

# Healthy Options / State Children's Health Insurance Plan (SCHIP)

## **How Does Healthy Options Work?**

When a person enrolls in Healthy Options, he or she selects a managed care health plan, such as Regence BlueShield. The health plans may differ in the type of providers and facilities included in their networks, referral practices and guidelines. However, all the health plans offer the same Healthy Options benefits package and provide benefits only when a Primary Care Provider provides or coordinates the member's care (except in an emergency or for women's health-care as defined by RCW 48.42.100).

## **Who to call with Questions about Healthy Options**

If Healthy Options members have questions regarding exemptions or plan enrollment, they may call the Department of Social and Health Services at **1 (800) 562-3022**.

Please contact Regence BlueShield for issues concerning Healthy Options members such as member eligibility, benefits, claims, payment and grievances.

**Regence BlueShield Customer Service: 1 (800) 669-8791**

The goal of Healthy Options is to provide quality health-care to all Healthy Options members. However, it can become difficult for you, the Primary Care Provider, to do your part in achieving this goal when members do not keep their scheduled appointments or do not understand the principles of their health care plan.

If you are having difficulty communicating with or providing treatment to a Healthy Options member, please contact a customer service representative at **1 (800) 669-8791** so we can work with the member to resolve any problems or misunderstandings. Additional information is available in the Healthy Options Member Non-Compliance Guidelines paragraph in this manual section.

## Definitions

**Action** - the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; or the failure to provide services or act in a timely manner.

**Advance Directive** - a written instruction, such as a living will or durable power of attorney for health care, recognized under the laws of the State of Washington, relating to the provision of health care when an individual is incapacitated .

**Appeal** - a request for review of an action. An appeal may be submitted verbally or in writing. A provider may not request an appeal, unless the member has given the provider their written consent to do so. The member's written consent must be submitted to Regence in order for the appeal to be processed.

**Appeal Process** - the procedure used to review an action.

**Children's Health Insurance Program (CHIP)** - the program that provides access to medical care for children under Title XXI of the Social Security Act, the Children's Health Insurance Program Reauthorization Act of 2009, RCW 74.09.450 and WAC 388-542.

**Children with Special Health Care Needs** - children identified by DSHS to Regence as children served under the provisions of Title V of the Social Security Act.

**Cold Call Marketing** - any unsolicited personal contact by the Contractor or its designee, with a potential member or an member with another contracted managed care organization for the purposes of marketing (42 CFR 438.104(a)).

**Comparable Coverage** - other insurance that DSHS has determined provides a full scope of health care benefits.

**Continuity of Care** - the provision of continuous care for chronic or acute medical conditions through member transitions in providers or service areas, between Regence and Medicaid fee-for-service in a manner that does not interrupt medically necessary care or jeopardize the member's health.

**Contracted Services** - covered services that are to be provided by Regence through its contract with the Department of Social and Health Services to serve Healthy Options members.

**Coordination of Care** - Regence's mechanisms to assure members and providers have access to and take into consideration, all required information about an member's conditions and treatments to ensure appropriate health care services are provided.

**Covered Services** - health care services that DSHS determines are covered for members.

**DSHS** - Washington State Department of Social and Health Services

**Duplicate Coverage** - when a member is privately enrolled on any basis with Regence and simultaneously enrolled with Regence under Healthy Options.

**EPSDT** - Early, Periodic Screening, Diagnosis and Treatment is a package of services in a preventive (well-child) exam covered by Medicaid.

**Emergency Medical Condition** - 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.

**Emergency Services** - inpatient and outpatient contracted services furnished by a provider qualified to furnish the services needed to evaluate or stabilize an emergency medical condition.

**Member** - a Medicaid recipient who is enrolled in Healthy Options managed care through Regence.

**Enrollee with Special Health Care Needs** - a member having a chronic and disabling condition that meets all of the following conditions:

- Have a biologic, psychologic, or cognitive basis;
- Have lasted or are virtually certain to last for at least one year; and
- Produce one or more of the following conditions stemming from a disease:
  - Significant limitation in areas of physical, cognitive, or emotional function;
  - Dependency on medical or assistive devices to minimize limitation of function or activities; or

In addition, for children, any of the following:

- Significant limitation in social growth or developmental function;
- Need for psychological, educational, medical, or related services over and above the usual for the child's age; or
- Special ongoing treatments, such as medications, special diet, interventions, or accommodations at home or school.

A member may be designated ESHCN either by DSHS or Regence.

**Grievance** - an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances may include, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights.

**Grievance Process** - the procedure for addressing members' grievances.

**Grievance System** - the overall system that includes grievances and appeals handled by Regence and access to the DSHS hearing system.

**Health Care Professional** - a physician or any of the following acting within their scope of practice; podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, pharmacist and certified respiratory therapy technician.

**Marketing** - any communication from Regence, or its subcontractors or providers, to a potential member or member with another Healthy Options carrier that can be reasonably interpreted as intended to influence them to enroll with Regence to either not enroll or end enrollment with another Healthy Options carrier.

**Marketing Materials** - materials that are produced in any medium, by or on behalf of the Contractor that can be reasonably interpreted as intended as marketing.

**Medically Necessary Services** - services that are "medically necessary" as is defined in WAC 388-500-0005. In addition, medically necessary services shall include services related to the member's ability to achieve age-appropriate growth and development.

**Medical Necessity Determination** - Regence will determine which services are medically necessary, according to the Utilization Management requirements contained in the Participating Provider Manual and the definition of Medically Necessary Services above. If a member does not agree with the determination the member may request an appeal of an adverse decision.

**MPA** - Medicaid Purchasing Agency, formerly Health and Recovery Services Administration (HRSA)

**Non-Participating Provider** - A provider who does not hold a current Participating Provider agreement with Regence BlueShield. These providers are only covered when:

- Regence BlueShield has approved the PCP's referral;
- The member sought emergency services outside the service area;
- The member no longer resides within the service area. These services are limited to a maximum of 90-days from the date the member moved.

**Notice of Action** -

- The letter sent to the provider who initiated a prior authorization informing them of the denial, reduction, suspension or termination of the service or;
- The letter to the provider or member who initiated an appeal informing them of the decision.

**Participating Provider** - A provider who has entered into a current Participating Provider agreement with Regence BlueShield.

**Patient Review and Coordination (PRC) program** - is a state-required program for Healthy Options members and the mechanism utilized by the Medicaid Purchasing Agency to fulfill federal and state Medicaid requirements. This program assists and educates those members who have prescription or service utilization issues

**Physician Group** - A partnership, association, corporation, individual practice association, or other group that distributes income from the practice among its members. An individual practice association is a physician group only if it is composed of individual physicians and has no subcontracts with physician groups.

**Physician Incentive Plan** - Any compensation arrangement between Regence and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services to Healthy Options members.

**Post-stabilization Services** - Contracted services, related to an emergency medical condition that are provided after an member is stabilized in order to maintain the stabilized condition or to improve or resolve the member's condition.

**Potential Member** - means any Medicaid or Children's Health Insurance Program (CHIP) recipient eligible, but not enrolled in Healthy Options.

**Primary Care Provider (PCP)** - A provider who has entered into a current Participating Provider agreement with Regence BlueShield. A participating provider has the responsibility for supervising, coordinating, and providing primary health care to members, initiating referrals for specialist care, and maintaining the continuity of member care. PCPs include, but are not limited to Pediatricians, Family Practitioners, General Practitioners, Internists, Physician

Assistants (under the supervision of a physician), or Advanced Registered Nurse Practitioners (ARNP), as designated Regence.

**Quality** means the degree to which Regence increases the likelihood of desired health outcomes of its members through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.

**Service Areas** means the geographic areas in which Regence serves Healthy Options members.

**Subcontractor** means any provider, entity or company that has contracted with Regence to provide services to or on behalf of our members. Examples include, but are not limited to, Free and Clear, McKesson, Health Integrated.

# General Information

## Eligibility

The Healthy Options program provides managed care health services to more than 650,000 Medicaid clients in Washington State.

Healthy Options members include:

- Temporary Assistance Needy Families (TANF) eligible (formerly AFDC).
- Children up to 200% of the Federal Poverty Level.
- Pregnant women up to 185% of the Federal Poverty Level.

CHIP members include children between 200% and 300% of the Federal Poverty Level. DSHS determines the client's enrollment and eligibility in a Healthy Options plan.

## Identification Cards

### Types of Cards

You will see two different types of identification cards. Healthy Options members will have a DSHS Services Card as well as their Regence identification card.

### Services Card

Medical Assistance clients are issued a plastic Services Card. The Services Card is permanent and is issued to each eligible family member. Eligibility information is not displayed on the card. The card will only contain the following information about the client: First name, Last Name, ProviderOne client identification number (9 digits followed by WA), and the date that the card was issued.

Using the ProviderOne client ID displayed on the front of the card is one way to access a client's eligibility information. The card also features a magnetic strip on the back and you may use a magnetic swipe card reader to obtain the most current eligibility information.



**Provider Website: [www.WAProviderOne.org](http://www.WAProviderOne.org)**

**Clients:** This is your permanent Services Card. **KEEP THIS CARD!**  
Present this card to each provider when requesting services.  
For any questions please call Customer Service.

**Customer Service .....1-800-562-3022**

**TTY/TDD .....1-800-848-5429**

**THIS CARD DOES NOT GUARANTEE ELIGIBILITY  
OR PAYMENT FOR SERVICES**

**Providers:** Always verify identity and eligibility.  
Eligibility may be obtained using this card,  
the Provider website, or Customer Service.



### **Types of Cards**

You will see two different types of identification cards. Healthy Options members will have a DSHS Services Card as well as their Regence identification card.

## **Regence BlueShield Identification Cards**

Healthy Options members will present a Services Card and Regence Healthy Options ID card at the time of service. The ID cards are neither an authorization for services nor a guarantee of payment. You should always verify a new member's identity in whatever manner is standard practice (e.g., ask to see their driver's license). **Always check your monthly member eligibility list.**

Primary Care Providers will receive a preliminary list of eligible members at the beginning of each month indicating the members who have either selected or have been assigned to the Primary Care Provider. A final list will be mailed by the tenth of each month.

Ask to see the member's Healthy Options card at the time of registration. Check the member's Services Card at each visit. You may also ask to see personal identification or call Customer Service at **1 (800) 669-8791** during business hours (7:30 am to 5:00 pm Monday through Friday) to verify coverage. Personal identification is needed only if you suspect someone is using another person's medical ID card.

## **Billing a Patient**

When contracting with patients for payment of services, providers must complete an Agreement to Pay for Healthcare Services form, DSHS 13-879 within 90-days before the service the member agrees to pay for is provided. Regence must be notified if a patient is being billed for a service.

Form DSHS 13-879 must be used in the following cases:

- The service is not covered
- The service is covered, but requires prior authorization and the prior authorization request has been denied
- The service is covered, but the specific treatment, supply or equipment based on personal preference that is not covered.

