

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 Asuris Northwest Health. 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 Asuris for issues concerning Healthy Options members such as member eligibility, benefits, claims, payment and grievances.

Asuris Customer Service: 1 (866) 240-9560

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 (866) 240-9560** 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 section of this manual.

Definitions

Action: is the denial or limited approval of a requested service. It can include:

- The type or level of service
- The reduction, suspension, or ending of a service that had been authorized
- The denial of payment of a service, in whole or in part
- The failure to provide services or act in a timely manner

Appeal: An “appeal” is when a member has requested us to review 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 Asuris in order for the appeal to be processed.

DSHS: Washington State Department of Social and Health Services

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

ESHCN: Enrollee with Special Health Care Needs. A member may be designated ESHCN either by DSHS or Asuris.

Medically Necessary Services: a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the member that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. Medically necessary Services include services related to the enrollee’s ability to achieve age-appropriate growth and development.

Medical Necessity Determination: Asuris 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.

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

- Asuris 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 Asuris.

PRC: 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. This program assists and educates those members who have prescription or service utilization issues

General Information

Eligibility

The Healthy Options program provides managed care health services to more than 450,000 Medicaid clients in Washington State.

Healthy Options clients 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.

The Department of Social and Health Services (DSHS) determines the client's enrollment and eligibility in a Healthy Options plan. DSHS sends the client a DSHS ID card on the first day of every month. The DSHS ID card indicates if the client is enrolled in a Healthy Options plan.

Identification Cards

DSHS Identification Card (Medical Coupon)

Individuals meeting a certain standard of financial and/or medical need are eligible for medical assistance and are issued a monthly DSHS Identification Card that they should present to you for services. The card contains various legends and messages to inform you of program and/or insurance coverage and any limitations of services for the member.

Make it a policy to review the card for the following information about the member:

- Beginning and ending dates of eligibility
- Member's case number
- The Member Identification Code for any person covered under the case number
- The name and address of the head of household, guardian or payee.
- Limitations on coverage (due to enrollment in Medicare, private insurance, HMO, hospice program, etc.)
- Retroactive or delayed certification eligibility dates

When billing DSHS, make sure the Member Identification Code is carefully copied from the DSHS ID card on the **proper field of the billing form**. Individual billing instructions specify the proper field for the Member Identification Code (1a on the *CMS-1500* claim form). You do not have to attach a copy of the identification card to your billing. When billing Asuris Healthy Options, use the Asuris-assigned ID number from the monthly eligibility roster instead of the Member Identification Code number.

Use of the Card

DSHS coverage is **not transferable**. If you suspect that a member has presented a card belonging to someone else, please request a photo ID or some other form of identification. **Do not accept a card that appears to have been altered**. Direct questions concerning member eligibility to the health plan that the member is enrolled in, or to the local Community Services Office.

Types of Cards

You will see two different types of identification cards:

1. **White with green print:** DSHS issues this card from Olympia on a monthly basis to all eligible members.
2. **Yellow with brown print:** This card is issued at the local Community Services Office when a white and green card has been lost or stolen or when a person becomes eligible during the month and needs proof of eligibility immediately.

DSHS Identification Card Fields

1. Address of Community Services Office.
2. Date eligibility begins.
3. Date eligibility ends.
4. First and middle initials (or a dash if middle initial is not known).
5. Six-digit birth date (month, day and year).
6. First five letters of the last name.
7. Tie breaker (An alpha character assigned by the Community Services Office).
Note: Use the PIC code of either parent for a newborn if the baby has not yet been issued a Member Identification Code; write "BABY ON PARENT'S PIC"

