HIGHMARK Delaware HEALTH OPTIONS

February 2019

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: CPT Changes for PICC Line Placement

The 2019 CPT Manual brings updates to **peripherally inserted central venous catheter (PICC)** coding. There are three code revisions, two new codes, and a new entry site for PICCs.

In addition to the basilic and cephalic veins, the saphenous vein is now included in the definition of a peripheral entry site.

Prior to 2019, there were only two codes for PICC placement:

- **36568** Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; younger than 5 years of age
    - **36569** age 5 years or older

The 2019 codes have been revised to add *without imaging guidance* and two new codes have been created to bundle imaging guidance:

- **36568** Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, without imaging guidance; younger than 5 years of age
    - **36569** age 5 years or older

- **36572** Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; younger than 5 years of age
    - **36573** age 5 years or older

There is also a 2019 revision to the PICC replacement code. This code now bundles imaging guidance:

- **36584** Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the replacement

Coding Tips:

- Radiology codes 71045, 71046, 71048 should not be reported for the purpose of documenting the final catheter position on the same day of services as 36572, 36573, or 36584

- Codes 36572, 36573, and 36584 include confirmation of the catheter tip location; the physician or other qualified health care professional reporting image-guided PICC insertion cannot report confirmation of the catheter tip location separately

- Report 36572, 36573, 36584 with modifier 52 when performed without confirmation of the catheter tip location

- Do not report 36568, 36569, 36572, 36573, or 36584 with radiology add-on codes 76937 or 77001

- For replacement of a PICC without subcutaneous port or pump, through the same venous access, without imaging guidance, use 37799

Coding Corner: CPT Changes for PICC Line Placement (cont.)

REFRENCE

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

NOTICE REGARDING BILATERAL PROCEDURES

Due to system processing issues, we previously advised providers to bill bilateral procedures with modifier 50 and 2 units. This issue has been corrected as of 12/14/2018. Claims received after that date should bill bilateral procedures as the State instructs with modifier 50 and 1 unit. Billing with 2 units will cause the claim to deny. Claims that were denied prior to 12/14/2018 have been adjusted by Highmark Health Options.

Asthma / COPD Overlap Syndrome

A study by Respiratory Health in Northern Europe (RHINE) and the Global Allergy and Asthma Network in Europe (GALEN) Swedish surveys discovered a higher incidence of insomnia and breathing problems for patients with asthma-COPD overlap syndrome, known as ACO, when compared to those with only asthma or COPD.

Researchers indicate this is the first study to evaluate the correlation concerning sleep-related indications and ACO.

As sleep disorders have a negative effect on quality of life, researchers point out the likeliness of the diminished quality of life in patients with ACO found in former studies may be explained by poor sleep.

Over 25,000 participants, 40 years old or older, took part in one of two Northern European broad-spectrum population surveys. Questions regarding COPD, asthma, respiratory and sleep-related symptoms (including trouble commencing sleep, difficulty sustaining sleep, early-morning awakening, and disproportionate somnolence during the day), were incorporated in both surveys.

After modification for gender, age, body mass index (BMI), smoking history, and level of education, the group with ACO was found to have a higher prevalence of insomnia and respiratory symptoms compared to patients that have either asthma or COPD. The study also finds ACO patients being two to three times more likely of having sleep-related issues when compared to the group that had neither asthma nor COPD.

The authors said future studies of patients with ACO are needed to identify patient interventions and the best methodology. (Credit: *The American Journal of Managed Care, May 2018.*)

Breast Cancer Screening

The impact that breast cancer has in the United States, for both victims and their families can be devastating. According to the American Cancer Society, breast cancer is mostly diagnosed between the ages of 55 to 64 and is the most common type of cancer in the United States and the fourth leading cause of cancer death[1]. It has been estimated that one in eight American women will be diagnosed with breast cancer at some point in their lives[1].

Despite being so prevalent and receiving nationwide attention, many women still worry about screening for breast cancer. Notably, there is concern about false positives that lead to unnecessary biopsies due in part to research that shows there is a zero to 54 percent over-diagnosis rate resulting in false positive screening results[2]. Although there is a risk for women receiving false positive results, regular breast cancer screenings are still effective in identifying a breast cancer threat and beginning treatment, ultimately saving a woman's life. That benefit must be weighed against any risk of a false positive and the decision to screen along with the risks and benefits of mammograms and potential for false positives should be discussed with your patient as a component of shared decision making. Regular screening is a great way to improve your patients' lives.

