In this newsletter:

Review the 2021 clinical practice guidelines.

CAHPS satisfaction scores are in.

Note these upcoming changes to the provider portal and authorization requests.

Earn compensation through Risk Adjustment programs.

... and more.

Quarterly Update for Providers

Fall 2021

HIGHMARK HEALTH OPTIONS

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Contact us.

Highmark Health Options Provider Services is the first line of communication for your questions and inquiries. Provider Services is available Monday–Friday, 8 a.m.–5 p.m., and can be reached by calling 1-844-325-6251 or emailing hho-depsresearch2@highmark.com.

Review the 2021 clinical practice guidelines.

To support providers, Highmark Health Options monitors industry changes that affect clinical practice guidelines. These guidelines outline appropriate health care for specific clinical conditions that may be relevant to patients. However, when it comes to taking care of patients, your judgment and knowledge of an individual patient supersedes clinical practice guidelines.

The Quality Improvement and Utilization Committee reviews clinical practice guidelines before distributing them to providers. The committee reviews to see if these guidelines are:

- Developed using evidence-based clinical practice guidelines from recognized sources in the profession and industry.
- Provided to improve health care quality by promoting peer-reviewed standards of care and best practices.

Find a complete listing of Highmark Health Options clinical practice guidelines online.

Provider 2021 HEDIS results have arrived.

Highmark Health Options thanks you for your cooperation and flexibility during this year's Healthcare Effectiveness Data and Information Set (HEDIS) audit. The 2021 HEDIS audit was a success because of your partnership.

The audit showed significant improvement in many health care delivery areas during 2021:

- 30-day hospital readmission
- Asthma medication ratio (ages 5–11) and (ages 12–18)
- Cervical cancer screening
- Comprehensive diabetes care: HbA1c control <8%
- Prenatal and postpartum care: Timeliness of prenatal care

The audit also highlighted some areas for improvement:

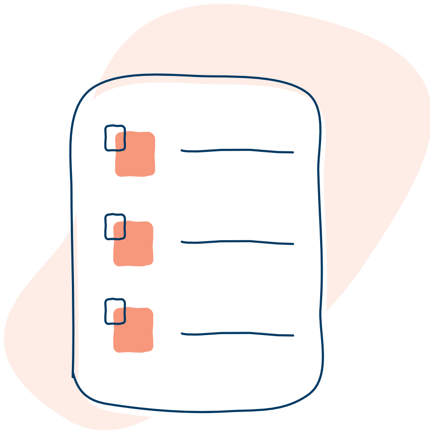
- Comprehensive diabetes care: Retinal eye exam
- Managing high blood pressure
- Prenatal and postpartum care: Postpartum visit

Scoring well on the HEDIS audit takes a collaborative effort. To better aid providers with the HEDIS measure rates, Highmark Health Options has developed several new initiatives, such as:

- Augmenting targeted member outreach and internal collaboration.
- Enhancing provider education.
- Hiring additional staff.
- Releasing several new processes to advance the accuracy and timeliness of data collection.
- Supplying members with tools that promote positive health outcomes, such as at-home A1c testing kits.

Contact Provider Relations at **1-844-325-6251** for more information about HEDIS measurements and results.

CAHPS satisfaction scores are in.



The 2021 Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores have arrived. Highmark Health Options members were selected at random and surveyed about their health care experience.

Survey respondents reported being most satisfied with:

- Customer service staff treating them with courtesy and respect.
- Doctors taking the time to explain things and answer questions.
- Their overall health care.
- Their ability to receive specialist care.
- Their interaction and communication with their doctors, such as being:
  - Shown courtesy and respect.
  - Informed about their care.
  - Listened to carefully.

Respondents also mentioned areas for improvement, such as:

- Receiving urgent care.
- Spending enough time with their doctor.

Thank you for working with Highmark Health Options to improve the health care experiences of all our members. Improving member experience is a team effort, and we welcome any suggestions you may have about improving the patient experience.

Complete yearly LDL-c and HbA1c screenings to close care gaps in SMD patients.

Patients with a schizophrenia-associated diagnosis are at higher risk for diabetes, potentially resulting in elevated cardiovascular risk and limited life expectancy. Encourage patients with this diagnosis to receive annual LDL-c and HbA1c screenings. These screenings evaluate risk for diabetes by assessing:

- Behavioral factors
- Lifestyle factors
- Medications

Highmark Health Options has launched a project to encourage completion of yearly LDL-c and HbA1c screenings for members. This project targets the combined behavioral health and physical health population ages 18–64 that meets the HEDIS SMD measure (schizophrenia with comorbid diabetes diagnoses).

