HIGHMARK HEALTH OPTIONS

Quarterly Update for Providers

Winter 2023

In this newsletter:

CAHPS® season is coming.

Expansion to the Healthy Rewards Program.

Lifestyle Management and Wellness Programs meet patient's needs.

Providers have an important role in the Care Management Program.

... and more.

In this issue

3 Contact us.
4 CAHPS® season is coming.
5 HEDIS® season is fast approaching.
6 Check out the Free Market Health specialty pharmacy program.
7 Detect diabetic retinopathy early by offering eye tests to patients with diabetes.
8 Use perinatal screenings to improve quality measures.
9 Remind patients about pediatric lead screening.
10 Talk to patients about medicines that cause weight gain.
11 Earn $100 incentive for referring eligible maternity patients with opioid use disorder.
12 Review the new timely access standard for behavioral health providers.
14 Review the vendor information for appeals to payment integrity.
15 CMS finalizes changes for Telehealth Services for 2023.
16 Be sure to review the 2023 CPT® Evaluation and Management (E/M) changes.
19 Respond in time to medical record requests.
20 Check the website updates and notices.
21 Expansion to the Healthy Rewards Program.
23 Learn which vaccines are important for patients with asthma or COPD.
24 Lifestyle Management and Wellness Programs meet patient's needs.
27 Remind patients about the Healthy Rewards Program to meet true performance measures.
29 Review the affirmative statement about provider incentives.
30 Care teams can partner with the Case Management team to provide collaborative care.
31 Providers have an important role in the Care Management Program.
32 The PCP Portfolio Report promotes quality and safety of care.
33 Provider network contacts.
34 Statement of Members' Rights and Responsibilities.
35 Check out this useful information.
35 Check out these tools.

When you see this icon, click it to return to this contents list.

Contact us.

Highmark Health Options Provider Services is the first line of communication for providers' 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.

CAHPS® season is coming.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is a tool that collects information about patients' health care experiences. The survey allows patients to disclose their thoughts about their health plan, which includes various aspects of care from doctors, provider practices, and health care facilities. Survey results are used to:

- Elevate the standards of patient-provider relationships.
- Identify key areas to provide better clinical care.
- Improve the delivery of services.

Highmark Health Options members will be surveyed during March and April. The results will be available by late summer.

HEDIS® season is fast approaching.

The Healthcare Effectiveness Data and Information Set (HEDIS) medical record data abstraction process for 2023 is right around the corner. Providers may receive a request from PalmQuest on behalf of Highmark Health Options asking for assistance to complete this review.

In-network providers are contractually required to provide medical record information. This information helps fulfill state and federal regulatory and accreditation obligations.

Providers contacted to participate in this season's HEDIS audit may find these tips and reminders helpful:

- Providers may receive a request by fax, letter, or phone call from PalmQuest for medical record chart copies.
- PalmQuest may arrange for the collection of medical records through a site visit (if feasible), by fax, or by mail.
- Providers are asked to respond to the request for medical records in a timely manner. Highmark Health Options has a limited amount of time to collect and review all the medical records.

If a practice currently utilizes an electronic medical records (EMR) system and is willing to grant our HEDIS Operations Nurse remote access, contact Su-Linn Zywiol. If at any time during the HEDIS season providers have questions or concerns, feel free to reach out to the Highmark Health Options HEDIS Operations Team at 1-302-502-4166.

Check out the Free Market Health specialty pharmacy program.

Highmark Health Options is implementing a new specialty pharmacy program with Free Market Health to streamline the specialty pharmacy process and ensure quality of care is provided to members. The new specialty pharmacy program facilitates a seamless match between specialty drug referrals and the best-fit specialty pharmacy.

This change will:

- Increase process efficiency, improve care quality, and decrease the time it takes for members to receive their medications.
- Offer transparent and fair access to authorized referrals to our specialty pharmacy network and reward high-quality care.
- Leverage dynamic drug rates and ensure specialty drugs remain affordable for our members.

