CHAPTER 4: PROVIDER RESPONSIBILITIES AND GUIDELINES

UNIT 3: FACILITY-SPECIFIC GUIDELINES

IN THIS UNIT

What Is My Service Area?

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

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

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

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

OBSOLETE

4.3 OVERVIEW OF FACILITY-SPECIFIC GUIDELINES

Introduction

A facility provider is a hospital, ambulatory surgery center, home health agency, hospice, home infusion agency, skilled nursing facility, an alcohol or drug treatment center, or other facility that is licensed or certified to perform designated, covered health care services by the state or jurisdiction where services are provided.

This unit includes facility-specific guidelines for facility providers and applies to Commercial and Medicare Advantage, unless otherwise noted. Section headings will help to identify if the information in the section is applicable to a specific facility type.

What Is My Service Area?

Facility Bulletins

In the past, Highmark published Facility Bulletins to communicate policies and procedures to facilities. Although the publication of newly created Facility Bulletins was discontinued in 2015, Highmark has reviewed previously published bulletins in Pennsylvania to evaluate their content. As the bulletins were evaluated, Highmark determined if the information was still current and valid, or if the information was outdated and/or superseded in a more recent bulletin (or communication). Those bulletins deemed to be outdated, or superseded in a more recent communication, were marked as obsolete and added to the Facility Bulletin Archive.

Facility Bulletins continue to be available online to providers as resources and for historical reference in all service areas. The *Highmark Provider Manual*, provider newsletters, Special Bulletins, and other communications (e.g., Plan Central Messages) should be referenced for the most up-to-date information.

Facility Bulletins can be accessed from the Provider Resource Center by selecting **NEWSLETTERS/NOTICES** from the main menu.

Medicare Advantage

For guidelines related to care management of Medicare Advantage members, please see **Chapter 5.3: Medicare Advantage Procedures**.

4.3 MEMBER ACCESS TO FACILITIES

Availability of facility services

Facility services need to be available to Highmark members on a twenty-four (24) hour per day, seven (7) day per week basis when medically appropriate and in accordance with industry standards.

Access to physician services

Access to physician services is an integral component of the facility services provided to members. Physician services are provided by either hospital-based physicians or physicians employed by a facility. If physician services are provided to Highmark members on behalf of a facility, the facility must verify that he physician has the appropriate training, education, and licensure to provide such services.

Equal access and non-discrimination in treatment of members

In addition to those requirements contained in your facility agreement and in any other applicable administrative requirements, network facilities agree to requirements of equal access and non-discrimination of Highmark members within this manual.

Facilities will provide members with equal access at all times to facility services. Facilities shall not deny, limit or fail to admit a member based on any factors related to race, color, national origin, ancestry, religion, sex, marital status, sexual preference, disability, age, source of payment, cost, anticipated cost, membership in a Product of Highmark or Health Plan or a member's health status. Facilities may also not refuse to render facility services based on the assumption that the anticipated cost that will be incurred will be in excess of Highmark's payment for covered services. Further, facilities shall not deny, limit, discriminate or condition the furnishing of facility services to members based on their known or believed relationship or association with an individual or individuals of a particular race, color, national origin, sex, age, or disability.

4.3 STATUS OF PATIENT VS. PLACE OF SERVICE

Policy

When a member who is an inpatient or outpatient of a hospital is taken outside of the hospital (e.g., MRI or CT mobile unit or doctor's office) for a procedure and is then returned to the hospital without being discharged, the service should be classified as inpatient or outpatient based on the status of the patient at the hospital versus the place where the service was performed.

Patient status definitions

The definition of the status of the patient is as follows:

Inpatient – A patient who is admitted as an overnight bed patient in a facility, such as a hospital or skilled nursing facility, at the time the procedure is performed.

Outpatient – A patient, other than inpatient, who is treated in a hospital, on hospital grounds, or in a hospital-owned or controlled satellite. This definition does not apply when a treating physician's solo practice is located in a hospital or hospital-owned building, and when the practice is not affiliated or controlled, in any way, by the hospital or related entity.