Contact Quality Improvement at **1-844-325-6251** for more information on LDL-c and HbA1c screenings.

Help patients hit glycemic targets for diabetes management.

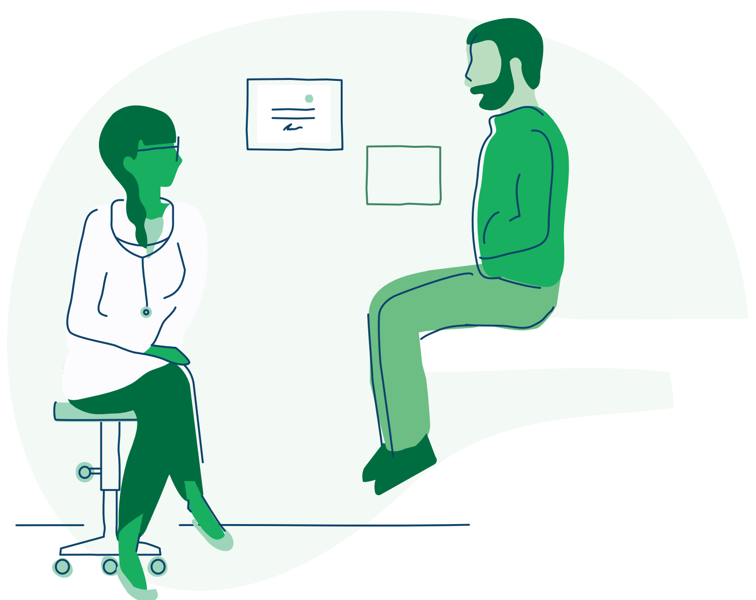
Studies have shown that glycemic control is fundamental to diabetes management. The Diabetes Control and Complications Trial (DCCT) showed that better glycemic control is associated with 50–76% reductions in rates of development and progression of complications in patients with diabetes. Achieving A1c targets of < 7% (53 mmol/mol) has been shown to reduce microvascular complications of type 1 and type 2 diabetes when instituted early in diabetes management.

Some patients with diabetes need help hitting their glycemic targets to manage their diabetes. Glycemic management is primarily assessed with the A1c test, which is performed routinely in all patients with diabetes both as an initial assessment and as part of continuing care. However, setting glycemic targets can be complex. Many providers individualize each patient's glycemic target to take into account numerous health factors, patient needs, and patient preferences.

Because A1c tests indirectly measure average glycemia, it is best to educate patients on self-monitoring of blood glucose or continuous glucose monitoring. Patients can then evaluate their individual response to therapy and assess whether they are achieving their glycemic targets.

Diabetes management includes:

- Hypoglycemia prevention
- Medical nutrition therapy
- Medication adjustments
- Physical activity



Source:

Glycemic Targets: Standards of Medical Care in Diabetes 2019

Encourage patients to get cervical cancer screenings.

Based on recent industry research, many patients may not be getting routine cervical cancer screenings. In 2018, the latest year for which incidence data is available, 12,733 new cases of cervical cancer were reported among women in the United States. Cervical cancer screenings can provide preventive education, early detection, and early treatment of cervical cancer.

Cervical cancer screenings:

- Determine if a patient has cervical cancer.
- Identify the stage of cervical cancer.
- Initiate the most appropriate treatment options.

Patient visits provide an opportunity to educate patients on the value of cervical cancer screenings. Remind them it is recommended that:

- Women ages 21–29 receive a Pap test every three years.
- Women ages 30–65 receive a Pap test along with an HPV test every five years.

Source:
U.S. Cancer Statistics: Data Visualization

Remind patients about breast cancer screenings.

According to the American Cancer Society, breast cancer is the most common type of cancer in the United States and is the fourth leading cause of cancer deaths. It is estimated that one in eight American women will be diagnosed with breast cancer at some point in their lives. Regular screenings can improve a patient's life. Remind patients about the benefits of breast screenings and encourage them to start getting screened at age 50.

Help patients distinguish chronic conditions from COVID-19 symptoms.

Patients with chronic conditions may experience greater complications from COVID-19. And they may struggle to distinguish chronic disease symptoms from symptoms of COVID-19 infection. These patients may require education about COVID-19 symptoms as well as encouragement to take precautions, including vaccination, social distancing, handwashing, and wearing a mask.

