CHAPTER 5: CARE AND QUALITY MANAGEMENT

UNIT 1: CARE MANAGEMENT OVERVIEW

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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.

5.1 INTRODUCTION TO CARE MANAGEMENT

Overview

Care management incorporates a comprehensive integrated solution that encompasses all aspects of engagement and self-management by providing information, support, and interventions across the continuum of care.

The Highmark Care Management Program focuses on the integration of the delivery of health care services with our members, their employers or groups, and our network providers. It is designed to comply with all federal, state, and external review body regulations and standards.

Employer groups and individuals receive a core set of services including:

- Utilization Management (medical, behavioral health, and pharmacy)
- Health Promotion
- Condition Management
- Case Management/Care Transitions
- Care Coordination

The activities and functions are used to optimize appropriate utilization of health care resources within the appropriate settings, including acute inpatient, outpatient, outpatient imaging, home health care, skilled nursing, and rehabilitation.

Various departments involved in coordination of services

Highmark's Clinical Services is directly responsible for implementation of the Care Management Program through its Utilization Management (UM) and Medical Management and Quality (MM&Q) departments. The staff consists of clinical, non-clinical, and administrative personnel who support the coordination and seamlessness of the services provided to the member. Highmark Behavioral Health Units are included within the scope of Clinical Services.

Within Clinical Services, the physician reviewers provide direction and oversight to the overall care planning process. They support the functions of the physician staff as well as the clinical staff.

Clinical Services' goal is to deliver a comprehensive and integrated care management program that positively impacts both members' health and medical benefit costs. Care managers may also manually refer members to case and condition management based on individual member needs.

Behavioral health

Additional information on the utilization processes and procedures specific to behavioral health can be located in **Chapter 5.4: Behavioral Health**. For requirements and guidelines for behavioral health providers, please see **Chapter 4.2: Behavioral Health Providers**.

5.1 COMPONENTS OF THE CARE MANAGEMENT PROGRAM

Scope of services

There are numerous components of the Care Management Program. These components are inclusive of both medical and behavioral health services.

The services listed below are integrated into Highmark's total Care Management Program. They include, but are not limited to:

- Health Information and Support
- Utilization Management
- Significant Medical Decision and Treatment Support
- Condition Management
- Maternity Education and Support
- Case Management
- Behavioral Health Case Management
- Coordination between Medical and Behavioral Health Management
- Prevention and Wellness
- Radiology Management
- External Review Services
- Medical Technology Assessment Reviews

Customized care management programs

Employer groups may select from a set of core services or increase their depth of services by adding programs such as wellness coaching or by intensifying their condition/disease management program.

This allows employers to address their specific population, whether they have employees who will benefit from chronic illness intervention and education or employees who are interested in participating in wellness programs beyond what may be provided in a traditional worksite wellness program.

5.1 PARTNERSHIP VENDORS

Partnerships enhance services

By partnering with vendors who provide expertise in specific care management services, Highmark is able to enhance the services provided to members. These vendors work in coordination with Highmark to provide a seamless, integrated program for Highmark members.

eviCore Healthcare

eviCore healthcare (eviCore) is an independent specialty medical benefits management company that provides utilization management services for several of Highmark's care management programs. These include:

- Radiation Therapy Authorization Program
- Laboratory Management Program
- Musculoskeletal Surgery and Interventional Pain Management Services Prior Authorization Program (effective October 1, 2018)

Additional information on all programs can be found on the Provider Resource Center by selecting **CARE MANAGEMENT PROGRAMS** from the main menu.

WholeHealth Networks, Inc.

Highmark has contracted with WholeHealth Networks, Inc. (WHN), a subsidiary of Tivity Health Support, LLC., (formerly "Healthways") to administer Highmark's Physical Medicine Management Program.

Additional information on Highmark's Physical Medicine Management Program can be located under **CARE MANAGEMENT PROGRAMS** on the Provider Resource Center.

What Is My Service Area?

naviHealth

Highmark has partnered with naviHealth to manage post-acute care services for Highmark's Medicare Advantage members. This will include long-term acute care (LTAC) services, inpatient rehabilitation, and skilled nursing facility (SNF) services.

Additional information on Highmark's partnership with naviHealth can be located on the Provider Resource Center – select **CARE MANAGEMENT PROGRAMS**, and then **Post-Acute Care Management for Medicare Advantage Members**.

National Imaging Associates Inc. (NIA)

Highmark's Radiology Management Program is administered by National Imaging Associates Inc. (NIA), an affiliate of Magellan Health, Inc., and an accredited and certified radiology management organization.

Additional information on the program can be found on the Provider Resource Center under **CARE MANAGEMENT PROGRAMS.** In addition, limited information is also located in the Highmark Provider Manual's **Chapter 4.5: Outpatient Radiology and Laboratory**.

5.1 UTILIZATION MANAGEMENT

Overview

Utilization management activities focus on opportunities to reduce clinically unnecessary variation in the delivery of services, to utilize clinically appropriate alternative levels of care, to assist with timely and effective discharge planning, to facilitate the appropriate use of benefits, and to proactively identify members who may benefit from other services such as health promotion and disease prevention programs, treatment decision support, chronic condition support, depression management services, and/or case management services.

