induced or gestational diabetes was expanded to include the measurement year and the prior year.

Denominator Codes Added
CPT codes 99304-99310, 99315-99316, 99318, 99324-99328, 99334-99337, 99455-99456

Continued on next page

7.3 Clinical Quality Updates, Continued

Comprehensive Diabetes Care, continued

Comprehensive Diabetes Care Denominator Codes Removed

CPT Codes	Revenue Codes
99271-99275	0115-0118
99351-99357	0125-0128
	0135-0138
	0145-0148
	0155-0158
	0490-0499 0920-0929
	0500-0509 0940-0949
	0530-0539 0960-0969
	0560-0569 0972-0979
	0650-0659 0984-0986
	0760-0769 0988-0989

Varicella Vaccination Status

The continuous enrollment requirement was expanded from the measurement year to the measurement year and the preceding six months.