Prescribers and their patients may notice new specialty pharmacies providing their medications because any accredited, in-network specialty pharmacy will be able to access specialty referrals for Highmark Health Options members.

Call Pharmacy Services at 1-844-325-6251 with any questions about this new program.

Detect diabetic retinopathy early by offering eye tests to patients with diabetes.

Early detection and treatment of diabetic retinopathy can reduce the risk of severe vision loss by 90% in patients with diabetes. However, a high percentage of patients with diabetes never get screened or receive an annual diabetic eye test.

Vision loss from diabetes is almost completely preventable, especially if patients receive an annual eye exam. With recent advances in telemedical screening technology, these quick and simple eye tests can be administered in the primary care setting, driving up screening rates and reducing the number of patients with vision loss.

The annual diabetic eye exam for diabetic eye diseases, such as diabetic retinopathy, is important to monitor the overall health of patients with diabetes. In addition, it can help improve quality measure compliance rates. While the comprehensive annual dilated eye exam is still considered a standard of care for patients with diabetes, most patients do not get a retinal scan for diabetes annually. Providers can identify at-risk patients early and can reduce the risk of vision loss by performing a diabetic eye test as a routine annual diagnostic.

Providers that perform diabetic eye exams interpreted by artificial intelligence can provide reports to the Quality team to evaluate HEDIS® compliance.

Diabetic retinopathy statistics

Diabetic retinopathy is the leading cause of preventable blindness for people ages 20–65 in the United States. According to the American Diabetes Association, 37.3 million people have diabetes. The CDC estimates that only 40%–50% of patients with diabetes receive this important annual diabetic eye test.

Remind patients that they may be eligible for a $25 Healthy Reward if they receive this screening.

Call the Quality team at 1-844-325-6251 with any questions about detecting diabetic retinopathy.

Use perinatal screenings to improve quality measures.

Providers offering perinatal care should be familiar with the quality measure guidelines. The guidelines recommend:

- A minimum of one prenatal visit within the first trimester visit (or 42 days of enrollment).
- Regular prenatal care visit throughout the pregnancy.
- A postpartum visit seven to 84 days after delivery.

Providers can improve their quality measures by asking patients about specific topics during their perinatal screening, such as:

- Exposure to environmental smoke
- Intimate partner violence
- Medications they are taking (prescribed and over-the-counter)
- Prenatal and postpartum depression (make note of the referral, when applicable, with notation of the depression scale used)
- Tobacco, alcohol, and illicit drug use (make note of the counseling or referral, when applicable)

Perinatal quality guidelines help with the healthy development of a fetus, healthy deliveries, and healthy postpartum outcomes. In addition, the guidelines can help reduce:

- Poor birth outcomes
- Low birth weights
- Infant and maternal mortality rates

Providers should complete and document perinatal screenings when caring for Highmark Health Options members. For more information, call Care Coordination at 1-844-325-6251.

Remind patients about pediatric lead screening.

A recent review of Delaware childhood blood lead testing data shows a significant decrease in childhood lead screenings during the COVID-19 pandemic. Lead testing rates dropped by an average of 54% in the first six months of 2020, compared to 2019. During the first six months of 2021, childhood lead testing rates in Delaware dropped by an average of 63%, compared to 2019.

The decrease in pediatric lead screenings is important because the pandemic has added to the risk of lead exposure. The Lead Poisoning Prevention Program supports providers to order a blood lead-level test for children for these reasons:

- Children and families are spending more time in their homes during the pandemic, increasing their risk of lead exposure from paint and dust, the primary sources of lead poisoning.
- Many families and property owners in older homes are also using this time to initiate do-it-yourself home projects or renovations, further increasing the risk of lead exposure.

Children age 6 and younger are most susceptible to lead poisoning because their brains and central nervous systems are still developing. Failure to detect lead poisoning has significant implications for children, such as damage to the brain and nervous system, slowed growth and development, and learning and behavior problems. Children with elevated blood lead levels:

- Have a lower chance of being on track for kindergarten.
- Are more likely to enter the juvenile justice system and be incarcerated as adults (ages 18–23).

