

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

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 Practitioner, 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 that he or she can work with the member to resolve any problems or misunderstandings. Please see the 'Healthy Options Member Non-Compliance Guidelines' located within this section of the manual, for more information on this subject.

Advance Directive

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"*.

Practitioners 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 practitioner 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 member's 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. Practitioners 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.*

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Available Treatment Options

Practitioners 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.

Benefits

Healthy Option 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 Practitioner (referral required)

Alternative Care Medicine

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

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

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. (See the "EPSDT" information in this section for more information.) These services require a referral.

Blood and Blood Products

The administration of whole blood and blood components, as well as human blood products, will be provided. (See 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 (see referral criteria in the "Referrals and Prior Authorization" section of this manual).

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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 Northwest Health 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 Northwest Health receives the claim from the practitioner. The date of payment is the date of the check or date of other form of payment.

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 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 Northwest Health.

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 MAA 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 Medicaid reimbursement rates. 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 Practitioner.

Note: *'Emergency services' shall mean medical or other health services which are rendered for a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (a) placing a member's health in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.'* (42 CFR 447.53(4), WAC 388-538-050).

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Exogenous Obesity

Coverage for services for this condition is allowed under MAA guidelines on a case-by-case basis. (See the “Referrals and Prior Authorization” section of this manual).

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. See “Exclusions” in this section of the manual. 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. (See the “Referrals and Prior Authorization” section of this manual for more information.)

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 practitioners, 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 Practitioner require a referral. Imaging not meeting MRI, ultrasound or tomography criteria require prior authorization. Please refer to the Prior Authorization section in the DSHS MAA guidelines for MRI’s requiring prior authorizations.

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Mental Health Inpatient

Inpatient Mental Health benefits are administered through the DSHS (Department of Social and Health Services) for members on Healthy Options.

Mental Health Outpatient

A PCP may refer a member to an Asuris contracted mental health provider (psychiatrist or psychiatric ARNP for testing, evaluation, diagnosis or treatment or psychologist for testing, evaluation and diagnosis only) or to the Regional Support Network (RSN) for treatment, standard referral requirements remain in place. A PCP may refer a member subject to the benefit limitations, as stated in the above.

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.
- Twelve hours of mental health treatment per calendar year for members who do not meet the RSN Access to Care Standards for receiving treatment. (If a member meets the RSN Access to Care Standards, all mental health treatment is covered by the RSN. In this case Asuris would not cover any mental health visits for the member).
- If a member is in need of mental health treatment in excess of twelve hours per calendar year, 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 contained in the "Outpatient Mental health Language" contained within the Healthy Options/SCHIP contract.

Services Not Covered by Asuris:

- Mental Health treatment in excess of 12 hours per calendar year
- 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 providers other than a psychiatrist or psychiatric ARNP
- Psychiatric and psychological testing, evaluation and diagnosis provided by any provider other than a psychiatrist, psychiatric ARNP or psychologist.

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When a member does not meet RSN Access to Care Standards

All referrals for mental health treatment will be reviewed to locate the PCP's 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 a 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's 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 a Asuris PCP, Asuris contracted mental health provider (psychiatrist or psychiatric ARNP for testing, evaluation, diagnosis or treatment or psychologist for testing, evaluation and diagnosis only) 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 contained 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 Language" contained above or found 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 then load the referral for the plan covered services listed above.

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Occupational Therapy

When ordered by the Primary Care Practitioner, the member can receive 1 evaluation and up to 12 visits per year to a participating occupational therapist. Refer to specific Medical Assistance Administration guidelines.

Organ and Tissue Transplant

Benefits are provided for transplants of the following organs. All services require prior authorization. See the “Referrals and Prior Authorization” section of this manual for more information:

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

Oxygen and Respiratory Services

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

Physical Examinations

Healthy Options members are covered for examinations when determined necessary by the Primary Care Practitioner 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 (See “Exclusions” in this section for additional information).

Physical Therapy

When ordered by the Primary Care Practitioner physical therapy visits are a benefit for Healthy Option members. The members can receive 1 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 Northwest Health 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 within the DSHS guidelines.

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(Physical Therapy, Continued)

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 M.D., D.O. or podiatrist to perform this care.