Form DSHS 13-879 is not required and a patient can be billed if any of the following apply:

- The patient was reimbursed directly for the service by a third party
- The patient refused to complete and sign the necessary to bill a third party insurance carrier.
- The member represents themselves as a private pay client not receiving medical assistance. (In this case, a patient must sign and date a declaration of medical coverage.)

Providers may not bill a patient for any of the following, under any circumstance:

- Missed appointment fees
- Shipping charges
- Concierge care
- Price differentials for upgraded services

If you are billing a Healthy Options member for services you must notify Regence.

## **Clean Claims**

A clean claim is a claim that can be processed without obtaining additional information from the provider of service or from a third party.

Regence BlueShield shall meet the following standards for processing claims for Healthy Option members:

- 95% of clean claims paid within 30 calendar days of receipt;
- 95% of all claims paid or denied within 60 calendar days of receipt and;
- 99% of clean claims within 90 calendar days of receipt.

The date of receipt is the date Regence BlueShield receives the claim from the provider. The date of payment is the date of the check or date of other form of payment.

## **Coordination of Benefits (COB)**

Healthy Options is secondary to all other insurance carriers. There are no exceptions. If you discover one of your Healthy Options patients are covered by other insurance please notify the Healthy Options customer service department at **1 (800) 669-8791** as soon as possible.

We notify DSHS if we receive information that a member is covered by other insurance. In most cases the member will be removed from a Healthy Options plan and be covered by the fee for service program through DSHS. We notify DSHS on an ongoing basis, however, the member will not be removed from Healthy Options until the following month of our notification. DSHS does not disenroll members retroactively based on the information we forward to them regarding other coverage. When submitting claims, please send in the claim with the explanation of benefits (EOB) from the other insurance carrier for the dates of service the patient is covered by Regence BlueShield.

## **Second Opinions**

Members have the right to obtain a second opinion if they want additional information or feel that the Primary Care Provider is not providing adequate care. The Primary Care Provider must provide a referral for a second opinion to either a specialist or another Primary Care Provider who practices outside the Primary Care Provider's office.

## **Advance Directives**

The goal of the “Natural Death Act” (Chapter 70.122 RCW) is to provide the member with the knowledge and tools necessary to create an advance care document if he or she so desires and to ensure that it becomes part of the medical record.

“In recognition of the dignity and privacy which patients have a right to expect, the legislature hereby declares that the laws of the state of Washington shall recognize the right of an adult person to make a written directive instructing such person’s physician to withhold or withdraw life-sustaining treatment in the event of a terminal condition or permanent unconscious condition. The legislature also recognizes that a person’s right to control his or her health may be exercised by an authorized representative who validly holds the person’s durable power of attorney for health care”\*.

Providers need to routinely ask all members, as part of the member registration process, if they have implemented an *Advance Directive*. When a member presents the provider with an *Advance Directive*, it must be documented in the member’s record and a copy of the document made a part of the member’s record. There are two advance directive forms: the ‘Power of Attorney for Healthy Care,’ and the “Living Will- Directives to Physicians.” If members have signed either of these forms, copies should also be included in the medical record.

The Federal “Patient self-determination Act” (Section 4751 of OBRA 1991) and the Washington “Natural Death Act” (Chapter 70/122 RCW) require that a process of member education be implemented by all institutions receiving reimbursement from Medicare and Medicaid. Members are to be advised of their right to execute an *Advance Directive* in the member record. For members 65 years old or older, documentation should include discussions of a member’s right to predetermine future health-care and specific treatment preferences if expressed. Providers and staff members who make entries on member charts regarding this subject should identify themselves by signing or initialing each entry.

*\*Washington State Chapter 70.122 RCW, Natural Death Act, 1966.*

## **Informed Consent**

The provider agrees to obtain informed consent before the medical treatment occurs. Information regarding the proposed treatment must be given in a language understandable to the member. The information must include the nature of the proposed treatment, expected results of the treatment and recognized serious possible risks, complications and expected benefits involved in the treatment and the recognized possible alternative forms of treatment including non-treatment. The provider agrees to comply with all program procedures regarding informed consent as outlined in the program materials.

A member may also elect not to be informed of the possible risks, benefits and alternatives to the treatment. In some compelling circumstance, involuntary treatment may be administered. In these instances, health care professionals or a judge may determine whether treatment is warranted.

If your patient is incapacitated, informed consent may be obtained from a person authorized by law to make treatment decisions. Such a person or 'surrogate' may be, in descending order of priority:

- a. An appointed guardian
- b. An individual to whom the member has given a Durable Power of Attorney for Health Care
- c. The member's spouse
- d. Children of the member who are 18 or over
- e. Parents of the member
- f. The member's brothers or sisters who are over 18

## **Delegation**

The Delegation Program establishes the framework within which Regence BlueShield may delegate some of its health care management functions to Medical Group Practice (MGP). The goal of Delegation is to assure that MGPs performing contractually delegated functions meet or exceed the performance standards set by Regence BlueShield. Regence BlueShield retains responsibility for assuring compliance with performance standards, while giving an MGP the authority to perform delegated functions. Delegated activities may include utilization management and credentialing.

Delegation Coordinators conduct oversight of delegated functions and assure ongoing management of the Delegation Program. The Utilization Management and credentialing Committee's meet regularly to review delegation issues, annual oversight, UM assessments, credentialing audits and new delegation applications.

For initial and ongoing delegation status, Regence BlueShield:

- Evaluates the MGP's ability to perform delegated functions prior to delegation
- Approves the MGP's UM program and/or credentialing to assure that delegation functions are being conducted in accordance with Regence BlueShield and NCQA standards

Upon approval for delegation status, Regence BlueShield and the MGP sign a delegation agreement that includes, but is not limited to:

- The responsibilities of both Regence BlueShield and the MGP
- The approved delegated functions
- The reporting requirements

Regence BlueShield retains the following:

- The right to deny or rescind an MGP's delegation status
- The authority to approve providers and facilities for all Regence BlueShield networks
- The authority to terminate or suspend individual providers

Upon approval of delegation status to an MGP, Regence BlueShield provides ongoing oversight and monitoring of delegated activities, which may include:

- Analysis of required reports
- At a minimum, an annual on-site audit to reevaluate delegated functions and programs
- Participation in applicable MGP committee meetings

If you are interested in The Delegation Program, please contact the Delegation Program coordinators at **(206) 287-5976** for more information.

## **Quality Improvement/Utilization Management**

Please see the Quality Programs and Care Management sections in this manual for information.

## **Compliance with the Healthy Options Contract**

Agreements between Regence BlueShield and the provider are in place to ensure the provider will comply with any term or condition of the Healthy Options agreement and is applicable to all services performed under that agreement.

## **Marketing**

Direct or non-direct door-to-door, telephonic or other cold-call marketing of enrollment is prohibited by the Healthy Options contract between Regence BlueShield and the Department of Social and Health Services.

## **Subcontractor Responsibilities**

In addition to the responsibilities listed in the "Provider Responsibilities" section the following apply to all Subcontractors:

- All subcontracts must be in writing with parties to the agreement identified
- All subcontracts must be approved by DSHS in advance for any subcontracted obligation.

- Subcontractors agree to hold DSHS and its employees and all enrollees served under the terms of this contract harmless and free of any financial obligation in the event of non-payment by Regence. The subcontractor further agrees to indemnify and hold harmless DSHS and its employees against all injuries, deaths, losses, damages, claims, suites liabilities, judgments, costs and expenses which may in any manner accrue against DSHS or its employees through the intentional misconduct, negligence, or omission of the subcontractor, its agents, officers, employees or contractors.

In the event of a subcontract termination, Regence remains obligated to DSHS for any work performed under the contract between Regence and DSHS.

## **Provider's Responsibilities**

### **Responsibilities of all Participating Providers**

Each participating provider has entered into an agreement with Regence BlueShield. This agreement contains important information about your responsibilities as a Regence BlueShield participating provider. If you have any questions about your responsibilities, please contact Provider Network Management at **1 (800) 562-2227**.

Briefly, participating providers have agreed, at a minimum, too:

- Notify Provider Network Management in writing at least 60 days prior to limiting or closing their practice to members.
- Provide services during normal business hours with 24-hour, 7-day-a-week emergency coverage.
- Refer members only to participating providers unless one is not available.
- Submit claims and encounter data for services provided to members.
- Accept the Medicaid reimbursement made by Regence BlueShield, or Regence BlueShield's reimbursement, as payment in full for covered services rendered to Healthy Options members.
- Accept our reimbursement as payment in full for covered service rendered to eligible members. The provider cannot seek additional reimbursement from the member for covered services.
- Provide consultation to other participating providers as reasonably requested.
- Maintain all required licenses, certifications, credentials and liability insurance, as defined by Regence BlueShield's credentialing program policies and procedures.
- Comply with Regence BlueShield's quality improvement, credentialing and utilization management programs, policies and procedures.
- Allow onsite reviews and medical record reviews by Regence BlueShield upon reasonable notice.
- Maintain confidentiality of Regence BlueShield's proprietary information.

- Promptly notify Regence BlueShield when an agreement between the Practitioner and other entity is made which states that monies owed to the Practitioner by Regence BlueShield are assigned to that entity. Please contact your provider consultant if this situation is applicable to your office.

When necessary, the provider may also be responsible for:

- Contacting the AT&T Language Line at 1 (800) 848-5459 no more than 15 minutes, when a limited-English-speaking client requires urgent care that cannot be rescheduled and the medical provider has no other resource for an interpreter
- Contacting the Washington State Relay Service for TDD connection at 1 (800) 833-6384 VOICE For Deaf or 1 (800) 833-6388 for deaf to communicate with a person who is deaf, deaf-blind, or hard of hearing
- Contacting the Medical Assistance Customer Service Center at 1(800) 562-3022 for help in obtaining an interpreter

Please refer to your agreement for more complete information about your responsibilities. The above list is a summary of some of your responsibilities for reminder purposes only. It is not intended to replace or redefine the responsibilities in your agreement.

### **Healthy Options Provider Responsibilities**

- Verify the member's eligibility at the time of service
- Checking to see whether the medical service to be provided is covered by the client's medical program
- Provide or arrange for primary care, specialty care and emergency room services for your assigned members.
- Refer members only to participating providers unless one is not available. Additional information is available in the Referrals section of this manual.
- Work with specialists and hospitals to manage the care delivered to Healthy Options members.
- Following medical service authorization procedures, as applicable
- Make available and encourage regularly scheduled EPSDT screenings for children. Additional information is available in the EPSDT paragraph of this manual section.
- Complete a mental health or substance abuse referral form and assist the member in making appointments and obtaining necessary treatment.
- Agree to obtain informed consent before the medical treatment occurs. Additional information is available in the Informed Consent section of this manual.
- Agree to comply with all program procedures regarding advance directives as durable power of attorney and anatomical gifts.
- Comply with all procedures regarding family planning, infertility services and sterilization and comply with all member consent procedures for sterilization, as outlined in the program materials.