Reminder: Observation status is an **outpatient** care option that can be used when a member's condition must be evaluated promptly, but appropriateness of an inpatient admission has not yet been confirmed. For more information, please see the applicable section on **Observation Services** in this unit.

4.3 OBSERVATION SERVICES

Introduction

Observation status is an outpatient care option that can be used when a member's condition must be evaluated promptly but appropriateness of an inpatient admission has not yet been confirmed.

Highmark encourages hospitals to perform the appropriate diagnostic services promptly so the determination can be made on an expedited basis.

Definition: Outpatient Observation Services -- from Centers for Medicare & Medicaid Services (CMS)

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.

Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.

Hospitals may also bill for patients who are directly referred to the hospital for outpatient observation services. A direct referral occurs when a physician in the community refers a patient to the hospital for outpatient observation, bypassing the clinic or emergency department visit.

Time frame for observation services

Highmark recognizes that most observation services do not exceed one day and in rare instances span beyond 48 hours. For purposes of reimbursement, Highmark will not reimburse for observation services that exceed **forty-eight (48) hours**.

Note: Observation services begin at the time the physician writes the order for outpatient observation. The reason for observation must also be stated in the orders.

Goal of observation

Observation status does not replace or extend outpatient ambulatory diagnostic or therapy services, nor is it to be used in conjunction with elective outpatient surgery, including post-procedure observation.

Observation is meant to be used for making a diagnosis and/or treating a patient in an acute-care facility **prior to or instead of** an inpatient admission.

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4.3 OBSERVATION SERVICES, Continued

Medicare Outpatient Observation Notice (MOON)

On August 6, 2015, Congress passed the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, which requires all hospitals and critical access hospitals (CAHs) to provide written and oral notification to all Medicare beneficiaries receiving observation services as outpatients for more than twenty-four (24) hours. The written notice must include the reason the individual is receiving observation services, and must explain the implications of receiving outpatient observation services, in particular the implications for cost-sharing requirements and subsequent coverage eligibility for services furnished by a skilled nursing facility.

The **Medicare Outpatient Observation Notice (MOON)** was developed by the Centers for Medicare & Medicaid Services (CMS) to serve as the standardized written notice. Beginning March 8, 2017, the MOON must be presented to Medicare beneficiaries, including those with Medicare Advantage plans, to inform them that the observation services they are receiving are outpatient services and that they are not an inpatient of the hospital or CAH. Hospitals and CAHs must deliver the notice **no later than thirty-six (36) hours** after observation services are initiated or sooner if the individual is transferred, discharged, or admitted.

The hospital or CAH must obtain the signature of the patient or a person acting on behalf of the patient ("representative") to acknowledge receipt of the notification. If the individual or representative refuses to sign it, the written notification is signed by the hospital staff member who presented it.

The CMS approved standardized MOON form (CMS-10611) and accompanying instructions are available on the CMS website at:

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html?redirect=/bni

Typical uses for observation

Although Highmark does not restrict coverage of observation services to particular medical conditions, observation services are for **urgent or emergent** medical conditions. Observation is only medically necessary when the patient's current condition requires outpatient hospital services, or when there is a significant risk of deterioration in the immediate future such that continued observation in a non-hospital environment is inadvisable.

The following circumstances typically warrant the use of observation:

- The hospital expects that the patient will be stabilized and released within forty-eight (48) hours.
- The clinical diagnosis and necessity of inpatient admission are unclear, but the hospital expects to determine these in less than forty-eight (48) hours.

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4.3 OBSERVATION SERVICES, Continued

Inappropriate uses for observation status

It is inappropriate to place a patient in observation status for any of the following reasons:

- Patient, physician, or hospital convenience
- Respite care
- Pre-operative preparations or evaluations that do not meet criteria for acute-care facility admissions
- Pre-procedure care for diagnostic procedures that do not meet criteria for acute-care facility admission
- Post-procedure care for diagnostic procedures

Medical Policy V-3

For additional information on medical necessity and documentation requirements, please see **Highmark Commercial Medical Policy V-3: Billing of Observation Services.**

Outpatient cost-sharing applies

Many Highmark benefit plans currently include member cost-sharing for outpatient hospital services, including those received in the emergency room. Under most benefit plans, this cost-sharing requirement is waived if the member is admitted as an inpatient.

