# Centers of Excellence/ Blue Distinction Center
# Orthopedics (hip replacement and knee replacement) and
# Spine (cervical and lumbar fusion, cervical and lumbar laminectomy/discectomy procedures)
# Frequently Asked Questions (FAQs)
# For Highmark Delaware Members Ages 18+

## Member Experience from Beginning to Post Surgery/Rehabilitation

1. **Who are the specialists who generally provide the diagnosis which leads to each of these procedures?**
   Orthopedic surgeons and neurosurgeons.

2. **What defines medical necessity for these procedures?**
   Medical necessity determinations are made using McKesson InterQual criteria and Highmark medical policy.

3. **Who makes the determination of medical necessity and are those determinations routinely reviewed by Aetna?**
   Admissions are issued pre-authorizations (aka pre-certifications or prior authorizations) when medical necessity is met and consultation is conducted with our physician (or psychiatrist) when medical necessity is indeterminate based on current information. Medical necessity is established by meeting specific criteria as described by Highmark policy which is based on nationally accepted standards of care. The nurse care managers utilize InterQual criteria and Highmark policy. If medical necessity is not established the case is referred to a Highmark medical director for review.
   a. **What other treatment, tests, etc. are needed before medical necessity is determined?**
      Documentation of the following are required to establish medical necessity:
      - A group of specific diagnosis that result in advanced disease
      - Radiologic or MRI imaging
      - Persistent uncontrolled pain
      - Functional limitations that interfere or limit activities of daily living including safety issues
      - Conservative medical treatment for a specific length of time that has failed (physical therapy, steroids activity modification etc.)
   b. **Describe the typical visits to/with a specialist(s) before determination for each procedure is made.**
      A member's experience is unique in each of the COEs as each health system has its unique culture and programs.
   c. **Does the specialist actually perform each procedure or is there another doctor/surgeon doing the actual procedure?**
      The specialist and any assistants would be performing the procedure.
   d. **Who is responsible for follow-up with the patient post-surgery – the patient's PCP, the specialist or the doctor/surgeon that performed the actual procedure (if different from the specialist who provided the initial diagnosis)?**
      The surgeon or physician extender in the practice who performed the procedure.

4. **How are Highmark members made aware of COEs for the procedure?**
   Members are informed of the program through several means:
   - Statewide Benefits Office's website.
   - The CCMU team (both CCA and HC) is equipped to discuss and assist the member in choosing a provider.

5. **If member wants to use a COE and this requires duplication of services because they have been under the care of a specialist who does not have admitting privileges to a COE, how will that be addressed? Does Highmark provide any assistance to help members with transferring test results and/or medical records to a specialist who has admitting privileges to a COE, to avoid duplication of services where possible?**
   Sometimes a COE will use existing films if they are of high quality. Most often a COE, because of the high quality standards, will want to repeat testing, as the prior facility would not necessarily meet that threshold. Highmark's CCMU unit provides help by requesting medical records (including lab results and imaging) be transferred or shared among new or existing providers. The Highmark team also assists members in finding in-network providers, including Blue Distinction facilities, and can assist with appointment scheduling.

6. **If a member chooses to utilize a COE facility that is not in the local area, how is the travel reimbursement determined and how does a member obtain information about the travel reimbursement?**
   The travel reimbursement is $50/night for lodging for each person, with a maximum of $100/night for the recipient of the services and one other person. Meals are not included in this reimbursement. The reimbursement period begins one day prior to surgery and ends six months after surgery and applies when the facility is more than 100 miles from the recipient's home. Members with questions should contact a Highmark Customer Care Advocate at 1-844-459-6452 for assistance.

**COE Designations**

1. **How are COEs designated?**
   The Blue Cross Blue Shield Association evaluates the applicants and determines whether or not they meet their criteria. They look at volume, quality, and if applying for BDC+, they also look at cost. More information on Highmark's program criteria for orthopedic care can be found on Highmark's website.

2. **How often are the COE facilities reviewed to determine continued eligibility as a COE? What data is considered when reviewing for continued eligibility?**
   The BDSC programs are "refreshed" every two years. Quality measures for each specialty care category within Specialty Care are based on nationally established, objective selection criteria developed with input from the medical community. These criteria take into account important clinical factors, such as the provider's overall patient results in a specialty care category, the provider's history performing a specialty procedure, and patient safety. Selection criteria for designation in each area of Specialty Care are re-evaluated and refreshed regularly to provide meaningful quality and cost differentiation. As part of these evaluation cycles, quality measures are reassessed with input from the medical community to be consistent with medical advances

and current clinical practices, guidelines and measurement. To remain designated, providers must reapply for Blue Distinction Center designations during each re-evaluation cycle.

3. **What mechanisms does Highmark have in place to provide State of Delaware members with changes in COE designation (i.e. updated lists of facilities)? How/when are changes reflected in Highmark's Find a Doctor provider search tool?**
   Lists are posted to the Provider Resource Center (PRC), Highmark Member website, and on the National BDC Finder. The National BDC Finder is updated every two weeks by BCBSA. The PRC and member website are updated by Highmark as changes are needed.

4. **If designation is lost, what is the notice timeframe to the facility, to the State of Delaware, to Highmark members, etc?**
   If a facility doesn't meet the selection criteria during the "refresh" cycle, they are de-designated at the end of the previous program cycle. Facilities are made aware of this possibility prior to submitting an application for continued designation during the refresh cycle. Facilities are required to notify BCBSA, if they no longer meet the selection criteria for the program (i.e., if the surgeons leave the hospital, if the hospital discontinues providing the services, etc.); in this case the facility is notified of the de-designation immediately.

5. **How does the loss of status impact members approved/scheduled for services? What is the transition of care process in place for Highmark members using a COE in this instance?**
   If a pre-authorization (aka pre-certification or prior authorization) has been provided to the facility for the member prior to the de-designation effective date of the facility, services are generally approved at the in-network benefit level and considered Transition of Care. If a pre-authorization has not been provided, the member has the right to appeal.

6. **For members who are in the process of preparing for treatment at a non-COE by the start of the July 1, 2018 plan year, is there a "grace period" so as not to penalize members who may be preparing for imminent treatment at a non-COE?**
   Highmark Comp PPO members who have obtained a pre-authorization (aka pre-certification or prior authorization) at a non-COE facility for orthopedic (hip replacement and knee replacement) or spine (cervical and lumbar fusion, cervical and lumbar laminectomy/discectomy procedures) from Highmark prior to July 1, 2018, and are enrolled in the Aetna HMO or Highmark Comprehensive PPO plan, will not be subject to the $500 copay for obtaining treatment at the non-COE facility as long as the surgery is performed within the 6 month period in which the pre-authorization applies.

7. **Where can members find a list of specialists performing these procedures at COE facilities?**
   Specialists with admitting privileges to COE facilities can be found on SBO's website.
   - Find a Provider with admitting privileges to COE facilities in DE and surrounding area