Chapter 6. Utilization Management

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6.1 Introduction

The Health Services Department provides utilization management and case management services for Highmark West Virginia products and FreedomBlue®. Services include but are not limited to:

- Authorizations (pre-service, concurrent and retrospective);
- Discharge planning;
- Case management;
- Behavioral health authorizations and case management;
- Transplant coordination;
- Referrals;
- Medical policies and use of clinical criteria; and
- Clinical appeals.

Through these activities, Highmark West Virginia works closely with providers and their staff to promote appropriate, coordinated and cost-effective care for members. These services are described in greater detail in this chapter.

6.2 Authorizations

6.2.1 Definition

An "authorization" is a determination by Highmark West Virginia 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. Authorization may also be called "pre-certification," "pre-authorization," "prior authorization," "prospective review," "pre-service review," "prior approval" or other similar terms.

All Highmark West Virginia products and FreedomBlue® require that certain services be authorized as a condition of coverage. If a service requires authorization, then the provider or member must contact Highmark West Virginia to request the medical necessity review.

An authorization is a determination of medical necessity only and doesn't guarantee coverage or payment. See Section 6.2.11.

6.2.2 Responsibility For Requesting

The provider should assume responsibility for requesting an authorization or ensuring that it has been requested, even if the member's contract places this obligation on the member. The provider will bear the financial cost if services are delivered and subsequently deemed not medically necessary. In these situations, the provider cannot bill the member.

In POS products, the PCP is responsible for obtaining authorizations for services needed by the PCP's designated members. If a referral is made to a specialist, the specialist can request an authorization for a service he or she will provide.

6.2.3 Services Requiring Authorization

Highmark West Virginia products and FreedomBlue® require authorization for all inpatient admissions and selected outpatient services, drugs and equipment.

The following services are representative of those that require authorization:

- Hospital inpatient admissions;
- Hospital admissions for childbirth if the inpatient stay extends beyond 48 hours after a vaginal delivery or 96 hours after a cesarean section delivery;
- All other inpatient admissions (e.g. skilled nursing facility, rehabilitation, behavioral health, long term acute);
- Behavioral health intensive outpatient and partial hospitalization;
- Behavioral health outpatient therapy prior to the 9th visit;
- Outpatient procedures listed on the Highmark West Virginia website;
- Potentially experimental, investigational or cosmetic services;
- Durable medical equipment listed on the Highmark West Virginia website and any non-standard issue (i.e. deluxe) DME;
- Outpatient therapies (physical, occupational, speech, chiropractic) after a specified number of visits or treatments;
- Pain management;
- Cardiac rehabilitation;
- Pulmonary rehabilitation;
- Home health care;
- Hospice;
- Clinical trials;
- Injectable drugs listed on the Highmark West Virginia website;
- Transplant services; and
- Out of network services.

This is not an all-inclusive list. A more comprehensive listing is published on the Highmark West Virginia website at www.highmarkbcbswv.com. Click on the Provider tab then select "Working with Highmark West Virginia."

Self-funded accounts, government programs and other groups with non-standard benefits may have their own lists of services requiring authorization. To determine whether a member's contract requires authorization for a specific service, you may:

- Check the member's benefits using NaviNet[SM];
- View this information on the Highmark West Virginia website, www.highmarkbcbswv.com; click the Provider tab then select "Working with Highmark West Virginia";
- Call Customer Service at the telephone number listed on the back of the member's ID card; or
- Contact Health Services at 1-800-344-5245 for Highmark West Virginia products or 1-800-269-6389 for FreedomBlue®.

Authorization of outpatient therapies (physical, occupational, speech, chiropractic) and behavioral health outpatient therapy requires the submission of a treatment plan. Sample plan formats can be found on the Highmark West Virginia website, www.highmarkbcbswv.com; click on the Provider tab then select "Resource Center."

6.2.4 When Highmark West Virginia Is Secondary

An authorization from Highmark West Virginia is generally not required when our coverage is secondary to another payor. Exceptions are noted below.

For POS products, authorization is required regardless of whether Highmark West Virginia is primary or secondary.

When Highmark West Virginia is secondary to Medicare, an authorization is required if:

- The member exhausts his/her Medicare benefit and desires to continue the service;
- The service is not covered by Medicare (e.g. home infusion); or
- The member is admitted to a Veteran's Administration facility.

Other exceptions for specific groups, if any, will be listed on the Highmark West Virginia website, www.highmarkbcbswv.com. Click on the Provider tab then select "Working with Highmark West Virginia."

6.2.5 How To Request

To request an authorization, you may:

- Submit a request via the internet through NaviNet[SM] (for selected services);
- Submit an electronic HIPAA 278 transaction;
- Call the pre-certification number on the back of the member's ID card;
- Call 1-800-344-5245 for Highmark West Virginia products;
- Call 1-800-269-6389 for FreedomBlue®;
- Fax the request to 1-304-347-7729 for Highmark West Virginia products; or
- Fax to 1-304-353-3581 for FreedomBlue®.

Requests should be submitted at least 14 days prior to a planned admission or service, when possible, or as soon as the intended admission or service is known. For emergency admissions and admissions related to childbirth, the provider or member must contact Highmark West Virginia within 48 hours after the emergency admission or for lengths of stay longer than 48 hours after a vaginal delivery or 96 hours after a cesarean section delivery.

Regular business hours for the Health Services Department, which processes authorization requests, are from 8:30 a.m. to 4:30 p.m., Monday through Friday. For urgent requests, you may speak to a clinical reviewer 24 hours a day, 7 days a week, by calling the toll-free numbers listed above.

When requesting an authorization, please provide the following information (if applicable) about the member to facilitate prompt review:

Information To Submit With Authorization Request

- General information (name, age, gender, etc.);
- Member ID number;
- Medical history;
- Any co-morbidity;
- All pertinent medical information (test results, prior treatment, etc.);
- Presenting symptoms;
- Acuity;
- Diagnosis;
- Service to be performed, including admission or procedure dates and location;
- Names of any health care providers involved in the care;
- Proposed length of stay and frequency or duration of services;
- Treatment plan and goals;
- Psycho-social issues impacting care; and
- Discharge plan.

Highmark West Virginia may request additional information if needed to complete the review.

6.2.6 Concurrent Review

Concurrent review is an assessment of medical necessity during the course of care, when there is a request to extend services previously authorized. Requests should be made at least 24 hours prior to expiration of the original authorization period (last day or treatment).

In addition to determining the need for continuation of services, concurrent review may:

- Help identify cases that may benefit from post-discharge case management or disease management services;
- Evaluate the level of care required and facilitate an alternative level of care as appropriate;
- Assure updating and coordination of the member's discharge plan;
- Identify cases with potential coordination of benefits, subrogation or Workers' Compensation issues; and
- Promote collaboration among providers to facilitate the member's movement through the health care system.

6.2.7 Retrospective Review

Retrospective review is an assessment of medical necessity conducted after services have been delivered. It may be requested by a provider or initiated by Highmark West Virginia.

Network providers have an obligation to cooperate with pre-service authorization review procedures. If the provider fails to comply, then Highmark West Virginia 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 pre-service basis may be subject to corrective action by the Credentials Committee.

6.2.8 Clinical Review Process

Initial reviews of authorization requests are performed by registered nurse reviewers with clinical experience. They utilize InterQual® Criteria, Highmark West Virginia or

FreedomBlue® medical policies and other clinical criteria to review the medical necessity of the requested service (see Section 6.5).