- Notifying the client that interpreter services, including services for the hearing impaired are available to the client at no charge
- Coordinating the interpreter services
- Notifying the independent interpreter or interpreter agency when interpreter services are required
- Notifying the interpreter of any changes to scheduled appointments
- Verifying the interpreter's picture identification with the interpreter
- Documenting in the client's record that the person is deaf, deaf-blind, hard of hearing or limited- speaking English and that interpreter services were provided. Include the name of the interpreter and what form of identification was presented.
- Arrange for and assure the continuity and coordination of each member's total health care needs including coordination with community-based and DSHS services/programs such as:
  - First Steps Maternity Services and Maternity Case Management
  - Transportation services
  - Regional Support Networks for mental health services
  - Developmental Disability services
  - Infant Toddler Early Intervention Program (ITIEP) for infants from birth to age 3
  - Patient Review and Coordination (PRC) for enrollees who meet the criteria
  - Health Department services, including Title V services for children with special health care needs
  - Home and Community Services for older and physically disabled individuals; and Alcohol and Substance Abuse services

## **The Primary Care Provider**

The Primary Care Provider is the manager and medical home of a member's total health care needs. This includes providing primary care and coordinating medical services. To complete a referral, the Primary Care Provider specifies the nature of the services and the name of the referral provider, on the recommended CHITA referral form. The form is available on the Washington Healthcare Forum's Web site, at: [www.wahealthcareforum.org](http://www.wahealthcareforum.org).

*Note:* If you are participating with a Managed Group Practice, please contact your Managed Group Practice administrator for referral and utilization management guidelines.

The Primary Care Provider maintains documentation of referral services in members' medical records for all specialty services. Additional DSHS services information is available in the Role of Primary Care Provider paragraph of this manual section.

Delegated managed group practices have an internal referral process. Please follow the guidelines set forth by your managed group practice.

### **Who Can the Primary Care Provider refer to?**

Primary Care Providers are required to refer to Regence BlueShield participating providers and facilities that agree to accept Healthy Options members.

### **What Services Require a Referral?**

All services not rendered by the Primary Care Provider **except** for the following:

- Routine lab and x-rays ordered by the Primary Care Provider when the lab or radiologist bill includes the referring provider's Regence BlueShield rider number.
- Hospital admits through the emergency room for the first 72 hours or admissions by the Primary Care Provider.
- Women's health care issues. See the Women's Health Care section of this manual for additional information.
- Members who self-refer to local Public Health Departments and Regional Support Network (RSN) facilities. Providers should bill DSHS for these services.
- One routine vision exam every two years (annually for members under age 21).

### **Primary Care Provider Types**

The following providers are acceptable to be Primary Care Providers (PCP) in the Healthy Option network:

- General Practice
- Family Practice
- Internal Medicine
- Osteopath
- Pediatrics
- ARNP-Family Practice
- ARNP-Adult Medicine Specialist
- ARNP-Women's Health Practitioner
- PA-Family Medicine
- PA-Pediatric
- Preventative Medicine

Please refer to your agreement for more complete information about your responsibilities. The above list is only a summary of some of your responsibilities for reminder purposes only. It is not intended to replace or redefine the responsibilities in your agreement.

### **Selecting a Primary Care Provider**

Regence BlueShield members must select or are assigned a participating Primary Care Provider (PCP) to coordinate all their health care including the

provision of primary care services and referrals to participating physicians, other health care professionals and facilities. Primary Care Providers also coordinate services to eligible Medicaid recipients through other divisions within DSHS that are not included in the Healthy Options program. Members are allowed to change Primary Care Providers as often as they wish by contacting the Regence BlueShield Healthy Options department. In most cases, a PCP change will be effective the first of the month following the change request.

### **Enrollees with Special Health Care Needs (ESHCN)**

Either DSHS or Regence may determine a member to be an “Enrollee with Special Health Care Needs”. Once an enrollee with special health care needs is identified, PCP’s, in consultation with other appropriate health care professionals must assess the health care needs of and develop, document and maintain in the member’s medical record an individualized treatment plan for that member. The treatment plan must include the following:

- An assessment that includes, at a minimum, an evaluation of the member’s physical and behavioral health status, clinical history, including medications, and an evaluation of the need for or use of supportive services and resources
- Includes short and long-term treatment goals, identification of barriers to meeting goals or complying with the treatment plan and development of schedules for follow-up treatment and communication with member
- Addresses integration and coordination of clinical and non-clinical disciplines and services.
- Is modified as needed to address emerging needs of the member
- Includes member participation
- Documents any communication barriers and how they were addressed

If the member’s treatment plan indicates frequent utilization of a specialist, the member may retain the specialist as a PCP, or alternative, be allowed direct access to specialists for needed care. These members may retain a specialist as a PCP or be allowed direct access to a specialist if the assessment and treatment plan demonstrates a need for a course of treatment or regular monitoring by such specialist.

### **The Specialty Care Provider’s Responsibilities**

Specialty care providers render consultation and/or specialty services for members who have been referred by their Primary Care Provider. They are responsible for promptly communicating their findings and treatment recommendations/outcomes to the Primary Care Provider. If the specialty care provider determines a need to render services not included in the original referral, he or she must obtain the Primary Care Provider’s approval prior to rendering these services, except in the case of a medical emergency.

### **Regence BlueShield’s Responsibilities**

Regence BlueShield performs the following functions:

- Issues the member a Regence BlueShield member identification card
- Sends monthly Member Eligibility Rosters to Primary Care Providers
- Processes claims
- Responds to inquiries about eligibility, benefits, claims, referrals and other issues or concerns that members and participating providers may have regarding Healthy Options
- Processes Grievances and Appeals at the member's request or by provider request with the member's written consent.

## **Referrals and Prior Authorizations**

### **Referrals**

The Healthy Options program requires members to use a Primary Care Provider to manage and coordinate their health care. The Primary Care Provider's responsibilities include issuing referrals for consultations, specialty and hospital services and sending referral information to Regence BlueShield or their managed group practice if delegated. In addition, Primary Care Providers are required to obtain prior authorization from Regence BlueShield for some services. The term preauthorization is used for services that require approval from Regence BlueShield, such as organ transplants.

### **Who Can Initiate a Referral?**

Primary Care Providers can initiate a referral. They may submit referrals in the following three ways:

#### **Consult/Office Calls only**

A Primary Care Provider can do this by limiting visits using appropriate procedure codes—incidental lab and x-ray included.

#### **Consult and Treatment**

If a Primary Care Provider specifies for consult and treatment, all care from the specialist will be considered authorized by this referral.

#### **Specific Services Listed**

A Primary Care Provider will list specifically, by procedure codes, what services he or she is expecting the specialist to perform.

#### **How to submit a Referral**

- Referrals are written by the Primary Care Provider to specialists and/or facilities for care.
- Referrals are active for six (6) months, or until the visits/services authorized are exhausted or if the member chooses a new Primary Care Provider or plan.
- Referrals may be updated without having to submit a new referral by contacting Regence BlueShield Healthy Options Customer Service.
- If a referral specialist or another provider must refer the member on for other care including hospitalization, the Primary Care Provider must be apprised of

the situation and provide an update to the original referral.

- Referral forms can be submitted to us for processing in any of the following ways:
  - Via the Provider Center
  - Call Healthy Options Customer Service at **1 (800) 669-8791**. A customer service representative is available to take your call weekdays from 7:30 am to 5:00 pm.
  - Via fax to **1 (253) 573-3253**
  - By mail to:  
Regence BlueShield Healthy Options  
PO Box 21267  
Seattle, WA 98111-3267

Once Regence BlueShield receives your referral and a number is assigned, a letter is sent to the member, the Primary Care Provider and the specialist. All services are subject to eligibility and benefits at the time the services are rendered. An assigned referral number does not constitute payment of services. Payment is subject to eligibility and all applicable provisions, limitations and exclusions of the agreement.

### **Referral Criteria**

All referrals are required to contain the following information:

- Member name, member number and date of birth.
- Primary Care Provider name, tax ID and rider number, signature and date.
- Full name of specialist or complete name of facility to which the member is referred (must be PAR, PPO, Allied. Exception: ER care and pre-authorized care received out of the service area) and tax ID and rider number.
- Diagnosis code.
- Beginning and ending date of service.
- Previous treatment (if applicable).
- Number of visits requested.
- The service or treatment that was required or requested (e.g., evaluation & treatment, evaluation & testing, Inpatient for surgical procedure, etc.).
- Note whether referral is new, updated or denied.

Referrals for chiropractic benefits will require the last date of the EPSDT exam.

Referrals not containing the required information will be returned for additional information.

### **Referral Denials (Actions)**

If a referral is denied, the Primary Care Provider will receive a letter informing him or her of the denial. This denial is referred to as an “Action”. The Primary

Care Provider should contact Regence BlueShield or the medical group practice for a clarification or understanding of the denial. If the member desires to appeal the “action”, they may contact Regence BlueShield’s customer service department at **1 (800) 669-8791** for information and assistance.

### **Prior Authorizations**

Regence BlueShield Healthy Options requires prior authorization for the same services contained on the Standard Group and Individual Prior Authorization List.

The following services require prior authorization:

- Electrical Bone Growth Stimulators
- Continuous noninvasive glucose monitoring device
- Wheelchairs
- Transplants
- Ventricular Assist Devices
- Total Artificial Hearts
- Long Term Acute Care Facility (may be covered by DSHS)
- Rehabilitation
- Skilled Nursing Facilities (may be covered by DSHS)
- Orthognatic Surgery (may be covered by DSHS)
- Sleep Apnea Surgery
- Varicose Vein Treatment
- Investigational Services (may be excluded)

A complete list of codes associated with the services listed above that requires prior authorization is available in the Care Management section of our *Provider Web Site* at **[www.wa.regence.com/provider](http://www.wa.regence.com/provider)**.

#### Prior-authorization reminders

- Before requesting a prior-authorization please verify the member’s eligibility and benefits.
- Prior-authorizations obtained within 30-business days prior to the date of service are valid except in the case of misrepresentation.
- Medical policies related to specific prior-authorizations are available on the *Regence Provider Web Site*.
- Covered services are determined by DSHS.
- Pharmacy prior-authorizations information and forms can be found on the RegenceRx Web site.

To inquire about prior authorization for a Healthy Options member, call Healthy Options Customer Service at **1 (800) 669-8791** for specific contract exclusions and limitations.

*Note:* Some services contained on the Standard Group and Individual Prior Authorization List are not covered by Healthy Options. These services may be

covered under the DSHS Fee-For-Service Program, through other contracts, by other divisions in DSHS or not covered by either DSHS or Regence. Services that are not covered by Regence BlueShield standard group and individual plans will not be included in Standard Group and Individual Prior Authorization List, however, may still require prior authorization. In these situations, DSHS prior authorization criteria will be followed.