Talk to patients about medicines that cause weight gain.

Some medications cause patients to gain weight. Provide routine screenings that monitor blood pressure, blood sugar levels, and cholesterol levels for your patients. Some types of medicines that cause weight gain are used to treat:

- Diabetes (including insulin)
- Pain (including steroids)
- Headaches
- Seizures
- Mental health conditions (antidepressants and mood stabilizers)

Patients may experience weight gain because their body is retaining more fluids or burning calories slower, or because the medicine is causing them to alter their eating habits. In addition, physical health problems can occur due to weight gain, such as:

- Heart disease
- Stroke
- High blood pressure
- High cholesterol
- Type 2 diabetes

Talk with patients about their medications, especially ones that might cause weight gain. Discuss with patients their medication options and be sure to explain potential weight gain side effects.

Earn $100 incentive for referring eligible maternity patients with opioid use disorder.

Providers can earn incentives with the new Maternal Opioid Use Disorder Referral Program. This program helps improve the health outcomes for pregnant and postpartum patients and their babies through education and connection to a treatment program.

Providers can receive an incentive payment of $100 for each valid member they refer.

To qualify for the incentive, providers must complete the Referral Request form for each identified pregnant and postpartum patient with an opioid use disorder diagnosis. Then send the form either via:

- Fax: 1-888-576-4895
- Email: Quality_of_Care@highmark.com

Highmark Health Options will then review the form to verify the patient meets the requirements. Not every patient identified within the pregnant and postpartum opioid use disorder population may be ready for treatment.

Continue to provide support and connect members with the Care Coordination team for follow-up.

Call Care Coordination at 1-844-325-6251 with questions about the incentive program.

Review the new timely access standard for behavioral health providers.

Effective Jan. 1, 2023, the post-discharge behavioral health standard of care has changed. Follow-up appointments must be scheduled within two business days after a patient has been:

- Discharged from an inpatient setting to the community.
- Discharged from a residential setting to the community.
- Evaluated in the emergency room.
- Evaluated by a behavioral health crisis provider.

Providers can review all appointment standards below.

Type of Care	Time Frame Requirement
Emergency services	Within 24 hours of request
Immediate treatment for patients experiencing a behavioral health crisis (including mobile team response based on the acuity of the patient)	Within 1 hour of request
Follow-up appointment after discharge from inpatient, residential, or BH emergency condition	Within 2 business days
Routine outpatient services with a nonprescribing clinician for an initial assessment	Within 7 calendar days of request
Nonemergency outpatient services for prescribing clinician services	Within 3 weeks of request

For more information, call Provider Services at 1-844-325-6251, Monday–Friday, 8 a.m.–5 p.m.

Review the vendor information for appeals to payment integrity.

Highmark Health Options uses vendors to assist with certain functions. Below are some vendors that Highmark Health Options uses and their roles.

Cotiviti

Performs data mining audits. Findings types and audit concepts include, but are not limited to, Medicare COB, multiple surgery reductions, and readmissions.

- Letters detailing findings are sent to providers via mail and providers have 30 days to respond.
- If a provider disagrees with findings, they have up to 30 days to submit an appeal.
- If no appeal is received within 30 days, the claim in question is sent to Highmark Health Options to be adjusted.

CGI

Performs data mining and complex audits. Findings types and audit concepts include, but are not limited to, new versus established patient billing, exceeds max units, and assistant surgeon billing.

- Letters detailing findings are sent out to providers via mail and providers have 30 days to respond.
- If a provider disagrees with findings, they have up to 30 days to submit an appeal.
- If no appeal is received within 30 days, the claim in question is sent to Highmark Health Options to be adjusted.

Complex reviews performed by CGI are audits that evaluate medical records for medical necessity. Providers must submit requested records within 30 days.