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.
- Please refer to DSHS MAA 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 M.D., D.O. or Podiatrist.
- Local nerve block for subregional anatomic areas (such as the 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.

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(Podiatry Services, Continued)

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

Practitioner 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)

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 practitioner for these services.

Second Opinions

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

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Special Duty Nursing

All services require prior authorization.

Speech Therapy

When ordered by the Primary Care Practitioner, 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 Northwest Health women's health-care practitioners 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 practitioner.

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 practitioner for a women's health care services, which is within the practitioner'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 Northwest Health 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

The Medical Assistance Administration 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.

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Asuris Northwest Health 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.

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Prescription Drug Program

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

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

- Be prescribed by a Primary Care Practitioner 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 Northwest Health 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 including but not limited to:

- Drugs prescribed for:
 - Weight loss or gain
 - Infertility, frigidity or impotence
 - Sexual or erectile dysfunction
 - Cosmetic purposes or hair growth
 - Tobacco cessation except as for provided for pregnant women in WAC 288-533-0345
- Free pharmaceutical samples
- OTD drugs which are not a less costly, therapeutically appropriate alternative to a legend drug
- Drugs requiring authorization for which authorization has been requested and 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

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(Prescription Drug Program, Continued)

- Investigation or experimental medications
- Medications for cosmetic purposes only (such as Retin-A for aging or Rogain 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
- Medications for smoking cessation, that is NOT part of the ante-partum or post-partum (up to two months after pregnancy) care

Certain over-the-counter drugs and supplies are covered under the Asuris Northwest Health Drug Card Program. You can find this listing on RegenceRx at:

<http://www.RegenceRx.com/learn/covered/healthyOptionsOTC.html>

For a listing of participating pharmacies, contact Asuris Northwest Health customer service at **1 (800) 669-8791**.

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EPSDT (Early & Periodic Screening, Diagnosis & Treatment)

The Federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) preventive health care program is designed to provide regular medical care for the purpose of early detection and treatment of health problems which, left unidentified, would impair physical, mental and emotional growth and development. **EPSDT is required for all Medicaid-eligible members 20 years old or younger.**

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

EPSDT Healthy Kids Screening Components

Comprehensive health, behavioral and developmental history

1. Unclothed physical examination performed at each screening examination
2. Height, weight and head circumference, for children up to 2 years old
3. Blood pressure check after 3 years old
4. Laboratory tests, including tests for anemia
5. Screening for risk of lead exposure
6. Vision and hearing testing
7. Review of immunization status
8. Nutritional status
9. Communication skills
10. Dental/oral health status if over 3 years old

Testing

1. Heredity/metabolic screening
2. Hemoglobin/hematocrit—once per age group
3. Urine testing for bacteria only—once per age group
4. Tuberculosis screening—once after six months old and before school entry
(May repeat screening if child is a member of a high-risk group).

Screening

Screening tools may be found in the MAA Healthy Kids/EPSDT Program Policy and Billing Instructions.

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.

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Additional EPSDT Billing Information

When billing for a Healthy Kids screening, 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 a Healthy Kids 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 Healthy Kids screening.

When problems are identified during a screening examination, treatment may be performed by the screening practitioner/provider, or the member may be referred to another practitioner/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 age 1 year
99391	Established member	infant under age 1 year
99382	New member, early childhood	age 1 through 4 years
99392	Established member, early childhood age	1 through 4 years
99383	New member, late childhood	age 5 through 11 years
99393	Established member, late childhood	age 5 through 11 years
99384	New member, adolescent	age 12 through 17
99394	Established member, adolescent	age 12 through 17
99385	New member	age 18 through 39
99395	Established member	age 18 through 39
0252M	*Interperiodic Screening	

* 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 Healthy Kids service performed, an inter-periodic screening may be billed.

Frequency of EPSDT

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

- A.** Routine newborn care in the nursery plus **FIVE WELL-BABY VISITS** to a Primary Care Practitioner's office during the first year of life.

For Example:

- Up to six weeks of age
- During two to three months of age
- During four to five months of age
- During six to seven months of age
- During nine months of age

- B.** **THREE** screening examinations between the ages of one year and two years.

- C.** **ONE** screening examination per twelve-month period after age two years, to age six years.