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, then he/she must refer the case to a physician medical director or other physician reviewer. The physician will evaluate the request using Highmark West Virginia's clinical criteria and considering the specific clinical aspects of the individual case. Only a physician may determine that a service is not medically necessary.

When conducting reviews, Highmark West Virginia:

Accepts information from any reasonably reliable source that will assist in the authorization process.
Collects only the information (including sections of medical records) necessary to make a determination to approve or deny the authorization request.

Highmark West Virginia requires that all reviewers make utilization management decisions based only on the medical necessity and appropriateness of care and the availability of coverage under our benefit contracts. We do not reward anyone conducting utilization review for issuing denials of coverage. We do not use financial incentives to encourage denials or other decisions that could result in underutilization of needed services or otherwise compromise members' health.

6.2.9 Peer-To-Peer Conversation

Highmark West Virginia provides the opportunity for a treating provider 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 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 West Virginia 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 1-800-344-5245 for Highmark West Virginia products or 1-800-269-6389 for FreedomBlue®.

The provider has two business days after notification of an authorization denial to initiate a peer-to-peer review. We will make the peer-to-peer conversation available within one

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.

6.2.10 Pre-Certification Penalty

In standard Highmark West Virginia insured products, the member is subject to a financial penalty (typically $500) if he or she fails to obtain pre-certification (authorization) for an inpatient hospital admission. This penalty is the member's responsibility. The remittance advice or provider explanation of benefits will so indicate and the provider may bill the member (unless the entire admission is deemed not medically necessary – see below).

The Federal Employee Program (FEP) also applies a $500 penalty if an authorization is not obtained for an inpatient hospital admission. However, the penalty is imposed on the provider -- in the form of reduced payment. The provider may not bill this amount to the member.

For all products, if an authorization is required but not obtained, and Highmark West Virginia ultimately determines that the service was not medically necessary, then the provider cannot bill the member for the service.

6.2.11 Disclaimers

An authorization is a determination of medical necessity only and does not guarantee coverage or payment. Payment is based on the member's coverage and eligibility at the time of service.

A service that has been authorized may nonetheless be denied payment if:

- The member is no longer eligible when the service is provided;
- The service is not a covered benefit under the member's contract; or
- The service actually provided is different from the service authorized.

Medical necessity determinations are not a substitute for the medical judgment of the treating provider. They are for reimbursement purposes only. They do not constitute medical advice or treatment, or establish any provider/patient relationship.

Providers must exercise their own independent medical judgment regarding the treatment of their patients who are Highmark West Virginia members. Highmark West Virginia

encourages providers to communicate openly with patients about their treatment options, regardless of benefit coverage limitations. Responsibility for medical treatment and decisions remains with the member and his or her physician.

6.2.12 Member Desire to Obtain Medically Unnecessary Service

On occasion, situations may arise where Highmark West Virginia 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 entire cost. The provider may bill the member for such services only if:

1. The provider requests a determination of medical necessity from Highmark West Virginia *in advance* of the provision of service and Highmark West Virginia determines *in writing* that the proposed service is not medically necessary;

2. The provider informs the member *in writing* and *in advance* of the provision of service of Highmark West Virginia's determination; 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 West Virginia.

The documentation for requirements two and three above cannot be a general form in which a 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 West Virginia has determined that the service is not medically necessary; and (iii) clearly memorialize the patient's agreement to be personally responsible for payment and not to submit a claim to Highmark West Virginia.

By this process, Highmark West Virginia 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 West Virginia. We 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.

For Physicians (MD & DO), see Chapter 13 for additional information.

6.3 Timeframes for Authorization Determinations

6.3.1 Pre-Service Determinations

For pre-service authorization requests, Highmark West Virginia will provide notification of our determination as soon as possible, taking into account the member's health condition, but no later than:

- 72 hours after receipt of the request in cases involving urgent care; or
- 14 calendar days after receipt of the request in non-urgent cases.

A case involving urgent care is one in which making a determination under the standard timeframes could seriously jeopardize the member's life, health or ability to regain maximum function or, in the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that could not be adequately managed without the care or treatment that is the subject of the request. If a physician indicates a case is one involving urgent care, it will be handled as such.

For non-urgent cases, we may extend the timeframe one time by up to 14 days. For products other than FreedomBlue®, if the extension is necessary because the member failed to submit information needed to make the determination, we will afford the member at least 45 calendar days to provide the specified information.

6.3.2 Concurrent Review Determinations

For requests to extend a current course of treatment previously authorized, Highmark West Virginia will provide notification of our determination as soon as possible, taking into account the member's health condition, but no later than:

- 24 hours after receipt of the request in cases involving urgent care, provided that the request was received at least 24 hours before the expiration of the currently authorized period or treatments; or
- 72 hours after receipt of the request if it is a case involving urgent care and the request was received fewer than 24 hours before the expiration of the currently authorized period or treatments; or
- Within the timeframes for pre-service determinations in non-urgent cases.

If Highmark West Virginia reduces or terminates authorization for a previously-authorized course of treatment before the end of the period or number of treatments originally authorized, we will issue the determination early enough to allow the member to appeal and receive a decision before the reduction or termination occurs.

6.3.3 Retrospective Review Determinations

For retrospective reviews, Highmark West Virginia will provide notification of our determination within 30 calendar days of receipt of the request.

This timeframe may be extended one time for up to 15 days. If this extension is necessary because the member failed to submit information needed to make the determination, we will afford the member at least 45 calendar days to provide the specified information.

6.3.4 Notification

If an authorization is granted, Highmark West Virginia will notify the member and requesting provider within the required timeframe for the type of review requested. The notification will include a reference number that the provider can use in referencing the authorization.

In concurrent review cases, notification of the authorization to extend services will include the number of extended days or units of service, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services.

If an authorization is denied, Highmark West Virginia will issue written notification to the member and requesting provider. The notification will include:

- The principal reason(s) for the denial;
- Reference to the plan provision on which the determination is based;
- In the case of denials for lack of information, a description of any additional information necessary to make the determination and an explanation of why it is necessary;
- A description of procedures and timeframes for appealing the denial;
- A statement that a copy of the clinical review criteria relied upon will be provided free of charge upon request; and
- A statement that an explanation of the scientific or clinical basis for the determination as it relates to the member's medical condition (clinical rationale) will be provided free of charge upon request.

6.4 Appeals

6.4.1 Types of Denials of Coverage

Providers treating Highmark West Virginia members may experience two types of denials of coverage:

- Denial due to benefit design: Only a member can request an appeal of this type of denial of coverage. Members may contact Customer Service by calling the number on the member's ID card.
- Denial due to lack of medical necessity or a determination that a service is experimental/investigational or cosmetic: A member *or* provider can request a review of this type of denial of coverage.

A provider may also challenge the payment/reimbursement amount or other adverse claim decision through the appeal process. See Chapter 10 of this *Provider Manual* for specific appeal provisions relative to provider audits performed by Highmark West Virginia.

6.4.2 Time Period For Requesting An Appeal

A provider has 180 days from the date of the initial denial of coverage or payment in which to request an appeal. If Highmark West Virginia elects to suspend recovery efforts during an appeal process, any applicable recovery time period limitations will toll starting with the initial overpayment notification.

6.4.3 Expedited Appeal In Urgent Care Cases

A provider or member may request an expedited appeal in cases involving urgent care. See Section 6.3.1 for the definition of a case involving urgent care.

