HIGHMARK Delaware HEALTH OPTIONS

July 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 Updates

National Drug Codes (NDC)

The National Drug Code (NDC) is a unique, three-segment number that identifies a drug. The three segments identify the labeler, the product, and the commercial package size. The NDC serves as a universal product identifier for drugs.

The Affordable Care Act (ACA) includes language to extend the Medicaid National Drug Rebate Agreement (NDRA), which is a federal rebate to drugs covered by the Medicaid Managed Care Organizations (MCOs). The language requires the State to collect the NDC and NDC units for all outpatient drug claims, regardless if payment is made based on HCPCS code, in order to invoice the manufacturers for the federal rebates.

Consequently, Gateway requires the use of NDCs when billing HCPCS (or "J codes") for drugs. The NDC must correspond to the drug and dosage of the HCPCS billed in order to considered reimbursement.

Converting NDCs from 10-digits to 11-digits

NCDs are displayed on drug packaging in a 10-digit code. Proper billing of an NDC requires an 11-digit number in the 5-4-2 format. For example:

10-Digit Format on Package	10-Digit Format Example	11-Digit Format	11-Digit Format Example
4-4-2	9999-9999-99	5-4-2	09999-9999-99
5-3-2	99999-999-99	5-4-2	99999-0999-99
5-4-1	99999-9999-9	5-4-2	99999-9999-09

NDC Resources

Resources for accurate NDC reporting include:

- CMS NDC-HCPCS Cross Walk: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2019ASPFiles.html
- FDA National Drug Code Directory: https://www.fda.gov/Drugs/InformationOnDrugs/ucm142438.htm
- Drug packaging

As of June 30, 2018, Gateway will be validating the accuracy of the NDC billed versus the HCPCS billed. In order to be considered for reimbursement, all applicable claim lines must list a valid NDC.

Coding Corner Updates cont.

Unclassified and Not Otherwise Specified (NOS) Drugs and Biologicals

Unlisted codes are commonly used when the:

- drug/biological does not have a specific HCPCS code
- drug/biological is administered by a route other than stated in the code
- amount of drug or biological is less than the amount, or of a different concentration, than specified in the HCPCS descriptor

When billing for a drug that does not have a specific HCPCS code, choose one of the following codes that best describes the medication:

- Drugs: **J3490** - Unclassified drugs (injections)
- Biologicals: **J3590** - Unclassified biologics (antigens, antitoxins, serums, and vaccines)
- Oral drugs: **J8499** - Prescription drug, oral, non-chemotherapeutic, nos (tablets, caplets, elixirs)
- Chemotherapeutic: **J8999** - Prescription drug, oral, chemotherapeutic, nos
- Antineoplastic: **J9999** - Not otherwise classified, antineoplastic drugs
- Ointments: **A6250** - Skin sealants, protectants, moisturizers, ointments, any type, any size
- Inhalers: **J3535** - Drug administered through a metered dose inhaler
- Medicare: **C9399** - Unclassified drugs or biologicals (for use in hospital outpatient departments who bill under OPPS)

New Community Resource Connection Tool Online Training Available for Providers

Our Community Resource Connection tool links members to health and wellness programs in their communities across the states that we serve along with nationwide agencies. The CRC tool is available to providers and can be accessed through the Provider Portal.

New Feature:
Providers can now select agencies for members to connect within their local communities. Once you click "Select This Agency," a pop-up box will appear for you to type in the member's Health Plan ID. Once the ID has been entered, click Submit. By selecting agencies and providing this documentation on community resources discussed with your patients, we will be able to provide extra support to connect members to local agencies and the information will be saved in the member's Health Plan profile.

Atlas Systems Outreach

The State of Delaware requires health plans to conduct a quarterly outreach to verify provider data. Beginning in the First Quarter of 2019, Highmark Health Options started conducting quarterly outreaches to verify your provider data. Our Vendor, Atlas Systems, Inc. is performing the quarterly outreach on our behalf.

The list of provider data elements that is currently being verified are:

- Practitioner Name
- Practice Name
- Practitioner Specialty
- Locations where the practitioner schedules appointments and sees patients
- Phone Number
- Address
- Whether the practitioner does or does not accept new Medicaid patients
- Languages spoken by the practitioner
- Age ranges seen by practitioner
- Wheelchair accessibility
- Group Website

What can you expect? Atlas will fax a letter to your practice locations within the first two weeks of a quarter. This letter will provide instructions on how to register on PrimeHub, the Atlas portal. Please complete your data verifications through this portal. If the data validations are not completed through the portal, Atlas will begin making calls to your practice locations to verify the data.