The utilization management process incorporates a rules engine that automatically triggers referrals to case management and condition management based on a select group of diagnoses and procedures that are entered. Care managers may also manually refer members to case and condition management based on individual member needs. Components of the utilization management process are described below.

Authorization

An **authorization** is a determination by Highmark that a health care service proposed for or provided to a member is "medically necessary" as that term is defined by the member's contract.

What Is My Service Area?

Prior authorization

Prior authorization (also known as preservice review or precertification review) is the process by which services requiring authorization are evaluated against criteria for medical necessity and appropriateness prior to the receipt of services.

Why blue italics?

Predetermination

Predetermination is the process in which members or providers may request that selected services that do not require authorization, such as potentially cosmetic procedures, selected drugs, behavioral health treatment, and high cost medical equipment, are reviewed prospectively in order to determine medical necessity, benefit availability, and financial responsibility.

In Pennsylvania, predeterminations are available for members with commercial benefit plans. Highmark Delaware will accept requests for predeterminations for Highmark Delaware members only from providers located outside of Delaware. Predeterminations are not available for Highmark West Virginia members.

Medicare Advantage members in Pennsylvania and West Virginia have a right to an advance determination by their health plan to verify whether services are covered prior to receiving them. A provider must advise the member to request a "preservice organization determination," or the provider can request the determination on the member's behalf. For more information, please see the Preservice Organization Determinations section in **Chapter 5.3: Medicare Advantage Procedures**.

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5.1 UTILIZATION MANAGEMENT, Continued

Inpatient admissions

Requests for inpatient services are evaluated according to criteria for medical necessity, appropriateness, the most appropriate setting, and according to benefit availability. Authorization is required for all in-network inpatient services and required under all Highmark products whenever a member is admitted as an inpatient to any of the following facilities:

- Acute Care
- Long-Term Acute Care (LTAC)
- Inpatient Rehabilitation Facility
- Mental Health or Substance Abuse Treatment Facility
- Skilled Nursing Facility(SNF)

Concurrent review

Concurrent review, also known as continued stay review, is the process for assessing and determining the ongoing medical necessity and appropriateness for an extension of services that have been previously authorized. Outpatient requests should be made at least twenty-four (24) hours prior to the expiration of the original authorization period (last day of treatment).

Concurrent review is also conducted for all inpatient settings after the initial authorization has been obtained, including acute inpatient, LTAC, SNF, and inpatient rehabilitation. Requests for continued stay should be made no later than the last covered day.

Concurrent review is conducted for all behavioral health inpatient services, for medical care for select facilities based on the reimbursement structure, for medical services reimbursed by the visit, or for accounts with specific contract provisions.

Retrospective review

Retrospective review (also known as post-service review) is the process of assessing the appropriateness of medical services rendered to a member after the service has been provided.

Network providers have an obligation to cooperate with preservice authorization review procedures. If the provider fails to comply, Highmark has the right to review the service retrospectively. If the service is deemed not medically necessary, then payment may be denied or recovered from the provider. Providers who consistently fail to request authorizations on a preservice basis may be subject to corrective action by the Credentials Committee.

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5.1 UTILIZATION MANAGEMENT, Continued

Clinical review process

Initial reviews of authorization requests are performed by registered nurse reviewers with clinical experience. They utilize InterQual® criteria, Highmark or Medicare Advantage medical policies, and other clinical criteria to review the medical necessity of the requested services.

The nurse reviewer may authorize a service that meets criteria. Reviewers have access to consult with a medical director. If an initial reviewer is unable to approve a service, the case is referred to a physician medical director or other physician reviewer. The physician will evaluate the request using Highmark's criteria and considering the specific clinical aspects of the individual case. Only a physician may determine that a service is not medically necessary.

Medical necessity reviews by Highmark medical directors and other clinical staff do not constitute medical advice or treatment, nor do they create any provider-patient relationship. Such reviews are solely for the purpose of determining whether services meet Highmark criteria for medical necessity, which is a condition for services to be covered and reimbursable.

Peer-to-peer conversation

Highmark provides the opportunity for a treating physician to discuss the denial of an authorization with the medical director or other physician reviewer who made the determination. The purpose of the **peer-to-peer conversation** is to allow the ordering or treating provider an opportunity to discuss the case directly with the reviewer and to provide any additional information or perspective that may be helpful, prior to initiating a formal appeal.

This discussion may help resolve the issue and spare the time and expense of an appeal. Highmark will advise the treating provider of the availability of this process when verbally notifying the provider of an authorization denial (if a peer-to-peer conversation has not already occurred).

The provider may initiate the peer-to-peer discussion by calling Clinical Services. The provider has two (2) business days after notification of an authorization denial to initiate a peer-to-peer review for authorizations that are not Medicare Advantage. We will make the peer-to-peer conversation available within one (1) business day after receiving a request. If the physician who issued the denial is unavailable, another physician reviewer will be available to discuss the case.

In the event the peer-to-peer conversation does not result in an authorization, we will inform the provider and member of their appeal rights and procedures.