Breast Cancer Screening is also a measure that impacts HEDIS rates. It's defined as the number of women 52 - 74 years of age as of December 31st of the measurement year who have received one or more mammograms (screening, diagnostic, film, digital or digital breast tomosynthesis*-{a newer mammography technology using three-dimensional images}) since October 1st two years prior to the measurement year. Women who have had both breasts surgically removed are excluded from the measure and women on hospice any time during the measurement period are excluded from the measure.

There are several ways that you can get more patients screened and improve your HEDIS rates:

- Create alerts or flags in the medical record that remind staff who interact with a patient to discuss breast cancer screening.
- Ask your patients if they have already had a mammogram that was ordered by another physician and get a copy to include in their medical record.
- Use other preventive appointments, such as well visits or annual flu shots, as an opportunity to discuss breast cancer screening.
- Offer scheduling or referral assistance to patients. You can even have standing referrals created for staff to provide patients while they are in the office.
- Come up with a schedule for screening that you can share with the patient. Having a schedule can help the patient plan for future appointments.

Every time you see your patient can be a good reminder to evaluate processes in your practice to determine what is and isn't working in efforts to obtain breast cancer screenings. Small incorporated changes could make a big difference in your patients' lives.

Recommendations for Perinatal Care

Nearly one in ten women in Delaware receives healthcare coverage through Medicaid. Offices who administer maternity care on a regular basis are very familiar with the HEDIS clinical guidelines that recommend:

- A prenatal visit in the first trimester visit;
- Regular visits throughout the pregnancy; and
- A postpartum visit 21 to 56 days after delivery.

Below is a brief list of additional recommended perinatal screenings:

- Prenatal and postpartum depression with documentation of referral when applicable with notation of the depression scale used;
- Tobacco, alcohol and illicit drug use screening with documentation of counseling or referral when applicable;
- Exposure to environmental smoke;
- Intimate partner violence; and
- Medication review (prescribed and over-the-counter).

Please complete and document these important perinatal screenings when caring for Highmark Health Options members. For more information, or to refer a patient to the MOM Options Maternity Program, call Highmark Health Options at 1-844-325-6251.

Medical Record Review Procedure

Introduction:

- Medical Record Review (MRR) Standards have been adopted by the Highmark Health Options Quality Improvement/Utilization Management (QI/UM) Committee.
- Medical Record Review Standards have been developed for:
    - PCPs and Specialists
    - OB/GYN Practices
    - Skilled Nursing Facilities
    - Home Health Agencies
    - Behavioral Health Practitioners

- The importance of having standards is to verify that Practitioners and Providers are:
    - aware of the expected level of care and associated documentation;
    - aware of the requirements for maintenance of confidential medical information and record keeping; and
    - assured that medical records are being evaluated in a consistent manner.

Goals:

- The Quality Improvement/Utilization Management Committee has established the scoring standard of 80% for the Medical Record Review elements.
- If the score of 80% has not been met for MRR, a follow–up review will be scheduled to assess improvement.
- Practitioners and providers are notified of their results and any areas of deficiency by letter within forty-five (45) calendar days of the review.
- Repeatedly failing to meet an overall performance score of 80% may lead to initiation of corrective action, up to and including termination from the Plan.

Frequency of Reviews:

Medical record reviews are conducted at least annually on a sample of PCPs, SCPs, and ancillary providers (e.g. Home Health Agencies, Skilled Nursing Facilities, and Behavioral Health Practitioners). Medical records for this review are obtained directly from the provider and may be reviewed at the provider's location (on-site review) or sent to Highmark Health Options for a desk-top review.

Clinical Practice and Preventive Health Guidelines

Highmark Health Options adopts clinical practice and preventive health guidelines to assist practitioners in providing appropriate healthcare for specific clinical conditions relevant to our members. These guidelines are developed using evidence-based clinical practice guidelines from professionally- and industry-recognized sources, or through the involvement of board-certified practitioners from appropriate specialties when guidelines from recognized sources are not available. They are provided in an effort to improve health care quality by promoting peer-reviewed standards-of-care and best practices. The Guidelines also serve as a guide for Highmark Health Options various Disease Management programs.

Highmark Health Options routinely monitors for industry changes that would affect its adopted guidelines. Before distribution, the guidelines are reviewed and approved by Highmark Health Options Quality Improvement and Utilization Management Committee.