When members come into a hospital through the emergency room, it often is not immediately clear whether they need to be admitted as an inpatient and the member may be placed in observation status. If a member is not truly admitted as an inpatient to the hospital, then the member **is responsible** for any applicable outpatient cost-sharing amounts indicated by their benefit plan.

EXAMPLE: The member is placed in observation status after being treated in the emergency room. After treatment in observation, the member is discharged to his or her home the following afternoon. The member has a $50 emergency room copayment. Since the member was not admitted as an inpatient, he or she would be responsible for the $50 emergency room copayment.

Because observation services can be provided in any room or bed in a hospital, and because the member often stays in the facility overnight and may be served a meal, it may seem to the member and family that he or she is receiving inpatient care. If it is eventually determined that the member's condition does not meet InterQual® admission criteria and he or she can safely be discharged to home, the member or family may be surprised to learn that the services received throughout the time spent in the hospital were actually classified as outpatient in nature. Because of this confusion, members may dispute their obligation to pay the cost-sharing amounts for which they are in fact responsible.

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4.3 OBSERVATION SERVICES, Continued

Outpatient cost-sharing applies (continued)

The most important step that hospitals can take to assist their own facility in collecting member cost-sharing amounts is to inform the member, and/or the family, that the services received were observation services -- not an inpatient admission. In an effort to educate members, Highmark has published articles about observation services in its member newsletters.

Hospitals are welcome to use the article as they choose to help Highmark members understand that observation services are classified as outpatient in nature and that if they receive such services and are not formally admitted as inpatients, they are responsible for the outpatient cost-sharing amounts required by their benefit plan.

EXCEPTION: Please note that this request is not applicable to situations in which the member is in fact admitted as an inpatient following observation.

Requesting an inpatient admission

The hospital can request authorization of an inpatient admission as soon as clinical findings indicate that the admission would be appropriate. **This can occur at any point during the observation period.** There is no need to wait until forty-eight (48) hours have elapsed.

The request for the inpatient authorization should ordinarily be made using the NaviNet® Automated Care Management function. If NaviNet is unavailable, contact Highmark Clinical Services at:

- In the PA Western Region, call **1-800-242-0514**.
- In the PA Central & Northeastern Regions, call **1-866-803-3708**.
- In the Delaware, call **1-800-572-2872**.
- In the West Virginia, call **1-800-344-5245**.

What Is My Service Area?

IMPORTANT! Always confirm benefits

Availability of benefits under the member's benefit plan is required in order for a service to be reimbursed by Highmark. Be sure to confirm the specific member cost-sharing responsibility for outpatient services for each member.

Availability of benefits can be verified through the Eligibility and Benefits function on NaviNet®. If NaviNet is unavailable, providers may contact the appropriate Highmark Provider Service unit by telephone:

- In the PA Western Region, call **1-800-242-0514**.
- In the PA Central & Northeastern Regions, call **1-866-803-3708**.
- In the Delaware, call **1-800-346-6262**.
- In the West Virginia, call **1-800-543-7822**.

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4.3 OBSERVATION SERVICES, Continued

What Is My Service Area?

Reporting observation services

Observation services are reported in Pennsylvania and West Virginia using the following revenue and procedure codes:

REVENUE CODE	PROCEDURE CODE
0762	G0378 (Hospital Observation Services, per hour)
0762	G0379 (Direct Referral to Observation) -- as applicable

When the patient was admitted directly to Observation, the hospital should report procedure code G0379 (Direct Referral to Observation), in addition to procedure code G0378. In such situations, payment for the services will be made on the basis of the presence of procedure code G0378 on the claim. No payment will be made based on the presence of procedure code G0379.