Some services require prior authorization from the HCA (e.g., hearing aids). Please fax the request and supporting documentation to 1 (866) 668-1214.

### **Non-participating Providers**

If the member's Primary Care Provider needs to refer a member for consultation and/or specialty services and a participating provider is not available; the Primary Care Provider must call Healthy Options Customer Service at **1 (800) 669-8791** and obtain prior authorization to refer the member to a non-participating provider. The member will not be responsible for any costs associated with the referral to or for the treatment of covered services provided by the referred to non-participating provider.

### **Appointment Standards**

Primary care practitioner appointments for preventive and routine care should be available to members in a timely manner. Practitioners must have a system in place in order to evaluate the urgent and emergent needs of members and to determine the appropriate site for care in a timely fashion. Regence has established the following access and availability standards that are used to monitor and measure practitioner accessibility and availability to our members, including government programs. Hours of operation and appointment availability for Healthy Option enrollees must be consistent to those for all other commercial enrollees. Regence BlueShield must ensure that the following appointment standards are met when referring to participating and/or non-participating providers:

<b>Type of Care/Need of Member</b>	<b>Acceptable Time frame</b>
Routine, symptomatic or chronic care	Within 72 hours
Routine, non-symptomatic preventive care	Within 4 weeks
Urgent exam	Within 24 hours
Emergent exam	Same day
Behavioral health	Within 24 hours for emergencies, 7 days for non-emergency care
After-hours care	Available 24 hours a day, 7 days a week
Specialty referral	Within 14 days
Waiting room time, all visits	No longer than 30 minutes

### **After-Hours Access**

PCPs are required to provide coverage 24 hours a day, seven days a week. The PCP or the designated covering provider will be available on a 24-hour basis to

provide care or to direct members to the most appropriate setting for treatment. Messages on after-hours electronic answering machines need to include the name and telephone number of the on-call provider. A tape-recorded telephone message instructing members to call a hospital emergency room is not adequate for 24-hour coverage.

### **Access to Phone Service**

It is important that members be able to obtain information regarding the process for accessing clinical care, resolving problems they experience, and making appointments. The member's health care provider must provide a response to member telephone calls within a reasonable time. The timeliness of a response needs to be appropriate to the member's stated condition.

Telephone requests from other providers requesting approval to treat members must be responded to in a timely manner and evaluated for appropriate action.

### **Available Treatment Options**

Providers will share information on available treatment options and alternatives with members including alternatives and options that are outside, as well as within Medicaid contract's scope of benefits.

### **Ninety (90) Day Termination Notice**

Notify Provider Services in writing, at least 90 days in advance of intent to withdraw from the Healthy Options network.

### **Practice Guidelines**

Clinical Practice Guidelines (CPGs) are systematically developed statements on medical practices that assist providers in making decisions about appropriate health care for specific medical conditions and recommended courses of intervention, but not as a substitute for an individual clinician's judgment. CPGs also help form the basis for designing appropriate disease management program interventions, coaching and wellness program content, and other Regence health care programs.

Regence CPGs are available on our *Provider Web Site* in the Care Management section, under Practice Guidelines.

### **Member Written Communication**

Any written information provider to members or potential members must be accurate, not misleading, understandable to the member and be written at or below the sixth grade reading level. All written communication must be submitted to Regence at least thirty (30) calendar days in advance of mailing. Regence must submit member written communication to DSHS for written approval prior to the materials being mailed.

## **Benefits**

Healthy Options members are eligible for, but are not limited to, benefits for the following services:

- Regular office visits
- Well-child care
- Pregnancy health care
- Inpatient hospital and emergency services
- Care by a specialist
- Second opinion by a specialist or another Primary Care Provider (referral required)

### **Alternative Care Medicine**

Healthy Options will not pay for services performed by the following providers:

- Acupuncturists
- Naturopaths
- Nutritionists
- Homeopaths
- Herbalists
- Christian Science practitioners or theological healers
- Masseurs, masseuse and massage therapists
- Any other licensed or unlicensed providers

### **Ambulance Transportation**

Healthy Options covers air/ground transportation for emergencies and medically necessary transfers.

### **Audiology / Speech Pathology**

Healthy Options members are provided services necessary to establish a diagnosis of hearing and/or speech impairment. These services require a referral. Additional information is available in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) section of this manual.

### **Blood and Blood Products**

The administration of whole blood and blood components, as well as human blood products, will be provided. Additional information is available in the Referrals and Prior Authorization section of this manual.

### **Chiropractic Services**

Chiropractic services are covered under the EPSDT/Healthy Kids program. A referral for chiropractic services must be made within 14 days of the EPSDT screening. Additional information and referral criteria is available in the Referrals and Prior Authorization paragraphs of this manual section. Chiropractic services for adults are not covered.

## **Durable Medical Equipment and Supplies**

Covered items include, but not limited to; surgical appliances; orthopedic appliances and braces; breast pumps; incontinence supplies for members over three (3) years of age; and medical supplies. Please refer to the DSHS guidelines for covered items and criteria requirements.

## **Emergency Services**

If a condition exists requiring emergency treatment, the cost of emergency treatment will be paid at the DSHS Fee Schedule. Once stabilized, the member may be moved to a participating facility at the discretion of the plan and in compliance with the member's Primary Care Provider.

The State of Washington defines an "emergency medical condition" as stated in The Consumer Assistance and Individual Market Stabilization Act (ESHB 2018), effective January 1, 1998, as:

"The emergent and acute onset of a symptom or symptoms including sever pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy".

If a member experiences a medical emergency and is unable to use a participating facility, he or she may obtain services from non-participating physicians and other health care professionals. Once stabilized, the member may be moved to a participating facility at the discretion of the plan, in compliance with the member's Primary Care Provider. The Primary Care Provider must refer coverage for necessary follow-up care.

Services will be covered as follows:

- Non contracted providers will be covered if services are not pre-approved by a plan provider or Regence BlueShield, but are administered to maintain the member's stabilized condition within one (1) hour of a request to Regence BlueShield for pre-approval of further post-stabilization care services.
- Services are not pre-approved by a plan provider or other Regence BlueShield representative, but are administered to maintain, improve or resolve the member's stabilization and Regence BlueShield does not respond to a request for pre-approval within thirty minutes, Regence BlueShield cannot be contacted; or a Regence BlueShield representative and the treating provider cannot reach an agreement concerning the member's care and a Regence BlueShield provider is not available for consultation. In this situation, Regence BlueShield shall give the treating physician the opportunity to consult with a Regence BlueShield provider and the treating provider may continue with care of the member until a Regence BlueShield provider is reached.

Regence BlueShield's responsibility for non-approved post-stabilization services ends when:

- A participating provider with privileges at the treating hospital assumes responsibility for the member's care;
- A participating provider assumes responsibility for the member's care through transfer;
- A Regence BlueShield representative and the treating provider reach an agreement concerning the member's care; or
- The member is discharged.

### **Exogenous Obesity**

Coverage for services for this condition is allowed under DSHS guidelines on a case-by-case basis. Additional information is available in the Referrals and Prior Authorization paragraphs of this manual section.

### **Family Planning and Infertility Services**

Healthy Options members may receive information and evaluation for contraception, pregnancy diagnosis, impotency, frigidity, sterility, infertility (limited to a determination of whether the member has a valid concern about infertility), sexually transmitted diseases, sexual dysfunction and voluntary pregnancy terminations (physical examinations may be required to determine reproductive health concerns). Members may self-refer to a local Family Planning agency for family planning services and treatment for sexually transmitted diseases. DSHS will pay for these services.

Voluntary pregnancy terminations are covered by DSHS. Additional information is available in the Exclusions list in this section. Sterilizations must meet federal and state requirements for both males and females. Healthy Options members are authorized sterilizations if they are 21 years and older and have waited at least 30 days (72 hours following emergency abdominal surgery or premature delivery) after signing the DSHS consent form.

### **Hemodialysis**

Benefits are provided for hemodialysis or other procedures or for treatment for acute and chronic renal failure, including the cost of equipment used in the course of treatment. Additional information is available in the Referrals and Prior Authorization paragraphs of this manual section.

### **Home Health/Hospice Services (Infusion Therapy)**

Benefits for home health services, including infusion therapy, at a member's home, by participating agencies and/or participating health care providers, require prior authorization.

### **Hospital Services**

- Inpatient medical (unless otherwise specified in contract)—inpatient rehabilitation. requires preauthorization
- Outpatient medical (includes scheduled outpatient procedures)

### **Injectable medications**

In compliance with the Health Care Authority (HCA) requirement, injectable drugs provided in an office setting and outpatient hospital claims with revenue codes 0634-0637 for injectable medications must include the 11-digit NDC.

The NDC must contain 11-digits in order to be recognized as a valid NDC. It is not uncommon for the label attached to a drug's vial to be missing "leading zeros." For example, the label may list the NDC as 123456789 when, in fact, the correct NDC is 01234056789. Make sure the NDC is listed as an 11-digit number, inserting any leading zeros missing from the 5-4-2 groupings as necessary.

The following HCPCS and CPT codes require a NDC:

- **Physician and medical vendor claims:** J0120-J9999, Q0136-Q0187, Q0515, Q3025-Q3026, S0012-S0198, S4989-S5014, S5550-S5553, S5570-S5571, 90281-90399, 1112J, Q4079, Q4082-Q4084
- **Kidney Center claims:** A4706-A4709, A4720-A4728, A4765-A4766, A4802, J0120-J9999, Q0136-Q0187, Q0515, Q3025- Q3026, Q0479, Q4083, Q4084, S0012-S0198, S4989-S5014, S5550-S5553, S5570, S5571, 90281-90399 **and** the revenue codes are equal to 0634 or 0635
- **Outpatient claims:** The revenue code is equal to 0634, 0635, 0636 or 0637 and the procedure code is not equal to 90400-90749

### **Claims submission information**

Paper and electronic claims lines billed without a valid NDC on those procedure codes that require a NDC will be denied for corrected billing. On electronic claims, list the 11-digit NDC in Loop 2410 with the corresponding HIPAA required fields.

## **Kidney Dialysis**

All services require prior authorization.

## **Laboratory, Radiology and other Medical Imaging Services**

All laboratory and radiology services not ordered by the Primary Care Provider require a referral. Imaging services that do not meet MRI, ultrasound or tomography criteria require prior authorization. Please refer to the Prior Authorization section in the DSHS guidelines for MRI's requiring prior authorizations.

## **Mental Health Inpatient**

Inpatient Mental Health benefits are administered through the DSHS (Department of Social and Health Services).