If the peer-to-peer conversation or review of additional information **results in an approval**, the physician reviewer informs the provider of the approval. If the

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5.1 UTILIZATION MANAGEMENT, Continued

Peer-to-peer conversation (continued)

conversation **does not result in an approval**, the physician reviewer informs the provider of the right to initiate an appeal, and explains the procedure to do so.

Effective September 12, 2017, the peer-to-peer review option prior to a pending denial decision is no longer available for Medicare Advantage. Elimination of the Medicare Advantage peer-to-peer review process will result in more timely and efficient processing of authorization requests. With notification of a denial decision, providers and members will continue to be informed of their appeal rights and procedures.

Note: For additional information on initiating a peer-to-peer conversation, please see the manual's **Chapter 5.5: Denials, Grievances, and Appeals**.

Discharge planning

Discharge planning is a proactive and collaborative process between the provider and the Care Manager or Health Coach and is an integral part of the inpatient review process, often beginning prior to a scheduled admission and continuing throughout the course of treatment. Members receiving inpatient acute, rehabilitation, and skilled nursing services are followed at specific intervals throughout the admission to anticipate and identify needs, quality of care concerns, gaps in care, and/or barriers to care.

Behavioral health

Highmark has a dedicated behavioral health unit staffed by behavioral health professionals and registered nurses with significant clinical behavioral health experience. The behavioral health case managers review authorization requests and referrals for behavioral health services. Case managers have access to Highmark medical directors and to consulting psychiatrists for consultation on individual cases.

For more information on behavioral health authorizations, please see **Chapter 5.4: Behavioral Health**.

5.1 ACCESS TO MEDICAL MANAGEMENT SERVICES

Overview

NaviNet® is key to Highmark's utilization management services. It is provided cost-free to Highmark network participating providers and can be used for submitting most authorization requests through the Automated Care Management (ACM) application. Other functionality available in NaviNet related to utilization management includes discharge planning, referrals to Case Management, and inquiry functions to confirm status of your authorization requests.

When NaviNet is not available or for non-routine inquiries that cannot be handled through NaviNet, Clinical Services can be contacted.

What Is My Service Area?

Clinical Services telephone availability

Clinical Services may be contacted by telephone when NaviNet is unavailable or for questions/issues that cannot be handled through NaviNet.

PENNSYLVANIA

- Medical Services:
  - Western Region
    - Facilities: **1-800-242-0514**
    - Professional Providers: **1-800-547-3627**
  - Central Region
    - Facilities: **1-866-803-3708**
    - Professional Providers: **1-866-731-8080**
  - Northeastern Region: **1-800-452-8507**
- Behavioral Health Services:
  - Western & Northeastern Regions: **1-800-258-9808**
  - Central Region: **1-800-628-0816**
- Medicare Advantage:
  - Freedom Blue PPO: **1-866-588-6967**
  - Community Blue Medicare HMO: **1-888-234-5374**
  - Community Blue Medicare PPO and Plus PPO: **1-866-588-6967**
  - Security Blue HMO (Western Region only): **1-866-517-8585**

DELAWARE

- Medical Services: **1-800-572-2872**
- Behavioral Health Services: **1-800-572-2872**

WEST VIRGINIA

- Medical Services: **1-800-344-5245**
- Behavioral Health Services: **1-800-344-5245**
- Medicare Advantage Freedom Blue PPO: **1-800-269-6389**

Hours of Availability:

- Monday through Friday -- 8:30 a.m. to 7 p.m.
- Saturday and Sunday -- 8:30 a.m. to 4:30 p.m. (limited staffing for urgent requests)

5.1 CRITERIA FOR MEDICAL MANAGEMENT DECISIONS

Introduction

When rendering a medical necessity determination, Clinical Services uses medical necessity criteria that are based on sound medical and clinical evidence. The criteria used are formally reviewed annually and revised as necessary.

In addition to nationally recognized evidence-based criteria, corporate medical policies are used that consider regional and local variations in medical practice. Procedures are also in place for applying criteria based on individual needs.

Definition: Medically necessary

Except where any applicable law, regulation, or government body requires a different definition (i.e., the Federal Employees Health Benefits Program, Centers for Medicare & Medicaid Services [CMS] as to the Medicare Advantage program, etc.), Highmark 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:

a. In accordance with generally accepted standards of medical practice;
b. Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease; and
c. 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.

Generally accepted standards of medical practice

For these purposes, **generally accepted standards of medical practice** means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Specialty Society recommendations, and the views of providers practicing in relevant clinical areas and any other relevant factors.

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5.1 CRITERIA FOR MEDICAL MANAGEMENT DECISIONS, Continued

Criteria used

The Medical Utilization Management staff uses the following criteria, guidelines and policies:

- InterQual® Level of Care Criteria
- Highmark Medical Policy
- Highmark Medicare Advantage Medical Policy
- American Society of Addiction Medicine (ASAM) criteria

InterQual®

The InterQual Levels of Care provide criteria for settings ranging from acute through outpatient. Care managers base medical necessity decisions for adult and pediatric acute, long-term acute, sub-acute and skilled nursing facility (SNF), rehabilitation, and home care services on the InterQual Criteria. The InterQual Criteria are embedded into the Automated Care Management (ACM) application in NaviNet.

