CHAPTER 3: COVERED BENEFITS AND SERVICES

UNIT 1: MEMBER BENEFITS

IN THIS UNIT

3.1 COVERED SERVICES

Overview

Health Options is responsible for all covered medical conditions within the Basic Benefit Package for each Health Options member. The package includes inpatient; outpatient and ambulatory medical and surgical services; gynecological, obstetric, and family planning services; limited behavioral health services; and a variety of others services.

Health Options members are also entitled to a number of services that are not included in the Basic Benefit Package. These services, referred to as "wrap-around" services, are covered under the State of Delaware's fee-for-service program.

All services provided must be medical necessary and some services may have limitations (e.g., behavioral health) or require authorization (e.g., orthotics). Please see Chapter 5, Unit 1 of this manual for the definition of medically necessary. A listing of services that require authorization can also be found in Chapter 5, Unit 1 of this manual.

Basic Benefits

The following list of Basic Benefits is not all-inclusive. Information on Additional Benefits can be found in Chapter 3, Unit 3 of this manual. Information on LTSS benefits can be found in Chapter 6, Unit 1 of this manual.

SERVICES	COVERAGE DESCRIPTION
Abortion	Covered under certain circumstances. Consent form required.
Acupuncture	Not covered
Allergy Testing	Covered
Bed Liners	Covered for members age 4 and up
Behavioral Health – Outpatient Mental Health and Substance Abuse Services	• Under age 18: Covered for 30 visits per year. After 30 visits per year, services are covered by the Department of Services for Children, Youth and Families (DSCYF) • Age 18 and older: Covered
Behavioral Health – Inpatient Mental Health and Substance Abuse Services	• Under age 18: Covered by DSCYF • Age 18 and older: Covered
Behavioral Health – Partial Hospitalization, Intensive Outpatient	Covered
Behavioral Health – Residential Treatment Facility	Covered
Blood and Plasma Products	Covered
Bone Mass Measurement (Bone Density)	Covered

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3.1 COVERED SERVICES, Continued

Basic Benefits (continued)

SERVICES	COVERAGE DESCRIPTION
Boney Impacted Wisdom Teeth	Covered
Care Management	Covered
Chemotherapy	Covered
Chiropractic Services	Not Covered
Colorectal and Prostate Screening Exams	Covered
CT Scans	Covered
Dental Services (Under age 21) Call 1-302-571-4900 or toll free 1-800-372-2022	The Delaware Medical Assistance Program covers certain dental care for children up to age 21. (Note: Dental benefit for the Delaware Healthy Children Program is up to the 19th birthday.) • Removal of bony impacted wisdom is covered
Dental Services (Adult)	Not covered except removal of bony impacted wisdom teeth
Diabetic Education	Covered
Diabetic Equipment	Covered Prior authorization if over $500
Diabetic Supplies	Covered Glucose monitors/strips
Dialysis	Covered
Diapers (for members age 4 and up)	Covered Prior Authorization if over $500
Drugs Prescribed by a Doctor	Covered
Durable Medical Equipment	Covered Prior Authorization if over $500
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (for under age 21)	Covered
Emergency Medical Transportation (air and ambulance)	Covered
Emergency Room Care	Covered
Eye Exam, Medical (for conditions such as eye infections, glaucoma, and diabetes)	Covered for all members
Eye Exam, Routine	Covered if age 20 and younger See additional benefits for adult coverage

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3.1 COVERED SERVICES, Continued

Basic Benefits (continued)

SERVICES	COVERAGE DESCRIPTION
Eyeglasses or Contacts	Covered if age 20 and younger. See additional benefits for adult coverage.
Family Planning Services	Covered
Genetic Testing	Covered
Glaucoma Screening	Covered
Gynecology Visits	Covered
Hearing Aids and Batteries	Covered if age 20 and younger
Hearing Exams	Covered
HIV/AIDS Testing	Covered
Home Health Care and Infusion Therapy	Covered
Hospice Care	Covered
Hospitalization	Covered
Imaging (CT, MR, PET, SPECT, Nuclear Studies)	Covered
Immunizations	Covered
Lab Tests and X-rays	Covered
Mammograms	Covered
Medical Supplies	Covered Prior authorization if over $500
Methadone/Medication Assisted Therapy	Covered
MRI, MRA, PET Scan	Covered
Non-Emergency Medical Transportation	Eligible Delaware Medicaid clients in need of non-emergency transportation should contact LogistiCare at 1-866-412-3778
Nursing Home	Covered up to 30 days per year. Additional days are considered long-term care; an application must be submitted to and approved by the Delaware Medical Assistance Program for long-term care.
Observation	Covered
Obstetrical/Maternity Care	Covered
Organ Transplant Evaluation	Covered
Organ Transplant	Covered
Orthopedic Shoes	Covered Prior authorization if over $500
Outpatient Surgery, Same Day Surgery, Ambulatory Surgery	Covered

