CHAPTER 3: PROVIDER NETWORK PARTICIPATION

UNIT 4: ORGANIZATIONAL PROVIDER PARTICIPATION (FACILITY/ANCILLARY)

IN THIS UNIT

FACILITY PROVIDERS

What Is My Service Area?

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

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

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

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

3.4 PARTICIPATION AND CREDENTIALING

Overview

Highmark credentials organizational providers (facility and ancillary) in order to ensure they are in good standing with all regulatory and accrediting bodies. Highmark's participation and credentialing requirements derive from internal business decisions as well as the standards set by those agencies.

Why blue italics?

Requirements

All organizational providers are required to have a license, certificate, registration, or permit, as applicable, in the state where they do business. It must be maintained and in good standing with that particular state. Participation with Medicare/Medicaid may be required for providers. Providers that are eligible for accreditation must also maintain an active accreditation status. *All organizational providers must submit their current certificate of liability insurance.*

For requirements for specific organizational provider types, click on the link below:

Organizational Provider Participation, Credentialing, and Contracting Requirements

This document is also available on the Provider Resource Center – select **CREDENTIALING**, and then **Organizational Initial Credentialing Set Up**.

Facility provider types

Highmark defines "facilities" as those providers billing services in the UB-04/837I format. Highmark holds contracts with facility provider types including, but not limited to:

- Acute care hospitals
- Psychiatric facilities
- Substance abuse treatment centers
- Skilled nursing facilities (SNFs)
- State-owned psychiatric hospitals
- Ambulatory surgical centers (ASCs)
- Renal dialysis facilities
- Hospice
- Home health
- Comprehensive outpatient rehabilitation facilities (CORFs)
- Rehabilitation hospitals
- Long-term acute care facilities (LTACs)
- Long-term services and supports (LTSS)/home and community-based service options (HCBS)

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3.4 PARTICIPATION AND CREDENTIALING, Continued

Ancillary provider network

Ancillary providers are credentialed by Highmark as organizational providers; however, ancillary providers bill services in the 1500/837P format.

The ancillary provider network includes freestanding and facility-based providers in the specialties including, but not limited to:

- Ambulance
- Durable medical equipment
- Home infusion
- Orthotics/prosthetics
- Independent laboratories

Availability

Facility services must be available to members on a twenty-four (24) hour per day, seven (7) day per week basis when medically necessary and in accordance with industry standards of care. Care should be provided in the most appropriate setting, in the most efficient manner, offering the most appropriate plan of treatment for the member.

Report changes

Please inform Highmark of any changes as required by your contract. Failure to keep this data current may lead to an incorrect listing in the provider directories, missed mailings or checks, and possibly incorrect payments.

The following list includes, but is not limited to, important informational changes that will require immediate written notification to Highmark:

- Change to hours of operation
- Address (physical location) change
- Mailing and/or billing address change
- Tax Identification Number (TIN) change
- Ownership/Corporation/Organizational changes
- Additions/deletions of Assignment Account members, if applicable
- Telephone number change, including area code (member access telephone number)
- Fax number change

Please see the section in this unit on **Reporting Mergers, Acquisitions, and Changes** for additional information.

FOR MORE INFORMATION

Please refer to **Chapter 3.1: Network Participation Overview** for additional information on Highmark network participation.

3.4 APPLICATIONS

Facilities and ancillary providers

To begin the process for credentialing and participation in Highmark's networks, facilities and ancillary providers must complete and submit the **Application for Facility and Ancillary Providers**. This application is also accessible on the Provider Resource Center -- select **CREDENTIALING** from the main menu, and then **Organizational Initial Credentialing Set Up**.

Note: Certain ancillary provider networks, such as durable medical equipment and laboratories, may be closed to new applicants. Highmark most often performs outreach in the provider community when it is determined that such services are needed. If an application is received for a closed network, a response may not be provided. Please see the **Provider Application for Facility and Ancillary Providers** page on the Provider Resource Center for current provider types with closed networks. In addition, closed network status will be noted on the **Organizational Provider Participation, Credentialing, and Contracting Requirements** document.

Urgent Care Centers/ Medical Aid Units and Retail Clinics

The **Urgent Care Center/Medical Aid Unit and Retail Clinic Application** is required to begin the process for participation in Highmark networks for Urgent Care Centers, Medical Aid Units (in Delaware), and Retail Clinics. This application is also available on the Provider Resource Center under **CREDENTIALING**, and then **Organizational Initial Credentialing Set Up**.