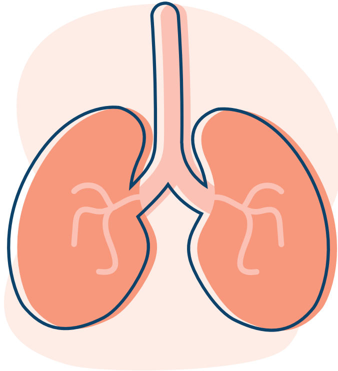
Cardiac conditions

It can be hard for patients to distinguish between cardiac-related symptoms and COVID-19 illness. COVID-19 can damage the heart muscle and affect heart function. Some of the symptoms common in COVID "long-haulers," such as palpitations, dizziness, chest pain, and shortness of breath, may be due to heart problems or from COVID-19 infection.

Cardiac patients can benefit from learning what to do when certain symptoms occur. Let them know that shortness of breath and chest pain are not always indicators of a serious problem, but if coupled with symptoms such as low oxygen or nausea and lightheadedness, they could signal a cardiac issue. The information in the chart below can help cardiac patients better understand what to do when certain symptoms occur:

Symptom	When to call 911	When to see a doctor
Shortness of breath	• Bluish lips or face • Oxygen saturation reading under 92% • Sudden onset	• Accompanied by fatigue or ankle swelling • Worse on exertion • Worse when lying down
Chest pain	• Severe chest pain accompanied by nausea, shortness of breath, lightheadedness, or sweating • Sudden chest pain, especially with shortness of breath lasting more than five minutes	• New chest pain that resolves in 15 minutes (otherwise call 911) • New exertional chest pain relieved by rest • Persistent, nonsevere pain increasing in frequency

COPD



Patients with COPD have a higher risk of severe COVID-19 illness. Discuss with them the benefits of getting vaccinated against COVID-19 and how the vaccine can protect them from severe COPD complications. Let patients know they may need to adjust their COPD action plan if COVID-19 becomes widespread in their area.

If a patient already has COPD, the following symptoms could be a sign of a COVID-19 infection:

- Changes in phlegm color or amount
- Increased oxygen use
- Lower blood oxygen levels at rest
- More coughing
- More use of rescue inhaler
- More wheezing
- New types of coughing
- Worsening breathing problems

Diabetes

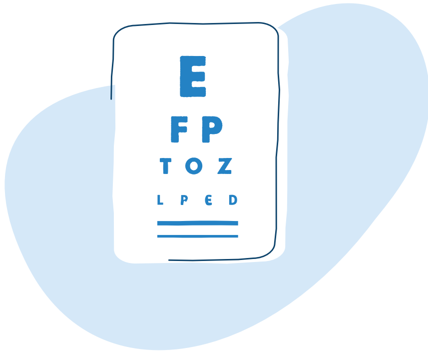
Patients with diabetes are likely to have worse outcomes if they contract COVID-19. Education and proper diabetes management can help lessen their chances of developing COVID-19 complications.

Viral infections like COVID-19 can increase inflammation and internal swelling in patients with diabetes. This can lead to more severe complications, such as diabetic ketoacidosis, making it hard for a patient to manage fluid intake and electrolyte levels.

When seeing a patient with diabetes who develops COVID-19 symptoms, make sure they:

- Are clear when explaining their symptoms.
- Have their glucose and ketone readings available.
- Keep track of their fluid consumption and report.

Diabetic eye screenings are covered.



Medicaid patients may not realize their diabetic eye screenings are included in their medical coverage. In addition, they may not know that diabetes is the leading cause of blindness in working-age adults in the United States, resulting in over 10,000 new cases of blindness each year. Diabetic eye screenings can lead to timely intervention and treatments that could save someone's sight.

The majority of patients who develop diabetic retinopathy have no symptoms until the very late stages, which may be too late for effective treatment. Regular screenings are an effective way to detect and treat vision-threatening diabetic retinopathy.

Proper diabetes management is the most effective way to help prevent diabetic retinopathy. However, some patients with diabetes are more at risk than others. Risk factors for developing diabetic retinopathy are:

- High blood cholesterol
- High blood pressure
- Sleep apnea
- Untreated or poorly managed diabetes

Encourage patients to quit smoking.