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- D. ONE** screening examination per 24-month period after age six up to age 21. Annual screenings shall be provided, if necessary.
- E. *Interperiodic Screening:** Interperiodic 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 Healthy Kids service performed, an interperiodic screening may be billed.
- F. Immunizations:** For members 18 years and younger, the following immunization materials should be received from the Department of Health. You need to bill the appropriate procedure code with modifier SL (e.g., 90700SL). The following is a list of procedure codes that identify these vaccines.
- G.** Do not bill CPT codes 90471 and 90472 when billing the following immunizations:

90633	90700
90645	90702
90646	90707
90647	90712
90648	90713
90657	90716
90658	90718
90659	90732
90669	90744
	90747

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Billing the Member

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 the Medical Assistance Administration (MAA). 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 the MAA upon request.

Note: *Please see the Billing section of Asuris Northwest Health manual for complete billing information.*

Delegation

The Delegation Program establishes the framework within which Asuris Northwest Health may delegate some of its health care management functions to Medical Group Practice (MGP). The goal of Delegation is to assure that MGP's performing contractually delegated functions meet or exceed the performance standards set by Asuris Northwest Health. Asuris Northwest Health 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 Northwest Health:

- 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 Northwest Health and NCQA standards

Healthy Options / SCHIP

(Delegation, Cont.)

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

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

Asuris Northwest Health retains the following:

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

Upon approval of delegation status to an MGP, Asuris Northwest Health 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.

Eligibility

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

Healthy Options clients include:

- TANF (Temporary Assistance Needy Families) 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 Medical Assistance ID card on the first day of every month. The Medical Assistance ID card indicates if the client is enrolled in a Healthy Options plan.

Healthy Options / SCHIP

Healthy Options Member Non-Compliance Guidelines

These are guidelines developed solely by Asuris Northwest Health 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 Practitioner.

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 Practitioner's advise not to use the ER.
- Use of the ER on the same day the member incurred a no show visit with the Primary Care Practitioner.
- Two non-emergency ER visits during practitioner 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 practitioner 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. (Practitioner to contact customer service immediately and document the situation). Please see the section below titled "DSHS Guidelines for Member's involuntary Termination form Plan Initiated by Asuris Northwest Health".

Non-compliance with Medical Advice

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

Healthy Options / SCHIP

DSHS Guidelines for Member's Involuntary Termination from Plan Initiated by Asuris Northwest Health

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 PDCP 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 Northwest Health 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.

Healthy Options / 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 practitioners 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 Practitioner provides or coordinates the member's care (except in an emergency or for women's health-care as defined by RCW 48.42.100).

Identification Cards

Medical Assistance Identification Card (Medical Coupon)

Persons meeting a certain standard of financial and/or medical need are eligible for medical assistance and are issued a monthly Medical Assistance Identification Card (MAID) 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 MAID 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). You do not have to attach a copy of the identification card to your billing. When billing Asuris Northwest Health Healthy Options, use the Asuris Northwest Health-assigned ID number from the monthly eligibility roster instead of the Member Identification Code number.

Use of the Card

Medical Assistance program 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 plan that the member is enrolled in or the local Community Services Office.

Healthy Options / SCHIP

Types of Cards

You will see two different types of medical 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.

Medical Assistance Identification Card/Explanation of 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, 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.

Healthy Options / SCHIP

(Medical Assistance Identification Card, Continued)

(1) 123 Main Street Anytown USA			MEDICAL IDENTIFICATION CARD This Card Valid From: 050195 (2) To:053195 (3)								
Patient Identification Code			Medical Coverage Information								
Initials	Birthdate	Last Name	TB	Insurance	Medicare	HMO	Detox	Restriction	Hospice	DO Chart	Other
A (4)	010790 (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					
						_____(21) SIGNATURE (Not valid unless signed)					

Asuris Northwest Health Identification Cards

Healthy Options members will present a Medical Assistance 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 (i.e., ask to see their driver's license). **Always check your monthly member eligibility list.**

Note: Please check the main Asuris Northwest Health manual for copies of ID cards.

Primary Care Practitioners 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 Practitioner. 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 Medical Assistance ID 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 a.m.-5:00 p.m., Monday through Friday) to verify coverage. Personal identification is needed only if you suspect someone is using another person's medical ID card.