- If there are findings, providers will receive findings letters.
- Providers have 30 days to respond to findings letters as well as Medical Record Requests.

HMS

Performs COB functions relating to the identification of other primary insurance coverage. HMS communicates other primary insurance coverage information to providers in the disallowance process by sending the provider a letter that includes detailed instructions and next steps.

- Providers should refer to the letter sent by HMS for information on how to contact HMS and for the timeframe required to respond.
- The standard timeframe for the provider to respond is 60 days from the date found on HMS's letter.
- If the provider agrees with HMS or if no response is received from the provider within the required response time frame, HMS will notify Highmark Health Options of the claim to be adjusted.

EQUIAN

Performs subrogation and discovery functions. Equian communicates other liable party information to providers in their discovery process by sending the provider a letter that includes detailed instructions and next steps.

- Providers are asked to refer to the letter sent by Equian for information on how to contact Equian.
- Equian will also notify Highmark Health Options of the claim(s) to be adjusted.

CMS finalizes changes for Telehealth Services for 2023.

The Centers for Medicare and Medicaid Services (CMS) released its final 2023 Medicare Physician Fee Schedule (PFS) rule. Some significant telehealth policy changes include:

- Discontinuing reimbursement of telephone (audio-only) evaluation and management (E/M) services.
- Discontinuing the use of virtual direct supervision.
- Five new permanent telehealth codes for prolonged E/M services and chronic pain management.

Codes	Description
G0316	Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary.
G0317	Prolonged nursing facility evaluation and management service(s) beyond the total time for the primary.
G0318	Prolonged home or residence evaluation and management service(s) beyond the total time for the primary service.
G3002	Chronic pain management and treatment.
G3003	Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional, per calendar.

- Postponing the effective date of the telemental health six-month rule until 151 days after the public health emergency (PHE) ends.
  - Under the rule, Medicare will cover a telehealth service delivered while the patient is located at home if the following conditions are met:
    - The provider conducts an in-person exam of the patient within the six months before the initial telehealth service.
    - The telehealth service is furnished for purposes of diagnosis, evaluation, or treatment of a mental health disorder.
    - The provider conducts at least one in-person service every 12 months of each follow-up telehealth service.
- Extending coverage of the temporary telehealth codes until 151 days after the PHE ends.

References: CMS Finalizes Changes for Telehealth Services for 2023

Be sure to review the 2023 CPT® Evaluation and Management (E/M) changes.

The following codes are being deleted.

Codes	Description
99217–99220, 99224–99226	Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary.
99241, 99251	Prolonged nursing facility evaluation and management service(s) beyond the total time for the primary.
99318	Prolonged home or residence evaluation and management service(s) beyond the total time for the primary service.
99324v99328, 99334–99337, 99339, 99340	Domiciliary, rest home (e.g., boarding home), or custodial care services
99343	Home or resident services
99354–99357	Prolonged services codes

Initial and subsequent services update.

This new section applies to hospital inpatient, observation care, and nursing facility codes. It applies to both new and established patient visits.

- These codes are used by physicians and other qualified health care professionals who have E/M services in their scope of practice.
- It explains the rules for physicians and other qualified health care professionals who are working in the same specialty and subspecialty in the same group practice.

Selecting a level of service using 2023 CPT E/M changes.

The AMA has extended the framework for code selection for office and outpatient visits implemented in 2021 to the remainder of E/M services that were selected based on history, exam, medical decision making, or time. The change affects these services:

- Hospital inpatient and observation care services (one set of codes will be used for both inpatient and observation)
- Consultation services
- Emergency department services (time may not be used as a factor when selecting an ED visit)
- Nursing facility services
- Home or residence services

For the categories of codes listed above, the level of E/M service may be selected by the medical decision-making or time. (Time is not a factor in selecting ED visits.) Code selection will be based on the three elements of medical decision-making, which are the:

- Number and complexity of problems that are addressed during the encounter
- Amount and/or complexity of data to be reviewed and analyzed
- Risk of complications or morbidity or mortality of patient management

Hospital inpatient and observation care services.