## **Mental Health Outpatient**

A PCP must first determine the diagnosis the member will be seen for. Then, by using the Access to Care Standards located on the MPA Web site, <http://hrsa.dshs.wa.gov/>, determine if the member meets the Standards. If the PCP is unable to make the determination, the PCP retains the right to refer the member to a Regence contracted mental health provider for psychiatric or psychological evaluation and testing and diagnosis before referring the member for outpatient mental health treatment. The PCP may refer a member to a Regence contracted mental health provider or to the RSN for treatment for covered services at Regence's expense when a member does not meet the Access to Care Standards.

- If member meets Access to Care Criteria, the member must be sent to a Regional Support Network (RSN) provider. A list of RSN providers is available on the MPA Web site.
  - A referral to the RSN is not required.
  - If, during evaluation, the RSN provider does not feel the member meets criteria but still wants to meet with them, a request to a load referral to this provider can then be submitted and should include that the member does not meet Access to Care Criteria.
  - If the RSN provider states that the member doesn't meet Access to Care Criteria and doesn't want to continue to see the member, the PCP can refer the member to a Regence contracted mental health provider based on benefit limitations for the referred to Specialist type.

**Regence Covered Services:**

- Psychiatric and psychological testing, evaluation and diagnosis are covered once every twelve (12) months for adults twenty-one (21) and over and are unlimited for children under age twenty-one (21) when identified in an EPSDT visit when the PCP has determined that the member does not meet the RSN's Access to care Standards for receiving treatment.
- Medication Management (90862) is unlimited when provided by the PCP or by PCP referral to a psychiatrist or psychiatric ARNP when provided in conjunction with Regence covered mental health treatment.
- For members who do not meet the RSN's access to care standards for receiving treatment, twelve hours per calendar year for treatments of adults and twenty hours per year for the treatment of children eighteen years old and younger are covered.
- If a member is in need of mental health treatment in excess of the above limits, Regence and the mental health provider must work with the RSN to transition care to the RSN, as appropriate to the member's condition to assure continuity of care. This, however, does not obligate Regence to pay for outpatient mental health treatment visits, psychiatric and psychological testing, evaluation and diagnosis in excess of the limitations stated in the Outpatient Mental health Language contained within the Healthy Options/SCHIP contract.

**Services Not Covered by Regence:**

- Mental health treatment in excess of twelve (12) hours per calendar year for adults or (20) twenty hours per calendar year for children eighteen and younger.
- Mental health treatment for members who meet the RSN Access to Care Standards, including prescription medication and medication management
- Services covered by DSHS Mental Health Division
- Mental health treatment provided by contracted providers or RSN providers when referred to by the member's PCP

**When a member does not meet RSN Access to Care Standards**

All referrals for mental health treatment will be reviewed to locate the PCPs determination as to whether or not the PCP feels the member meets the RSN Access to Care Standards.

- If an outpatient mental health referral is received without a decision notation, Regence will follow up with the provider
- If the PCP does not feel the member meets the Access to Care Standards, the referral to the plan contracted mental health provider will be loaded.

If the PCP does not feel the member meets the Access to Care Standards, the provider will refer the member to the RSN for a psychiatric evaluation. To assist in determining whether or the member meets the Access to Care

Standards, the PCP may consult with another Regence contracted provider or refer the member to a Regence contracted mental health provider for psychiatric or psychological evaluation, testing and diagnosis before referring the member for outpatient mental health treatment.

Regence is responsible for claims payment for outpatient mental health treatment provided by a Regence PCP, Regence contracted mental health provider or RSN provider when the member has been referred by their PCP to the RSN and the member does not meet the RSNs Access to Care Standards.

- Covered services will be limited to procedure codes equivalent to those covered under the DSHS Fee-For-Service program
- Benefits are limited to those listed in the Covered Services section above

If the member is in need of the care that extends beyond the visit limit contained within the Healthy Options/SCHIP contract, Regence will work with the RSN as appropriate to the member's outpatient mental health treatment visits, psychiatric and psychological testing, evaluation and diagnosis in excess of the limitations contained in the Outpatient Mental Health paragraphs above or in the Healthy Options/SCHIP contract.

#### **When the Member meets the RSN Access to Care Standards**

If the PCP feels the member meets the Access to Care Standards, the provider will refer the member to the RSN for a psychiatric evaluation. To assist in this determination, the PCP may consult with another Regence contracted provider or refer the member to a Regence contracted mental health provider for psychiatric or psychological evaluation, testing and diagnosis before referring the member for outpatient mental health treatment.

- The RSN will provide a detailed psychiatric evaluation to confirm that the member meets the Access to Care Standards. If the member meets the Access to Care Standards, the RSN is responsible for the care, not Regence. Regence will not load referrals in this situation.
- Medication management associated with the treatment provided by the RSN is to be covered by the RSN, not Regence.
- If the RSN performs an evaluation and it is determined that the member does not meet the Access to Care Standards, the RSN will generate a "Notice of Action" stating that the member does not meet the standards. Regence must work with the RSN to obtain the Notice of Action.
- Once the Notice of Action is received, Regence will track and load the action into our systems indicating the evaluation has been performed and the member does not meet the Access to Care Standards.
- Regence will load the referral for the plan covered services listed above.

Adult Diagnosis best referred to the RSN include:

<b>Disorder Type</b>	<b>Diagnosis Code(s) - Coverage Category A</b>	<b>Diagnosis Code(s) - Coverage Category B</b>
Attention-Deficit and Disruptive Behavior disorders		314.00, 314.01 and 314.9
Dementia		294.10, 294.11, 290.40 - 290.43, 294.8
Schizophrenia and other Psychotic Disorders	295.10 - 295.30, 295.40, 295.60, 295.70, 295.90, 297.1, 298.8, 297.3, 293.81, 293.82 and 298.9	
Mood/Depressive Disorders	296.20 - 296.26, 296.30 - 296.36, 300.4 and 311	
Bipolar Disorders	A296.00 - 296.06, 296.40 - 296.46, 296.60 - 296.66, 296.50 - 296.56, 296.7, 296.80, 296.89.	296.90 and 301.13
Anxiety Disorders	309.81, 308.3,	300.01, 300.21 - 300.23, 300.29, 300.3, 300.2 and 300.00
Somatoform Disorders		300.80 - 300.82, 300.11, 307.89, and 300.7
Factitious Disorders		300.16 and 300.19
Dissociative Disorders		300.12 - 300.15 and 300.6
Eating Disorders		307.1, 307.51 and 307.50
Adjustment Disorders		309.0, 309.24, 309.28, 309.3, 309.4, 309.9
Personality Disorders		301.0, 301.20, 301.22, 301.7, 301.83, 301.50, 301.81, 301.82, 301.6, 301.4 and 301.9

A = Covered

B = Covered with Additional Criteria

**Additional Criteria for Diagnosis B RSN Coverage**

- High Risk Behavior demonstrated during the previous 90-days - aggressive and/or dangerous, puts self or others at risk of harm, is at risk of grave disability, is at risk of psychiatric hospitalization or at risk of loss of current placement due to the symptoms of a mental illness

- Two or more hospital admissions due to a mental health diagnosis during the previous 2-years.
- Psychiatric hospitalization or residential treatment due to a mental health diagnosis of more than 6-months in the previous year or is currently being discharged from a psychiatric hospitalization
- Received public mental health treatment on an outpatient basis within the PHI system during the previous 90-days and will deteriorate if services are not resumed (crisis intervention is not considered outpatient treatment).

Youth Adult Diagnosis best referred to the RSN include:

<b>Disorder Type</b>	<b>Diagnosis Code(s) - Coverage Category A</b>	<b>Diagnosis Code(s) - Coverage Category B</b>
Attention-Deficit and Disruptive Behavior disorders		312.81, 312.82, 312.89, 313.81, 312.9, 314.00, 314.01 and 314.9
Other Disorders of Infancy, Childhood, or Adolescence	309.21	313.23, 313.89, 307.3 and 313.9
Schizophrenia and other Psychotic Disorders	295.10 - 295.30, 295.40, 295.60, 295.70, 295.90, 297.1, 298.8, 297.3, 293.81, 293.82 and 298.9	
Mood/Depressive Disorders	296.20, 296.22 - 296.26, 296.30 - 296.36, 300.4 and 311	
Bipolar Disorders	A296.00 - 296.06, 296.40 - 296.46, 296.60 - 296.66, 296.50 - 296.56, 296.7, 296.80, 296.89.	296.90 and 301.13
Anxiety Disorders	309.81, 308.3,	300.01, 300.21 - 300.23, 300.29, 300.3, 300.2 and 300.00
Somatoform Disorders		300.80 - 300.82, 300.11, 307.89, and 300.7
Factitious Disorders		300.16 and 300.19
Dissociative Disorders		300.12 - 300.15 and 300.6
Eating Disorders		307.1, 307.51 and 307.50
Adjustment		309.0, 309.24, 309.28,

Disorders		309.3, 309.4, 309.9
Personality Disorders		301.0, 301.20, 301.22, 301.7, 301.83, 301.50, 301.81, 301.82, 301.6, 301.4 and 301.9

A = Covered

B = Covered with Additional Criteria

Additional Criteria for Diagnosis B RSN Coverage

- High Risk Behavior demonstrated during the previous 90-days - aggressive and/or dangerous, puts self or others at risk of harm, is at risk of severe functional deterioration, is at risk of hospitalization or at risk of loss of current placement due to mental illness or at risk of out of home placement due to the symptoms of an emotional disorder or mental illness.
- At risk of escalating symptoms due to repeated physical or sexual abuse or neglect and there is significant impairment in the adult caregiver's ability to adequately address the child's needs.
- Two or more hospital admissions due to a mental health diagnosis during the previous 2-years.
- Psychiatric hospitalization or residential treatment due to a mental health diagnosis for more than 6-months duration in the previous year or is currently being discharged from a psychiatric hospitalization.
- Received public mental health treatment on an outpatient basis within the PIHP system during the previous 90-days and will deteriorate if services are not resumed (crisis intervention is not considered outpatient treatment)
- Child is under 6-years of age and there is a severe emotional abnormality in the child's overall functioning as indicated by one of the following:
  - Atypical behavioral patterns because of an emotional disorder or mental illness (odd disruptive or dangerous behavior which is aggressive, self injurious, or hypersexual; display of indiscriminate sociability/excessive familiarity with strangers.
  - Atypical emotional response patterns as a result of an emotional disorder or mental illness which interferes with the child's functioning (e.g. inability to communicate emotional needs; inability to tolerate age-appropriate frustrations; lack of positive interest in adults and peers or failure to initiate or respond to most social interaction; fearfulness or other distress that doesn't respond to comfort from caregivers).

### **Partnership Access Line (PAL)**

Washington State Law (RCW 74.09.490) requires health plans administering benefits for Washington State Medicaid patients to "evaluate the appropriateness of the psychotropic medications prescribed to children under five years old."