Healthy Options / SCHIP

Informed Consent

The practitioner 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 practitioner 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 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; or (f) the member's brothers or sisters who are over 18.

Medical Provider's Responsibilities

When Medical Assistance Administration clients need interpreter services in order to receive medical health care services, the medical provider is responsible for:

- Verifying that the member is an eligible Medical Assistance Administration client
- Checking to see whether the medical service to be provided is covered by the client's medical program
- Notifying the Medical Assistance Administration client that interpreter services are available to the client at no charge
- Coordinating the interpreter services
- Following Medical Assistance Administration medical service authorization procedures, whenever applicable
- 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.

Healthy Options / SCHIP

Other Provider Responsibilities

When necessary, the provider may also be responsible for:

- Contacting the Medical Assistance Administration (**1 (800) 848-5459**) for connection to the AT&T Language Line 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 (**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 Administration (**1(800)562-3022**) for help in obtaining an interpreter

Primary Care Provider Types

The following practitioners 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

Quality Improvement/Utilization Management

Please see the Quality Improvement and Utilization Management sections within this manual for complete information.

Referrals and Prior Authorizations

Referrals

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

Healthy Options / SCHIP

(Referrals continued)

Who Can Initiate a Referral?

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

Consult/Office Calls only

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

Consult and Treatment

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

Specific Services Listed

A Primary Care Practitioner 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 Practitioner to specialists and/or facilities for care.
- Referrals are active for 6 months, or until the visits/services authorized are exhausted or if the member chooses a new Primary Care Practitioner or plan.
- Referrals may be updated without having to submit a new referral by contacting a Asuris Northwest Health Healthy Options Customer Service.
- If a referral specialist or another practitioner/provider must refer the member on for other care including hospitalization, the Primary Care Practitioner must be apprised of the situation and provide an update to the original referral.

Referral Criteria

All referrals are required to contain the following information:

- Member's name, member number and date of birth.
- Primary Care Practitioner's 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 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., Eval & Treat, Eval & Testing, Inpatient for surgical procedure, etc.).
- Note whether referral is new, updated or denied.

Healthy Options / SCHIP

(Referrals Continued)

Referrals for chiropractic benefits will require the last date of the Early & Periodic Screening, Diagnosis & Treatment (EPSDT) exam.

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

Denials

If a referral is denied, the Primary Care Practitioner will receive a letter informing him or her of the denial. The Primary Care Practitioner should contact Asuris Northwest Health or the medical group practice for a clarification or understanding of the denial. If the member desires to appeal the denial, they may contact Asuris Northwest Health's customer service department at **1 (800) 669-8791** for information and assistance.

Submission of Referrals

Referral forms can be submitted to us for processing in any of the following ways:

- Mail referrals to:
Asuris Northwest Health Healthy Options
PO Box 21267
Seattle, WA 98111-3267
- Call Healthy Options Customer Service at **1 (800) 669-8791** (A Customer Service representative is available to take your call weekdays from 7:30 a.m. to 5:00 p.m.).
- Fax to **1-253-573-3253** Via Asuris Online Services.

Once Asuris Northwest Health receives your referral and a number is assigned, a letter is sent to the member, the Primary Care Practitioner 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.

Healthy Options / SCHIP

Emergency

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 health care practitioners/providers. 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 Practitioner. The Primary Care Practitioner 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 Northwest Health, but are administered to maintain the enrollee’s stabilized condition within 1 hour of a request to Asuris Northwest Health for pre-approval of further post-stabilization care services.
- Services are not pre-approved by a plan provider or other Asuris Northwest Health representative, but are administered to maintain, improve or resolve the enrollee’s stabilization and Asuris Northwest Health does not respond to a request for pre-approval within thirty minutes, Asuris Northwest Health cannot be contacted; or a Asuris Northwest Health representative and the treating physician cannot reach an agreement concerning the enrollee’s care and a Asuris Northwest Health physician is not available for consultation. In this situation, Asuris Northwest Health shall give the treating physician the opportunity to consult with a Asuris Northwest Health physician and the treating physician may continue with care of the enrollee until a Asuris Northwest Health physician is reached.

Asuris Northwest Health’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;
- A Asuris Northwest Health representative and the treating physician reach an agreement concerning the enrollee’s care; or
- The enrollee is discharged.