With the deletion of observation codes 99217–99220, and 99224–99226, the same codes will be used to report services for patients who are in observation or are inpatients. There are two sets of codes:

Codes	Description
99234–99236	For patients who are admitted and discharged on the same calendar day.
99221–99223, 99231–99233, 99238, 99239	For patients whose stay is longer than a single calendar day (initial service, for subsequent visits, and for discharge services).

Admission and discharge on the same calendar date.

Codes 99234—99236 are used for hospital inpatient or observation care and include the admission and discharge on the same date, whether the patient is an inpatient- or in observation-level care. To report these services, there must be two encounters:

- Admission
- Discharge

The documentation should reflect that the patient was seen twice.

CMS and CPT rules for admission and discharge, same calendar date with application of CMS eight-hour rule.

With the deletion of observation codes 99217–99220, and 99224–99226, the same codes will be used to report services for patients who are in observation or are inpatients. There are two sets of codes:

Hospital Length of Stay	Discharged On	Code(s) to Bill CMS	Code(s) to Bill CPT
< 8 hours	Same calendar date as admission or start of observation	Initial hospital services only 9921 –	Adm/Discharge 99234 – 99236
8 or more hours	Same calendar date as admission or start of observation	Adm/Discharge 99234 – 99223	Adm/Discharge 99234 – 99236
< 8 hours	Different calendar date than admission or start of observation	Initial hospital services only 99221 – 99223	Initial and discharge, 99221 – 99223 on adm. 99238 – 99239 on d/c
8 or more hours	Different calendar date than admission or start of observation	Initial and discharge 99221 – 99223 on adm, 99238 – 99239 on d/.	Initial and discharge, 99221 – 99223 on adm. 99238 – 99239 on d/c

References: 2023 CPT® E/M Changes

Respond in time to medical record requests.

Providers are required to respond to all medical record requests in a timely manner. Each request should be reviewed thoroughly. In addition, providers must submit all documentation requested. If additional clarification is needed, providers can contact the individual who sent the request.

Providers should include the following information with the medical records:

Member-identifying information, e.g., photo ID, member card.

- Consent to treat
- Privacy practices disclosure
- Release of Information for payment
- Notes and documentation for service dates

Providers can contact Payment Integrity at 1-844-325-6251 to request an extension if they need more time to gather information for the submission.

Check the website updates and notices.

Providers should regularly check the Highmark Health Options website for updates and notices. The website provides news and updates from us, as well as the latest breaking stories from the health care industry. The website offers providers tools to stay informed.

Expansion to the Healthy Rewards Program.

The Highmark Health Options Healthy Rewards Program has been expanded to include member participation in two Highmark Health Options wellness programs: Diabetes Prevention Program and LEAN Healthy Weight Management Program.

Highmark Health Options is working with the YMCA of Delaware to offer adult members (ages 18 and older) the resources and tools to help members achieve their wellness goals.

Eligible members get monetary incentives for attending class(es) and achieving specified milestones.

Diabetes Prevention Program

The YMCA of Delaware's Diabetes Prevention Program (DPP) is based on the national Diabetes Prevention Program funded by the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC). The program is available to Highmark Health Options members at no cost.

The DPP is a 12-month program that focuses on helping members adopt healthy habits to reduce their chances of developing type 2 diabetes. Members work online or on site with a trained lifestyle coach and a small group of people working towards the same goal.

Members identified as having prediabetes can qualify for the program:

More information about this program can be found on the YMCA website.