- on the claim in this case. When using a parents' PIC for babies born as twins or triplets, etc., identify each baby separately (i.e., twin A, twin b, triplet c)
8. Insurance carrier code-A four character alphanumeric code (insurance carrier code) in this area indicates that private insurance coverage is available.
 9. Medicare-An X will indicate this member may also have Medicare coverage.
 10. HMO-Indicates enrollment in a Medicaid-paid managed health care plan.
 11. Detox-An X will indicate the member is eligible for a three-day alcohol or a five-day drug detoxification program.
 12. Restriction-An X will indicate the member is assigned to one physician and one pharmacist.
 13. Hospice-An X will indicate the member has chosen hospice care.
 14. DD client-An X will indicate this person is a client of the DSHS Division.
 15. Other-This area is not currently used.
 16. Name and address of member, head of household or guardian.
 17. Program and Scope of Care indicator.
 18. Other messages.
 19. Case number. (Letters C, E, S, G, J, & O indicate a Healthy Options member).
 20. Internal control number for DSHS use only.
 21. Member's signature—may be used to verify identification.

(1) 123 Main Street Anytown USA To:053195 (3)				MEDICAL IDENTIFICATION CARD This Card Valid From: 050195 (2)							
Patient Identification Code			Medical Coverage Information								
Initials	Birthdate	Last Name	TB	Insurance	Medicare	HMO	Detox	Restriction	Hospice	DO Chart	Other
A (4)	01079 0 (5)	CITIZ (6)	A (7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)
(16) A.A. Citizen 31 That Street Anytown, WA 98000						(17) MIP No out of state Care (18) Delayed Cert 081595 (19) 00-C-000000-0 (20) L0000990 * 1112348					
SHOW TO MEDICAL PROVIDER AT TIME OF EACH SERVICE						NOT TRANSFERABLE					
						_____ SIGNATURE (Not valid unless signed) (21)					

Asuris Identification Cards

Healthy Options members will present a DSHS ID card and Healthy Options ID card at the time of service. The ID cards are neither an authorization for services nor a guarantee of payment. You may want to 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.

Member card samples are available in the Identifying Members section of this manual.

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 DSHS ID card at each visit. You may also ask to see personal identification or call Customer Service at **1 (866) 240-9560** 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 the Member

You must notify Asuris if you are billing the member for services, whether the service provided is covered by Healthy Options or not.

You may bill eligible Healthy Options members only when **all** of the following conditions are met:

- When the service(s) or item(s) are not covered by Healthy Options or DSHS. Non-covered services are defined as any services excluded from the medical program's scope of care. The billing instructions or fee schedule published for each type of service will specify covered vs. non-covered services.
- When authorization for a service(s) or item(s) has been requested and the request has been denied.
- When the member signs a DSHS approved consent form before receiving the service(s) or item(s). A separate form is needed for each date of visit or service. The agreement must be kept in the member's file and be made available to DSHS and/or Asuris upon request.

Note: Please see the Filing Claims section of this manual for complete billing information.

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.

Asuris shall meet the following standards for processing claims for Healthy Option enrollees:

- 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 Asuris 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 (866) 240-9560** as soon as possible.

We notify the Department of Social and Health Services (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 Asuris.

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 Asuris 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 Asuris. Asuris 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, Asuris:

- 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 Asuris and NCQA standards

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

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

Asuris retains the following:

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

Upon approval of delegation status to an MGP, Asuris 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.

Provider's Responsibilities

Responsibilities of all Participating Providers

Each participating provider has entered into an agreement with Asuris. This agreement contains important information about your responsibilities as an Asuris participating provider. If you have any questions about your responsibilities, please contact Provider Network Management at **1 (800) 562-2156**.

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

- 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 Asuris, or Asuris' 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 Asuris' credentialing program policies and procedures.
- Comply with Asuris' quality improvement, credentialing and utilization management programs, policies and procedures.
- Allow onsite reviews and medical record reviews by Asuris upon reasonable notice.
- Maintain confidentiality of Asuris' proprietary information.

When necessary, the provider may also be responsible for:

- Contacting the AT&T Language Line at 1 (800) 848-5459 for 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.
- Arrange for and assure the continuity and coordination of each member's total health care needs.
- 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 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 paragraph of this section.
- 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.

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.

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 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 Asuris 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 Asuris 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, or Community Health Clinics.