The provider or member may call or fax the request to:

Telephone: 1-800-344-5245 FreedomBlue®: 1-800-269-6389 Fax: (304) 347-7726

The provider or member may submit written comments, documents, records or other relevant information which Highmark West Virginia will take into account in considering the appeal.

We will provide verbal notification of our determination as soon as possible taking into account the member's health condition, but no later than 72 hours after the request. This will be followed by a written notification within 3 calendar days.

For FreedomBlue®, the 72-hour timeframe may be extended by up to 14 calendar days if the member so requests or if we need additional information. If the appeal is denied, we will forward the case to the Center for Health Dispute Resolution, an independent review entity contracted by the Centers for Medicare and Medicaid Services, which will conduct its own review of the case.

For Highmark West Virginia products, if the denial is upheld, the notification will include:

- principal reasons for the decision;
- upon request, an explanation of the scientific or clinical judgment for the determination as it relates to the medical condition, if the determination is based on medical necessity or experimental nature of the care;
- a reference to the specific plan provision;
- a statement that the claimant is entitled to receive reasonable access and copies of all documents relevant to the member's claim;
- a description of any additional information needed to approve the claim, and an explanation of why such material or information is necessary;
- the right of the claimant to bring a civil action on the review;
- a statement that the clinical rationale, internal rule, guideline protocol, or the specific rule, guideline, other similar criterion relied upon in used in making the appeal decision will be provided in writing upon request; and
- the procedure to initiate a standard appeal.

6.4.4 Standard Appeal

Standard appeals (i.e. non-urgent) may be requested via NaviNet[SM] by submitting a claims investigation (this allows the submission of an "electronic inquiry" to Highmark West Virginia), or by completing the *Provider Inquiry Form* located on the Highmark West Virginia website at www.highmarkbcbswv.com by clicking on the Provider tab and then selecting "Resource Center." Forward the completed form to:

Clinical Appeals: Highmark Blue Cross Blue Shield West Virginia Health Services Department Attention: Clinical Appeals P. O. Box 1353 Charleston, WV 25325	Telephone: 1-800-344-5245 FreedomBlue®: 1-800-269-6389 Fax: 1-304-347-7726

Reimbursement Appeals: Highmark Blue Cross Blue Shield West Virginia Attn: Customer Service	P.O. Box 7026 Wheeling, WV 26003

The provider or member may submit written comments, documents, records or other relevant information which Highmark West Virginia will take into account in considering the appeal.

We will provide written notification of our determination within 30 calendar days of the request.

If the denial is upheld, the notification will include;

- The principal reason(s) for the determination;
- The clinical or other rationale or a statement that this will be provided free of charge upon request; and
- A statement that a copy of the clinical or other criteria used to make the determination will be provided free of charge upon request

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6.4.5 Information To Include In Appeal

When requesting an appeal, a provider should submit the following information to facilitate prompt review:

- Member's name and ID number;
- Service(s) for which coverage was denied and, if applicable, the date(s) of service;
- Description of the issues that are the subject of the appeal;
- Treating provider's full name and telephone number; and
- Any other information or materials relevant to review of the case.

For durable medical equipment and outpatient therapies, the appeal must be requested by the ordering provider.

6.4.6 Appeal Peer Reviewers

For appeals of a clinical nature, reviews will be performed by a physician or other health care professional who is in the same or similar specialty as typically manages the health care service or condition subject to review. Physician reviewers will be board certified.

The reviewer will not be the person who made the original determination or the subordinate of such person. The reviewer may be a Highmark West Virginia medical director, a physician or other professional provider affiliated with a contracted independent review organization, a network professional provider or other consulting provider. Presently, we contract with two nationally-accredited review organizations. These are:

Network Medical Review
605 Fulton Avenue, Suite 2002
Rockford, IL 61103
www.nmrco.com

National Medical Reviews, Inc.
8 Neshaminy Interplex, Suite 207
Trevose, PA 19053
www.nmrusa.com

6.4.7 Disclaimers

The disclaimers regarding authorizations set forth in Section 6.2.11 of this *Provider Manual* are also applicable to all appeals.

6.4.8 Appointment As Member's Representative

A member may appoint another individual, including a provider, to act as his or her representative and file an appeal on the member's behalf. To appoint a representative, the member must complete and sign a representative form, which must be submitted with the appeal. A member may request the form by calling the Customer Service telephone number on the back of his or her ID card. Please note, however, that a provider may not act in a power of attorney capacity for a member for whom the provider is treating.

6.4.9 Medical Necessity External Review Process

For MDs and DOs there is an external review process available once the internal process has been exhausted. Please see Chapter 13 of this *Provider Manual* for more information.

6.5 Clinical Criteria

6.5.1 Overview

Highmark West Virginia clinical reviewers use medical policies and other clinical criteria and resources to evaluate the medical necessity of services and to make other utilization review and coverage determinations. These determinations are also governed by definitions for terms such as "medically necessary," "experimental or investigational" and "cosmetic" that are contained in the member's contract.

This Section 6.5 describes some of the most frequently used criteria and provides definitions from our standard contracts. Section 6.6 provides information on Highmark West Virginia medical policies.

6.5.2 Definition of Medical Necessity

All Highmark West Virginia health benefit contracts require that a covered service be "medically necessary" in order to be reimbursed. We may review medical necessity on a pre-service, concurrent or post-service basis to ensure that this requirement has been met.

Though the definition may vary slightly for FEP, FreedomBlue® and certain self-funded accounts, generally, "Medically Necessary" or "Medical Necessity" shall mean health care services 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.

Highmark West Virginia reserves the right to determine, in its sole judgment, whether a service is medically necessary and appropriate. No benefits hereunder will be provided unless Highmark West Virginia determines that the service or supply is medically necessary and appropriate. Denial of coverage can only be determined by a Highmark West Virginia medical director; however, approval may be made by either a Highmark West Virginia medical director or nurse. In addition, Highmark West Virginia does not revoke Medical Necessity determinations absent the evidence of fraud, evidence that the information submitted was materially erroneous or incomplete, or evidence of material

change in the member's health condition between the date the service was precertified and the date of service.

The fact that a provider may recommend, prescribe or provide a service does not mean that the service automatically will be considered medically necessary. This determination will be made by Highmark West Virginia.

Highmark West Virginia may review medical necessity before services are provided (i.e. if the provider or subscriber contacts us to pre-certify or pre-authorize the medical necessity of the service), at the time a claim is submitted, or retroactively after a claim is paid (e.g. through provider profiling or retroactive audits).

6.5.3 Experimental or Investigational Services

Highmark West Virginia health benefit contracts exclude from coverage services that are deemed "experimental or investigational." "Experimental or investigational" is defined in our standard contracts as a treatment, service, procedure, facility, equipment, drug, service or supply ("intervention") that has been determined not to be medically effective for the condition being treated and therefore is considered experimental/investigational in nature. An intervention is considered to be experimental/investigational if:

- The intervention does not have Federal Drug Administration approval to be marketed for the specific relevant indication(s); or
- Available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or
- The intervention is not proven to be as safe or effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or
- The intervention does not improve health outcomes; or
- The intervention is not proven to be applicable outside the research setting.

These criteria apply even if there is no available alternative to treat an injury, ailment, condition, disease, disorder, or illness. The determination will be made by Highmark West Virginia, in its discretion, and is conclusive.

The definition of "experimental or investigational" may vary for individual members based on the terms of their specific contracts and coverage provided.