These patients will need a second opinion from a pediatric psychiatrist other than the current prescribing physician.

We identify members with Healthy Options who are under the age of five who receive psychotropic medications and do not have a second opinion on file. We then notify the prescribers that they will need to consult with another expert practitioner in child psychiatry for a second opinion.

As a resource, these prescribers may access the PAL toll-free number 1 (866) 599-7257. PAL is a telephone-based child mental health consultation system funded by the state legislature, being implemented now in Washington State. PAL employs child psychiatrists, child psychologists and social workers affiliated with Seattle Children's Hospital to deliver its consultation services. At this time, the PAL team is making itself available to any primary care provider or psychiatrist throughout Washington.

Prescribers of Healthy Options members under the age of five receiving psychotropic medications must send documentation of a second opinion in order to continue coverage for their patient's medication. Documentation of a second opinion can be submitted by the following methods.

- Fax: 1 (800) 884-1053, **ATTN: Pharmacy Prior Authorization - Healthy Options**
- Pharmacy Customer Service Phone: 1 (800) 643-5918

Contact PAL at 1 (866) 599-7257 for assistance obtaining a second opinion. For any other questions, please contact Pharmacy Customer Service at 1 (800) 643-5918.

### **Organ and Tissue Transplant**

Benefits are provided for transplants of the following organs.

- Bone marrow
- Cornea
- Heart
- Heart-lung
- Kidney
- Kidney-pancreas
- Liver
- Lung
- Pancreas
- Peripheral blood stem cell

All services require prior authorization. Additional information is available in the Referrals and Prior Authorization paragraphs of this manual section.

### **Outpatient Rehabilitation (Occupational, Physical and Speech Therapies)**

#### **For members age 21 or older**

Effective April 1, 2011 Occupational, Physical and Speech Therapy services have been changed for Healthy Options members age 21 or older for services provided at the following locations:

- The member/patient's residence through a Medicare-certified Home Health Agency;
- An outpatient hospital clinic; or
- A free-standing therapy clinic.

The following are the new benefit limits for Outpatient Rehabilitation:

- Physical Therapy 24 units (approximately 6 hours)
- Occupational Therapy 24 units (approximately 6 hours)
- Speech Therapy 6 units (a total of 6 untimed visits)
- One evaluation and one re-evaluation at time of discharge for each therapy type are covered.

Therapy services provided before April 1, 2011 do not count toward the new benefit limits.

Therapists must use the following modifier when billing for services

<b>Modality</b>	<b>Modifiers</b>
Physical Therapy	GP
Occupational Therapy	GO
Speech Therapy	GN

These benefit limits do not apply to therapy services provided and billed by physicians, ARNPs, PA-Cs or audiologists and should be billed using an "AF" modifier.

Outpatient rehabilitation for members age 21 or older must:

- Meet reasonable medical expectation of significant functional improvement within 60 days of initial treatment;
- Restore or improve the member to a prior level of function that has been lost due to medically documented injury or illness;
- Meet currently accepted standards of medical practice and be specific and effective treatment for the member's existing condition; and
- Include an on-going management plan for the member and/or the member's caregiver to support timely discharge and continued progress.

### Additional Units

Additional units may be covered when medically necessary as follows:

- Up to 24 additional units of physical therapy
- Up to 24 additional units of occupational therapy; and
- Up to 6 additional units of speech therapy.

Please see the DSHS *Outpatient Rehabilitation Billing Instructions* for when additional units are allowed.

If a member's benefit limit of outpatient rehabilitation has been exhausted, including initial units plus additional authorized units, a provider may request a limitation extension (LE).

Please refer to the DSHS Billing Instructions titled *Outpatient Rehabilitation Services Billing Instructions* for a complete description of covered services.

### **For Members age 20 or younger**

Outpatient Rehabilitation (Occupational, Physical and Speech Therapies) visits for members age 20 or younger are unlimited. Outpatient Rehabilitation must be ordered, referred or prescribed by the member's Primary Care provider.

### **Oxygen and Respiratory Services**

Oxygen related equipment, administration and therapy are covered when medically necessary. Please refer to Oxygen and Respiratory Therapy guidelines for covered services and prior authorization requirements.

### **Physical Examinations**

Healthy Options members are covered for examinations when determined necessary by the Primary Care Provider for the prevention (or advance) of disease and/or as required under the EPSDT program or women's health-care issues according to current medical practice. Additional information is available in the Exclusions list in this manual section.

### **Podiatry Services**

Routine foot care is a benefit only when a medical condition affecting the legs or feet (such as diabetes or arteriosclerosis obliterans) is present. Podiatry services for these covered procedures require an M.D., D.O. or podiatrist to perform this care.

### **Provider Services**

Coverage is provided for, but not limited to, the following services:

- Maternity
- Office visits (includes related supplies, injectable, etc.)
- EPSDT visits
- Consultation
- Immunization
- Surgery (unless an exclusion)

- Injection (unless an exclusion)  
Other (specialty care (e.g., allergy, neurology, psychiatrists, psychological evaluation, oncology and orthopedics))

### **Orthoptic (eye training)**

Beginning February 1, 2009 orthoptic (eye training) is a covered benefit subject to prior authorization. Please see the DSHS prior authorization guidelines for this service.

### **Orthotics**

- Biochemical evaluation (the evaluation of the foot that includes various measures and manipulations necessary for the fitting of an orthotic) is included in the orthotic fee.
- The manufacturer of the shoes must also be a Medical Assistance Administration provider. It is important that you verify that the manufacturer will accept the medical assistance ID (MAID) cards. The shoe manufacturer must also obtain prior authorization before providing the custom shoes.
- Reimbursement for orthotics includes 90-day follow-up care.
- Evaluation and Management (E&M) codes can be billed in addition to orthotics if the E&M services performed are justified and documented in the client's medical records.

Refer to DSHS guidelines for covered orthotics and prior authorization requirements.

### **Routine Foot Care**

Beginning January 1, 2011 some foot care benefit services will no longer be covered. The only services that will continue to be covered are those defined as being medically necessary by specific diagnosis. Please refer to the DSHS Billing Instructions titled *Physician-Related Services/Healthcare Professional Services Billing Instructions* for a list of covered diagnosis codes.

### **Examples of medical necessity include, but are not limited to:**

- Limitation of ambulation due to mycosis.
- Likelihood that absence of treatment will result in significant medical complications

The following services are not covered:

- Treatment of asymptomatic flat feet
- Treatment of fungal (mycotic) disease is considered routine foot care and is not covered unless medical necessity is documented in the client's chart

### **Reconstructive Surgery**

Healthy Options members may receive reconstructive surgery to correct functional disorders resulting from a congenital disease, condition or anomaly or

to correct a condition following an injury or incidental to surgery. All reconstructive surgery requires prior authorization.

### **Routine Eye Examinations**

Benefits are provided for one vision exam per year for members under 21 years of age; members 21 years of age and older can receive one vision exam every two calendar years. Members may self-refer to a participating provider for these services.

### **Special Duty Nursing**

All services require prior authorization.

### **Temporomandibular Joint (TMJ) and Myofacial Pain Dysfunction (MPD)**

All services require prior authorization; medically necessary services only.

### **Women's Health Care**

Women may self-refer to any of the following participating Regence BlueShield women's health-care providers for covered care necessary to provide women's routine and preventive health-care and maternity services: physicians, advanced registered nurse practitioners, osteopaths (when practice includes women's health-care), midwives, physician's assistant, specialists in OB/GYN, or gynecological oncologists. This is in addition to the member's designated source of primary care if that source is not a women's health care provider.

Women's health care services also include any appropriate health care service for other health problems, discovered and treated during the course of a visit to a women's health care provider for a women's health care services, which is within the provider's scope of practice. Services and materials listed requiring prior authorizations still require prior authorization even when discovered during a women's health care visit.

### **Hysterectomies**

The member does not need a referral to be covered for a hysterectomy. However, hysterectomies are authorized only for medical reasons unrelated to sterilization. A valid hysterectomy consent form must be submitted to Regence BlueShield Healthy Options Operations Department for services to be considered for payment. Any consent form can be used, but it must contain all the consent requirements. Prior authorizations: see specific Medical Assistance Administration guidelines for 45 years and younger.

### **Mammograms**

DSHS has adopted the National Cancer Institute (NCI) recommendations regarding screening mammograms, CPT code 76092. For clients age 40 and over, an annual screening mammogram is allowed. Other screening mammograms may be allowed if determined medically necessary and documented in the client's record.

Regence BlueShield Healthy Options recognizes the following diagnosis codes as “women’s health-care services” when billed in the first or second diagnosis field on the claim.

V22.0-V28.9-Normal Pregnancy;supervision of high-risk pregnancy, postpartum care and examination; encounter for contraceptive management; outcome of delivery; observation and evaluation of newborns for suspected conditions not found.	078.11- Condyloma Warts genital
054-054.12, 054.19- Genital herpes	099-099.2- Other venereal disease
099.41 – Chlamydia	099.50, 099.53, 099.55- Chlamydia unspecified site and trachomatis
174-174.0 – Malignant neoplasms of female breast	179-184.9 – Malignant neoplasms of genitourinary organs
198.6 – Secondary malignant neoplasm of ovary	198.81-198.82 – Secondary malignant neoplasm of breast secondary malignant neoplasm of genital organs
217 – Benign neoplasm of breast	218-221.9 – Uterine leiomyoma, other benign neoplasms of uterus, benign neoplasm of ovary, benign neoplasm of other female genital organs.
233-233.3 – Carcinoma in situ of breast and genitourinary system	236-236.3 – Neoplasm of uncertain behavior
238.3 – Neoplasm of certain behavior, breast/genitourinary organs	239.3 – Neoplasm of unspecified nature, breasts
256 – 256.9 – Neoplasms of unspecified nature, breast/ovarian dysfunction	595 – Cystitis
610 – 627.9- Disorder of breast, inflammatory disease of female pelvic organs and other disorders of female genital tract	628 Infertility
629-629.9- Other disorders of female genital tract	630-630.9 – Ectopic and molar pregnancy
639-630.0 – Ectopic and molar pregnancy	634-638.9 –Complication following abortion and ectopic/molar pregnancy
639-638.9–Spontaneous abortions (miscarriages)	640-677 – Maternity care
752-752.49 – Congenital anomalies of genital organs	795.0-795.2 – Non-specific abnormal Pap smear or karyotype
V02.7-V02.8 – Carrier or suspected carrier of infectious disease	V10.3 – History of breast cancer
V10.4-V10.45 –History of genital cancer	V13.2 – Hisotry of other disease of genital and obstetric disorder
V15.7 – Other history, presenting hazards to health/contraception	V23.5-V25.2 – Encounters with contraceptive management
V25.1-V25.02 – Encounters with contraceptive management	V72.3- Gynecological exam
V72.4 – Pregnancy examination-test/confirmed or unconfirmed	V76.1 – Special screening for malignant neoplasm of breast
V76.2 – Special screening for malignant neoplasm of cervix	V73.88-V73.99 – Other specified screening for chlamydial disease.