Note: For more information on the ACM application via NaviNet, please see the applicable section in **Chapter 5.2: Authorizations**.

Utilization decision making

Highmark makes utilization review decisions based only on appropriateness of care and service and the existence of coverage. Such reviews are solely for the purpose of determining whether services meet Highmark criteria for medical necessity and are being delivered in the most appropriate setting, which are conditions for services to be covered and reimbursable.

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.

Highmark Medical Policy

Highmark's Medical Policy guidelines address both clinical and claim payment reimbursement issues. These policies are developed and maintained in accordance with national standards such as those set by the National Committee for Quality Assurance (NCQA).

The Medicare Advantage Medical Policy guidelines are based on national coverage determinations issued by the Centers for Medicare & Medicaid Services (CMS) and local coverage determinations established by Novitas Solutions, Inc. in Pennsylvania and Palmetto GBA in West Virginia.

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5.1 CRITERIA FOR MEDICAL MANAGEMENT DECISIONS, Continued

Highmark Medical Policy (continued)

Both Highmark Medical Policies and Highmark Medicare Advantage Medical Policies are available on the Provider Resource Center under **CLAIMS, PAYMENT & REIMBURSEMENT**.

Additional information regarding Medical Policy may also be found in the **Highmark Medical Policy** section of this unit.

Clinical judgment

Please note that the use of these and other guidelines requires, and *never replaces*, clinical judgment.

Criteria review

All criteria are reviewed, approved and/or revised at least once annually by the Care Management Committee (CMC). The CMC is comprised of practicing physicians in the community and physicians in hospital administrative positions who are involved in care management functions.

IMPORTANT! FEP medical policies

Federal Employee Program (FEP) medical policies are specific to FEP benefits and may differ from Highmark's medical policies; however, in the absence of FEP medical policy, consult Highmark medical policy for guidance.

To view FEP medical policies in their entirety, please refer to the Federal Employee Program's website at **www.fepblue.org**. Select the **Benefit Plans** tab, and then click on **Brochures & Forms** to access the *FEP Medical Policy Manual*.

Policies are not intended to be prescriptive; thus, medical policy is not an authorization, certification, explanation of benefits, or a contract. Benefit eligibility and application are determined by the Federal Employee Program.

5.1 CRITERIA FOR BEHAVIORAL HEALTH DECISIONS

Basis of authorization decisions

Highmark's Behavioral Health Unit bases its decisions to authorize care on available clinical information, availability and appropriateness of less restrictive treatment settings, appropriate medical necessity criteria, the member's benefits, and the safety of the patient and others.

Criteria

With the exception of substance abuse treatment, Highmark's Behavioral Health Unit applies InterQual® Criteria for Behavioral Health when reviewing the medical necessity and appropriateness of behavioral health services.

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

FOR MORE INFORMATION

Please see **Chapter 5.4: Behavioral Health** for additional information on medical necessity criteria for behavioral health services.

5.1 HIGHMARK MEDICAL POLICY

Overview

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. Highmark's Medical Policy guidelines have been integrated into the claims processing system, which allows for cost-effective claims processing and ensures accurate administration of our members' health care benefits.

In addition to medical policies for our commercial products, Highmark also maintains medical policy guidelines for our Medicare Advantage products in Pennsylvania and West Virginia. Please see **Chapter 5.3: Medicare Advantage Procedures** for additional information.

What Is My Service Area?

Policy

Medical policies do not constitute medical advice, nor are they intended to govern the practice of medicine. They are merely intended to reflect Highmark's coverage and reimbursement guidelines. Coverage for services may vary for individual members based on the terms of the benefit contract.

Highmark retains the right to review and update the medical policy guidelines in its sole discretion. These guidelines are the proprietary information of Highmark. Any sale, copying, or dissemination of the medical policies is prohibited; however, limited copying of medical policies is permitted for individual use.

Medical Policy development

Highmark continually reviews its existing medical policies to ensure that they reflect evidence-based medicine, the current standard of care, and the appropriate place of service. Highmark's Medical Policy Department ensures that medical policies are developed and maintained in accordance with national standards such as NCQA and the Blue Cross and Blue Shield Association. For Highmark Medicare Advantage products, the Centers for Medicare & Medicaid Services (CMS) requires that Medicare Advantage insurers use CMS national policy and the regional Medicare B Carrier's local policy.

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 Food & Drug Administration (FDA) and professional medical societies.

After the Medical Policy department has performed its initial research, it may solicit opinions from appropriate Highmark Professional Consultants. If the procedure in question is performed by a particular specialty, consultants within that specialty may be contacted, or the issue may be referred to one of four

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5.1 HIGHMARK MEDICAL POLICY, Continued

Medical Policy development (continued)

specialty subcommittees for review and recommendation regarding a medical policy coverage position. The specialty subcommittees are made up of external practicing physicians in the areas of Cardiology, Hematology/Oncology, Musculoskeletal, and Neurosciences. To develop a draft policy, the Medical Policy department utilizes input from all of these sources.

Once the policy is drafted, 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.

Provider involvement

Health care professionals play an important role in Highmark's Medical Policy development. They provide medical expertise that helps in the development of coverage and reimbursement guidelines.