6.5.4 Cosmetic Services

Highmark West Virginia's standard health benefit contracts exclude from coverage surgery and other services and devices primarily to improve appearance. Exceptions include:

- Services that restore a body function or treat a condition caused by disease, trauma, birth defects, growth defects or prior therapeutic processes;
- Reconstructive surgery following covered services for a mastectomy, including reconstruction of the other breast for the purpose of restoring symmetry; or
- Reconstructive or cosmetic surgery necessary as a result of an act of family violence.

Complications resulting from a non-covered procedure requiring medical treatment meeting medical necessity will be covered, and benefits will be provided according to the member's contract language.

The exclusion for cosmetic services may vary for individual members based on the terms of their specific contracts.

6.5.5 Authorization of Potentially Experimental/Investigational, Cosmetic or Medically Unnecessary Services

Providers are strongly encouraged to request an authorization from Highmark West Virginia prior to providing services that may be considered experimental / investigational or cosmetic in nature. Providers are also encouraged to request an authorization for any service the medical necessity of which may be questioned.

To request an authorization, you may call the Highmark West Virginia Office of Medical Management at 1-800-344-5245, or you may fax information to 1-304-347-7729. Seeking a determination of medical necessity by requesting an authorization in advance of providing a service is beneficial to both the provider and the member. Knowing whether the service is considered by Highmark West Virginia to be medically necessary (together with knowing whether it is a covered benefit and the patient is an eligible member) prior to rendering service lets both the provider and patient know whether Highmark West Virginia will reimburse for the service.

6.5.6 Clinical Criteria Used

In reviewing the medical necessity or potentially experimental/investigational status of services, Highmark West Virginia clinical staff use the following criteria and resources:

- InterQual® Criteria;
- Highmark West Virginia Medical Policy;
- Highmark West Virginia Medicare Advantage Medical Policy;

- Blue Cross Blue Shield Association Medical Policy; and/or
- Specialist Consultation.

Use of these and other guidelines do not replace or preclude clinical judgment. Highmark West Virginia medical directors review and base the determination of medical necessity on the clinical circumstances of each individual case.

Highmark West Virginia uses the following InterQual® Criteria, published by McKesson Corporation:

- Acute Adult;
- Acute Pediatric;
- Subacute, Skilled Nursing Facility;
- Long Term Acute Care;
- Rehabilitation Acute Care;
- Home Care;
- Behavioral Health Level of Care Continuum;
- Adult Procedures; and
- Pediatric Procedures.

These criteria are reviewed and updated annually.

6.6 Medical Policies

6.6.1 Purpose

Highmark West Virginia uses medical policies, as well as other clinical criteria, as guidelines in evaluating medical necessity and potentially experimental / investigational services. Our medical policies may also clarify benefit language in members' contracts. Medical policies may include coding and billing guidance as well as clinical guidelines. Where feasible, Highmark West Virginia's medical policies are integrated into our claims system to facilitate automated processing of claims consistent with the policies.

Highmark West Virginia's medical policies are developed to support determinations of medical necessity and evaluation of potentially experimental/investigational services. Medical policies also clarify and support benefit language in members' benefit contracts. Policies may include not only clinical considerations but also billing and reimbursement guidelines, some of which may be integrated into the claims system, to support processing of claims consistent with the policies.

6.6.2 Availability

Highmark West Virginia medical policies are published on our website at www.highmarkbcbswv.com. Click on the Provider tab then select "Working with Highmark West Virginia."

You may search medical policies by:

- key words (e.g. nerve blocks, anesthesia);
- code (e.g. 99212, 250.9); or
- policy number (e.g. A-10).

A second option is to search by category of service (e.g. anesthesia, consultations, maternity, radiology, surgery, visits). You may also access an alphabetical index of all policies and an index by category by clicking on "Index of All Policies" at the bottom of the main search page.

6.6.3 Development

The Medical Policy Committee is responsible for the development and review of Highmark West Virginia medical policies. The Committee is chaired by a medical director. Members include clinical managers and staff. Input on operational and reimbursement aspects of policies is solicited from other areas of the company such as benefits, reimbursement, provider relations, claims, and customer service.

The Medical Policy Committee may solicit input from physicians or other professional consultants who practice in the specialty affected by the policy under review.

As an affiliate of Highmark, Highmark West Virginia is able to benefit from the significant resources Highmark invests in the development of its medical policies. Most Highmark West Virginia medical policies originate with Highmark. As part of its process, Highmark evaluates the scientific literature, reviews position papers developed by national specialty associations, invites comment from local medical societies and solicits input from practicing physicians and other professionals – using a network of over 250 professional consultants.

The Highmark West Virginia Medical Policy Committee and MACs review draft Highmark policies and tailor them, where necessary, to reflect Highmark West Virginia's coverage and reimbursement decisions.

The Medical Policy Committee reviews all existing medical policies on a periodic basis to ensure they remain consistent with current standards of care.

6.6.4 Participation in the Highmark Process

A Highmark West Virginia medical director participates in an internal Highmark workgroup that initially reviews proposed new or revised medical policies. Highmark also circulates its draft policies to Highmark West Virginia for comment. In addition, a Highmark West Virginia medical director serves on the Highmark Medical Affairs Committee. This committee, comprised primarily of practicing physicians in Highmark's networks, is responsible for evaluating the medical efficacy of new and evolving procedures and technologies. It is appointed by and makes recommendations to the Highmark board of directors.

Highmark utilizes a system of about 260 professional consultants as a resource in the development of medical policies. These consultants are all in active practice and represent every specialty recognized by Highmark. Prior to consideration of a medical policy by its Medical Affairs Committee, Highmark solicits input from consultants in the specialty affected by the policy.

Highmark West Virginia chartered a similar system of professional consultants from its provider networks, in early 2007. When these consultant arrangements are fully in place, Highmark will include solicitation of input from Highmark West Virginia providers as part of the medical policy development process.

6.6.5 Highmark West Virginia Process

The Highmark West Virginia Medical Policy Committee is responsible for the development of new or revised medical policies for Highmark West Virginia. The committee is chaired by a medical director. Membership includes clinical managers and staff representing such areas as precertification, case management, medical review and disease management. Input on the operational and reimbursement aspects of policy guidelines are provided from other areas of the company, such as benefits, reimbursement, provider relations, claims, and customer service.

The Medical Policy Committee may solicit input from physicians or other professional consultants who practice in the specialty affected by the policy under review.

All existing policies are reviewed on a periodic basis to ensure they remain consistent with current standards of care.

6.6.6 Communication of New Guidelines

The Medical Policy Committee will establish an effective date for new or revised guidelines. If the guidelines will have a material adverse effect on providers, the Committee will establish an effective date to allow for at least 60 days advance notice. For professional providers, 90 days advance notice will be given.

Communication may be through a variety of means, including: an article in the *Provider News*, a special mailing to all or a subset of providers, a news bulletin on the Highmark West Virginia website, and presentations at provider workshops.

The policies themselves will be published on the Highmark West Virginia website and accessible for review by both providers and members.

6.6.7 FreedomBlue® Policies

CMS requires that Medicare Advantage plans follow Medicare national coverage decisions and local policies established by the applicable regional Medicare Part B carrier. A Medicare Advantage plan may elect to provide benefits for services not covered by traditional Medicare but must, at a minimum, cover those services Medicare covers.

Highmark Health Insurance Company has developed medical policies specifically for its FreedomBlue® Medicare Advantage products, which reflect CMS and local Part B carrier guidelines. For FreedomBlue®, Highmark West Virginia will use its commercial policies only as "gap fill" policies where there is not a CMS or local carrier policy.