### Prescription Drug Program

Benefits for prescription drugs and certain over-the-counter medications and supplies are provided through contracted pharmacies throughout Washington. The member can fill prescriptions at participating pharmacies by presenting his or her Regence BlueShield drug ID card at the time of purchase.

In order for a prescription drug to be **covered**, it must meet all of the following requirements:

- Be prescribed by a Primary Care Provider or specialist who is licensed to do so
- Be a covered over-the-counter medication or a prescription medication that is currently included in the Regence BlueShield prescription drug formulary
- Be a drug or device approved by the Food and Drug Administration

Medicine or supplies that are **not covered** under the Prescription Drug Program include, but are not limited to:

- Drugs prescribed for:
  - Weight loss or gain
  - Infertility, frigidity or impotence
  - Sexual or erectile dysfunction
  - Cosmetic purposes or hair growth
- Free pharmaceutical samples
- OTC drugs which are not a less costly, therapeutically appropriate alternative to a legend drug
- Drugs requiring authorization for which authorization has been requested and was denied
- Drugs which have been terminated or removed from the market
- More than a 34-day supply of any product except:
  - Drugs when the smallest package size is greater than a 34-day supply
  - Drugs with special packaging instructions which would require dispense of a quantity that exceeds a 34-day supply
  - Contraceptive patches, contraceptive rings, and oral contraceptives not used for emergency contraception
  - When a drug is specifically exempt from the 34-day limit
- Any vitamin product other than:
  - Prenatal vitamins prescribed to pregnant women
  - Vitamins determined to be the least costly therapeutic alternative for the treatment of a member's diagnosed condition
  - When Regence agrees that the vitamin product is the least costly alternative in treating documented vitamin deficiency which has been confirmed by laboratory testing
- Drugs, biological products, insulin, supplies, appliances and equipment included in other reimbursement methods
- Drugs that are not FDA approved
- Non-formulary drugs, unless prior authorization has been granted by Regence
- Any drug for which there is no charge
- Investigation or experimental medications
- Medications for cosmetic purposes only (such as Retin-A for aging or Rogaine for baldness)
- Medication for cosmetic purposes (such as Sporanox for unsightly toenails)
- Prescription refills without a physician's authorization

- Injectables that are normally not self-administered

Certain over-the-counter drugs and supplies are covered under the Regence BlueShield Drug Card Program.

Beginning July 1, 2008 all prescriptions for psychotropic medications for children under five will require prior authorization. A second opinion from an expert in child psychiatry is required prior to prescribing or continuing to prescribe these medications.

For a listing of participating pharmacies, contact Regence BlueShield Customer Service at **1 (800) 669-8791**.

### **Early & Periodic Screening, Diagnosis & Treatment (EPSDT)**

EPSDT screenings are defined by federal rules as “regularly scheduled examinations and evaluations of the general physical and mental health, growth, development and nutritional status of infants, children and youth” that are provided as part of a health supervision program. **EPSDT is required for all Medicaid-eligible members 20 years old or younger.**

*Note:* Regence BlueShield will notify members about the EPSDT program within 30 days of enrollment and Primary Care Providers will be sent a monthly report of their members who are in need of immunizations or screenings.

### **EPSDT Screenings include**

- Comprehensive health, behavioral and developmental history
- Comprehensive physical exam performed at each screening examination
- Developmental testing
- Laboratory tests, including tests for anemia
- Screening for risk of lead exposure
- Vision and hearing testing
- Review of immunization status
- Nutritional status
- Health education and counseling
- Age appropriate mental health and substance abuse screening
- Dental/oral health assessment including:
  - How to clean teeth as they erupt
  - How to prevent baby bottle tooth decay
  - How to look for dental disease
  - Information on how dental disease is contracted
  - Preventive sealant
  - Application of fluoride varnish, when appropriate (fluoride varnish is covered through the DSHS FFS program)
  - Appropriate audiometric tests (CPT codes 92552 and 92553)

### **Phenylketuria (PKU) test**

One test at birth, per child, to detect the presence of Phenylketuria. The infant should be re-evaluated after receiving dietary protein for 24 to 48 hours. If the presence of PKU is detected, coverage for the formulas determined to be medically necessary for the treatment will be provided.

### **Additional EPSDT Billing Information**

When billing for an EPSDT screening/exam, enter a check mark in the EPSDT field (field 24H) on the claim form. Please use the appropriate procedure code(s) when billing for services needed to supplement an EPSDT screening (such as lab work, hearing tests, x-rays or immunizations). These services must be billed on the same claim form used for the screening. Hearing test procedures can be billed separately in addition to the EPSDT screening.

When problems are identified during a screening examination, treatment may be performed by the screening provider, or the member may be referred to another provider. Any office, laboratory, radiology, immunization or other procedure rendered as part of follow-up treatment must be billed on a separate claim (HCFA-1500) from the screening examination.

### **EPSDT CPT Codes**

<b>99381</b>	New member	Infant under one year of age
<b>99391</b>	Established member	Infant under one year of age
<b>99382</b>	New member, early childhood	Age one through four years
<b>99392</b>	Established member, early childhood age	Age one through four years
<b>99383</b>	New member, late childhood	Age five through 11 years
<b>99393</b>	Established member, late childhood	Age five through 11 years
<b>99384</b>	New member, adolescent	Age 12 through 17 years
<b>99394</b>	Established member, adolescent	Age 12 through 17 years
<b>99385</b>	New member	Age 18 through 39 years
<b>99395</b>	Established member	Age 18 through 39 years

\* Inter-periodic screening (or interim screening) is used to rule out suspected health problems if regular screening(s) have already been conducted for the year. Also, when an immunization(s) is the only EPSDT service performed, an inter-periodic screening may be billed.

### **Frequency of EPSDT Screenings**

The frequency of EPSDT screenings, in accordance with the DSHS recommendation includes:

- A.** Five total screenings during the first year of life. Below is a recommended schedule for children from birth to one year of age:
- 1st screening: Birth to 6 weeks old
  - 2nd screening: 2 to 3 months old
  - 3rd screening: 4 to 5 months old
  - 4th screening: 6 to 7 months old
  - 5th screening: 9 to 11 months old
- B. THREE** screening exams are recommended between the ages of one and two years.
- C. ONE** screening exam is recommended per twelve-month period for ages 2 through 6.
- D. ONE** screening examination per 24-month period for children ages 7 through 20. Annual screenings shall be provided, if necessary.

### **Referrals**

- **Chiropractic Services** - Eligible members may receive chiropractic services when a medical need for the service is identified through an EPSDT Screening. A PCP referral is required.
- **Dental Services** - Eligible members may go to a dental provider without an EPSDT screening or referral. (These services are paid by DSHS. The provider must accept reimbursement from DSHS).
- **Orthodontics** - Eligible members may go to a dental provider without an EPSDT screening or referral. (These services are paid by DSHS. The provider must accept reimbursement from DSHS). DSHS will only reimburse orthodontics for children with cleft lip or palates or severe handicapping malocclusions. Orthodontic treatment for cosmetic or other conditions is not reimbursable.
- **Lead Toxicity Screening** - health care providers should use clinical judgment when screening for lead toxicity. The Lead Toxicity Screening Risk Factor Questionnaire is no longer required.
- **Fetal Alcohol Syndrome (FAS) Screening** - as part of the EPSDT screening, every child six months of age and older should be screened for risk of exposure to maternal consumption of alcohol and for the facial characteristics of FAS. Children can be referred to a diagnostic clinic if there is known in-utero exposure to alcohol, or there is suspicion of facial characteristics of FAS or microcephaly.

### **Maternity Support Services**

Maternity Support Services may include assistance with transportation to and from medical appointments, child care during medical appointments, childbirth education and parenting classes, nutritional assessment, linkage with the Women, Infants and Children (WIC) Program, interpreter services, in-home visits to assess client needs and family planning. Maternity Case Management provides the basic services of MSS and case management for individuals whose pregnancy is at high risk for a poor birth outcome.

All providers are encouraged to refer all eligible pregnant women to First Steps and document the referral in the chart.

A referral to a First Steps provider may be initiated by the pregnant woman, the Community Service Office, or the provider, by calling Healthy Mothers Healthy Babies at **1 (800) 322-2588** or by contacting a local First Steps provider. If you need assistance in obtaining a current list of local providers, please contact a provider customer service representative at **1 (800) 377-1737**.

### **Special Beginnings®**

Special Beginnings® is a maternity management program. The goal of the program is to improve pregnancy and birth outcomes and minimize avoidable costs by:

- Reinforcing the need for prenatal care and encouraging compliance with attending physician appointments
- Identifying factors which put a pregnancy at risk
- Working with the OB provider to ensure compliance to the treatment plan
- Providing prenatal teaching and support appropriate to the level of risk identified
- Providing individual case management for participants identified as high risk

Special Beginnings nurses are available 24 hours a day/7days a week by calling **1 (888) JOY-BABY (569-2229)**.

### **First Steps**

First Steps is a Medicaid program designed to benefit low-income pregnant women and their families. This program does not take the place of the Primary Care Provider in providing prenatal care. First Steps provides health related and social services paid for outside the Healthy Options plan. The goals of First Steps are to assure timely access to prenatal care and assure healthy birth outcomes by providing Maternity Support Services (MSS) and/or Maternity Case Management (MCM).

### **Interpretation Services for Limited-English Speaking Members**

To ensure equal access to services, interpreter services are available to Limited English Proficient (LEP), deaf, deaf-blind, or hard of hearing clients.

#### **The following services are available for our members:**

- TTY/TTD phone line for our speech and hearing impaired members. Dial 711.
- A language line can be accessed through our member Customer Service phone number.
- Conserjeros Latinos is our bi-cultural and bilingual liaisons deliver support and assistance to those who need help navigating the health care system due to language and cultural barriers.

## Who is Eligible?

All clients who are eligible for medical assistance are eligible for interpreter services.