- 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 Options 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

Asuris 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 Asuris 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 Asuris 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 enrollee
- Includes enrollee 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.

Asuris' Responsibilities

Asuris performs the following functions:

- Issues the member an Asuris 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 Asuris or their managed group practice if delegated. In addition, Primary Care Providers are required to obtain prior authorization from Asuris for some services. The term preauthorization is used for services that require approval from Asuris, 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 Asuris 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 (866) 240-9560**. 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:
Asuris Healthy Options
PO Box 21267
Seattle, WA 98111-3267

Once Asuris 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 Asuris or the medical group practice for a clarification or understanding of the denial. If the member desires to appeal the "action", they may contact Asuris' customer service department at **1 (866) 240-9560** for information and assistance.

Prior Authorizations

Asuris Healthy Options requires prior authorization for the same services contained on the standard *Group and Individual Products Pre-authorization List*. This list is available on our *Provider Web Site* in the Care Management section.

To inquire about prior authorization for a Healthy Options member call Healthy Options Customer Service at **1 (866) 240-9560** for specific contract exclusions and limitations.

Note: Some services contained on the standard *Group and Individual Products Pre-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 Asuris. Services that are not covered by Asuris standard group and individual plans will not be included in standard *Group and Individual Products Pre-authorization List*, however, may still require prior authorization. In these situations, DSHS prior authorization criteria will be followed.

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 (866) 240-9560** 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

Asuris must ensure that the following appointment standards are met when referring to non-participating providers:

Type of Care/Need of Member	Acceptable Time frame
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

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.

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 in this 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 enrollees 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 Asuris, but are administered to maintain the enrollee's stabilized condition within one (1) hour of a request to Asuris for pre-approval of further post-stabilization care services.
- Services are not pre-approved by a plan provider or other Asuris representative, but are administered to maintain, improve or resolve the

enrollee's stabilization and Asuris does not respond to a request for pre-approval within thirty minutes, Asuris cannot be contacted; or an Asuris representative and the treating provider cannot reach an agreement concerning the enrollee's care and an Asuris provider is not available for consultation. In this situation, Asuris shall give the treating physician the opportunity to consult with an Asuris provider and the treating provider may continue with care of the enrollee until an Asuris provider is reached.

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

- A participating provider with privileges at the treating hospital assumes responsibility for the enrollee's care;
- A participating provider assumes responsibility for the enrollee's care through transfer;
- An Asuris representative and the treating provider reach an agreement concerning the enrollee's care; or
- The enrollee 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 in this 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 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)

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.

Mental Health Outpatient

A PCP must first determine the diagnosis the member will be seen for. Then, by using the Access to Care Criteria located on the HRSA Web site, <http://hrsa.dshs.wa.gov/>, determine if the member meets the criteria.

- If member meets Access to Care Criteria or the PCP is unsure if member meets Access to Care, the member must be sent to a Regional Support Network (RSN) provider to have RSN evaluation done. A list of RSN providers is available on the HRSA Web site.
 - A referral does not need to be loaded for this evaluation.
- 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, a referral request can be made to an Asuris contracted mental health provider based on benefit limitations for the referred to Specialist type.

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 Asuris 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, Asuris 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 Asuris 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 Asuris:

- 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, Asuris 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.

The PCP retains the right to refer the member to an Asuris contracted mental health provider for psychiatric or psychological evaluation, testing and diagnosis before referring the member for outpatient mental health treatment. The PCP may refer a member to Asuris contracted mental health provider or to the RSN

for treatment for covered services at Asuris' expense, when a member does not meet the Access to Care Standards.

Asuris is responsible for claims payment for outpatient mental health treatment provided by an Asuris PCP, Asuris 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, Asuris 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.

- 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 Asuris. Asuris 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 Asuris.
- 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. Asuris must work with the RSN to obtain the Notice of Action.
- Once the Notice of Action is received, Asuris 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.
- Asuris will load the referral for the plan covered services listed above.

Occupational Therapy

When ordered by the Primary Care Provider, the member can receive one evaluation and up to 12 visits per year to a participating occupational therapist. Refer to specific DSHS guidelines.