Seventy percent of smokers want to quit, but only 20% will attempt it, either on their own or by asking for help. Help patients begin to live a tobacco-free life by starting the conversation. Educate patients about tobacco cessation using the 5A's strategy. The 5A's are:

- Ask about and document tobacco use status at every visit.
- Advise in a clear, personalized manner that tobacco users stop smoking.
- Assess willingness to quit at this time. Or ask former tobacco users how recently they stopped and what challenges they may still have trouble dealing with.
- Assist by prescribing NRT, when applicable.
- Arrange follow-up, including counseling.

Find more information on how to help patients quit smoking on the CDC website.

Help patients understand the information you provide.

Patients may not understand the health information you provide. In fact, more than one-third of U.S. adults has limited health literacy, making it difficult for them to read, understand, and apply health information. Some patients may not even realize they have deficiencies in their comprehension and ability to recall important information.

Helping patients understand the health information you provide can lead to better health outcomes and improve their lifestyle. To facilitate patient understanding:

- Avoid medical jargon.
- Consider their preferences and needs in conjunction with best practices when determining their care.
- Give them details about the medication being prescribed:
  - Any common side effects they may encounter.
  - How they are expected to take them.
  - What the medications are for.
- Help interpret information they may bring to their appointment.
- Learn about them as individuals.
- Speak clearly using language they will understand.
- Take the time to listen.
- Use the teach-back method by having them repeat, in their own words, what you explained to them.
- Watch their facial expressions to see if they understand or appear confused.
- When referring a patient, provide the name and number of the specialist.

Pediatric patients need blood lead level screenings.

Pediatric patients should be screened at age 1 and again at age 2 to assess their blood lead levels (BLLs). If a child receives lead screening via capillary stick and results are 5 mcg per deciliter or above, a venous blood draw is required to validate results. In addition, pediatric patients with lead levels above 5 mcg per deciliter will have intervention from the Department of Public Health.

EPSDT staff receives monthly reporting from Labcorp for HHO members with elevated blood lead levels. They provide outreach to all the families of children with elevated BLLs and coordinate care with PCPs, the Department of Public Health, and Child Watch.

Lead poisoning is harmful to children, especially those under age 6, because it can cause learning difficulties and developmental delays. Lead absorbed into the body can poison children and cause serious damage to their vital organs. A study showed that 34% fewer U.S. children had lead testing January through May 2020 compared to the same period in 2019. It is estimated that 9,603 children with elevated BLLs missed the regular screenings in the 34 jurisdictions surveyed.[1]

Remind parents that lead is a toxic metal found in a variety of household products and materials. Let them know they can reduce lead exposure to their children by:

- Cleaning windowsills and floors regularly with a damp paper towel and throwing away the towel.
- Having their home tested for lead paint, especially if it was built before 1978.
- Letting water run for a few minutes before using or consuming it.
- Making sure their child does not have access to peeling paint or chewable surfaces painted with lead-based paint.
- Removing their shoes before entering the house.
- Using lead-free dishes when eating.
- Storing leftover food in glass, plastic, or stainless steel containers.
- Washing their child's hands, face, and toys regularly.

Source:
[1]CDC, "Decreases in Young Children Who Received Blood Lead Level Testing During COVID-19—34 Jurisdictions, January–May 2020

Note these upcoming changes to the provider portal and authorization requests.

The new provider portal launches this winter, replacing NaviNet, the Enhanced Provider Portal, and parts of Highmark's Provider Resource Center.

What can you expect?

- Simplified navigation, including easier, immediate access to tools all in one place, accessible on both desktop and mobile devices.
- Pop-up notifications and personalized messages based on specialty.
- Secure digital forms instead of paper forms to download and fax or mail in.

Upcoming changes to the way you request authorizations.

Starting **Oct. 22, 2021**, authorization submissions will no longer be accepted through NaviNet. While the new provider portal is being developed, temporary manual processes will be in place for:

- Medication authorizations (medical benefit J codes). Submit by fax to **1-855-476-4158** or call the Pharmacy Department at **1-844-325-6251** Monday–Friday, 8 a.m.–5 p.m.
- All other authorizations. Submit authorizations by calling Utilization Management at **1-844-325-6251**, Monday–Friday, 8 a.m.–5 p.m.
- Appeals and claims disputes. Fax appeals and claims disputes to Appeals and Grievances at **1-844-207-0334**.
- Fax appeals to **1-844-207-0334**.
- Fax claims disputes to **1-833-202-9390**.