## When are Interpreter Services Covered by DSHS?

Interpreter services for deaf, deaf-blind, hard of hearing and Limited-English-Proficient (LEP) clients will be covered by DSHS when **all** of the following conditions are met:

- The deaf, deaf-blind, hard of hearing, or LEP client is an eligible client
- The deaf, deaf-blind, hard of hearing or LEP client and the medical provider determine that an interpreter is necessary in order for the client to appropriately access necessary medical and health care services covered by the client's medical program
- The medical provider has informed the client that interpreter services are available at no cost to the client
- The interpreter is enrolled with DSHS
- Interpreter services are provided for medical services covered by the client's medical plan
- The interpreter presents current identification to the medical provider with his or her name (e.g., driver's license) prior to providing all interpreter services

## When are Interpreter Services Not Covered by DSHS?

Interpreter services will not be covered by DSHS when they are:

- Requested by someone other than the medical provider.
- Provided for medical services that are not medically necessary.
- Provided for medical services that are not covered by the client's medical program. **For example**, interpreter services for non-emergent medical care are not covered by DSHS when the client is eligible for only emergency medical assistance (Medically Indigent program).
- Provided to the interpreter's own family members. This ensures a client's right to confidentiality and to interpreter services that are not biased by family ties or opinion.
- Provided by an interpreter who is a paid employee of the medical provider serving the deaf, deaf-blind, hard of hearing or LEP client and the interpreter is providing interpreter services in the employer's place of business.
- Either the client or the interpreter fails to appear.
- The medical provider does not require interpreter services to communicate with a medical assistance client (e.g., wait time prior to the scheduled appointment time).
- Interpreter encounters exceed 24 units per client, per day. (DSHS will pay for up to 24 units per client, per day).
- The interpreter providing the service is not DSHS certified or qualified

## **Transportation**

Ambulance service is covered when medically necessary for basic life support, advanced life support or inter-facility transportation. DSHS covers costs for other transportation for medical services through its transportation program.

## **Services Covered by Fee-For-Service or Through Selective Contracts**

- Health care services covered through the Division of Developmental Disabilities for institutionalized clients
- Voluntary termination of pregnancy, including complications
- Transportation Services other than ambulance: taxi, cabulance, voluntary transportation, public transportation
- Medically necessary removal of cochlear implants
- First Steps Maternity Case Management and Maternity Support Services. Additional information is available in the Maternity Support Services section of this manual.
- Sterilizations for members under age 21 or those that do not meet other federal requirements
- Health care services provided by a DSHS approved neurodevelopment center
- Certain services provided by a health department or family planning clinic when a member self-refers
- Pharmaceutical products for prescriptions from health departments, family planning clinics, community mental health providers whose services are purchased by the Mental Health Division, providers of voluntary pregnancy termination and dentists
- Laboratory services required for medication management of drugs prescribed by community mental health providers whose services are purchased by the Mental Health Division
- Inpatient psychiatric professional services
- Services ordered as a result of an EPSDT exam that is not otherwise covered services
- Gender dysphoria surgery and related procedures, treatment, prosthetics, or supplies when approved by DSHS
- Gastroplasty
- Prenatal diagnosis and/or genetic counseling provided to members to allow members and their PCPs to make informed decisions regarding current genetic practices and testing

## **Services Covered by Other Divisions within DSHS**

- Substance abuse treatment services covered through the Division of Alcohol & Substance Abuse
- Inpatient detoxification services for alcohol (3 days) and drugs (5 days) with no complicating medical conditions
- Nursing facility and community based services (e.g., COPES and Personal Care Services) covered through the Aging and Adult Services Administration

- Self-referred Mental health services for all Medicaid clients by the Mental Health Division in DSHS, including 24-hour crisis intervention, outpatient mental health treatment services and inpatient psychiatric services and Regional Support Networks (RSN)

### **Services Not Covered by either DSHS or Regence BlueShield**

- Products, services and supplies related to sex transformations.
- Medical examinations for Social Security Disability.
- Cosmetic services: services for which plastic surgery or other services are indicated primarily for cosmetic reasons
- Physical examination required for obtaining or continuing employment, insurance or governmental licensing
- Experimental investigational services and any services associated with services that are experimental or investigational
- Reversal of voluntary, surgically induced sterilization
- Personal comfort items, including but not limited to guest trays, television and telephone charges
- Biofeedback therapy
- Treatment of infertility, impotence and sexual dysfunction
- Immunization required for international travel purposes only
- Any other services, product, or supply not covered by the under its fee-for-service program
- Court-ordered services
- Any services provided to an incarcerated member, beginning when a law enforcement officer takes the member into legal custody
- Tissue or organ transplants that are not specifically listed as covered

### **Beginning January 1, 2011, the following services have been eliminated from all Medical Assistance Programs**

- School-based medical services for special students as described in the billing instructions for school medical services
- Eyeglass frames, lenses and fabrication services covered under 's selective contract for these services and associated fitting and dispensing services for adults 21 years of age or older
- Dental care and prostheses for most populations, including physicals required prior to hospital admissions for oral surgery services for adults 21 years of age or older
- Hearing aid devices, including fitting, follow-up care and repair medically necessary removal of cochlear implants services for adults 21 years of age or older.
- Many Podiatry services. (Refer to the DSHS Billing Instructions for covered services)

## Patient Review and Coordination Program

The Patient Review and Coordination (PRC) program is a state-required program for Healthy Options members and the mechanism utilized by the Health and Recovery Service Administration (HRSA) to fulfill both federal and state Medicaid requirements.

On January 1, 2008 Regence BlueShield implemented the state-required PRC program for Healthy Options members. This program assists and educates those members who have prescription or service utilization issues. This is accomplished via coordinated efforts of the health plan and community efforts from our health care providers.

### We need your help!

These members who have been assigned to the PRC program need Primary Care Providers (PCP) to provide and coordinate care for them. If you are interested in learning more about the PCP's role, please contact the PRC Case Manager at (253) 761-1310. If you are interested in being a PCP to some of these members, please call Provider Services at 1 (800) 562-2156.

### How can Regence BlueShield assist the Primary Care Provider?

Case managers help members and providers navigate the health care system, provide education and guidance, and assist PCPs by communicating vital information to the medical team. We understand that many members on the PRC program require a multifaceted referral and treatment approach. This means that a member's PCP will have our support with the following:

- **Care Coordination.** Regence will help coordinate the care for PRC program members. This means you will have personal contact with the care coordinator who is directly involved with the PRC member and their health care.
- **Locating Specialists.** We will assist in locating specialists if a PRC member requires additional medical support.
- **Collaboration.** The PRC program is a resource for patient compliance. Case management will provide you with feedback about the PRC member's progress and compliance, including pharmaceutical and/or ER utilization reports.
- **State Resources.** Case managers have state resources that are available to PRC members. One example is Medicaid's Transportation Program that arranges and pays for transportation to medical appointments.

### Identification of possible PRC placement

Members who meet the following criteria may be placed in the PRC program when medical and/or billing histories document any of the following.

- (a) Any two or more of the following conditions occurred in a period of 90-consecutive calendar days in the previous twelve months. The member:
  - I. Received services from four or more different providers, including physicians, ARNPs and physician's assistants
  - II. Had prescriptions filled by four or more different pharmacies;
  - III. Received ten or more prescriptions;
  - IV. Had prescriptions written by four or more different prescribers;
  - V. Received similar services from two or more provider's in the same day; or
  - VI. had ten or more office visits.
  
- (b) Any one of the following occurred within a period of 90-consecutive calendar days in the previous twelve months. The member:
  - I. Made two or more emergency department visits;
  - II. Has a medical history that indicates "at-risk" utilization patterns;
  - III. Made repeated and documented efforts to seek health care services that are not medically necessary; or
  - IV. has been counseled at least once by a health care provider, or a DSHS or Regence staff member, with clinical oversight, about the appropriate use of health care services.
  
- (c) The member received prescriptions for controlled substances from two or more different prescribers in any one month in a period of 90-consecutive days in the previous twelve months
  
- (d) The member's medical and/or billing history demonstrate a pattern of the following at any time in the previous twelve months:
  - I. The member has a history of using healthcare services in a manner that is duplicative, excessive, or contraindicates; or
  - II. The member has a history of receiving conflicting healthcare services, drugs, or supplies that are not within acceptable medical practice.

If you have a patient who meets the above criteria and you feel would benefit from being placed in the PRC program, please contact the PRC Case Manager at (253) 761-1310.

Additional information about the PRC program may be found in the Washington Administrative Code 388-501-0135 on the Washington State Legislature Web site at <http://apps.leg.wa.gov/wac>.

## **Healthy Options Member Non-Compliance Guidelines**

These guidelines developed solely by Regence BlueShield and do not necessarily reflect those of DSHS. Requests to have a patient removed from a provider's roster will be handled on a case by case basis in conjunction with the Primary Care Provider.

These guidelines are suggestions for use in offices that do not have set standards currently in effect; they do not replace any office protocols and procedures that are currently in place.

### **No Show Visits**

- Three per family member per six month period OR
- Four per family per 12 month period

### **Inappropriate ER Usage**

- Two non-emergency visits per family member per six month period, unless referred to the ER by the PCP OR
- Two occasions of non-compliance with Primary Care Provider's advice not to use the ER.
- Use of the ER on the same day the member incurred a no show visit with the Primary Care Provider.
- Two non-emergency ER visits during provider office hours, unless referred to the ER by the PCP

### **Verbally Abusive Parent/Member**

- Documented cases of two instances when member/parent was verbally abusive to the provider and/or office staff.
- A combination of one instance of abusive behavior with any of the situations listed above.
- In these situations, please contact Case Management Intake at 1 (866) 543-5765 so that a medical and/or psychological evaluation may be initiated

### **Physically Abusive Member**

An immediate request will be made to DSHS to initiate removal from the Healthy Options program if member is physically abusive or threatening. Providers should contact customer service immediately and document the situation. Please see the DSHS Guidelines for Member's involuntary Termination from Plan Initiated by Regence BlueShield paragraphs below for additional information.

### **Non-compliance with Medical Advice**

- Two occasions of intentional non-compliance of provider's medical instruction.
- Intentional misuse of prescription medications.
- Two occasions of unwillingness to accept the provider's diagnosis or follow through with prescribed treatment plan.

### **DSHS Guidelines for Member's Involuntary Termination from Plan Initiated by Regence BlueShield**

Formal requests will be submitted to DSHS at the customer service representative's discretion for removal from the Healthy Options plan. The option

of changing the member's PCP will not be ruled out prior to requesting removal of the member from Healthy Options. All requests for removal need to be made in writing with documentation attached and submitted to a customer service representative. The final decision will be made by DSHS only.

To request a member's involuntary termination, all of the following must be substantiated in writing:

- The member's behavior is inconsistent with Regence BlueShield policies and procedures addressing unacceptable member behavior;
- Regence has provided a clinically appropriate medical and/or psychological evaluation to determine whether there is a treatable condition contributing to the member's behavior and such evaluation either finds no treatable condition or the member's behavior continues to prevent the provider from safely providing medical care to the member.
- The member received written notice from the Contractor or its intent to request their termination of enrollment, unless the requirement for notification has been waived by DSHS because the member's conduct presents the threat of imminent harm to others. The notice to the member shall include their right to use the grievance process to review the request to end the member's enrollment.

The member will not be terminated until DSHS has notified us in writing that enrollment is terminated.

DSHS will not terminate a member solely due to a request based on an adverse change in the member's health status, cost of meeting their health care needs, because of the member's utilization of medical services, uncooperative or disruptive behavior resulting from their special needs or treatable mental health condition.