Over 500 independent health care professionals are active in a variety of positions that influence the core of Highmark's operations. They make up the majority of committees that help to define medical policy, resolve claims disputes, and promote the delivery of quality medical care to Highmark members.

Place of service requirements

Highmark develops medical policy as the foundation for determining coverage eligibility for certain health care services rendered to its members. Highmark continually reviews its existing medical policies to ensure that they reflect evidence-based medicine, the current standard of care and the appropriate place of service. Place of service requirements are indicated on select commercial medical policies to clearly define the most appropriate setting for specific services.

If place of service requirements apply, the medical policy will include a **Place of Service** section. Additional policy guidelines are also listed under this heading, if applicable.

Note: Place of service requirements do not apply to Highmark's Medicare Advantage business, which is governed by regulations and policies developed and promulgated by the Centers for Medicare & Medicaid Services.

Determining medical policy criteria

Facilities must coordinate with the ordering and/or performing provider before the date of service. The facility should work with the ordering and/or performing provider, as necessary, to ensure medical policy criteria are met. Alternatively, the facility can initiate an inquiry through the Provider Service Center if there are concerns about whether the facility services to be performed meet applicable Highmark medical policy criteria.

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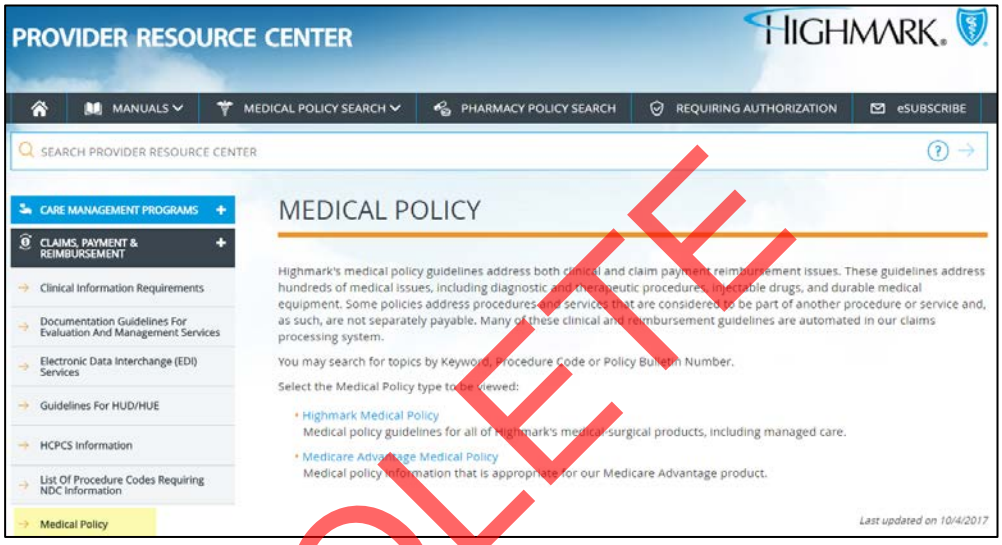
5.1 HIGHMARK MEDICAL POLICY, Continued

What Is My Service Area?

Accessing Highmark's medical policies

Highmark's commercial and Medicare Advantage medical policies are accessed on the Provider Resource Center under **CLAIMS, PAYMENT & REIMBURSEMENT**. Select **Medical Policy**, and then the medical policy type – **Highmark Medical Policy** or **Medicare Advantage Medical Policy** (Medicare Advantage applies only in Pennsylvania and West Virginia).



Medical policy may differ in our service areas based on state regulatory requirements. Please be sure to access the appropriate medical policies from the Provider Resource Center for your service area and/or based on the member's coverage.

Note: Highmark medical policies online are considered to be current; however, users can access and review terms of previous versions of a policy prior to the effective date of the current version.

Notification of new policies and updates to existing policies

Our **Medical Policy Update** newsletter, published monthly, provides advance notification of new policies and upcoming changes to existing medical policies. You can find current and past issues of Medical Policy Update by selecting **NEWSLETTERS/NOTICES** on the Provider Resource Center.

In addition, you can sign up for "e-Subscribe" and receive a monthly email notification when the latest issue of Medical Policy Update is published. To subscribe, select **NEWSLETTERS/NOTICES** from the main menu on the Provider Resource Center, and then click on **E-Subscribe For Publications And Notifications**.

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5.1 HIGHMARK MEDICAL POLICY, Continued

IMPORTANT!

New medical policies and updated versions of existing medical policies are **not available for viewing until the effective date of the policy**, or the following Monday if that date falls on a weekend or holiday.

Claim impacts based on application of medical policy

Although claims for services impacted by Highmark medical policy may be paid when submitted, Highmark reserves the right to review such cases retrospectively to ensure that payments made were appropriate based upon the applicable medical policy requirements. Complete and careful documentation must be maintained in the member's medical record in case of any such post-payment review.

If it is determined that Highmark medical policy requirements were not met in a particular case and, therefore, a service is not eligible for coverage, the payment Highmark has made for the services will be retracted. As always, if the facility disagrees with the result of such a review, it can appeal the decision.

Conflicts

In the event of a conflict between the requirements of the *Highmark Provider Manual* and Medical Policy, the following order of control should apply:
a) First, Medical Policy; (b) Second, the *Highmark Provider Manual*.