Our members use the Highmark Health Options Provider Directory to make the best informed decisions when selecting a provider. It is, therefore, to your advantage to make sure your directory information is correct and current.

If you have questions regarding this communication, please contact your Provider Relations Representative.

New Opioid Training for Providers

Initiating Opioid Therapy and Implementing the CDC Guideline

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 our **Training for Providers webpage**.

Starting the Conversation About Tapering Chronic Opioids

The Centers for Disease Control (CDC) discourages increasing opioid doses to 90 morphine milligram equivalents (MME)/day or more for chronic non-cancer pain. But this doesn't mean forcing tapers or suddenly stopping high opioid doses. For this reason, Food and Drug Administration (FDA) will now require tapering guidance in opioid labels due to concerns that abruptly stopping is leading to illicit use or even suicide.

It's important to tailor care to your patient while considering the guidelines. Identify patients where opioid risks exceed benefits such as, those on high doses, with side effects, and etc. Help them buy in to a slow taper. Ask patients how well their chronic opioid is working. Educate that the goal is not complete pain relief but to improve pain and function. Discuss opioid downsides such as cognitive slowing, constipation, and etc. Patients may not realize chronic use can cause hyperalgesia, an increased sensitivity to pain or low hormone levels and reduced libido or energy.

Evidence suggests tapering to lower doses improves quality of life and function and pain doesn't usually worsen. In fact, it may improve. Emphasize alternatives such as non-opioids, physical therapy, and etc. Reassure that any withdrawal symptoms are minimal and manageable with a slow taper which can be further slowed or paused if needed. Plus, symptoms can be eased with other meds such as loperamide, clonidine, and etc.

Tapers should be individualized to patient needs. For instance, suggest reducing the daily opioid dose by about 10% every 1 to 2 weeks or slower, such as monthly, if patients have been on opioids for years. Many patient on chronic pain meds may have trouble tapering off opioids completely. Success for these patients may be settling on a lower opioid dose.

Opioid Tapering Tips

Clinical Question	Suggested Approach/Pertinent Information	
What are some situations in which opioid tapering and/or discontinuation might be considered?	**Situation**	**Alternative to Discontinuation (if benefit Outweighs Risk), and other Considerations**
	Misuse	• Re-evaluate treatment • Educate patient • Increase frequency/intensity of monitoring. • Involve addiction or mental health providers. Prescribe limited quantities. • Egregious misuse (e.g., injecting tablets) will likely require discontinuation.
	Use of illicit drugs or non-prescribed opioids	• Refer, ideally to a specialized program that can provide directly-observed therapy.
	Diversion	• Usually requires immediate discontinuation. • Alternative is to refer to a specialized program that can provide directly-observed therapy.
	Non-adherence to opioid agreement	• Restructure therapy (e.g., more intense monitoring, opioid tapering, and addition of non-opioid or psychiatric treatment).
	Overdose	• Dose reduction. • If discontinued, consider rapid taper over two to three weeks.
	Adverse effects (e.g., sleep apnea, low libido, nausea, constipation)	Consider opioid rotation (i.e., switching patient from one opioid to another). Consider tapering to a safe dose and continuing.

Opioid Tapering Tips cont.

	No progress toward therapeutic goals	If there is no sustained, clinically meaningful improvement (≥30%) in pain AND function, compared to baseline or dosage increase, using validated tools, then: • discontinue, or • go back to previous (i.e., lower) dose if it provided some benefit. Tools recommended to assess progress in this context include the Three Item PEG Assessment Scale and the Two Item Graded Chronic Pain Scale
	Reduced analgesia	Restructure therapy (e.g., more intense monitoring, opioid tapering, and addition of non-opioid or psychiatric treatment).
	Hyperalgesia	Restructure therapy (e.g., more intense monitoring, opioid tapering, and addition of non-opioid or psychiatric treatment).
	Repeated dose escalation or need for high doses (e.g., ≥90 mg morphine equivalents/day)	Assess risk/benefit: • Assess underlying diagnosis and concomitant conditions. • Assess psychological issues and social situation. • Assess pain control, function, quality of life, and progress toward therapeutic goals. • Assess adverse effects. • Assess adherence. Rule out misuse and diversion. Restructure therapy (e.g., more intense monitoring, opioid tapering, and addition of non-opioid or psychiatric treatment). Consider opioid rotation. Consider dose reduction rather than complete discontinuation if opioid is providing some benefit. Consider prescribing naloxone for patients on high doses to keep patients and families safe.