As required by the definition of the procedure code, **units** must equal the **hours of observation services provided**. Observation hours should be rounded to the nearest minute, as directed below:

MINUTES	UNITS
0 – 30 minutes	0 units
31 – 59 minutes	1 unit

The claim for observation services must include one of the following services in addition to the reported observation services. The additional services listed below must have a line item date of service on the same day or the day before the date reported for observation:

- *Type A or Type B emergency department visit (CPT codes 99281-99285 or HCPCS codes G0380-G0384); or*
- *Clinic visit (HCPCS code G0463); or*
- *Critical care (CPT code 99291); or*
- *Direct referral for observation care reported with HCPCS code G0379 (APC 5013) must be reported on the same date of service as the date reported for observation services.*

Hospitals are reminded that observation services resulting in an inpatient admission are to be reported on the inpatient claim and are reimbursed via the payment for the inpatient stay. **No separate reimbursement will be made for the observation services.**

Why blue italics?

IMPORTANT!

Highmark Delaware providers need to follow their current reimbursement method and continue to submit claims according to their contract.

4.3 PURCHASED SERVICES PROVIDED TO MEMBERS REGISTERED AS INPATIENTS OR OUTPATIENTS

Overview

When a Highmark member is registered as an inpatient or an outpatient at a participating facility, **the facility is responsible to provide or arrange for all of the care and services the member receives during that stay or visit.** This section is meant to clarify Highmark's policy and procedure for providing services and/or dispensing supplies and/or equipment to Highmark members when they are registered as inpatients or outpatients.

Purchased services defined

If a participating facility is not able to provide (or chooses not to provide) a particular service or supply to Highmark members when they are registered as inpatients or outpatients, then the facility must make the appropriate arrangements with another entity/vendor to provide those services.

The key to understanding this requirement is not the type of service -- but the entity providing the service. If a facility does not have the proper equipment or expertise to provide a given service, and engages with an outside vendor to render it, then that service by definition is called a **purchased service.**

Examples of purchased services include, but are not limited to, the following:

- Durable medical equipment, orthotics, prosthetics, and supplies (DMEPOS)
- Laboratory and pathology services
- Cardiac event monitors

Limited reimbursement

Additional reimbursement is very limited, and **most services, supplies, and equipment are not eligible for separate payment and are considered to be inclusive of your consolidated payment from Highmark**. It is important to reference your Highmark contract to determine your specific reimbursement methodology and continue to submit claims accordingly.

Using vendors

If a vendor has been engaged by your facility to provide certain services or supplies to a Highmark member registered as an inpatient or outpatient at your facility, and the services or supplies are not eligible for separate payment, then it is your responsibility to enter into a financial arrangement to pay this vendor for the services or supplies provided.

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4.3 PURCHASED SERVICES PROVIDED TO MEMBERS REGISTERED AS INPATIENTS OR OUTPATIENTS, Continued

Using vendors (continued)

The vendor may not bill Highmark -- or the member -- directly, and your facility is obligated to reimburse the vendor according to the financial arrangement made between your facility and the vendor. Highmark is not responsible and will not make a separate payment to the vendor.

Note: Contracted facilities may bill the member for cost-sharing amounts (deductible, coinsurance or copayment) as required by the member's benefit plan.

Certain supplies billable to Highmark

When a Highmark member is registered as an inpatient or outpatient at a participating facility, **certain supplies are considered billable and eligible for separate payment ONLY when one of the following apply:**

- The equipment or supplies requires approval and authorization by Highmark's Clinical Services; ***or***
- The equipment or supplies are customized specifically for the individual member's use in the home setting (e.g., customized power wheelchairs, customized splints or braces provided to the member for use in the home).

Note: In this instance, DMEPOS providers may bill Highmark directly, but **only** for the equipment/supplies as outlined above. Any other DMEPOS provided are not eligible for separate reimbursement, and claims should not be submitted directly to Highmark.

What Is My Service Area?

Exceptions for Medicare Advantage

When a Medicare Advantage member is registered as an inpatient or outpatient at a participating facility, certain clinical laboratory services are considered billable. **Chemotherapy sensitivity tests performed on live tissue are the only laboratory services billable and eligible for separate payment from Highmark.** In this instance only, reference laboratories are permitted to bill and seek payment from Highmark directly.