IMPORTANT! FEP Medical Policies

Federal Employee Program (FEP) medical policies are specific to FEP benefits and may differ from Highmark's medical policies; however, in the absence of FEP medical policy, consult Highmark medical policy for guidance.

To view FEP medical policies in their entirety, please refer to the Federal Employee Program's website at **fepblue.org**. Select the **Benefit Plans** tab, and then click on **Brochures & Forms** to access the FEP Medical Policy Manual.

Policies are not intended to be prescriptive; thus, medical policy is not an authorization, certification, explanation of benefits, or a contract. Benefit eligibility and application are determined by the Federal Employee Program.

5.1 NON-COVERED SERVICES

Policy

Non-covered services include those ineligible under the member's plan documents, deemed experimental or investigational, or deemed not medically necessary by Highmark.

Except otherwise stated herein, a provider may, at all times, bill a commercial member for non-covered services if the provider has given the member advance written notice that the service(s) may not be eligible for coverage and an estimate of the cost thereof. Thereafter, the member must agree in writing to assume financial responsibility for the service(s) in advance of receiving such service(s). The signed agreement shall be kept in the provider's records.

Member desire to obtain medically unnecessary services

On occasion, situations may arise where Highmark determines, in advance of a service being provided, that the service is not medically necessary, yet the member still desires to obtain the service and is willing to bear the cost. The provider may bill the member for such services only if:

1. The provider has requested a determination of medical necessity from Highmark **in advance** of providing the service and Highmark determines **in writing** that the proposed service is not medically necessary;
2. The provider informs the member of Highmark's determination **in writing** and **in advance** of providing the service; and
3. The member indicates **in writing** that he or she understands and agrees that he/she will be totally responsible for paying for the service and is waiving all rights to submit a claim to Highmark.

The documentation for requirements two and three above cannot be a general form in which the patient agrees to be financially responsible for any charges not paid by insurance. The documentation must: (i) describe the specific service in question; (ii) state clearly that Highmark has determined that the service is not medically necessary; and (iii) clearly document the patient's agreement to be personally responsible for payment and not to submit a claim to Highmark.

By this process, Highmark acknowledges that, in limited circumstances, a member may want to enter into a private arrangement with a network provider to obtain and pay for a service, knowing that the service is not reimbursable under the member's coverage with Highmark. Highmark will not preclude the provider from billing the member in these special circumstances as long as the written documentation is prepared in advance of the service to demonstrate that the member entered into the arrangement knowingly and with full knowledge of the financial consequences.

5.1 MEDICAL RECORDS REQUEST

Introduction

Medical records are requested by Highmark when it does not have the information needed to determine the medical necessity and appropriateness of the services being provided.

When medical records are requested

If Highmark does not have sufficient information to determine whether services are medically necessary and appropriate, medical records will be requested. Medical records can be requested for either medical or behavioral health services, and for either inpatient or outpatient services.

The medical record requests are made in writing. The request is addressed to the attention of the hospital's Medical Records Department.

Minimum necessary standards

Medical record requests will be limited to only the minimum necessary amounts of personal health information (PHI) needed to accomplish the intended purpose for which the PHI is being requested, used, or disclosed.

Confidentiality

In accordance with applicable regulatory and accrediting body requirements, as well as Highmark corporate policy, all personally identifiable confidential information obtained to manage a member's care is maintained in such a manner as to protect the privacy of all individuals.

Provider responsibility for timeliness

Regulatory standards require health plans to make medical necessity decisions within strict time frames. In some cases, the regulatory standard does not provide additional time for obtaining medical records.

For this reason, it is important for providers to provide all relevant medical records within the time frame stipulated in the written request. **Lack of response or a late response to the request for medical records may result in a denial of payment.**

Non-reimbursement policy

According to Highmark policy, Highmark does **not** reimburse participating network providers for supplying medical records to Highmark.

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5.1 MEDICAL RECORDS REQUEST, Continued

BlueCard requests

On occasion, Highmark may request medical records for an out-of-area member in the BlueCard Program who has received services from you. The request is made in writing via a standard Medical Records Request Form.

Please respond to these requests as quickly as possible. The Blue Cross Blue Shield Association (which sponsors the BlueCard Program) encourages a response time frame of **ten (10) days or less**. Your prompt return of medical records helps to expedite the review process and avoid unnecessary claim denials.

When mailing medical records, please attach/enclose the original Medical Record Request Form. This helps to ensure that the records reach the individual who requested them.

Note: For additional information for medical record requests for out-of-area BlueCard members, please refer to **Chapter 2.6: The BlueCard Program**.

5.1 MEMBER CONSENT FOR RELEASE OF MEDICAL RECORDS

Routine situations

As a HIPAA covered entity, Highmark has established the following policy regarding routine member consent:

Highmark's policy is that it will not request or obtain consent of its members in connection with the use or disclosure of protected health information (PHI) for treatment, payment, or health care operations. Under certain limited situations, Highmark may elect to obtain consent from a member.