Opioid Tapering Tips cont.

How do I prepare patients for opioid discontinuation?	• When starting chronic opioid therapy, set clear expectations. This may help prevent opposition to discontinuation if it is indicated later. • Use motivational interviewing techniques to identify reasons for patient opposition to discontinuation. • Identify and treat depression to improve pain control and improve taper success. **Patient education points:** • Chronic pain is complex; opioids are not a "cure-all," and may not provide adequate pain relief long-term. • Side effects of chronic opioid therapy include low hormone levels leading to fracture risk, low libido, and low energy and mood; sedation; cognitive slowing; worsening sleep apnea, leading to fatigue; and constipation. • When opioids are no longer providing good pain relief, most people feel better without them. • Most patients do not experience increased pain. • You are not abandoning the patient, and will still help them with their pain.9 Pain will be addressed with non-opioid alternatives. • Withdrawal symptoms are uncommon if the dose is tapered slowly.
What can be expected if the opioid is tapered or discontinued?	Patients being tapered due to lack of efficacy may or may not experience a worsening of pain.1 In a VA population (n = 50) being tapered for reasons other than aberrant behavior, 70% of patients had no change or less pain vs baseline despite a 46% average dose reduction. Function and quality of life may improve. Patients should expect to have some insomnia and anxiety. • Patients should plan ahead for not feeling well. Increased pain is an early symptom of withdrawal; pain with opioid dose reduction is not a sign that the opioid is effective for the patient's pain. Pain due to withdrawal should resolve after the first week. Unmasking of psychiatric conditions may occur.

Opioid Tapering Tips cont.

How should the opioid be tapered/discontinued?	**General concepts:** • High-quality evidence to guide tapering is lacking; individualize. • The reason for discontinuation and amount of opioid being used will influence the rate of taper. • At high doses, rapid taper may cause withdrawal or drug seeking. • Discontinue immediately if there is diversion. • Adjust taper based on response, such as appearance of withdrawal symptoms. • Consider referral for patients who have risk factors for failure: high-dose, substance use disorder, active psychiatric disorder, previous outpatient taper failure, or benzodiazepine use. • If benzodiazepine discontinuation is indicated, discontinue opioids before discontinuing benzodiazepines. • Consider consolidating the patient's opioids into a single long-acting formulation. Choose a product that offers small dose increments (e.g., morphine 10 mg) to facilitate a slow taper. A short-acting formulation can be used once the lowest dose of the long-acting formulation is reached. • Fentanyl patch can be tapered in decrements of 12 mcg/hr. • Before constructing the taper, check for insurance coverage limitations, and availability of specific opioid products/strengths at your local pharmacy. Flexibility may be needed. • Consider incorporating physical therapy or cognitive behavioral therapy into the treatment plan to help patients manage chronic pain during the taper. Some patients report that self-directed exercise or other physical activity, meditation, or massage therapy has helped them cope during the taper. **Tapering protocols:** • Taper over two to three weeks in the event of severe adverse effects, overdose, or substance abuse disorder.2 • Otherwise, a decrease of 10% of the original dose per week is a reasonable starting point.11 An even slower taper (e.g., 10% every two to four weeks) may be needed for patients who have been taking opioids for years.9 • High doses may be able to be tapered rapidly (e.g., 25% to 50% every few days) until reaching 60 mg to 80 mg of morphine or its equivalent. Then the rate can be slowed (e.g., 10% of the original dose per week) to prevent withdrawal. • Keep in mind that a more rapid taper may be possible. The minimum dose to prevent withdrawal may be only 25% of the previous day's dose. • A sample "Opioid Tapering Template" is available at http://www.rxfiles.ca/rxfiles/uploads/documents/Opioid-Taper-Template.pdf.

Opioid Tapering Tips cont.