The FreedomBlue® medical policies are published on the Highmark West Virginia website.

6.6.8 Use of Other Policies and Consultants

If a provider or member requests coverage for a service for which there is no Highmark West Virginia medical policy, we may consult national Blue Cross Blue Shield Association policies or the guidelines of other plans as a resource in evaluating medical necessity or potentially experimental/investigational services. The medical director may also review the underlying scientific literature and/or seek opinions from one or more specialist consultants.

6.6.9 Disclaimers

Highmark West Virginia medical policies do not constitute medical advice nor are they intended to govern the practice of medicine. They are intended only to reflect Highmark West Virginia's coverage and reimbursement guidelines. Highmark West Virginia reserves the right to review and update its medical policies at its sole discretion.

Medical necessity reviews by Highmark West Virginia 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 West Virginia criteria for medical necessity, which is a condition for services to be covered and reimbursable.

6.6.10 Acknowledgement

The five-digit numeric codes that appear in some Highmark West Virginia medical policies are obtained from the Physician's Current Procedural Terminology ("CPT"), which is copyrighted by the American Medical Association ("AMA"). This includes CPT descriptive terms, numeric identifying codes and modifiers for reporting medical services and procedures, and other materials that are copyrighted by the AMA.

6.7 Referrals

6.7.1 Definition

A referral is the official direction by a PCP of a member to another network provider for specialty care or other services the PCP is unable to provide. Highmark West Virginia requires referrals only in its POS products.

In POS plans, the PCP has primary responsibility for arranging and coordinating the health care of his/her designated members. The member receives the highest level of benefits if services are provided by the member's PCP or if the PCP refers the member to other network providers for specialty care. A lower level of benefits is paid if the member self-refers to other providers.

6.7.2 When A Referral Is Required

A referral by a member's PCP is required to initiate any evaluation, treatment or other service that will be performed by a provider other than the PCP. A referral is not

required for diagnostic laboratory or radiology testing ordered by the PCP, if performed by a network provider.

A referral is not required for an annual gynecological exam or for maternity care provided by a network OB/GYN provider. If a problem is found during the annual gynecological exam that requires treatment, the gynecologist may treat the member for up to three months from the date of the exam. If treatment needs to extend beyond this period, a referral is required; the gynecologist should contact the member's PCP to initiate the referral.

For all services, a referral should be made by a PCP only when, in his or her professional judgment, the service is medically necessary and appropriate for the diagnosis, evaluation or treatment of the member. Referrals should not be made based solely on a member's request.

6.7.3 Length Of Referral

Generally, a referral allows a specialist to provide treatment for a member's condition for up to 90 days from the anticipated date of service noted on the referral request form. Some treatment regimes may require more than 90 days to complete and some continue indefinitely. A PCP may request a referral for up to 180 days for chemotherapy and radiation therapy services.

The following services require a referral for the initial evaluation. Additional visits or services require an authorization:

- Speech therapy;
- Occupational therapy; or
- Pain management.

The following services require a referral for a specified number of visits or treatments in a calendar year. Additional visits or treatments require an authorization:

- Physical therapy and chiropractic services – referral required for first 20 visits/treatments; and
- Outpatient behavioral health services – referral is required for first eight visits.

6.7.4 Services Included In Referral

A specialist to whom a member has been referred may evaluate and treat the member as needed. The following services may be performed without an authorization from Highmark West Virginia:

- Medically necessary office visits for the evaluation, management and treatment of any condition within the scope of the provider's specialty; and
- Any related diagnostic tests performed in the specialist's office.

A specialist must contact the member's PCP to request a referral if the member needs:

- To see another specialist;
- Therapies (e.g. physical, occupational, speech) or chiropractic services;
- Home health care;
- Durable medical equipment;
- Orthotics/prosthetics; or
- Additional treatment beyond the period specified in the original referral.

6.7.5 How To Request A Referral

Referrals must be made in advance of the service, except for urgent and emergency care. Highmark West Virginia reserves the right not to approve referrals retroactively, which will result in the service being paid at a lower level of benefits.

For urgent and emergency services, a referral must be requested within 48 hours after the care is initiated in order for the member to receive the highest level of benefits.

A PCP may request a referral by telephone, fax or mail.

Telephone: Call 1-800-344-5245. Please have available the following information:

- Subscriber's ID number;
- Patient's name;
- PCP's full name;
- Specialist/provider to whom member is being referred, including telephone number and address;
- Diagnosis code (ICD-9 preferred);
- Services/number of visits requested; and
- Date span requested for referral.

Fax: Fax referral request to 1-888-383-7081. Please use the Referral Request Form reprinted at the end of this section and:

- Print legibly;
- Complete all fields;
- Use ICD-9 diagnosis codes; and

- Provide first and last name of specialist/provider to whom referring, along with telephone number and address.

Mail: Use Referral Request Form and mail to:

Highmark Blue Cross Blue Shield West Virginia
Health Services Department
Attention: Referrals
P. O. Box 1353
Charleston, WV 25325

If the provider calls in a referral request, we will enter the referral and provide a reference number during the call. If the request is faxed to us, we will respond by fax within two business days.

6.7.6 Non-Standard Contracts

The guidelines set forth in this Section 6.7 regarding when referrals are required, length of referrals and what services are included pertain to Highmark West Virginia's standard POS products. Self-funded accounts or other groups with non-standard benefits may have different requirements.

A PCP should contact the Customer Service telephone number on the back of the member's ID card to confirm the referral requirements for the member's specific contract.

6.7.7 Use of Non-Network Providers

The PCP must obtain an authorization to refer a member to a non-network provider. In reviewing such requests, we will consider the medical necessity of the service and the availability and accessibility of the service within the network.

6.8 Case Management

6.8.1 Purpose

Case management services are offered to assist members who have complex or high-cost health care needs. Case management is a collaborative process involving the case manager, member, family and providers. 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.

6.8.2 How Candidates Are Identified

Highmark West Virginia uses clinical and utilization indicators to identify members who may benefit from case management. The indicators include, but are not limited to the following:

- Complex disease processes;
- Catastrophic medical events;
- High-cost cases;
- Psycho-social issues;
- Member exposure to financial risk;
- Complications of care;
- Multiple admissions and readmissions; and
- Complex discharge-planning needs.

Highmark West Virginia encourages providers to take a proactive role in identifying members with case management needs. If you have a patient who may benefit from case management services, please contact the Office of Case Management at 1-800-344-5245 for Highmark West Virginia products and 1-800-269-6389 for FreedomBlue®. Case managers are available between 8:30 a.m. and 4:30 p.m., Monday through Friday.

6.8.3 Screening

Once a referral is received, a case manager screens the case to determine whether the member meets the case management program's acceptance criteria. The criteria assess the severity of the member's condition and treatment needs.

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 re-referred at a later date if there is a change in his or her clinical condition.

6.8.4 Initiation Of Services

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

Once consent is received, the case manager will work collaboratively with the member, member's treating physician and other providers to discuss goals and to plan for the member's needs. An individualized case management plan is developed with input from the member.

The plan typically includes short-term goals addressing the member's immediate health status and long-term goals to achieve sustained health improvement. Necessary resources including health care services such as home health, durable medical equipment, rehabilitation therapies and disease management are identified. Needed community resources to provide transportation, meals or other public assistance are also identified.