After Oct. 22 and during the transition to the new provider portal, you can continue to use NaviNet for eligibility inquiry, claims inquiry, updates, and more. The temporary manual process will be in place until new online tools are available.

Highmark Health Options is available to:

- Answer your calls, receive incoming faxes, and build the authorization shells.
- Provide an automatic approval authorization without a clinical review in accordance with established guidelines, in some instances.
- Update you on your appeals and claims disputes submissions.

If you have questions or concerns, contact Provider Services at 1-844-325-6251.

Collaboration makes discharge planning more successful.

Discharge planning is vital to patients' health success. Preventing readmissions should be viewed as part of a patient's care journey. Balancing patient visits and discharge planning can be difficult at times. Here are a few tips to make discharge planning more successful:

- Assess patients post-discharge.
- Collaborate with the LTSS Case Managers and Care Coordinators. Case Managers are required to:
  - Ensure patient needs are met, such as durable medical equipment is delivered, home environment is safe, medication is available, and follow-up visits are scheduled and attended.
  - Follow up after discharge with patients and their support system to ensure a safe discharge has occurred.
  - Partner with the multidisciplinary team and facility staff upon admission and follow up weekly for patient status.
  - Review patient clinical information.
- Coordinate with facility staff and providers for patient discharge needs.
- Include patient, family, and caregivers or guardians in the discharge plan.
- Obtain recommendations for care plan.
- Return calls from case managers and hospital social workers for assistance.
- Share and exchange relevant clinical information.

QI/UM programs support better care and services for patients.

The Quality Improvement and Utilization Management (QI/UM) team works closely with providers to review the care and services patients receive and seek feedback about potential improvements. Once a year, the QI/UM team reviews how well Highmark Health Options has collaborated with providers to meet patient care and service needs, assessing how well patients:

- Learn about patient safety.
- Obtain care for long-standing health problems.
- Receive preventive care.

The most recent evaluation revealed some excellent aspects about Highmark Health Options. Some of these include:

- Accreditation by the National Committee for Quality Assurance.
- Better patient health outcomes in key areas, such as preventive screenings, diabetes management, and healthy weight.
- Patient engagement through patient attendance at meetings, such as the Member Advisory Council and QI/UM Committee.

Contact Provider Services for more information about this program, including the annual evaluation of the QI/UM program and progress in meeting the program goals. Ask for a written summary by calling **1-844-325-6251.**

Help prevent domestic violence.

You can play a role in preventing and ending domestic violence. It is estimated that 1 in 4 women will be victimized by domestic violence in her lifetime. The Delaware Coalition Against Domestic Violence has information and resources available to help you talk to patients about domestic violence. In addition, you can encourage patients to use the Delaware Coalition Against Domestic Violence as a resource. Trained advocates can help victims create confidential, personalized safety plans.

100 West 10th St., Suite 903
Wilmington, DE 19801
Phone: **1-302-658-2958**
National Hotline: **1-800-799-7233**
dcadvadmin@dcadv.org

Local 24-hour hotlines and shelters are available:

- New Castle County: **1-302-762-6110** (bilingual)
- Kent and Sussex Counties:
  1-302-422-8058/1-302-745-9874 (bilingual)

Note these changes regarding drugs requiring prior authorization.

Highmark Health Options has implemented a prior authorization process for a subset of medications. This authorization requirement applies to all members. Failing to obtain an authorization for these medications will result in a claim denial.

Important medications/HCPCS code changes:

- Biosimilar products
- Oncology agents with the exception of reference products that require a trial of the biosimilar agent when clinically appropriate:
  - Avastin (J9035)
  - Herceptin (J9355)
  - Neulasta (J2505)
  - Neupogen (J1442)
  - Remicade (J1745)
  - Rituxan (J9312)

Now require authorization as of Aug. 15, 2021:

- Myobloc (rimabotulinumtoxinB) (J0587)
- Xeomin (incobotulinumtoxinA) (J0588)

Now require authorization as of Sept. 1, 2021:

- Aduhelm (aducanumab-avwa) (J3590)*
- Amondys 45 (casimersen) (J3490)*
- Evkeeza (evinacumab-dgnb) (J3590)*
- Nulibry (fosdenopterin) (J3490)*
- Uplizna (inebilizumab-cdon) (J1823)

*These medications will be reviewed under the applicable miscellaneous procedure code until a permanent code is assigned.

Find the most current list of drugs requiring prior authorization on the Highmark Health Options website.

Ask patients if they have advance directives.