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3.1 COVERED SERVICES, Continued

Basic Benefits (continued)

SERVICES	COVERAGE DESCRIPTION
Pain Management Services	Covered
Pap Smears and Pelvic Exams	Covered
Parenting/Childbirth Education	Covered
Personal Care /Aide Services (in home)	Covered
Podiatry Care (routine diabetic care or peripheral vascular disease)	Covered
Prescription Drugs	Covered
Primary Care Provider Visits	Covered
Private Duty Nursing	Covered
Prosthetics and Orthotics	Covered Prior authorization if over $500
Radiation Therapy	Covered
Rehabilitation (inpatient hospital)	Covered
Skilled Nursing Facility Care	Covered up to 30 days per year
Sleep Apnea Studies	Covered
Smoking Cessation Counseling	Covered
Specialty Physician Services	Covered
Surgical Center	Covered
Therapy – Outpatient Occupational, Physical, Speech	Covered

3.1 PRESCRIPTION DRUGS

Overview

Health Options provides coverage for outpatient prescription drugs and certain over-the-counter products for non-institutionalized members when the drug labeler participates in the Federal Medicaid Drug Rebate Program and is included on the Delaware Department of Health and Social Services (DHSS) Preferred Drug List (PDL) or the Health Options supplemental formulary. Practitioners are requested to prescribe medications included in the PDL/formulary whenever possible. The PDL/formulary is updated on a regular basis and can be accessed online at www.highmarkhealthoptions.com.

Medication additions or deletions reflect the decisions made by Health Options Pharmacy and Therapeutics Committee and inclusion on the DHSS-approved PDL. If a formulary/PDL deletion is made that affects one of your patients, Health Options will provide you with notification within thirty (30) days prior to the change.

Additional copies of the formulary/PDL can be printed directly from our website or requested through Pharmacy Services by calling 1-844-325-6253.

Prior authorization and exceptions

Some medications, although listed on the formulary/PDL, require prior authorization to be covered. All prior authorization and step therapy criteria can be found on the Health Options website.

If use of a formulary/PDL medication is not medically advisable for a member, you must initiate a Request for Medicaid Drug Exception. Please refer to the provider section of the Health Options website at www.highmarkhealthoptions.com for a copy of this form.

The exception process allows for a 24-hour turnaround when reviewing requests for non-formulary, non-preferred, prior authorization, and step therapy medications. In the event that a decision has not been made within 24 hours, Health Options will authorize a temporary supply of the non-formulary, non-preferred, prior authorization, or step therapy medication. For emergently needed medications, the pharmacist may authorize up to a 3-day supply of the medication.

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3.1 PRESCRIPTION DRUGS, Continued

When prescription medications are covered

Prescription medications are reimbursed when the medication is prescribed for a Food and Drug Administration (FDA) approved indication(s); prescribed for indications, dosages, and formulations that are part of nationally-developed standards; prescribed for indications, dosages, and formulations that have been shown to demonstrate both efficacy and safety in a minimum of two peer-reviewed journals.

Any other prescription is considered experimental and, therefore, not covered unless specific authorization has been given by Health Options for an individual member based on a demonstration of medical necessity.

Over-the-counter (OTC)

Select over-the-counter (OTC) pharmaceuticals, including vitamins, are a covered benefit for all non-institutionalized members. Members must have a written prescription for each OTC pharmaceutical/vitamin, and the prescription must be filled by a Health Options participating pharmacy. The labeler of the OTC product must also be participating in the Federal Medicaid Drug Rebate Program.

Non-covered pharmacy services

The following are non-covered pharmacy services:

- Drugs or devices marketed by a manufacturer who does not participate in the Federal Medicaid Drug Rebate Program
- Drug Efficacy Study Implementation (DESI) drugs
- Drugs used for cosmetic purposes or hair growth
- Fertility drugs
- Investigational/experimental drugs
- Drugs not approved by the FDA
- Compounded prescriptions that do not contain at least one FDA-approved covered ingredient
- Drugs for obesity
- Drugs used to correct sexual dysfunction
- Drugs used for treatment of sexual or erectile dysfunction
- Drugs to promote weight gain not due to AIDS wasting or cachexia
- Drugs not medically necessary

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3.1 PRESCRIPTION DRUGS, Continued

Delaware Prescription Monitoring Program

Providers are required to follow all requirements of the Delaware Prescription Monitoring Program (PMP), including mandatory registration to access the PMP.