Some of the guidelines maintained by Highmark Health Options:

- ADHD
- Adult Preventive Care
- Asthma
- Asthma Child
- Bipolar
- Bipolar in Children and Adolescents
- Cardiac
- Child Preventive
- Childhood Obesity
- Colitis/Crohn's Disease
- COPD
- Depression
- Diabetes
- Hemophilia
- Hereditary Angioedema (HAE)
- HIV
- Hypertension
- Opioid Dependency
- Palliative Care
- Prenatal Care - Routine and High Risk
- Schizophrenia
- Sickle Cell Disease
- Substance Abuse

A complete listing of Highmark Health Options adopted guidelines is viewable online at www.highmarkhealthoptions.com. Select the *Providers* tab and then click on the *Clinical Guidelines* link. Physical copies are available upon request. For a paper copy, please contact the Quality Improvement Department at 1-844-325-6251.

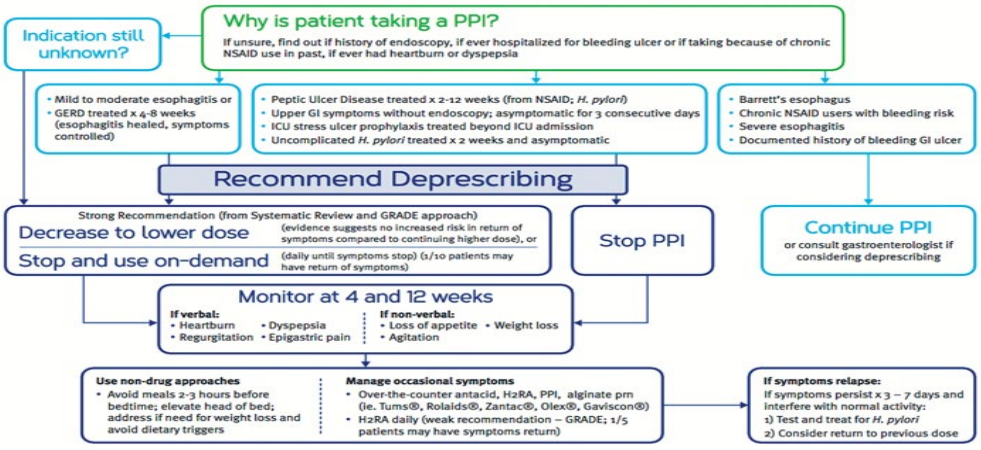
Proton Pump Inhibitors (PPI): Considerations with Long-Term Use

Since the introduction of the first Proton Pump inhibitors (PPI) in 1989, this class of medications has become a staple in the management of gastroesophageal reflux disorder (GERD) and other acid –related disorders. PPIs are very strong agents that greatly reduce acid secretion by irreversibly binding to Hydrogen and Potassium adenosine triphosphates', or the proton pump located over parietal cells. Overall these medications have among the highest sales levels in the US.

PPIs have proven to be very effective and safe in managing GERD, healing peptic ulcer disease, and reducing the incidence of NSAID associated gastropathy, becoming one of the most prescribed medications by healthcare providers. Their great efficacy and low toxicity resulted in the approval of the first OTC product in 2003, giving patients an alternative to H2-receptor antagonists such as Zantac and Pepcid. These same factors have also contributed to their overuse and misuse; healthcare providers are often prescribing these agents for prolonged periods of time even lifetime.

Over the past few years there has been growing concern over potential adverse effects associated with long term therapy. Some of these concerns include hypergastrinemia, development of pneumonia, dementia, and drug interactions. The FDA has issued many different warnings regarding the potential effects of long term use of PPIs: risk of fractures, hypomagnesemia, Clostridium difficile-associated diarrhea, vitamin B12 deficiency, acute interstitial nephritis (AIN), and cutaneous and systemic lupus erythematosus events.

De-prescribing PPI Algorithm



References:

Ambizas, E. (2017, July 19). *US Pharmacist.com*. Retrieved from https://www.uspharmacist.com/article/proton-pump- inhibitors-considerations-with-long-term-use

Overcoming the Stigma of Naloxone Prescribing

Some patients with chronic pain benefit from opioid treatment, but these medications carry certain risks, including respiratory depression, so co-prescribing naloxone for patient safety is an important tool for physicians. So how do you explain the safety benefits of naloxone to patients without the stigma that overdose carries? Dr. Philip Coffin, MD director of substance use research at San Francisco Department of Public Health has a few tips.

HOW TO TALK TO YOUR PATIENTS ABOUT NALOXONE

Routinely co-prescribing naloxone is important not just for patients physicians think may overdose, but also for safeguarding others who may have access to these medications. So it's important to frame the conversation with patients and emphasize that opioid medications carry certain risks, not that the patient's themselves are risky. This helps reduce the stigma and helps make patients feel like they are not being targeted or somehow accused of being out of control with their medications.