Highmark Health Options Medicaid members are required to execute advance directives because they have the right to accept or refuse medical or surgical treatment. The medical record review standards state that providers should ask members age 21 and older if they have advance directives and document the patient's response.

Take these steps:

- Determine whether a patient has executed an advance directive prior to delivering certain services.
- Maintain a copy of a patient's advance directive in their medical record.
- Take time to educate patients about advance directives, if requested.

Find advance directive forms (PDF) on the Highmark Health Options website.

Encourage new parents to use the Postpartum Food Box program.

To support new parents, Highmark Health Options and the State of Delaware have partnered with the ModivCare transportation service and the Food Bank of Delaware to provide nutritional assistance through the Postpartum Food Box program. These free meal boxes offer nutritional assistance for Highmark Health Options members who recently gave birth. Once per week for eight weeks, members receive meal boxes that contain:

- Nonperishable food items, such as a variety of milk, rice, and canned fruits and vegetables. Two options are available:
  - **Option 1** contains cereal, peanut butter, canned chicken, split peas, mac n' cheese, pasta, and spaghetti sauce.
  - **Option 2** contains oatmeal, red beans and rice, tuna, egg noodles, mashed potatoes, and beef stew.
- Diapers: Size 1 diapers, as available.
- Wipes: One standard pack of wipes, as available.

For patients to be eligible, they should:

- Sign up during their first eight-week postpartum visit.
- Not surpass their 12th week of postpartum.

Care Coordination can assist providers with this effort through outreach and education to their patients. Encourage patients to call **1-844-325-6251** to learn more.

Earn compensation through Risk Adjustment programs.

Highmark Health Options offers providers competitive compensation for participating in the Retrospective Gap Closure (RGC) and Prospective Gap Closure (PGC) programs. To earn the compensation, you must bill confirmed conditions on the encounter for PGC and on a corrected claim for RGC:

Category Conditions	PGC Compensation	RGC Compensation
Condition 1 Confirmed	$25	$125
Condition 2 Denied	$5	$5
Condition 3 N/A	$0	$0
	$30	$130

Use the Assess tool, a web-based platform, to identify risk adjustable patient conditions and improve recapture rates. Conditions are generated based on aggregated historical and current claims. Using Assess will lead to better condition capture rates, which enhances:

- Aligned care management programs
- Patient care
- Risk stratification

Training will be accessible via live, virtual training sessions, and recorded demonstrations. When enrolled, you will receive biweekly progress reports to monitor progress and compensation earned.

To enroll in the new Risk Adjustment programs and start using the Assess tool, contact:

Bryan W. Boyd, Senior Project Manager

Felicia Y. Herron, Risk Revenue Program Manager

Iyana Johnson, Clinical Transformation Consultant

Treat seasonal affective disorder and substance use disorder simultaneously.

Patients with both **seasonal affective disorder (SAD) and substance use disorder (SUD)** benefit more when the disorders are treated simultaneously.[1] If only the substance use is addressed, untreated SAD may trigger a relapse, and an untreated SUD may worsen depressive symptoms. Simultaneous treatment can help prevent patients with SAD symptoms from self-medicating with substances and alcohol.[2,3]

SAD is a type of depression related to seasonal changes, with symptoms beginning and ending about the same times each year.[4,5] Symptoms usually start in the fall and continue through the winter months.

When SAD is a potential diagnosis, you can rule out other factors, such as thyroid, anemia, and adrenal issues. To be diagnosed with SAD, a patient must meet the full criteria for major depression coinciding with specific seasons for at least two years. Common SAD symptoms include:

- Agitation
- Anxiety
- Craving carbohydrates
- Episodes of violent behavior
- Hypersomnia
- Insomnia
- Lethargy
- Overeating
- Poor appetite with associated weight loss
- Restlessness
- Social withdrawal (feel like hibernating)
- Weight gain

SAD Facts

- SAD affects 5–10% of the population.
- Four out of five people who have SAD are women.
- Onset is between ages 20 and 30.
- SAD is more common in younger people.
- About 20% of Americans with an anxiety or mood disorder also struggle with a SUD, and vice versa. In addition, 50% of all people who struggle with a mental health disorder will also experience a SUD at some point.