For more information on participation requirements for Urgent Care Centers and Medical Aid Units, please see the **Urgent Care Centers/Medical Aid Units** section of this unit.

Behavioral health

The **Application for Behavioral Health Providers** is to be used for freestanding behavioral health facilities/centers. This application is also available on the Provider Resource Center – select **CREDENTIALING**, and then **Behavioral Health Initial Credentialing Set Up**. In this location on the Provider Resource Center, you will also find the following documents for freestanding behavioral health providers:

- **Behavioral Health Services Grid**
- **Freestanding Behavioral Health Provider Autism Spectrum Disorder Services Grid**

Please fax the completed application and all supporting documentation to the applicable fax number for your service area as indicated on the application.

3.4 REPORTING MERGERS, ACQUISITIONS, AND CHANGES

Overview

Highmark requires advance notification of the following events: mergers, acquisitions, changes of ownership, legal name changes, new or changed locations, or services or related events (individually or collectively, referred to as a "Facility Event").

Facilities are instructed to initiate the change notification process to notify Provider Contracting thirty to sixty (30-60) days prior to the effective date of a Facility Event. A facility is also required to comply with any applicable notification requirements set forth in its facility agreement.

After determining all information and notices are complete, Provider Contracting will initiate internal processes as appropriate with respect to Highmark's approval and file modifications.

Required form

Highmark provides a standard form that is required for providing appropriate notification of significant changes as identified above. To view and print the form, please click on the link below:

Highmark Facility/Ancillary Change Form

The **Highmark Facility/Ancillary Change Form** is also available on the Provider Resource Center -- select **FORMS**, and then **Miscellaneous Forms**.

The completed form must be faxed to the appropriate regional fax number noted on the last page of the form. Upon receipt of the completed form and required documents, Highmark will review the submitted information and notify the facility if additional information is needed.

Highmark approval required

New facility locations cannot be billed under the Highmark facility agreement until Highmark has received proper contractual notice and given its prior approval, as set forth in the applicable facility agreement.

The approval requirement applies to all new facility locations, whether the location is brand new, the result of the movement of services or combination of services, or addition of services through a merger, acquisition, change of ownership or some other legal event of an existing health care entity or practice (e.g., acute care facility, ambulatory surgery center, or physician practice).

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3.4 REPORTING MERGERS, ACQUISITIONS, AND CHANGES, Continued

Highmark approval required (continued)

If a facility bills for services at a new location prior to notification and approval by Highmark, this may result in the following occurrences and/or as may be provided for in the facility agreement and related agreements and documents, a breach of contract:

- Denial of payment
- Denial of authorization
- Decreased payment
- Increased audit activity

Highmark's approval of a Facility Event is for the purpose of recognizing an event in terms of the provider's contract(s) with Highmark, and the rights and obligations of each party thereunder.

Address & phone number changes

For address and phone number changes unrelated to a Facility Event, please use the **Address/Phone Number Change Form For Facility & Ancillary Providers**.

This form is also available on the Provider Resource Center – select **FORMS**, and then **Miscellaneous Forms**.

3.4 ELECTRONIC TRANSACTION REQUIREMENTS

Overview

In support of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, Highmark has taken steps to eliminate paper transactions with our contracted providers. As part of this initiative, all facilities are required to enroll in NaviNet and Electronic Funds Transfer (EFT), and will receive paperless Remittance Advices.

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

NaviNet® and EFT enrollment required

All Highmark network participating providers are required to enroll in NaviNet® and Electronic Funds Transfer (EFT).

NaviNet integrates all insurer-provider transactions into one system (e.g., eligibility and benefit inquiries, claim status inquiries, claim submission, authorization requests, etc.). This service is available at no cost to Highmark network participating providers.

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

- EFT is a secure process which directs Highmark claim payments to the provider's checking or savings account as directed by your facility. Payments are typically in the designated bank account by Wednesday of each week.
- Paperless Remittance Advices reduce the amount of paper flowing into the facility's office. Remittance Advices are available for viewing via NaviNet, which is earlier than receiving them by mail.

FOR MORE INFORMATION

For guidance on enrolling in NaviNet and EFT and paperless remittances, please see the section on **Electronic Transaction Requirements** in **Chapter 3.1: Network Participation Overview**.