Highmark's purchased service policy does not apply in the case of DMEPOS items provided to Medicare Advantage members residing in a SNF **who have exhausted their 100-day skilled nursing benefit or are receiving a non-skilled level of care.** Under these circumstances only, the billing process should be treated as if the member is living in his or her own residence. Therefore, the DMEPOS provider would bill the claim to Highmark directly.

4.3 POST-EXPOSURE RABIES TREATMENT

Background

The Centers for Disease Control and Prevention (CDC) recommends the following regimen for post-exposure rabies treatment:

- **Wound Cleansing:** All post-exposure prophylaxis should begin with immediate thorough cleansing of the wound.
- **Rabies Immune Globulin (RIG):** RIG is administered to provide immediate antibodies until the body can respond to the vaccine; this is given only once on the day of exposure (day 0) and should **not** be administered to previously immunized individuals.
- **Vaccine:** Injections of the rabies vaccine are given on days 0, 3, 7, & 14; a fifth dose on day 28 may be recommended for immunocompromised persons. Previously vaccinated individuals should receive two doses, one immediately and one three days later.

Place of service

Post-exposure rabies treatment can be sought from a hospital, PCP, urgent care centers, or the Health Department. However, rabies immune globulin (RIG) and rabies vaccine may not be readily available at physicians' offices or locations other than hospitals. Because of the need for timely treatment, individuals most often will seek initial treatment in a hospital emergency room and return to the hospital to complete the vaccine series.

Reporting services

Hospitals are to report post-exposure rabies treatment as indicated below.

Initial Visit in the Emergency Room

- Revenue Codes: **450** (Emergency Room); **250** (Pharmacy)
- Procedure Codes:
  - Rabies Immune Globulin (RIG)
    - **90375** – Rabies immune globulin (RIG), human, for intramuscular and/or subcutaneous use; ***or***
    - **90376** – Rabies immune globulin, heat-treated (RIG-HT), human, for intramuscular and/or subcutaneous use
  - Rabies Vaccine
    - **90675** – Rabies vaccine, for intramuscular use; ***or***
    - **90676** – Rabies vaccine, for intradermal use
- Appropriate ICD-10 diagnosis code(s) for the exposure.

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4.3 POST-EXPOSURE RABIES TREATMENT, Continued

Reporting services (continued)

Follow-Up Visits for Rabies Vaccine

- Appropriate revenue codes, such as:
  - **510** (Clinic – general)
  - **761** (Treatment Room)
  - **771** (Preventive care services vaccine administration)
- Procedure Codes:
  - **90675** – Rabies vaccine, for intramuscular use; ***or***
  - **90676** – Rabies vaccine, for intradermal use
- Appropriate ICD-10 diagnosis code(s) for the exposure.

Reimbursement and member cost sharing

Reimbursement is subject to medical necessity and the benefits available under the member's benefit plan at the time of service. Providers are reminded to always confirm a member's eligibility and benefits prior to rendering services.

Contracted facilities may bill the member for cost-sharing amounts (copay, deductible, coinsurance) as applicable under the member's benefit plan.

4.3 EARLY MATERNITY DISCHARGE AND HOME HEALTH EVALUATION

Newborns' and Mothers' Health Protection Act (NMHPA)

The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) is a federal law that affects the length of time a mother and newborn child are covered for a hospital stay in connection with childbirth. Group and individual health plans subject to NMHPA may not restrict benefits for a hospital stay in connection with childbirth to less than forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a delivery by cesarean section.

If the baby is delivered in the hospital, the 48-hour or 96-hour period starts at the time of delivery. If the baby is delivered outside the hospital and later admitted to the hospital in connection with childbirth (as determined by the attending physician) the period begins at the time of admission.

If the attending physician, in consultation with the mother, determines that the mother or the newborn child can be discharged before the 48-hour or 96-hour period, the health plan does not have to continue covering the stay for the one ready for discharge.

The federal NMHPA does not require follow-up visits. Some states, however, mandate expanded coverage for shorter lengths of stay.

What Is My Service Area?