The case manager will continue to communicate with the member, physician(s), and other providers on a regular basis as long as the member remains in the program, to monitor the member's progress toward the established goals and to help coordinate an adjustment of the plan or care when necessary.

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

6.9 Discharge Planning

6.9.1 Objectives

Discharge planning involves identifying the care needs of a member upon discharge from a hospital and developing a plan to meet those needs. The process ideally begins prior to a scheduled admission or at the time of an emergency admission. The initial discharge plan is reassessed throughout the member's stay.

Objectives of discharge planning include:

- To develop and implement collaborative discharge plans;
- To facilitate continuity of care and integration of services;

- To arrange for the provision of care in the most appropriate setting (e.g. skilled nursing, inpatient rehabilitation, home care);
- To promote the use of alternative levels of care, as appropriate;
- To direct members to network providers; and
- To provide early identification of members who may benefit from case management or disease management programs.

6.9.2 Available Assistance

The hospital is normally responsible for coordinating the discharge plan for the member. However, facilities are encouraged to contact Highmark West Virginia for assistance whenever complex cases are identified. We can assist in coordinating services -- including transfers to other facilities, referrals to case management and disease management programs, and evaluation of available community resources, as appropriate.

For assistance, please contact the Office of Case Management at 1-800-344-5245.

6.9.3 Directory Of Community Resources

Mountain State has developed a county-by-county directory of social services and other community resources that can be used as a resource when planning for a member's discharge needs.

The directory may be accessed on our website at www.highmarkbcbswv.com. Click on the Providers Tab, Resource Center and then choose Community Resources from the menu on the left side of the page.

6.9. Information Needed

When contacting Highmark West Virginia to assist in the discharge planning process, a facility should have available and be prepared to discuss the following information:

- The member's level of function, pre- and post-service;
- The member's ability to perform self-care activities;
- The member's primary caregiver and support system;
- The psychosocial needs of the member and his or her caregiver(s);
- Special equipment, medication, dietary needs, safety needs or obstacles to care; and
- Needs requiring referral to case management or disease management programs.

6.9.5 Use Of Network Providers

If a Highmark West Virginia member needs special services or equipment at discharge, the facility should arrange for these with Highmark West Virginia contracted providers. Please see Section 2.5.2 of this *Provider Manual* for information on how to locate a network provider.

6.9.6 Notice of Discharge and Medicare Appeal Rights: Hospitals

Highmark Health Insurance Company (HHIC) issued Bulletin MSFB-HOSP-2007-003 on May 2, 2007 to alert providers to the fact that CMS was preparing to change the process whereby Medicare beneficiaries, including members of Medicare Advantage plans, are notified of their discharge appeal rights. At that time, the specifics of the process were not available. The final information was released by CMS on May 25, 2007.

Notification Process in Place Prior to July 2, 2007
Currently, CMS requires acute care facilities to give all inpatients with coverage under Traditional Medicare or a Medicare Advantage plan a copy of the "Important Message From Medicare" ("Important Message"). This document provides information about rights to benefits, right to appeal and the beneficiary's liability for payment if a denial of benefits is upheld upon appeal.

Medicare Advantage members who disagree with the discharge decision also receive a "Notice of Discharge and Medicare Appeal Rights," or NODMAR, prior to discharge. This document informs the member that covered inpatient care is ending, notes the date/time when patient liability for continued inpatient care will begin, and describes the member's appeal rights.

Summary of the New Process Effective July 2, 2007
Effective July 2, 2007, hospitals should no longer follow the notification process described above. Instead, acute care facilities will need to take the steps listed below in order to notify Medicare and Medicare Advantage inpatients of their rights at discharge**:**

1. Give all Medicare/Medicare Advantage inpatients **a new version of the Important Message From Medicare,** at or near the time of admission;
2. Provide a **follow-up copy** of the Important Message to all Medicare/Medicare Advantage patients (or, if necessary, to their representative) prior to discharge; and
3. Prepare and deliver a **Detailed Notice of Discharge** to any Medicare/Medicare Advantage patient wishing to initiate an expedited appeal (called a "fast track appeal" by the Quality Improvement Organization, or QIO). (If necessary, this Notice too can be given to the

member's representative.)

1. Give a New "Important Message From Medicare" at or Near the Time of Admission

"At or Near the Time of Admission"
Under the new notification process, acute care facilities are required to give **all** their Medicare and Medicare Advantage inpatients a revised "Important Message From Medicare" no later than two days after admission to the inpatient level of care. (Please note that time spent in observation status does not count toward that deadline, because observation status is not an inpatient level of care.)

CMS allows acute care facilities to provide the new version of the Important Message From Medicare at a pre-admission visit (e.g., when pre-admission testing is done), so long as this occurs no more than 7 days before admission.

Delivering the Initial Important Message and Documenting Delivery
The new version of the Important Message includes specific information about the patient's discharge and appeal rights. The member will need to sign and date the Important Message to indicate that he or she received and understood it. If, in the judgment of the acute care facility, the member is not able to receive and/or understand the Important Message, the acute care facility must provide it to the patient's representative, who must then sign and date it on the member's behalf.

The acute care facility must provide the member with the signed Important Message. In addition, it will need to retain a copy of the signed document in the member's medical record or in some other location/format, in order to be able to demonstrate that the requirement was met, in the event of an audit.

Copying the Important Message From Medicare Form
A current copy of the revised Important Message From Medicare is available at the following Web site address:

http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp.

2. Give a Follow-Up Copy of the Important Message From Medicare No More Than Two Days Prior to Discharge

Why a Follow-Up Copy?
The point of providing the patient with information about his or her rights at discharge is to ensure that the patient or representative has the opportunity to become familiar with the process before the time of

discharge. However, since some time may pass and the original may be misplaced before the time of discharge actually arrives, **CMS has determined that acute care facilities must also deliver a follow-up copy of the *signed* Important Message to the patient *no more than 2 days before discharge to a lower level of care*. This is to ensure that the relevant information is available to the member when he or she is considering filing an appeal.** (For this follow-up step, the acute care facility may prefer to give the member a blank Important Message document rather than a photocopy of the original one. However, if it chooses this approach, the acute care facility will need to obtain the member's signature on this new document as well.)

Do Not Routinely Deliver the Follow-Up Copy on the Day of Discharge
While the time frame for giving the follow-up copy is "no more than 2 days before discharge," CMS has also stated that "Acute care facilities may not establish policies that allow the follow-up copy of the [Important Message] to be delivered routinely to patients on the day of discharge." In other words, CMS is concerned that members should have both the information and the time needed to consider their options. If, for a specific reason, a member *must* receive the form on the date of discharge, CMS recommends that he or she receive the information early on that day, preferably at least four hours before the time of discharge.

Documentation to Demonstrate Compliance
Acute care facilities must be able to demonstrate (e.g., in the event of an audit) that these requirements have been met. It has been suggested that acute care facilities may wish to consider having the patient initial the follow-up copy of the signed Important Message document, in order to indicate receipt. The acute care facility may also document the delivery of the follow-up copy. This is not the only acceptable approach, however. Each facility or health system will need to implement its own process to demonstrate compliance.

3. Give a Detailed Notice of Discharge to Patients Wishing to Request an Expedited Review

The third component of the notification process applies **only** to patients who wish to initiate an expedited review of the discharge decision.

Initiating an Expedited Review
To initiate an expedited review, the member places a call to the Quality Improvement Organization (QIO), as directed on the Important Message. Once the QIO receives the request, it notifies the acute care facility to forward the relevant records and complete and deliver the Detailed Notice. It also notifies the member's health plan that the request has been received.