LEAN Healthy Weight Management Program

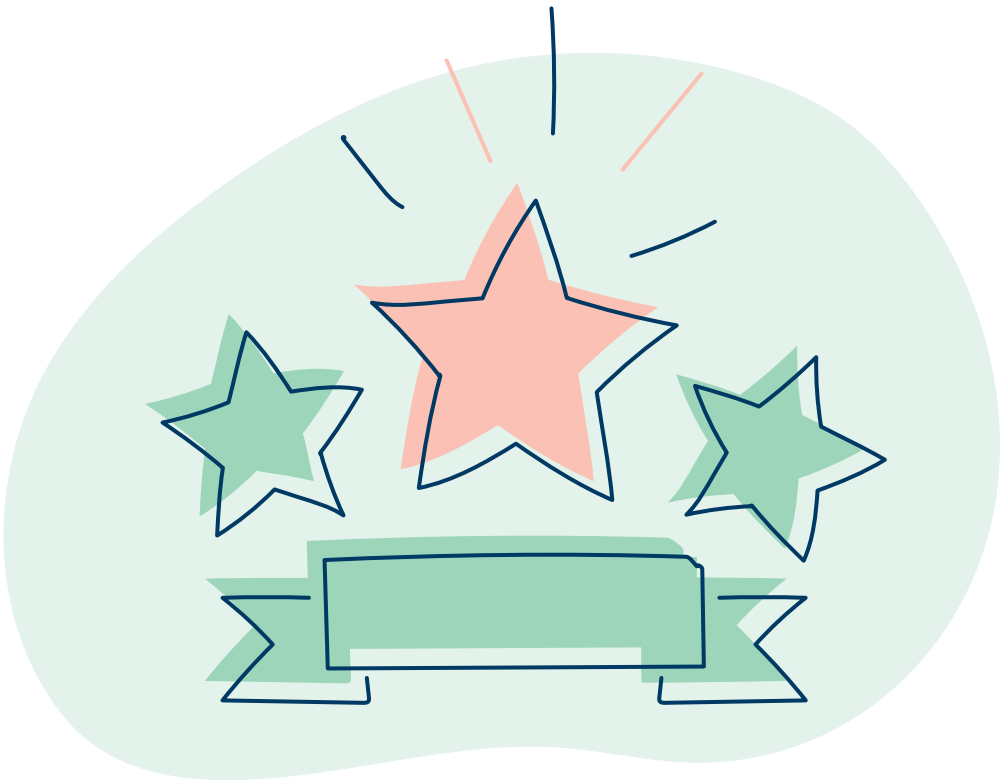
The YMCA of Delaware's weight-loss program, Lifelong Essentials for Activity and Nutrition (LEAN) Program is a 12-week program offered at no cost.

The LEAN Program is available online and on site and provides tools, knowledge, and group support to help members develop a personalized nutrition and exercise plan that works for them. Members with a qualifying diagnosis, such as specified elevated body mass index (BMI), are eligible to participate.

More information about the Diabetes Prevention Program and the LEAN Program can be found online.

Providers with Highmark Health Options patients who may be eligible for these programs can refer them via YMCA of Delaware's Healthcare Provider Referral link, or have members call the YMCA of Delaware Healthy Living Department at 1-302-572-9622.

For any other questions, contact Highmark Health Options Care Management Team at 1-844-325-6251, or visit the website.



Learn which vaccines are important for patients with asthma or COPD.

Per the Centers for Disease Control and Prevention (CDC), patients with asthma or COPD are at higher risk for serious illness or could even die from certain vaccine-preventable diseases.

Statistics indicate some people would be willing to get vaccines if it's easy to do so; others may need reassurance or information. Providers play a vital role in reaching both groups. They can offer vaccinations to patients, while serving as a trusted messenger for patients with concerns.

For people who have asthma or COPD, the CDC recommends the following vaccines:

- Flu vaccine every year to protect against seasonal flu
- Tdap vaccine to protect against tetanus, diphtheria, and pertussis (whooping cough)
- Pneumococcal vaccines to protect against serious pneumococcal diseases
- Zoster vaccine to protect against shingles (if 50 years or older)

Lifestyle Management and Wellness Programs meet patient's needs.