Pennsylvania Health Security Act 85 of 1996

The General Assembly of the Commonwealth of Pennsylvania enacted the Health Security Act in 1996 (Act 85). This Act applies only to Highmark health insurance policies that provide maternity benefits and are issued through Highmark plans located in Pennsylvania.

As in the NMHPA, Pennsylvania's Act 85 also requires that every health insurance policy that provides maternity benefits to provide coverage for a minimum of forty-eight (48) hours of inpatient care following normal vaginal delivery and ninety-six (96) hours of inpatient care following cesarean delivery. Act 85 also provides for a shorter length of stay if the treating or attending physician determines that the mother and newborn meet medical criteria for safe discharge.

In addition to minimum maternity stay requirements, Act 85 provides coverage for at least one (1) home health care visit within forty-eight (48) hours after discharge when discharge occurs prior to forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following cesarean delivery. The visit must be provided by a licensed health care provider whose scope of practice includes postpartum care.

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4.3 EARLY MATERNITY DISCHARGE AND HOME HEALTH EVALUATION, Continued

Pennsylvania Health Security Act 85 of 1996 (continued)

The initial home health visit following discharge should be used to verify the condition of the infant and the mother. The initial visit does not require authorization. **Any additional visits, if needed, require authorization and should be coordinated by the home health agency (HHA).**

What Is My Service Area?

Eligibility and benefits

When coordinating a home health visit following an early maternity discharge, providers should first check the member's eligibility and benefits to determine if their coverage follows the mandate.

Pennsylvania's Act 85 is tied directly to the maternity benefit. In NaviNet's *Eligibility and Benefits Inquiry*, select the **Inpatient Facility Services** category to determine if Act 85 applies to the member's Maternity coverage:

Maternity	
Coverage	Yes
State Mandated Benefits	Yes
Home Health Care Visit	Yes

Authorization requirements

HHAs are reminded that authorization is not required for the initial evaluation of the mother and baby when the group has elected to follow the mandate and meets the criteria for early discharge. Any additional visits, if needed, require authorization and should be coordinated by the HHA.

If the member's coverage does not follow Act 85 or the length of stay does not fall within the designated time frames, the HHA must check for the availability of home health benefits. If coverage is available for home health care, each visit may require authorization.

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4.3 EARLY MATERNITY DISCHARGE AND HOME HEALTH EVALUATION, Continued

Scenarios

The table below reviews several scenarios and clarifies when authorization is required for home health visits following a maternity stay:

What Is My Service Area?

Does this group follow the PA Act 85 Mandate?	Discharged prior to 48 hours for vaginal delivery or 96 hours for cesarean?	Is auth required for this group?	Scenario
No	Yes	Yes	Although the member was discharged prior to 48 hours for a vaginal delivery or 96 hours for cesarean section, the group does not follow Act 85. Since the member does have a benefit for home health care visits, the services are eligible. These visits require authorization.
No	Yes	No	This group does not follow the mandate but also does not have an authorization requirement for home health care visits. As long as the member has the benefit for home health care visits, the services would be eligible if they are medically necessary or appropriate. No authorization is necessary.
Yes	Yes	Initial visit - No Additional visits - Yes	If the member is discharged prior to 48 hours for a vaginal delivery or 96 hours for cesarean section, the initial visit does not require authorization since the member's coverage follows Act 85. All subsequent visits require authorization.
Yes	No	Yes	Although the member's coverage follows Act 85, the member was not discharged prior to 48 hours for a vaginal delivery or 96 hours for cesarean section. Authorization is required for all visits.

Claims rejected for auth in error

If a claim is rejected for no authorization when an authorization is **not** required based on the scenarios above, the HHA should submit a claim investigation via NaviNet's Claim Investigation Inquiry.

4.3 BREAST PUMPS AND LACTATION COUNSELING

Introduction

Under the Affordable Care Act of 2010 (ACA), specific women's preventive health care services are required to be covered for eligible health plan members without cost sharing to members. Such services include breastfeeding support, supplies, and lactation counseling services.

Coverage at a glance

Breastfeeding support, counseling, and supplies are covered ACA Women's Preventive Health Services Mandate with no cost sharing to the member when performed by **in-network** providers.