Delivery of the Detailed Notice of Discharge: A Delegated Responsibility
In an implementation memo dated June 1, 2007 to all Medicare Health Plans, CMS's Director of the Medicare Enrollment and Appeals Group stated that "…the plan must, directly *or by delegation*, deliver a Detailed Notice of Discharge (the Detailed Notice) to the enrollee as soon as possible…" (Emphasis added.) HHIC recognizes that the acute care facility, in coordination with the physician, determines the date of discharge and possesses the clinical information used to make the discharge decision. To minimize the potential for delays while information is exchanged multiple times, HHIC believes it is most efficient to delegate the preparation and delivery of the Detailed Notice to the acute care facility. (HHIC will collaborate on this task with those acute care facilities for which it performs Continued Stay Review services for Medicare Advantage members.)

Preparing and Delivering the Detailed Notice
The Detailed Notice provides the member with the clinical and coverage reasons why the member's physician has determined that the current level of care is no longer reasonable or medically necessary. It must provide information specific to the patient's situation. CMS's instructions require that the Detailed Notice must be written in full sentences, in plain language, so that the patient or representative can understand why this discharge is being recommended. It must be delivered to the patient or representative no later than noon of the day after the acute care facility is notified that the expedited review has been requested. The member is not required to sign the Detailed Notice; however, HHIC recommends that the acute care facility retain a copy of the Notice with the other documentation related to the member's inpatient stay, in accordance with the acute care facility's record retention policy.

Copying the Detailed Notice of Discharge Form
A copy of the Detailed Notice of Discharge is available, along with CMS's instructions for completion, at the following Web site address:

http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp.

Acute care facilities are strongly encouraged to read ALL instructions for completion of the Detailed Notice of Discharge carefully. CMS has emphasized the importance of providing all the information required on the notice.

Time Line for the New Notification Process
The table below outlines the steps of the revised process through which people who have coverage under Traditional Medicare and under Medicare Advantage plans such as FreedomBlue® are to be notified of their rights at discharge.

Step	Time Frame	Who Does it	What is Done
1	As early as 7 days before admission (at a preadmission visit) but no later than 2 calendar days of admission	Acute care facility	Prepares and issues to the patient or the patient's representative the revised version of the Important Message from Medicare.
2	At delivery of the Important Message From Medicare	Patient or representative	Signs and dates the Important Message From Medicare to indicate that he or she has received and understood the notice. (If the patient or patient's representative refuses to sign the Important Message, the acute care facility can make a note to that effect on the form, date it and keep the annotated version.)
3	Following delivery	Acute care facility	Gives the signed original Important Message to the patient, and keeps a copy in the patient's record.
4	No more than 2 days before discharge	Acute care facility	Provides the patient with a follow-up copy of the original signed Important Message. The acute care facility can give a new blank copy of the document instead, but will need to have this document too signed by the patient or representative. (This step is not required if the member is discharged within 2 days of admission.)
5	At delivery of the second copy of the Important Message	Patient or representative	In a manner determined by the acute care facility, acknowledges receipt of the follow-up copy of the signed Important Message.
6	Following delivery of the second copy of the Important Message	Acute care facility	Documents that the follow-up copy was received by the patient or representative.
7	Following delivery of the follow-up copy of the Important Message	Patient or representative	Decides whether to accept the discharge or to request an expedited review by the Quality Improvement Organization (QIO).

Next Steps

If the member decides to accept the discharge, he or she leaves the acute level of care and goes home or to an alternative level of care.

If the member disagrees with the discharge decision, he or she has until midnight on the day of the scheduled discharge (while he or she is still an inpatient) to decide to pursue an appeal. If the member decides to pursue the appeal, these additional steps would take place:

Step	Time Frame	Who does it	What is done
8	IF the patient disagrees with the discharge decision, no later than midnight on the day of discharge	Patient or representative	Contacts the Quality Improvement Organization (QIO) as directed on the Important Message to request an expedited review.
9	Once contacted by the patient	QIO	Notifies the acute care facility that the patient has requested an expedited QIO review. Notifies the member's health plan that the review has been requested.
10	No later than noon of the day after QIO notification	Acute care facility	Forwards to the QIO all the information it needs for the expedited review. Prepares and delivers to the patient or representative a completed Detailed Notice of Discharge. Sends the member's health plan a copy of the completed Detailed Notice of Discharge.
11	No later than 1 day after receiving all the necessary information	QIO	Completes its review and communicates its decision to the member, the acute care facility and the health plan.

Valid Delivery Requirement
Medicare's "valid delivery" requirement applies to these new notices. In order for delivery of the notice to be considered valid, the following criteria must be met:

- The member must be able to understand the purpose and contents of the notice in order to be able to sign indicating receipt.
- The member must be able to understand that he or she can appeal the discharge decision.

If either of these criteria is not met, the acute care facility must deliver the form to another individual acting as the member's representative.

Further Changes Are Possible
As always, it is possible that Medicare may make additional changes in this process or in the forms themselves. This bulletin provides the most up-to-date information available at the time of publication. Please continue to monitor the CMS Web site for further

developments or clarifications regarding notification of Medicare and Medicare Advantage members of their rights at discharge from acute care facility inpatient care. The address for this portion of the site is http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp.

Additional Resources
The Web site address for the West Virginia QIO is as follows:

http://www.qiwv.org

If you are located outside of West Virginia, please refer to your local QIO.

Acute care facilities may secure the Important Message From Medicare document, the Detailed Notice of Discharge document and a CMS Question and Answer document, entitled "Final Rule: Notification of Hospital Discharge Appeal Rights" from the Web site address offered below:

http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp.

6.9.7 Notice of Medicare Non-Coverage: SNFs, Home Health Agencies, CORFs

This process applies only to skilled nursing facilities ("SNFs"), home health agencies ("HHAs") and comprehensive outpatient rehabilitation facilities (CORFs) providing services to FreedomBlue® Medicare Advantage members.

CMS requires that SNFs, HHAs and CORFs deliver a Notice of Medicare Non-Coverage ("NOMNC") to Medicare Advantage members prior to the termination of services. Members have a right to an expedited review by a Quality Improvement Organization ("QIO") if they disagree with the decision to end services. The provider must issue the NOMNC regardless of whether or not the member agrees that services should end.

The NOMNC is a standardized notice that:

- Documents the date that services (and coverage) will end;
- States the date the member will become financially liable if services are continued;
- Describes the member's appeal rights and right to receive a detailed explanation of the decision to end services; and
- Provides the telephone number and address of the QIO.

For FreedomBlue® members, SNFs, HHAs and CORFs are required to use the NOMNC form reprinted at the end of this section. As required by CMS, the provider must deliver the NOMNC to the member at least two days prior to the ending of services. If the

services are expected to be fewer than two days in duration, the notice must be provided at the time of admission or initiation of services. If, for non-residential services, the span of time between visits exceeds two days, the provider may deliver the notice at the next to last visit (to prevent having to make an additional trip to deliver the notice).

The member must sign the NOMNC to acknowledge receipt. If the member refuses to sign, the provider should document this. If the member is unable to comprehend the contents of the notice and his/her right to appeal the termination of services, then the NOMNC must be delivered to and signed by the member's appointed or authorized representative.