Highmark Health Options staff can provide your patients with ongoing disease education and health care management to promote positive lifestyle changes with our Lifestyle Management and Wellness Programs. More Lifestyle Management and Wellness Program information is available on our website.

Asthma Program

Members:

- Learn the difference between a long-term asthma controller medicine and a rescue inhaler.
- Identify asthma triggers.
- Understand how an Asthma Action Plan can help them make good choices.
- Understand the long-lasting effects of uncontrolled asthma.

Chronic Obstructive Pulmonary Disease Program

Members:

- Learn how diet and exercise can help them breathe easier.
- Can identify which inhalers to use and how to use them correctly.
- Understand the warning signs of a flare-up so it can be caught and managed early.
- Understand how to use oxygen safely.

Cardiac Program

Members:

- Learn how to make small changes in diet and activity to manage heart disease.
- Find out how to prevent a cardiac condition from getting worse.
- Understand the importance of medications and how to take them.
- Understand how uncontrolled blood pressure may lead to heart disease.

Diabetes Program

Members:

- Learn how to prevent diabetic complications by managing blood sugar.
- Identify and complete the necessary tests needed to be "in control."
- Understand what is normal, what is not, and when to call the doctor.
- Understand how unmanaged diabetes may lead to heart disease.

LEAN Healthy Weight Management Program

Members:

- Learn easy ways to take care of their health.
- Learn how to manage their weight with better choices, such as diet and activity.
- Help identify tools they need for optimal health and nutrition.
- Learn how smart choices may prevent other health problems, such as high blood pressure or diabetes.

Diabetes Prevention Program

Members:

- Learn how to lose weight.
- Adopt healthy habits.
- Hear about ways to manage stress.
- Greatly lower their risk of developing type 2 diabetes.

Remind patients about the Healthy Rewards Program to meet true performance measures.

The Healthy Rewards Program for patients can help providers meet their true performance measures. The program is a benefit that gives patients money for completing important healthy activities. The program is offered through TheraPay Rewards.

The TheraPay Rewards app lets patients track the healthy activities they have completed and their rewards. Providers can encourage patients to complete eligible activities to receive rewards.

Reward activities can include:

Reward Activity	Rewards per Year	Reward Amount
Annual well-child (ages 3 - 19)	1 visit	$25
Annual wellness visit with PCP (age 20 and older)	1 visit	$25
Asthma controller medicine (ages 5 - 18)	Up to 6, 30 day fills	$25 for each 30 day fill; max $150
Blood sugar screening (A1c test)	1 screening	$15
Breast cancer screening	1 screening	$30
Cervical cancer screening	1 screening	$30
Doctor visit after giving birth (postpartum visit) (on or between 7 - 84 days after delivery)	1 visit	$25
Lead screening (before the age of 24 months)	1 screening	$25
Well-baby visit (before the age of 30 months: 6 visits during first 15 months and 2 visits between 16 - 30 months	Up to 8 visits	$20 for each visit; max $80
Colonoscopy	1 screening	$25
Diabetic Retinal Eye Exam	1 screening	$25
Post Hospital Discharge - PCP Visit within 30 days (after being discharged from a hospital stay)	1 visit	$50 if seen by a PCP within first 14 days post discharge; Incentive drops to $25 if visit with provider is 15 to 30 days post discharge

Reward Activity	Rewards per Year	Reward Amount
A1c Home Kit	1 completion	$25
Fit Kit	1 completion	$25
Ivira-CBP (Controlling Blood Pressure monitoring program	1 activation	$25
Ivira-AMR (Asthma management program)	Up to 6 phone visits	$10 for each call; max $60

Providers with any questions about the Healthy Rewards Program, can call Reciprocity Health, the parent company of TheraPay, at 1-866-469-7973, Monday–Friday, 8 a.m.–5 p.m.