Healthy Options / SCHIP

Prior Authorizations

Prior authorization is required by Asuris Northwest Health or the delegated managed group practice for the following services (this is not an exhaustive list):

Any care requested outside of the service area	Blepharoplasties (eyelid surgery) chart notes required
Blood and blood products (not related to inpatient services)	Breast reconstruction
Durable medical equipment over \$400 or as indicated in the MAA Billing Guidelines as (*), BR, or percentage	Enteral therapy
Exogenous obesity (allowed under MAA guidelines on a case by case basis)	Castroplasty- chart notes required
Hemodialysis	Home health/hospice care
Home phototherapy	Imaging not meeting MRI, ultrasound or tomography criteria (EX: bone scans, thermographs, etc.)
Impotence- for diagnosis only	Infertility for diagnosis only
Infusion therapy	Inpatient rehabilitation
Kidney dialysis	Mastectomy for gynecomastia
Nasal reconstruction- chart notes required	Neurodevelopmental evaluation- chart notes required
Pain management	Ptosis corrective treatment-chart notes required
Reduction mammoplasty	Services beyond the contract maximum benefit
Sleep studies	Temporomandibular joint (TMJ) and myofacial pain dysfunction (MPD)
Transplants (prior authorization required by Asuris Northwest Health only)	Varicose and spider veins corrective treatment- chart notes required
Hysterectomies for members 45 and younger without a cancer diagnosis of the female reproductive organ(s)	Services or supplies that require Prior authorization on the DSHS Fee for Service Program

Complete a referral form and submit to Asuris Northwest Health when requesting prior authorization to refer the member to a non-participating practitioner.

Non participating Practitioners

If the member's Primary Care Practitioner needs to refer a member for consultation and/or specialty services and a participating practitioner is not available; the Primary Care Practitioner must send a referral form to Asuris Northwest Health and obtain prior authorization to refer the member to a non-participating practitioner. 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 practitioner.

Healthy Options / SCHIP

(Non-participating Practitioners, Continued)

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

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

Responsibilities of all Participating Providers

Each participating provider has entered into an agreement with Asuris Northwest Health. This agreement contains important information about your responsibilities as a Asuris Northwest Health participating practitioner. If you have any questions about your responsibilities, please contact provider network management at **1 (800) 562-2227**.

Briefly, participating providers have agreed, at 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 Asuris Northwest Health, or Asuris Northwest Health'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 practitioner cannot seek additional reimbursement from the member for covered services.
- Provide consultation to other participating practitioners as reasonably requested.
- Maintain all required licenses, certifications, credentials and liability insurance, as defined by Asuris Northwest Health's credentialing program policies and procedures.
- Comply with Asuris Northwest Health's quality improvement, credentialing and utilization management programs, policies and procedures.
- Allow onsite reviews and medical record reviews by Asuris Northwest Health upon reasonable notice.
- Maintain confidentiality of Asuris Northwest Health's proprietary information.

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(Responsibilities of all Participating Providers, Continued)

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.

Ninety (90) Day Termination Notice

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

Role of the Primary Care Practitioner

The Primary Care Practitioner 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 Practitioner specifies the nature of the services and the name of the referral provider, on the recommended CHITA referral form. A copy of this form is available in the 'Forms' section of this manual, or 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.

Responsibilities of the Primary Care Practitioner:

Briefly, Healthy Options practitioners have agreed, at minimum, to:

- Verify the member's eligibility at the time of service.
- Provide or arrange for primary care, specialty care and emergency room service's for your assigned members.
- Refer members only to participating providers unless one is not available. (See 'Referral Section' for additional information.)
- 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.
- Make available and encourage regularly scheduled EPSDT (Early and Periodic Screening, Diagnosis and Treatment) screenings for children. (See the 'EPSDT' section of this manual for additional information.)
- 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 (See 'Informed Consent' in this section for more information.)
- Agree to comply with all program procedures regarding advance directives as durable power of attorney and anatomical gifts.

Healthy Options / SCHIP

(Responsibilities of the Primary Care Provider, Cont.)

- Comply with all procedures regarding family planning, infertility services and sterilization and to comply with all member consent procedures for sterilization, as outlined in the program materials.
- Arrange for interpreter services, including services for the hearing impaired.

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.