If the provider is unable to personally deliver the NOMNC to the representative, then the provider must telephone the representative to advise him/her of the date the member's services will end and inform him/her of the member's right to appeal. The information provided must include, at a minimum:

- The date services end and when the member's liability begins;
- How to get a copy of a detailed notice describing why the member's services are not being continued;
- A description of the member's appeal rights;
- By what time and date the appeal must be filed;
- The entity required to receive the appeal, including name, address, telephone number and fax number;
- The telephone number of at least one advocacy organization, or 1-800-MEDICARE, that can provide additional assistance in explaining and filing an appeal; and
- Confirmation that the representative understood the information provided.

The provider must confirm the telephone contact by written notice (the NOMNC) mailed the same day. The provider must place a dated copy of the notice in the member's medical record along with an entry documenting the telephone contact. This documentation should include:

- That the staff person told the representative the date the member's financial liability begins, the member's appeal rights, and how and when to initiate an appeal;
- Name of the staff person;
- Name of the representative contacted;
- Date and time of the telephone contact; and
- Telephone number called.

If direct phone contact cannot be made, the provider must send the NOMNC notice to the representative by certified mail, return receipt requested. The provider must place a copy of the notice in the member's medical record and document the attempted telephone contact. This documentation should include:

- Name of the staff person initiating the contact;
- Name of the representative the provider attempted to contact;
- Date and time of attempted call(s); and
- Telephone number called.

When the return receipt is returned by the post office it should be placed in the medical record also.

SNFs, HHAs and CORFs should follow the procedures described below in issuing a NOMNC:

Step	Action
1	The provider delivers the NOMNC to the member or the member's authorized representative at least two days prior to discontinuation of services.
2	The member or representative signs the form to acknowledge that he or she has received it. If the member does not agree with the decision to end services, he or she can initiate an appeal by contacting the designated QIO.
3	The provider provides a copy of the form to the member and keeps another copy for its medical records.
4	If the member disagrees with the discharge decision, the facility faxes a copy of the signed form to FreedomBlue® at 1-304-343-3581.
5	On the date that the QIO receives notification that the member has appealed the decision, it notifies both the provider and Highmark West Virginia that the member has requested an immediate review.
6	Before close of business on the date of the appeal, the provider supplies the QIO with the signed form, all applicable medical records and any other information that the QIO may request.
7	Before close of business on the date of the appeal, Highmark West Virginia supplies the member with a Detailed Explanation of Non-Coverage (DENC). The provider must cooperate in timely providing records or information requested by Highmark West Virginia to prepare the DENC.
8	After it receives all of the necessary information from Highmark West Virginia and the provider, the QIO solicits the view of the member and makes a determination whether an extension of services is medically necessary. The QIO will typically render a decision prior to the termination of services. If all of the required information is not delivered in the requested time frame, the QIO may make its decision based on the information available, or defer to a later date.

Copies of the NOMNC form and instructions are provided below and may be copied for use by the provider. The documents are also published on our website at www.highmarkbcbswv.com. Click on the Provider tab then select "Resource Center."

6.10 Behavioral Health

The Highmark West Virginia Office of Case Management has a dedicated behavioral health unit staffed by registered nurses with significant clinical behavioral health experience. The behavioral health case managers review authorization requests and referrals for behavioral health services and provide case management for members with DSM-IV diagnoses who have chronic conditions or who utilize multiple behavioral health services. Case managers can also assist members and providers in locating an in-network behavioral health provider.

Case managers have access to Highmark West Virginia medical directors and to consulting psychiatrists for consultation on individual cases.

We protect the confidentiality of behavioral health information providers submit to us. You may leave information on voice mail for the telephone numbers provided below and be assured that confidentiality will be maintained.

6.10.1 Authorizations

Behavioral health services requiring an authorization include:

- Inpatient behavioral health admissions;
- Intensive outpatient services;
- Partial hospitalization; and
- Outpatient therapies.

To submit an authorization request, you may:

- Submit a request via the internet through NaviNet^{SM};
- Call the pre-certification number on the back of the member's ID card;
- Call 1-800-344-5245 for Highmark West Virginia products;
- Call 1-800-269-6389 for FreedomBlue® (Medicare Advantage);
- Call 1-888-211-4523 for the Federal Employee Program; or
- Fax the request to 1-304-347-7723

Please see Section 6.2 of this *Provider Manual* for additional general information on authorizations.

6.10.2 Referrals

For point of service referrals, you may:

- Call 1-800-344-5245 (select option 3); or
- Fax to 1-304-347-7723

Please see Section 6.7 of this *Provider Manual* for additional general information on referrals.

6.10.3 Case Management

To refer a member for behavioral health case management, please call 1-800-344-5245 (select option 3).

When behavioral health conditions co-exist with chronic or complex physical conditions, a behavioral health case manager will work with the member's medical case manager to help coordinate needed services, locate providers and determine the most appropriate care settings.

6.10.4 Benefits

For information regarding a member's behavioral health benefits, please contact the Customer Service number on the back of the member's ID card.

6.10.5 Definition of Medical Necessity for Behavioral Health Providers

Medical Necessity criteria for Behavioral Health services is defined in Chapter 6.5.2 of this *Provider Manual*.

6.10.6 Network Providers in Highmark West Virginia's Directory

Highmark West Virginia's network psychiatrists are listed in the Provider Directory on Highmark West Virginia's public member website. Highmark West Virginia allows its PCPs to direct care to network psychiatrists.

6.10.7 Prudent Layperson Laws for Emergency Services

Highmark West Virginia defines prudent layperson laws as defined in the member's certificate.

6.10.8 Authorization Form for Behavioral Health Providers to Release Medical Information to Highmark West Virginia

The form "Highmark West Virginia Privacy Form Standard Authorization" was developed to assist network and non-network behavioral health specialists to obtain the proper permissions to provide behavioral health clinical information to Highmark West Virginia, its subcontracts and business associates. The form is available on the website at www.highmarkbcbswv.com. Click on the Provider tab and then select "Resource Center." You may also contact the Customer Service number on the back of the member's identification card to obtain a copy of this form.

6.11 Transplant Coordination

Transplants must be authorized prior to the initial evaluation by the transplant center. Please call 1-800-344-5245 to initiate the review.

Highmark West Virginia members have access to the Blue Distinction Centers for Transplants ("BDCT"), a national network of transplant centers of excellence developed by the Blue Cross Blue Shield Association. Network facilities offer heart, liver, simultaneous pancreas-kidney, pancreas, single and bilateral lung, bone marrow, and combination heart/bilateral lung transplants.

Transplants performed by BDCT are reimbursed under a global fee arrangement that affords significant savings to the member and plan. Highmark West Virginia will educate members on the benefits of using a BDCT. Providers are encouraged to refer their members to us for more information.

Once a member has been approved for a transplant, a Highmark West Virginia transplant coordinator offers case management services. Members may receive education and assistance regarding benefits, travel and lodging arrangements, how to stay healthy and keep out of the hospital, taking medications, keeping appointments, etc.

The transplant coordinator also assists with discharge planning needs, such as arranging for home health services or durable medical equipment. In addition, we can inform members about programs that may be able to assist with the cost of anti-rejection medications.

The transplant coordinator may be reached by calling 1-304-347-7687.

6.12 Cost Management Programs

As outlined in your provider agreement, Highmark West Virginia may establish cost management programs. The following programs, are included but not limited to cost management programs in effect between Highmark West Virginia and you, as a provider:

i. Utilization Management
ii. Care and Case Management
iii. Medical Policy
iv. National Imaging Associates' Radiology Management Program