3.4 URGENT CARE CENTERS/MEDICAL AID UNITS

Introduction

Urgent care is care for an illness, injury, or condition serious enough that it requires care right away, but not so severe as to require emergency room care.

When urgent care is needed, Urgent Care Centers and Medical Aid Units provide Highmark members with a convenient option for non-life-threatening injuries and illnesses when their personal physicians are unavailable.

Urgent Care Centers (UCCs)

An Urgent Care Center (UCC) generally provides immediate care for acute, non-life threatening illnesses and injuries outside of a hospital emergency department. Services are provided on a walk-in basis without a scheduled appointment.

Urgent care medicine differs from emergency medicine in that its primary focus is on acute medical problems at the lower end of the severity spectrum. Individuals who present to an Urgent Care Center and are judged to need emergency care are transferred to a hospital emergency department.

What Is My Service Area?

Delaware regulations for UCCs and MAUs

There is significant variation among states regarding regulation of urgent care facilities. Delaware law limits the use of the terms "emergency" or "urgent" by a facility if that facility is not able to handle life-threatening emergency care.

Delaware law defines "Free Standing Emergency Center" as a facility that is:

- Physically separate from a hospital
- Using in its title or in its advertising the words "emergency," "urgent care," or parts of those words or other language or symbols which imply or indicate to the public that immediate medical treatment is available to individuals suffering from a life-threatening medical condition
- Capable of treating all medical emergencies that have life-threatening potential
- Not a trauma center
- Open twenty-four (24) hours a day, seven (7) days a week
- Generally able to treat most emergencies

In Delaware, a facility is considered to be an "Urgent Care Center (UCC)" and credentialed as such only if they are licensed as a Free Standing Emergency Center. Facilities providing urgent care that are not licensed are called and credentialed as "Medical Aid Units (MAUs)."

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3.4 URGENT CARE CENTERS/MEDICAL AID UNITS, Continued

Application process for Highmark network participation

To begin the application process for participation in Highmark's networks, complete the **Urgent Care Center/Medical Aid Unit and Retail Clinic Application**. Each location will require a separate application. This application is available on the Provider Resource Center. Select **CREDENTIALING**, and then **Organizational Initial Credentialing Set Up**.

You will be contacted by Highmark Provider Information Management if additional information is needed. Please allow up to 180 days for the application to be processed.

Please Note: You must also complete the eviCore healthcare (eviCore) privileging application, as necessary, to apply for privileging for radiology services that may be provided (for dates of service beginning January 1, 2019). For the application and additional information, select **CARE MANAGEMENT PROGRAMS** from the main menu on the Provider Resource Center, and then **Advanced Imaging And Cardiology Services Program**.

A GEO access analysis will be completed to determine the number of members and existing Urgent Care Centers within a reasonable radius of the provider's ZIP code. Highmark may approve or deny provider network participation based on the results of the GEO access analysis.

If Highmark approves network participation, a contract is sent to the provider to sign and return to Highmark. When Highmark receives the signed contract, a new provider number is assigned and a welcome letter and the executed contract, with the effective date indicated, is sent to the provider. **No claims should be billed until all steps are completed; claims submitted prior to completing all steps will reject.**

Credentialing requirements

Highmark credentials Urgent Care Centers and Medical Aid Units at the facility level as part of the application and contracting process.

Effective August 1, 2017, Highmark eliminated the requirement that practitioners in network participating Urgent Care Centers and Medical Aid Units need to be credentialed by Highmark. Although this professional credentialing by Highmark is no longer required, practitioners are still required to submit the **Request for Addition/Deletion to Existing Assignment Account** electronic form as they join or leave the group. The form is also available on the Provider Resource Center. Select **FORMS**, and then **Provider Information Management Forms**.

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3.4 URGENT CARE CENTERS/MEDICAL AID UNITS, Continued

Accreditation requirements

Highmark requires that Urgent Care Centers/Medical Aid Units have accreditation from one of the following organizations:

- Joint Commission (JC)
- National Urgent Care Center Accreditation (NUCCA)
- Accreditation Association for Ambulatory Health Care (AAAHC)
- Center for Improvement in Healthcare Quality (CIHQ)
- Urgent Care Association of America (UCAOA)

Initial applicants that are not accredited must pass a Highmark Health Services Site Visit. Initial applicants that are not accredited must obtain accreditation by a Highmark recognized accrediting organization within eighteen (18) months after they are credentialed. If accreditation is not obtained within that time frame, the contract may be terminated.