Dr. Coffin considers these 3 important things when co-prescribing naloxone:

1**. Talking about Overdose**

The Word overdose to a patient and too many providers means injecting heroin or taking a whole bottle of pills. It's not what the medical system means when talking about overdose with opioids. So it's critical not to start out the conversation with the word "overdose". What the medical system means is that there are more opioids in the body at a given time than your body can handle. So it may mean a patient has sleep apnea and if they stop using the C-PAP machine, the opioids they take may suppress their respiration too much for them to breath enough at night and patient could effectively overdose. It may also mean that a young family member may get into the medicine cabinet and accidentally take the medicine and overdose. Emphasis on that these are risky medications and importance of having an antidote nearby is key.

2. **The Risks Involved**

Many times patients do not really hear risks involved with opioid use. When you pair the conversation with an actual prescription for naloxone and with an actual intervention, it helps to impress upon the patient that the physician's goal in working with patients with opioids is to maximize patient safety and well-being.

3. **Who should get naloxone?**

There are 2 contexts in the distribution of naloxone. One is distribution to users through the needle exchange programs. This is where it's most likely to be used to reverse overdose. The next is co-prescribing naloxone to patients. Many times these patients who are prescribed opioids perceive their risk of overdose to be low or non-existent. Many patients that do overdose perceive the event as an adverse drug reaction to their medications. When naloxone is co-prescribed its helps the physician address the broader topic of opioid issues.

Overcoming the Stigma of Naloxone Prescribing (cont.)

Training for Providers

The CDC launched two (2) new opioid trainings that support providers in the safer prescribing of opioids for chronic pain. The modules are part of a series of interactive online trainings that feature recommendations from the CDC Guideline for Prescribing Opioids for Chronic Pain. The seventh module, Determining Whether to Initiate Opioids for Chronic Pain, helps providers identify and consider important patient factors when starting or continuing opioid therapy, while the eighth module, Implementing CDC's Opioid Prescribing Guideline into Clinical Practice, walks providers through a quality improvement (QI) process using a set of 16 clinical measures outlined in the Quality Improvement and Care Coordination: Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain. Both modules include clinical scenarios and tools and a resource library to enhance learning.

These and all the modules in the series offer free continuing education available on the CDC's Training for Providers webpage at www.cdc.gov/drugoverdose/training/

References

Parks, T (2016, June 3). AMA Retrieved from AMA.org: https://www.ama-assn.org/delivering-care/opioids/antidote-3-things-consider-when-co-prescribing-naloxone.

Provider Network Contacts

Provider Relations:

Desiree Charest - Sussex County
Provider Account Liaison
**includes servicing of LTSS Providers*
DCharest@Highmarkhealthoptions.com
302-217-7991

Cory Chisolm - All Counties
Provider Account Liaison
Ancillary Strategy
CChisolm@Highmarkhealthoptions.com
302-217-7960

Nikki Cleary- All Counties
Provider Account Liaison for Hospitals and Ambulatory Surgery Centers
NCleary@Highmarkhealthoptions.com
302-502-4094

Chandra Freeman – Kent County and City of Newark
Provider Account Liaison
**includes servicing of LTSS Providers*
CFreeman@Highmarkhealthoptions.com
302-502-4067

Felicia Herron– New Castle County
Provider Account Liaison
**includes servicing of LTSS Providers*
FHerron@Highmarkhealthoptions.com
302-217-7973

Tracy Sprague
Provider Account Liaison/Provider Complaints
TSprague@Highmarkhealthoptions.com
302-502-4120

Paula Victoria
Manager, Provider Relations, LTSS
PVictoria@Highmarkhealthoptions.com
302-502-4083

Provider Contracting:

Melanie Anderson
Director, Provider Networks & Contracting
MAnderson@Highmarkhealthoptions.com
302-502-4072

Elsa Honma
Provider Contract Analyst, LTSS and Nursing Homes
EHonma@Highmarkhealthoptions.com
302-317-5967

Kia Knox
Senior Provider Contract Analyst
KKnox@Highmarkhealthoptions.com
302-502-4041

Andrea Thompson
Provider Contract Analyst, Behavioral Health
AThompson@Highmarkhealthoptions.com
302-502-4024

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.
Opioid Management Program	855-845-6213	Mon.- Fri. 8 a.m. to 5 p.m.