How should the patient be monitored during dose reduction or discontinuation?	Check pain control and functional status at each visit. • Manage increased pain with non-opioids. Monitor for psychiatric disorders such as depression or panic disorder. Monitor for withdrawal (e.g., flu-like symptoms, insomnia, anxiety, abdominal cramps and other GI symptoms, goose bumps, fatigue, malaise). • If withdrawal symptoms occur, manage the symptoms (see below) and slow the taper (e.g., to 5% per week) or suspend the taper; do not increase the dose (i.e., don't "backpedal"). Warn patients that they are at risk of overdose if they try upping the dose on their own. Opioid tolerance is lost after a week or two of abstinence.
What adjunctive medications may help with withdrawal symptoms?	• Acetaminophen or NSAIDs for malaise and myalgia's. • Ondansetron 8 mg q 12 h for nausea and perhaps other symptoms. • Trazodone (or hydroxyzine, below) for insomnia (25 mg to 100 mg at bedtime). • Hydroxyzine 25 to 50 mg three times daily as needed for anxiety, itching, lacrimation, cramps, sweating, and rhinorrhea. • Loperamide for diarrhea (not usually needed for gradual taper). • Clonidine (e.g., for increased heart rate and blood pressure; chills; anxiety) is not usually needed for gradual tapers.

References

CDC. (n.d.). *CDC*. Retrieved from Centers for Disease Control: https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf

CDC. (n.d.). *CDC*. Retrieved from CDC: https://www.cdc.gov/drugoverdose/pdf/Assessing_Benefits_Harms_of_Opioid_Therapy-a.pdf

Medications to Require Medical Prior Authorization

A subset of medications require a pre-service authorization for medications obtained through the medical benefit. This prior authorization process applies to all Highmark Health Options members. Medical necessity criteria for each medication listed below is outlined in the specific medication policies available online. To access Highmark Health Options medication policies, please visit: https://www.highmarkhealthoptions.com/Provider/Medication-Information/Medication-Prior-Authorization-Criteria. Failure to obtain authorization will result in a claim denial.

PROCEDURE CODES REQUIRING AUTHORIZATION AS OF 6/3/2019

Procedure Code	Description	Procedure Code	Description
J0584	Crysvita (Burosumab-twza)	**Q2042**	Kymriah (Tisagenlecleucel)
J0180	Fabrazyme (Agalsidase Beta)	**J9217**	Lupron (Leuprolide acetate)
Q5108	Fulphila (Pegfilgrastim-jmdb)	**Q5107**	Mvasi (Bevacizumab-awwb)
J1559	Hizentra (immune globulin)	**Q5110**	Nivestym (Filgrastim-aafi)
J1575	Hyqvia (immune globulin/hyaluronidase)	**Q5104**	Renflexis (Infliximab-abda)
Q5103	Inflectra (Infliximab-dyyb)	**Q2041**	Yescarta (Axicabtagene Ciloleucel)
Q5109	Ixifi (infliximab-qbtx)		

What if the medication not on the list?
If the medication you are prescribing for your patient is not addressed on the Highmark Health Options Medication Prior Authorization Criteria website (https://www.highmarkhealthoptions.com/Provider/Medication-Information/Medication-Prior-Authorization-Criteria) that means it does not require a pre-service prior authorization. The process for obtaining this medication, which is not listed above, has not changed.
If you intend to bill the medication on the medical benefit, you will administer the medication and submit the claim as you have in the past.

Would you prefer to get the medication through pharmacy?
This change only applies to the medical benefit. If the medication is to be billed at the pharmacy/specialty pharmacy, you will continue to submit requests to Highmark Health Options Pharmacy Services. They can be reached at 1-844-325-6253.

Submitting a Request
The most efficient path of submitting a request (for one of the medications on the list above) is via Navinet. A form has been added to Navinet with autofill functionality to make completing and submitting your online request easier and faster. If you have questions regarding the authorization process and how to submit authorizations electronically via Navinet, please contact your Highmark Health Options Provider Relations Representative directly or Provider Services Department using the phone number 1-844-325-6251.

Additional Information

- Any decision to deny a prior authorization or to authorize a service is made by a licensed pharmacist based on individual member needs, characteristics of the local delivery system, and established clinical criteria.
- Authorization does not guarantee payment of claims. Medications listed above will be reimbursed by Highmark Health Options only if it is medically necessary, a covered service, and provided to an eligible member.
- Non covered benefits will not be paid unless special circumstances exists. Always review member benefits to determine covered & non-covered services.
- Current and previous provider notifications can be viewed at: https://www.highmarkhealthoptions.com/provider/communications

Provider Network Contacts

Provider Relations:

Desiree Charest - Sussex County
Provider Account Liaison
**includes servicing of LTSS Providers*
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Paula Brimmage
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Terri Krysiak
Provider Contract Analyst,/PR Representative Behavioral Health In training (Elsa still working BH and bringing Terri up to speed)
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302-502-4054

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.