Four major types of treatment for SAD:

Treatment type	Treatment guidelines
Medication: Patients with SAD may have trouble regulating chemicals in their body, such as serotonin or melatonin.	• Selective serotonin reuptake inhibitors (SSRIs) • Bupropion, another type of antidepressant
Light therapy:[6] Darkness increases the production of melatonin, leaving people feeling sleepier and more lethargic. **Note:** Before recommending light therapy, find out if the patient has a diagnosis of bipolar disorder. Use of light therapy can cause manic episodes.	Artificial light: • Replaces the diminished sunshine of the fall and winter months. Typically, light boxes filter out the ultraviolet rays and require 20–60 minutes of exposure to 10,000 lux of cool-white fluorescent light. • Is effective in up to 85% of cases. • Light use studies showed that overall exposure to 2,500 lux light intensity for two hours daily for one week produced significantly more remissions.[6]
Psychotherapy: Cognitive Behavioral Therapy has been shown to be helpful, but research is limited.	Mind and body techniques: • Guided imagery • Meditation • Music or art therapy • Relaxation techniques, such as yoga or tai chi
Vitamin D: Patients with SAD may produce less vitamin D, and this insufficiency may be associated with clinically significant symptoms of depression.	• Some studies have found vitamin D replacement to be as effective as light therapy. • Other studies found no effect from vitamin D.

Sources:

[1] Leo Sher, et al., "Alcoholism and Seasonal Affective Disorder." Comprehensive Psychiatry 45, no. 1, 51–56.

[2] National Institute on Drug Abuse, "Comorbidity: Substance Use Disorders and Other Mental Illnesses."

[3] Thomas Kelly and Daley, Dennis, "Integrated Treatment of Substance Use and Psychiatric Disorders." Social Work in Public Health 28, no. 3–4 (May 2013), 388–406.

[4] NIMH: Seasonal Affective Disorder

[5] Mental Health America: SAD

[6] Michael Terman, et al., "Light Therapy for Seasonal Affective Disorder: A Review of Efficacy." Neuropsychopharmacology 2, no. 1 (1989).

Use the Elder Abuse Suspicion Index (EASI) to assess suspected elder abuse.

Elder abuse is a critical incident that needs to be reported to Highmark Health Options and the State when you suspect or have knowledge of such an incident. EASI is a questionnaire developed to raise your suspicion about potential elder abuse in patients. If patients answer "yes" to one or more of the following questions, you may want to report a possible critical incident. When administering this questionnaire, interview the patient and caregiver separately.

Elder Abuse Suspicion Index (EASI)

Ask patient Q.1–Q.5; Q.6 answered by provider.			
Within the last 12 months:			
1. Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	YES	NO	Did Not Answer
2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids, or medical care, or from being with people you wanted to be with?	YES	NO	Did Not Answer
3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	YES	NO	Did Not Answer
4. Has anyone tried to force you to sign papers or to use your money against your will?	YES	NO	Did Not Answer
5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	YES	NO	Did Not Answer
6. Elder abuse may be associated with findings such as poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Provider, did you notice any of these today or in the last 12 months?	YES	NO	Not Sure

The PCP Portfolio Report promotes quality and safety of care.

The PCP Portfolio Report helps identify ways we can work together to improve care quality and safety through information sharing. This report is available on NaviNet. The report is updated quarterly in April, July, October, and January.

The report compares providers to others in their peer groups and contains key utilization, pharmacy, and quality measures. Quality of care and services provided to our members is evaluated based on these measures. When outliers are found, we send a letter to providers to explain these findings.

Provider feedback is incorporated into these reports. Based on feedback from the last report, you can now reach out to members. Doing so enables you to close care gaps and eliminate outliers identified in reports.

Note: The PCP Portfolio Report is not tied to any reimbursement or incentive and is designed exclusively to improve quality and safety of care.

If you have questions, contact Su-Linn Zywiol, Strategy Program Manager.

Coding Corner: Evaluation and management (E/M) coding.

On Jan. 1, 2021, Highmark Health Options implemented new guidelines for E/M documentation. These new guidelines allow you to choose whether your documentation is based on medical decision-making (MDM) or total time:

- MDM: No material changes were made to three current MDM subcomponents, but extensive edits were made to the elements for code selection and many definitions in the E/M guidelines (PDF) were revised or newly created.
- Time: The definition of time is minimum time, not typical time, and represents total physician or qualified health care professional (QHP) time on the date of service. These definitions apply only when code selection is primarily based on time and not MDM.

You can use whichever method is most beneficial for each patient visit. While your work in capturing the patient's pertinent history and performing a relevant physical exam contributes to both MDM and time, these elements alone should not determine the appropriate code level. History and exam elements should be captured only when clinically appropriate.