Role of the Specialty Care Practitioner

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

Selecting a Primary Care Practitioner

Through Asuris Northwest Health, members select or are assigned to a participating Primary Care Practitioner to coordinate all their health care including the provision of primary care services and referrals to participating physicians, hospitals and other health care practitioners. Primary Care Practitioners also coordinate services provided 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 Practitioners as often as they wish by contacting the Asuris Northwest Health Healthy Options department. In most cases, a PCP change will be effective the first of the month following the change request.

Healthy Options / SCHIP

Services Covered by MAA 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 MAA billing instructions for school medical services
- Eyeglass frames, lenses and fabrication services covered under MAA'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 (see 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

Healthy Options / SCHIP

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 practitioners 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 practitioner, 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 prenatal risk 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** or **1 (888) 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 Practitioner 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).

Healthy Options / SCHIP

Interpretation Services for Limited-English Speaking Members

To ensure equal access to services, the Medical Assistance Administration delivers interpreter services 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 will MAA pay for Interpreter Services?

MAA will pay for interpreter services for deaf, deaf-blind, hard of hearing and Limited-English-Proficient (LEP) clients when **all** of the following conditions are met:

- The deaf, deaf-blind, hard of hearing, or LEP client is an eligible Medical Assistance Administration 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 the Medical Assistance Administration.
- 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.

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(When will MAA Not pay for Interpreter Services?, Continued)

When will MAA Not pay for Interpreter Services?

The Medical Assistance Administration will not pay for interpreter services when:

- 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**, the Medical Assistance Administration will not pay for interpreter services for non-emergent medical care 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 Medical Assistance Administration 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. (The Medical Assistance Administration will pay for up to 24 units per client, per day).
- The interpreter providing the service is not DSHS certified or qualified

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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 MAA or Asuris Northwest Health

- 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
- Orthoptic (eye training) care for eye conditions
- Immunization required for international travel purposes only
- Any other services, product, or supply not covered by the Medical Assistance Administration 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

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The Primary Care Practitioner

The Primary Care Practitioner must complete a referral form whenever referring a Healthy Options member to a specialist, other practitioner/provider or outpatient facility. The standard CHITA referral form does not have to be used; any existing form used within a practitioner's/provider's facility is acceptable as long as all pertinent information is included. Copies of the completed form must be submitted to Asuris Northwest Health or the Primary Care Practitioner's managed group practice and to the referred to practitioner/provider. If the billing for referral services performed matches the referral from the Primary Care Practitioner, the claim will be adjudicated. A claim will be denied if a referral is not on file with Asuris Northwest Health.

The Primary Care Practitioner maintains documentation of referral services in members' medical records for all specialty services. See "General Information" under "Role of Primary Care Practitioner" for information regarding other DSHS services.

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 Practitioner refer to?

Primary Care Practitioners are required to refer to Asuris Northwest Health participating providers and facilities that agree to accept Healthy Options members.

What Services Require a Referral?

All services not provided by the Primary Care Practitioner **except** for the following:

- Routine lab and x-rays ordered by the Primary Care Practitioner when the lab or radiologist bill includes the referring practitioner's Asuris Northwest Health rider number.
- Hospital admits through the emergency room for the first 72 hours or admissions by the Primary Care Practitioner.
- Women's health-care issues (see the "Women's Health-Care" section of this manual).
- 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).

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The Role of Asuris Northwest Health

Asuris Northwest Health performs the following functions:

- Issues the member a Asuris Northwest Health member identification card.
- Sends monthly Member Eligibility Rosters to Primary Care Practitioners.
- Processes claims.
- Responds to inquiries about eligibility, benefits, claims, referrals and other issues or concerns that members and participating practitioners may have regarding Healthy Options.

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.

What is Healthy Options?

Healthy Options is a program established by Washington state, Department of Social and Health Services (DSHS) for selected Medicaid recipients. The state contracts with managed care companies, such as Asuris Northwest Health, to offer Healthy Options to eligible state residents. Each managed care company, in turn, contracts with physicians, hospitals, clinic and other practitioners to form its own provider network that offers preventive health services and cost-efficient quality medical care to Healthy Options members.

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 Medical Assistance Customer Service Center at **1 (800) 562-3022**.

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

Asuris Northwest Health Customer Service: 1 (800) 669-8791