Non-routine situations

For certain situations, a member may be asked to sign an authorization to use or disclose specific PHI. This includes information related to any of these topics:

- Psychotherapy notes
- Substance abuse
- Sensitive diagnoses such as HIV, STDs, or AIDS

When asked for medical records of this nature, the facility is responsible for obtaining the authorization from the member and submitting it to the Clinical Services department with the requested records.

5.1 CASE MANAGEMENT

Overview

Highmark's Health Management Services (HMS) department is responsible for case management services, offered at no cost to Highmark members. 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 needs for health care services.

Case management is a collaborative process involving the physician, the patient and his or her support system, our Health Coaches, and other health care service providers to encourage and assist patients to achieve their optimum level of health, self-management, and social and occupational functioning. Case management usually, but not always, follows a significant health-related event, such as hospitalization.

Purpose

Case management is offered to assist members who have complex or high-cost health care needs. Its purposes are:

- To help determine the health care needs of the patient; and
- To help plan for and coordinate the provision of needed services through communication, education, and the use of available resources, to achieve jointly established short and long term goals.

Activities include assessment, planning, facilitation, advocacy, communication, and education to help the member meet his or her health care needs. Case managers can also help protect the welfare and safety of members through identifying and reporting risks of abuse, violence, and suicide. Case management can also assist members to understand their benefits and other consumer protections including medical directives and power of attorney.

What Is My Service Area?

Provider referrals for case management

Highmark encourages providers to identify members who could benefit from coordinated case management services. To discuss your patient's needs , please contact the HMS health coaching staff at:

- Pennsylvania: **1-800-596-9443**
- Delaware: **1-800-572-2872**
- West Virginia: **1-800-344-5245**; for Medicare Advantage Freedom Blue PPO, please call **1-800-269-6389**

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

Continued on next page

5.1 CASE MANAGEMENT, Continued

Provider referrals for case management (continued)

- 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

Identifying members for case management

Highmark's health coaching staff uses clinical, utilization, and predictive modeling indicators to identify members who could benefit from case management. The indicators include, but are not limited to, the following:

- High risk diagnoses
- Complex disease processes
- Catastrophic medical events
- High-cost cases
- Complications of care
- Situational and discharge planning needs
- Psycho-social issues
- Financial issues
- Complex care coordination needs
- Multiple admissions and readmissions
- Health risk assessment screening

Screening and consent

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 Health Coach. Case management is a voluntary program and requires the member's consent. If the member is accepted into the program, the assigned Health Coach will contact the member and/or the member's family, when necessary, to obtain permission for case management.

The case management program recognizes that a patient's condition is dynamic and changes over time. If a member is not accepted into the program when initially referred, he or she may be referred again at a later date if there is a change in his or her clinical condition.

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5.1 CASE MANAGEMENT, Continued

Health Coach responsibilities

The Health Coach is responsible for the following:

- Contacting the member and his or her providers when appropriate
- Conducting a 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

Health Coaches have access to Highmark physician medical directors and other consulting physicians who can assist in the review of and planning for individual cases, conditions, and services.

Case management services

Highmark Health Coaches are licensed registered nurses (RNs) or licensed behavioral health professionals able to assist your patient by providing services including, but not limited to, the following:

- 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, including development of short- and long-term goals
- Intervention to assist with obtaining medical supplies or equipment
- Coordination of services amongst providers
- Communication of adverse situations to the physician or service provider
- Evaluation and assistance with financial concerns
- Assessment and assistance with advanced care planning
- Information related to available community resources such as self-help support groups and other similar services

5.1 CONDITION MANAGEMENT

What is condition management?

Condition management programs focus on improving the outcomes of members identified with chronic illnesses by improving their self-management skills and understanding of their illness and treatment options.

Once the member chooses to participate, they are enrolled in a program specific to their needs. Members may provide consent to allow the Health Coach to discuss their condition with their caregivers.

Available programs

Members may be identified for one of the following condition management programs:

- Asthma
- Baby Blueprints
- Chronic Kidney Disease (CKD)
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Disease
- Heart Failure
- High Risk Pregnancy
- HIV/AIDS
- Hyperlipidemia
- Hypertension
- Inflammatory Bowel Disease
- Metabolic Syndrome
- Migraine
- Musculoskeletal Pain
- Osteoporosis
- Pediatric Obesity
- Upper GI
- Wellness

Availability of Health Coaches

Health Coaches are available to receive inbound calls twenty-four (24) hours a day, seven (7) days a week. Health Coaches are available for outbound calls to members from 8:30 a.m. until 9:00 p.m. Monday through Friday, and on weekends when requested by the member.

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5.1 CONDITION MANAGEMENT, Continued

Primary goals of condition managment

Highmark's condition management programs focus on the following goals:

- Improving the quality of care and outcomes for members with chronic illnesses by addressing and closing gaps in care and improving their self-management skills;
- Improving member decision-making skills, including understanding of their treatment options in the context of their personal values, preferences, and priorities;
- Promoting dialogue and communication between the provider and member;
- Reducing clinical progression of conditions by encouraging preventive screenings and immunizations; and
- Reducing potentially avoidable healthcare costs and enhancing the provider's ability to provide high-quality, evidence-based care.