The PMP system collects information on all controlled substances (schedules II-V) prescriptions. Prescribers registered with the PMP can obtain immediate access to an online report of their current or prospective patient's controlled substance prescription history. Pharmacies and prescribers are not permitted to distribute prescription history reports from the PMP system to patients.

Providers are encouraged to use this information as part of your clinical assessment to improve patient care and monitor for misuse and diversion of controlled substances. All PMP users must comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule requirements.

Pharmacy and PCP Lock-In

Health Options has the right to lock members to specific provider types when it has been determined that the member has abused his or her health care benefits. Health Options complies with all applicable State and Federal regulations concerning member lock-in, including the requirements of the Delaware Medicaid and Medical Assistance Program and the Delaware Medicaid Managed Care Organizations Agreement.

Several reasons may indicate the need to lock a member to a specific primary care physician and/or pharmacy, such as continuity of care and coordination of care, physician and pharmacy shopping for the purpose of obtaining controlled or non-controlled drugs, altering a prescription, over-utilization of any provider type, or fraudulent use of any Health Options services, i.e., borrow or use of Health Options identification card (other than their own) to gain medical services.

Members who have been selected for lock-in will be sent a letter notifying them of the lock-in. Included with the lock-in letters are instructions on how to file a grievance through Health Options' grievance process.

The Pharmacy Fraud Analyst is responsible for monitoring the member's lock-in by utilizing the "Lock-in Database." The Pharmacy Fraud Analyst evaluates/reviews the member's pharmacy and medical claims utilization and inquires as to what physicians other than the member's PCP are writing prescriptions, including the total number of units obtained, number of days' supply, and the dosage as prescribed.

Providers should contact the Health Options Pharmacy Department at 1-844-325-6253 if they have questions or they need to refer a member for lock-in consideration.

3.1 URGENT AND EMERGENT SERVICES

Emergency Services

The definition of an emergency is: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

The following conditions are examples shared with the patient of those conditions that most likely require emergency treatment:

- Danger of losing life or limb
- Poisoning
- Chest pain and heart attack
- Overdose of medicine or drug
- Choking
- Heavy bleeding
- Car accidents
- Possible broken bones
- Loss of speech
- Paralysis
- Breathing problems
- Seizures
- Criminal attack (mugging or rape)
- Heart attack
- Blackouts
- Vomiting blood

Situations when emergency care is typically not needed

Health Options members have been informed, through the Member Handbook, of general instances when emergency care is typically not needed. These are as follows:

- Cold
- Sore throat
- Small cuts and bruises
- Ear ache
- Vomiting
- Rash
- Bruises
- Swelling
- Cramps
- Cough

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3.1 URGENT AND EMERGENT SERVICES, Continued

Hospital guidelines for triage

In all instances, when a member presents to an emergency room for diagnosis and treatment of an illness or injury, the hospital's pre-established guidelines allow for the triage of illness and injury.

Follow-up care after emergency room visit

All follow-up care after an emergency room visit must be coordinated through the primary care practitioner. Members are informed via the Member Handbook to contact their primary care practitioner for a referral for follow-up care in instances such as:

- Removal of stitches
- Changing of bandages
- Cast check
- Further testing

Urgent Care

The definition of urgent care is medically necessary treatment that is needed within forty-eight (48) hours to prevent deterioration to the member's health. Examples of urgent care include: persistent rash, recurring high-grade temperature, non-specific pain, or fever.

3.1 NON-COVERED SERVICES

Services that are not covered

Some of the services not covered by the Delaware Medical Assistance Program or Health Options include the following:

- Autopsies.
- Chiropractic services.
- Cosmetic surgery, unless medically necessary.
- Dental services for members 21 years of age and older.
- Christian Science nurses and/or sanitariums.
- Experimental procedures, unless prior approval is received from Health Options.
- Exercise equipment for the home.
- Care outside of the service area *except* in an emergency.
- Care outside of the continental U.S.
- Hippotherapy.
- Non-emergency services from an out-of-network provider that are not prior approved.
- Personal items or services such as television or a telephone while in the hospital.
- Prescription drugs not listed on the approved drug list, unless an exception is made.
- Drugs designated as less than effective by the Food and Drug Administration (FDA). These are known as DESI for the Drug Efficacy Study Implementation drugs.
- Drugs prescribed for the treatment of erectile dysfunction.
- Infertility treatment.
- Work-related and travel physicals.
- Services/items that are not medically necessary.
- Respite care.
- Services that are not covered by the Medicaid Program.
- Non-medical items or services.
- Hearing aids for members 21 years of age and older.
- Residential weight loss clinics.
- Paternity tests.
- Surgery, medication, or any other medical procedures or services related to gender re-assignment.