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 section.

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 section.

Physical Therapy

When ordered by the Primary Care Provider, physical therapy visits are a benefit for Healthy Option members. The members can receive one evaluation and up to 12 visits per year to a participating physical therapist, participating physiatrist or participating physical therapist assistant when supervised by a participating licensed physical therapist when provided as part of an outpatient treatment program. Contact Asuris for appropriate treatment settings. If additional physical therapy is needed, the provider must request DSHS approval to exceed the limits. Please refer to the Limited Extension process with in the DSHS guidelines.

For Children (age 20 or younger)

The EPSDT/Healthy Kids screening provider must:

- Determine if there is a medical need for physical therapy; and
- Document the medical need and the referral in the child's physical therapy file.

The physical therapist must:

- Keep referral information on file in the form of a prescription, notes from telephone calls, etc;
- Contact the referring EPSDT/Healthy Kids screening provider for information concerning the need for physical therapy services; and
- Keep the referring and/or continuing care provider apprised of the assessment, prognosis, and progress of the child(ren) the provider has referred to them for services.

Please refer to WAC 388-86-027 for additional information with EPSDT exams and physical therapy.

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 MD, DO 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

- Routine care will be paid only when a medical condition affecting the legs or feet (such as diabetes or arteriosclerosis obliterans) requires that such care can be performed by an MD, DO or Podiatrist.
- Local nerve block for subregional anatomic areas (e.g., ankle or foot) are included in the "package" for the surgical procedure and are not reimbursed separately.
- Reimbursement for debridement of nails is limited to a maximum of one treatment in a 60-day period unless documented in the client's chart as medically necessary.

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.

Speech Therapy

When ordered by the Primary Care Provider, the member can receive one (1) evaluation and up to twelve (12) visits per year to a participating speech therapist. Refer to specific Medical Assistance Administration guidelines.

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 Asuris 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 enrollee'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 Asuris 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.

Asuris 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 – History 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 Asuris 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 Asuris 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 Asuris 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 Asuris
- 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 Asuris Drug Card Program. You can find this listing on our Pharmacy Web site at: <http://www.regencrx.com/learn/covered/healthyOptionsOTC.html>

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 Asuris Customer Service at **1 (866) 240-9560**.

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: Asuris 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)

Phenylketonuria (PKU) test

One test at birth per child to detect the presence of Phenylketonuria. 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

99381	New member	Infant under one year of age
99391	Established member	Infant under one year of age
99382	New member, early childhood	Age one through four years
99392	Established member, early childhood age	Age one through four years
99383	New member, late childhood	Age five through 11 years
99393	Established member, late childhood	Age five through 11 years
99384	New member, adolescent	Age 12 through 17 years
99394	Established member, adolescent	Age 12 through 17 years
99385	New member	Age 18 through 39 years
99395	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) 462-5680**.

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.

Who is Eligible?

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

When Are Interpreter Services Covered?

Interpreter services for deaf, deaf-blind, hard of hearing and Limited-English-Proficient (LEP) will be covered 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 service
- 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?

Interpreter services will not be covered 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 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. (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
- 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
- Voluntary termination of pregnancy, including complications
- Transportation Services other than ambulance: taxi, cabulance, voluntary transportation, public transportation
- Dental care and prostheses, including physicals required prior to hospital admissions for oral surgery
- Hearing aid devices, including fitting, follow-up care and repair
- 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
- Protease inhibitors
- 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 enrollees to allow enrollees 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 Asuris

- Products, services and supplies related to sex transformations.
- Medial 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 enrollee, beginning when a law enforcement officer takes the enrollee into legal custody
- Tissue or organ transplants that are not specifically listed as covered

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 Asuris 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 Asuris 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.** Asuris 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 Asuris 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 patter 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 are guidelines developed solely by Asuris 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 member 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 Asuris 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 Asuris

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 Asuris policies and procedures addressing unacceptable enrollee behavior;
- Asuris 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 enrollee'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.