5.1 BLUE DISTINCTION PROGRAMS

Overview

Blue Cross and Blue Shield companies work with more than 90 percent of all doctors and hospitals nationwide and, therefore, have a unique perspective on doctors and hospitals that are effective in improving patient care and health. This perspective is the foundation of **Blue Distinction**®, the Blue Cross and Blue Shield national doctor and hospital recognition program. These recognized doctors and hospitals are changing health care to be more patient-focused, coordinated, and in many cases, affordable.

Blue Distinction designations are based on strict performance criteria formulated through insights and recommendations from the medical community to be consistent with medical advances and current clinical practices, guidelines, and measurement. The aim of the Blue Distinction designation is to help Blue Plan members find the highest quality care available in their area. The Blue Distinction portfolio includes three programs:

- **Specialty Care** recognizes providers that demonstrate proven expertise in delivering effective and cost-efficient care for select specialty areas. The program targets procedures and episodes of care in areas of high or increasing demand, yet with variations in quality and cost.
- **Total Care** recognizes providers participating in locally tailored programs (Patient-Centered Medical Homes, Accountable Care Organizations, or similar programs) designed to lower cost trend through better coordinated care and performance-based payment.
- **Flexible Network** is the nation's largest custom-tiered network solution, enabling accounts to achieve the optimal balance of savings and employee access via customizable benefit levels.

Blue Distinction Specialty Care

Blue Distinction® Center

Blue Distinction® Center+

The Specialty Care Program relies on objective, nationally consistent quality and affordability criteria, enabling Blue Cross and Blue Shield Plans to recognize providers that demonstrate expertise in delivering quality specialty care effectively and cost-efficiently.

The foundation of Specialty Care is the quality-focused Blue Distinction Center designation. An additional and more select value-based designation, Blue Distinction Center+, further distinguishes providers delivering quality, cost-efficient specialty care. Quality is key: only those providers that first meet Blue Distinction Centers' objective, nationally-consistent quality criteria are considered for designation as a Blue Distinction Center+.

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5.1 BLUE DISTINCTION PROGRAMS, Continued

Blue Distinction Specialty Care (continued)

Blue Distinction. Center

Blue Distinction. Center+

The Blue Distinction Specialty Care Program includes two levels of designation:

- **Blue Distinction Centers** are health care facilities recognized for their expertise in delivering quality specialty care safely and effectively.
- **Blue Distinction Centers+** are health care facilities recognized for their expertise and efficiency in delivering specialty care**.** To earn this designation, hospitals must meet the same quality criteria as Blue Distinction Centers, and then go an extra step to demonstrate they do so efficiently (i.e., cost of care measures).

Blue Distinction Specialty Care has seven areas of specialty care:

- Bariatric surgery
- Cardiac care
- Cancer care
- Knee and hip replacement
- Maternity care
- Spine surgery
- Transplants

In 2019, new fertility care and gene therapy programs will be launched.

Blue Distinction Total Care

Blue Distinction. Total Care

Blue Distinction Total Care is a national program that recognizes doctors who spend more time on prevention, holistic ("total") care, and personalized care planning for their patients. Total Care encourages a focus on health care instead of sick care. The program is designed to encourage strong relationships between doctors and their patients that can lead to better health.

Designation as a Blue Distinction Total Care provider means this provider has met the established national criteria and has been designated by the local plan. Blue Cross and Blue Shield companies nationwide use the same criteria to select programs for Blue Distinction Total Care.

Blue Distinction Specialty Care benefit designs

Highmark offers health plans that may include a benefit for Blue Distinction Specialty Care. Members may be able to reduce their out-of-pocket costs by receiving quality care in any one of five specialty areas at Blue Distinction Center and/or Blue Distinction Center+ providers.

These Blue Distinction service-based plans recommend Blue Distinction Centers/Centers+ for the following specialty care: bariatric surgery, cardiac care, knee and hip replacement, spine surgery, and transplants. These benefit plans may also include a travel and lodging benefit for members who may have to travel beyond a specified mileage limit to access a Blue Distinction Center.

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5.1 BLUE DISTINCTION PROGRAMS, Continued

Blue Distinction Specialty Care benefit designs (continued)

To assure Highmark members receive the highest quality specialty care, professional providers are encouraged to recommend facilities that have received Blue Distinction designation. As you verify a member's eligibility and benefits prior to rendering services and making recommendations for specialty care, please be sure to verify if the member's coverage includes a benefit for Blue Distinction Specialty Care.

To verify in NaviNet®, select **Additional Benefit Provisions** on the *Eligibility and Benefits Detail* page, and then select the **Other Services** benefit category from the pop-up box.

Locating Blue Distinction recognized providers

Information on Blue Distinction designations for participating physicians and hospitals is available in the Highmark Provider Directory. The Provider Directory is accessible on the home page of Highmark's public websites. Click on **ACCREDITATIONS** on the provider's profile page to determine if a physician has received the Blue Distinction Total Care designation or the facility has received Blue Distinction Center and/or Blue Distinction Center+ designation(s) for any of the seven types of specialty care.

BCBSA Blue Distinction Center Finder

To locate Blue Distinction Centers and Blue Distinction Centers+ near you or in other locations, you can also use the Blue Cross and Blue Shield Association's **Blue Distinction Center Finder**.