- Out-of-network coverage is pursuant to the terms of the member's individual benefits.
- Out-of-network cost sharing and balance billing may apply.
- Only durable medical equipment (DME) providers can bill for breast pumps and supplies.

Verify eligibility and benefits

You can verify whether a Highmark member is covered under the federal Women's Preventive Health Mandate via NaviNet or the applicable HIPAA electronic transactions. In NaviNet's **Eligibility and Benefits Inquiry,** select **Additional Benefit Provisions**, and then select Other Services from the pop-up box. Scroll to **Women's Health Services** to determine if your patient is covered under the federal mandate.

Breastfeeding pumps and supplies

Breastfeeding pumps and supplies are covered without cost sharing for women covered under the ACA Women's Preventive Health Services Mandate. Eligible members are entitled to one breast pump per pregnancy when supplied by any network participating durable medical equipment supplier.

Eligible Highmark members can order high-quality breast pumps directly from two of the leading manufacturers in the industry: Ameda and Medela. Members can call the selected manufacturer or place an order online in advance of their delivery. The manufacturer will confirm a member's eligibility and submit claims to Highmark for processing. Eligible members can be directed to contact the manufacturers as follows:

MANUFACTURER	PUMP	WEBSITE	PHONE/HOURS
Ameda	Purely Yours Electric Breast Pump with Dual Collection Kit	www.insured.amedadirect.com	**Phone:** 1-877-791-0064 **Hours:** 8 a.m. - 6 p.m.
Medela	Pump in Style Advanced Breast Pump Starter Set	www.medeladelivers.com	**Phone:** 1-800-866-2825 **Hours:** Monday – Friday, 9 a.m. - 6 p.m.

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4.3 BREAST PUMPS AND LACTATION COUNSELING, Continued

Breastfeeding supplies procedure codes

For eligible members whose coverage falls under the ACA women's health mandate, breast pumps and supplies are covered without member cost sharing when provided by participating DME providers. The following are eligible procedure codes for breastfeeding pumps and supplies:

PROCEDURE CODE	DESCRIPTION
E0602	Manual breast pump
E0603	Electrical breast pump
A4281	Tubing for breast pump replacement
A4282	Adapter for breast pump replacement
A4283	Cap replacement for breast pump bottle
A4284	Breast shield and splash protector
A4285	Polycarbonate bottle
A4286	Locking ring

Lactation counseling/ support

Based on the ACA mandate, lactation services are eligible with no member cost sharing as follows:

- When provided by credentialed physicians who can employ lactation consultants or use their nursing staff to provide support. (This includes services provided by a physician assistant [PA] or certified registered nurse practitioner [CRNP] when under the supervision of a credentialed physician. Lactation consultants are not credentialed and cannot receive direct payment for their services.)
- When billed using the appropriate procedure codes — **99401**, **99402,** and **99503** — and the appropriate diagnosis code of **Z39.1**.

Additionally, breastfeeding counseling/support is eligible with no age limit or frequency restrictions, and lactation counseling/support is considered to be a preventive service.

Please also note the following:

- When the service is provided by the pediatrician, then it is integral to the baby exam.
- When a lactation consultant provides the service in the pediatrician office, the billing is for the mother.
- When the services are provided as part of the maternity hospitalization, the payment is bundled and paid per the facility contract and integral to that admission.
- The service is part of the standard preventive schedule for non-grandfathered groups (NGF); please check NaviNet for benefit coverage.

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4.3 BREAST PUMPS AND LACTATION COUNSELING, Continued

FOR MORE INFORMATION

Highmark **Medical Policy E-37** includes medical guidelines not outlined in the ACA mandate; however, these medical policy guidelines would apply to those groups that do not follow the Women's Health Federal Mandate. The policy addresses:

- Newborns who are detained in the hospital after the mother is discharged
- Babies who have congenital anomalies that interfere with feeding

Highmark Medical Policy can be accessed from the Provider Resource Center by selecting **CLAIMS, PAYMENT & REIMBURSEMENT** from the main menu.