HIGHMARK Delaware HEALTH OPTIONS

August 2018

PROVIDER UPDATE

An Update for Highmark Health Options Providers and Clinicians

Provider and Clinical Updates

If you believe you received patient information from Highmark Health Options in error, please contact the Corporate Compliance and Privacy Team at privacyteam@gatewayhealthplan.com.

Important Phone Numbers

Coding Corner: Anatomical Modifiers

The American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS) instruct using anatomical modifiers to provide the most specific detail of procedures billed. Use of these modifiers prevents denials of claims for several procedures performed on different anatomical sites, on different sides of the body, or at different sessions on the same date of service. The modifier must reflect the documentation in the medical record.

The following anatomical modifiers are required for reimbursement when appropriate.

Bilateral Procedures:

Modifier	Description
LT	Left Side (used to identify procedures performed on the left side of the body)
RT	Right side (used to identify procedures performed on the right side of the body)
50	Bilateral

Eyelids:

Modifier	Description
E1	Upper left, eyelid
E2	Lower left, eyelid
E3	Upper right, eyelid
E4	Lower right, eyelid

Fingers:

Modifier	Description
FA	Left Hand, thumb
F1	Left hand, second digit
F2	Left hand, third digit
F3	Left hand, fourth digit
F4	Left hand, fifth digit
F5	Right hand, thumb
F6	Right hand, second digit
F7	Right hand, third digit
F8	Right hand, fourth digit
F9	Right hand, fifth digit

Coding Corner: Anatomical Modifiers (cont.)

Toes:

Modifier	Description
TA	Left foot, great toe
T1	Left foot, second digit
T2	Left foot, third digit
T3	Left foot, fourth digit
T4	Left foot, fifth digit
T5	Right foot, great toe
T6	Right foot, second digit
T7	Right foot, third digit
T8	Right foot, fourth digit
T9	Right foot, fifth digit

SOURCES

American Medical Association, *Current Procedural Terminology (CPT)*

CMS, *Pub 100-4 Medicare Claims Processing Manual, Chapter 12, 30.M*
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

2018 HEDIS Audit

Every year, NCQA-accredited health plans conduct a HEDIS® (Healthcare Effectiveness Data and Information Set) audit to measure performance against industry benchmarks. The audit uses a wide variety of indicators covering effectiveness of care, medication management, utilization management, preventive screenings, and more. The final results are analyzed annually, trended over time, and compared to other health plans nationwide.

The 2018 HEDIS audit resulted in several rates surpassing the NCQA 75th percentile. In addition, Highmark Health Options saw significant improvement in the following measures:

- Adult BMI Assessment
- Comprehensive Diabetes Care: HbA1c Control <8%
- Cervical Cancer Screening
- Immunizations for Adolescents: HPV Vaccines

The audit also showed several measures performing below expectations, thereby resulting in opportunities for improvement. Some of these measures include:

- Timeliness of Prenatal Care
- Postpartum Care
- Breast Cancer Screenings

Highmark Health Options, after reviewing the final results, has developed several initiatives to positively impact the rates of various measures. In addition to targeted member outreach and internal collaboration, Highmark Health Options has hired additional staff, enhanced provider education, and has put several new processes in place in the Member Services department. We are hopeful that these changes will not only improve HEDIS rates, but also make a positive impact on our Highmark Health Options members.

Compliance with Policies

Highmark Health Options has policies in place to make sure that the care and services our members get are what they need. As a valued partner, both practitioners and providers need to know what these policies are as well.

Examples of some policies may be:
- Time limits for having copies made of a member's medical record;
- Protecting member privacy; and
- Responsibility of Specialists to provide written correspondence to the Primary Care Practitioner for continuity and coordination of care.