License requirements

Licensing is not required for Urgent Care Centers in Pennsylvania and West Virginia.

In Delaware, Urgent Care Centers are required to be licensed as a Free Standing Emergency Center. Medical Aid Units do not require licensing.

Additional participation requirements

Additional requirements for Urgent Care Center and Medical Aid Unit participation in Highmark networks includes, but is not limited to, the following:

- Medical Director who is a Highmark network participating physician with a valid license in the state(s) where the Urgent Care Center(s) is located. The Medical Director maintains responsibility for all medical personnel within the Urgent Care Center.
- Services provided on a walk-in basis with no appointment required.
- Hours of operation must be as follows:
  - Monday-Friday: Minimum twelve (12) hours per day
  - Saturday and Sunday: Minimum eight (8) hours per day
- Post-services coverage, which at a minimum shall include access to a physician by telephone, should be available 24 hours a day, seven days a week to all members who have received services.
- Claim submission via 1500/837P.
- Inspect, calibrate, service, and ensure equipment is in optimal working condition and meets all federal, state, and local safety standards.
- Compliance with federal and state requirements regarding the dispensing, recording, and controlling of medications.
- Store pharmaceuticals and medical supplies under proper and secure conditions.

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3.4 URGENT CARE CENTERS/MEDICAL AID UNITS, Continued

Additional participation requirements (continued)

- The provider should participate in, cooperate with, and abide by the decisions of Highmark's peer review, utilization review, and quality improvement programs; medical record audits; and other activities deemed appropriate by Highmark for assuring quality care, cost effectiveness of care, and patient satisfaction.

Urgent care does not replace the member's PCP. Communication with the member's PCP regarding the care rendered to the member is essential.

On-site services required

The following services must be available during all hours of operation:

- X-ray (routine plain film) and phlebotomy services
- Licensed provider on-site with the appropriate state license and resources to obtain and read X-rays
- Administration of intramuscular, oral, and IV medication/fluids on-site
- Minor procedures such as suturing, cyst removal, incision and drainage, splinting, etc.
- Staff trained in equipment located on-site (i.e., automated external defibrillator (AED), oxygen)
- Working telephone to contact 911 if necessary

Verify eligibility and benefits for Urgent Care

Providers are advised to verify a member's eligibility and benefits via NaviNet® Eligibility and Benefits Inquiry or a 270/271 HIPAA electronic transaction. Member benefit plans vary and urgent care may not be a covered service for certain members.

To confirm coverage for urgent care provided by Urgent Care Centers in Pennsylvania and West Virginia, and Medical Aid Units in Delaware, select **Additional Benefit Provisions** (upper right) from the NaviNet Eligibility and Benefits page. Select **Professional Services** (from the pop-up box), and then scroll until you reach the **Urgent Care** category.

What Is My Service Area?

IMPORTANT! Verifying Highmark Delaware UCC benefit

To verify a Highmark Delaware member's benefits for services in an Urgent Care Center (a "Free Standing Emergency Center"), select **Additional Benefit Provisions** from the NaviNet Eligibility and Benefits page, and then select **Outpatient Facility Services** (from the pop-up box). Scroll to the **Emergency Room Care** category – differences between coverage for Emergency Room and Freestanding Urgent Care will be noted.

Please note that member cost-sharing may be different for services at Urgent Care Centers and Medical Aid Units.

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3.4 URGENT CARE CENTERS/MEDICAL AID UNITS, Continued

Billing guidelines

Highmark will only accept claims from Urgent Care Centers and Medical Aid Units that are billed electronically via an **837P transaction** or **1500 claim form**. This applies to all services provided, including diagnostic services.

All claims should include the following:

- S9088 – services provided in an Urgent Care Center (list in addition to code for service)
- Evaluation and Management procedure code, as applicable
- All other eligible services provided during the visit (i.e., X-rays)

Please Note: Medicare Advantage members do not have coverage for S9088. The code may be billed; however, claims will reject as non-billable to the member. In addition, self-funded groups may choose to not provide coverage for this code.

Supplies and oral medications are considered an integral part of the Evaluation and Management or procedure performed. No additional reimbursement is provided for supplies or oral medications.

If a member is referred/transferred to an emergency room, the Urgent Care Center/Medical Aid Unit may bill for services that were provided and collect any applicable member responsibilities, including copayments, coinsurance, and deductible. If the member was directed to an emergency room without treatment, a claim should not be submitted to Highmark.