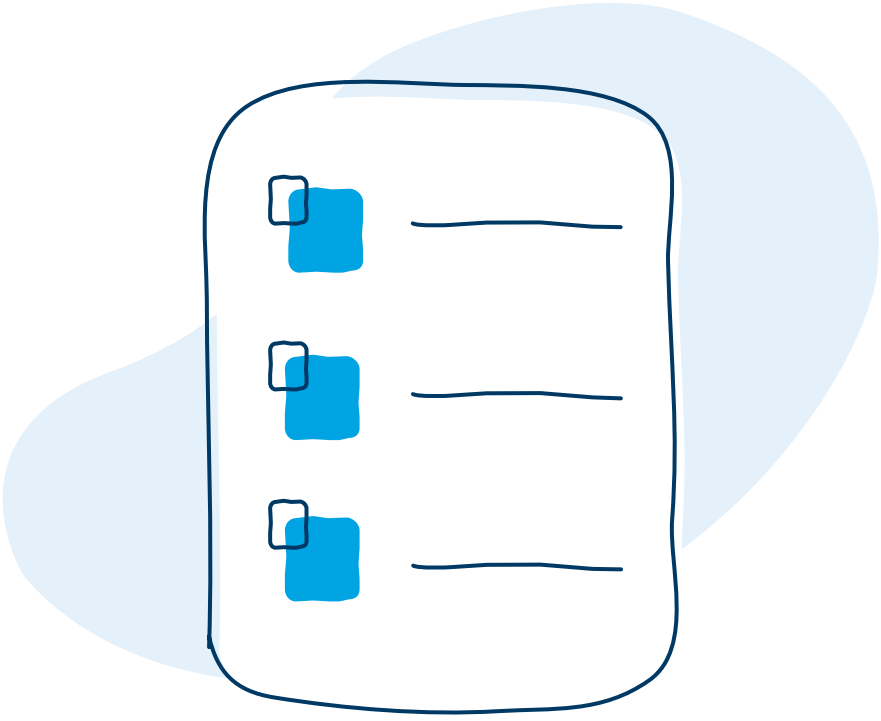
Review the affirmative statement about provider incentives.

Financial incentives for Highmark Health Options utilization management (UM) decision-makers do not encourage decisions that result in underutilization. Highmark Health Options UM decisions are based only on the appropriateness of care and services and the member's existence of coverage.

Highmark Health Options monitors for overutilization and underutilization of care to:

- Prevent inappropriate decision-making.
- Identify causes and corrective action.
- Indicate inadequate coordination of care or inappropriate use of services.

Providers and other individuals are not rewarded by Highmark Health Options for issuing denials of coverage or service.



Care teams can partner with the Case Management team to provide collaborative care.

Providers are encouraged to work with Highmark Health Options to provide collaborative care for patients. Primary care physicians are required to work with Case Managers to ensure proper care is being provided and case status remains up-to-date. Case Managers can help:

- Assess a patient's situation and needs.
- Provide ongoing coordination to see that a patient's care needs are being met.
- Work with patients and their families to develop care plans to map out what kind of services they need, how often they are needed, and more.

Providers should work with Case Managers to provide the care patients need. Contact Case Management with any questions at **1-844-325-6251**.

Providers have an important role in the Care Management Program.

The Highmark Health Options Care Management team can partner with providers to decrease the number of times a patient goes to the emergency department, help a patient avoid going back to the hospital, and support a personal plan of care for a patient.

Highmark Health Options has nonclinical and clinical staff available to:

- Address patient's physical and/or behavioral health issues.
- Link patients to applicable services, such as local community resources, and self-management tools.
- Remind patients to go to their annual physicals and help them make appointments.
- Review medications with patients.

Call Care Management at 1-844-325-6251 with any questions about the Care Management Program.

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 January, April, July, and October.

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.

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

For more information, contact Su-Linn Zywiol, Strategy Program Manager.

Provider network contacts.

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302-502-4054

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.

Community Support offers a way to free or reduced-cost services in the community. Search for local support resources to access food, housing, transportation, utility assistance, medical care, job training and more.

Visit the Highmark Health Options website for more resources and the latest updates.