There are some special services that need to be authorized by Highmark Health Options before the service is provided. The Highmark Health Options member must seek authorization for the services listed below:

- Non-emergency Ambulance Services, except for trips for dialysis;
- Chiropractic Treatment;
- Durable Medical Equipment, (such as wheelchairs) Orthotic and Prosthetic Devices and Medical Supplies (more than $500);
- Scheduled Hospital Admissions;
- Hospital Admissions for Acute Medical, Rehabilitation or Long Term Acute Care;
- Home Health Visits;
- Home Infusion;
- Outpatient CT Scans, MRI/MRA, Nuclear Cardiology Tests and Pet Scans;
- Non-Participating Providers;
- Certain Outpatient Services/Surgery;
- Outpatient Neuropsychiatric and Psychiatric Testing;
- Electroconvulsive (ECT) Therapy;
- Outpatient Rehabilitation Services (Occupational, Cardiac, Physical, Speech and Language Therapy); and
- Skilled Nursing Facility Care

*Behavioral Health/Substance Abuse:
Providers are required to submit a prior authorization for Substance Abuse should a service exceed 14 days for Inpatient Substance Abuse Treatment, 5 days for Withdraw Management Treatment, and 30 days for Intensive Outpatient Services. Highmark Health Options will review services using the ASAM criteria.

If a Highmark Health Options member has a legitimate medical emergency requiring immediate medical attention in order to prevent death, loss of a limb or function of a limb, they should go to the nearest emergency room (ER). Some possible examples of an emergency are uncontrollable bleeding, chest pain or sudden confusion and slurred speech. In these situations, the member does not need to get approval from their PCP. As soon as possible, they should tell you about their emergency. If the member is not sure if they have a medical emergency, the member should call you to help determine if their care can best be handled in your office or the ER. All PCPs and Specialists are required to have coverage in the evenings and on weekends. This may be through an answering service or an on-call doctor.

If you have any questions about Highmark Health Options policies, please call the Provider Services Department at 1-844-325-6251.

Community Repository

Highmark Health Options web-based search platform provides resource assistance to members by encouraging preventive care and detailing many other services. A key objective of the repository is engaging members in healthy behaviors through health education and locating programs for wellness and disease self-management. Additionally, members can be connected to a wide array of local resources such as food banks, shelters and housing, child care, clothing and furniture, legal assistance, transportation assistance, pastoral care, and financial assistance with utilities.

The repository is available not only to members, but also to providers. Go to www.highmarkhealthoptions.com/communityrepository for assistance in finding state and local community resources that may be helpful for members.

Provider Network Contacts

Provider Relations:

Paula Victoria
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Felicia Herron– New Castle County
Provider Account Liaison
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Chandra Freeman – Kent County and City of Newark
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Provider Contracting, continued

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Elaine Yakich
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Shawn Smith
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412-255-1195

Important Addresses and Phone Numbers

Addresses	
Office Location	Highmark Health Options 800 Delaware Avenue Wilmington, DE 19801
Member Correspondence	Highmark Health Options – Member Mail P.O. Box 22188 Pittsburgh, PA 15222-0188
Provider Correspondence	Highmark Health Options – Provider Mail P.O. Box 22218 Pittsburgh, PA 15222-0188

NaviNet	
NaviNet Access 24/7	Click here to enter the NaviNet Portal

Department	Contact Number	Hours
Provider Services	1-844-325-6251	Mon. – Fri. 8 a.m. to 5 p.m.
Member Services	1-844-325-6251	Mon. – Fri. 8 a.m. to 8 p.m.
Member Services (DSHP Plus)	1-855-401-8251	Mon. – Fri. 8 a.m. to 8 p.m.
Authorizations	1-844-325-6251	Mon. – Fri. 8 a.m. to 5 p.m. (24/7 secure voicemail for inpatient admissions notification)
Care Management/Long Term Services and Supports (LTSS)	1-844-325-6251	Mon. – Fri. 8 a.m. to 5 p.m. (after hours support accessible through the Nurse Line)
Member Eligibility Check (IVR)	1-844-325-6161	24/7
Behavioral Health	1-844-325-6251	Mon. – Fri. 8 a.m. to 5 p.m.