Elements of Medical Decision-Making

Code	Level of MDM (Based on 2 out of 3 elements of MDM)	Number and Complexity of Problem Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	**Straightforward**	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk or morbidity from additional diagnostic testing or treatment**

Chart continues on next page.

Elements of Medical Decision-Making

Code	Level of MDM (Based on 2 out of 3 elements of MDM)	Number and Complexity of Problem Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below	Risk of Complications and/or Morbidity or Mortality of Patient Management
99203 99213	**Low**	**Low** • 2 or more self-limited or minor problems or • 1 stable chronic illness or • 1 acute, uncomplicated illness or injury	**Limited** (Must meet the requirements of at least 1 of the 2 categories) **Category 1: Tests and documents** • Any combination of 2 from the following: - Review of prior external note(s) from each unique source* - Review of the result(s) of each unique test* - Ordering of each unique test* **or** **Category 2: Assessment requiring an independent historian(s)** (For the categories of independent interpretation of test and discussion of management or test interpretation, see moderate or high)	**Low risk of morbidity from additional diagnostic testing or treatment**
99204 99214	**Moderate**	**Moderate** • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment or • 2 or more stable chronic illnesses or • 1 undiagnosed new problem with uncertain prognosis or • 1 acute illness with systemic symptoms or • 1 acute complicated injury	**Moderate** (Must meet the requirements of at least 1 out of 3 categories) **Category 1: Tests, documents, or independent historian(s)** • Any combination of 3 from the following: - Review of prior external note(s) from each unique source* - Review of the result(s) of each unique test* - Ordering of each unique test* - Assessment requiring an independent historian(s) **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported) **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing treatment** Examples only: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health

Elements of Medical Decision-Making

Code	Level of MDM (Based on 2 out of 3 elements of MDM)	Number and Complexity of Problem Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below	Risk of Complications and/or Morbidity or Mortality of Patient Management
99205 99215	**High**	**High** • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment or • 1 acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** (Must meet the requirements of at least 2 of the 3 categories) **Category 1: Tests, documents, or independent historian(s)** • Any combination of 3 from the following: - Review of prior external note(s) from each unique source* - Review of the result(s) of each unique test* - Ordering of each unique test* - Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported) **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**High risk of morbidity from additional diagnostic testing treatment** Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis

Table 2: 2021 Requirements for E/M Codes 99212 – 99215

Code	History/Exam	MDM	Total Minutes
99212	Medically appropriate history and/or examination	Straightforward	10–19
99213		Low	20–29
99214		Moderate	30–39
99215		High	40–54

References:
AAPC: 99202-99215: Office/Outpatient E/M Coding in 2021
CMS: Evaluation and Management Services Guide Booklet (PDF)
AMA: CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99417) Code and Guideline Changes (PDF)
AMA: CPT® Evaluation and Management | American Medical Association (technical changes highlighted in blue) (PDF)

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Provider Complaints
(not claims related)

HHO-ProviderComplaints@highmark.com
Phone: 1-844-228-1364
Fax: 1-844-221-1569

Statement of Members' Rights and Responsibilities.

The organization's member rights and responsibilities statement specifies that members have:

1. A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
2. A right to be treated with respect and recognition of their dignity and their right to privacy.
3. A right to participate with practitioners in making decisions about their health care.
4. A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
5. A right to voice complaints or appeals about the organization or the care it provides.
6. A right to make recommendations regarding the organization's member rights and responsibilities policy.
7. A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
8. A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
9. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Check out this useful information.

Atlas Systems Inc. continues to conduct quarterly outreach to verify provider data on Highmark Health Options' behalf.

Balance billing: Payment by Highmark Health Options is considered payment in full. Under no circumstance may a provider bill; charge; collect a deposit from; seek compensation, remuneration, or reimbursement from; or have any recourse against a member.

Medical records: Highmark Health Options may request copies of medical records from providers. If medical records are requested, the provider must supply copies at no cost within 30 calendar days of the request.

Taxonomy: Highmark Health Options requires that credentialed taxonomy be included for all billing, rendering/performing, and attending providers on an inbound claim.

Check out these tools.

Cultural Competency Toolkit: Highmark Health Options has assembled a list of resources and tools to assist you in providing care that is sensitive to the cultural and linguistic differences of our members.

Visit our website for more resources and the latest updates.