

A Newsletter for
Highmark Health Options
Providers and Clinicians



PROVIDER UPDATE

2017 Risk Management Webinar Sessions

PAGE 3

JUNE 2017

PROVIDER UPDATE



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OFFICE STAFF

PHYSICIAN LEADERS & OFFICE MANAGERS YOU ARE CORDIALLY INVITED TO ATTEND THE 1ST IN A SERIES OF THREE 2017 RISK MANAGEMENT WEBINAR SESSIONS

In an effort to promote awareness of Retrospective Risk Management & Quality Improvement for services provided to Highmark Health Options members, the Risk Revenue and Provider Engagement Management Team is hosting a three-part webinar series titled:

What's At Risk? Know the What? And the Why? Of Successful Patient Risk Management

Highmark Health Options welcomes you to attend our upcoming Provider Education Webinars to learn more about Retrospective and Prospective Risk Gap Closure analysis and what it means to you. The discussion will include program overview, operational efficiencies, medical coding and provider incentive structure. Hour-long provider education webinars will take place on the following dates:

**FRIDAY, JUNE 30
12 P.M. EST**

**FRIDAY, SEPTEMBER 22
12 P.M. EST**

**FRIDAY, DECEMBER 15
12 P.M. EST**

How to Register:

<https://gatewayhealthevents.webex.com/gatewayhealthevents/onstage/g.php?MTID=e71d82928701514c48526bdbb604b7b28>

We urge you to make every effort to attend the series webinars, and look forward to working with you on this exciting campaign. If you have any questions or would like to learn more, please contact your respective plan Provider Engagement Team: DEproviderengagement@gatewayhealthplan.com



Medicaid Retrospective Risk Gap
Closure Overview & Mission



Medicaid Retrospective Claims
Resubmission Campaign Model
Workflow



Incentive Overview

ADDING THAT “SPECIAL TOUCH” TO YOUR PRACTICE

Positive patient-provider interactions are vital to a member's overall health care experience. Whether it be a wellness visit or a simple call to the doctor's office, every interaction matters. Sufficiently communicating and educating your patients will help strengthen your relationship and positively impact their time with you.

Here are a few things to consider during your next patient interaction:

- Smile!
- Make eye contact between typing notes into the computer
- Avoid long silent pauses while using the computer
- Speak in terms the patient will understand
- Share reminders for appointments, immunizations and screening tests
- Suggest alternative physical activities to promote a healthy lifestyle

Remember, patients look to you in times of need, so it's important to make them feel comfortable and in good hands. Adding that “special touch” to each patient interaction will increase each patient's overall health care experience. Thank you for your big contribution to our members' health and health care experience!

AFFIRMATIVE STATEMENT ABOUT INCENTIVES

Highmark Health Options Utilization Management (UM) decisions are based only on the appropriateness of care and services and existence of coverage. Highmark Health Options does not specifically reward practitioners or other individuals for issuing coverage or service denials. Financial incentives for UM decision makers do not encourage decisions that result in underutilization. Highmark Health Options monitors for both over and underutilization of care to prevent inappropriate decision making, identify causes and corrective action, and to indicate inadequate coordination of care or inappropriate use of services. Highmark Health Options is particularly concerned about underutilization and monitors utilization activities to assure members receive all appropriate and necessary care.

MEDICAL NECESSITY DETERMINATION

Highmark Health Options will provide Covered Services consistent with the definition of Medical Necessity provided below.

MEDICAL NECESSITY:

The essential need for health care or services which, when delivered by or through authorized and qualified providers, will:

- Be directly related to the diagnosed medical condition or the effects of the condition of the member (the physical or mental functional deficits that characterize the member's condition), and be provided to the member only;
- Be appropriate and effective to the comprehensive profile (e.g., needs, aptitudes, abilities and environment) of the member and the member's family;
- Be primarily directed to the diagnosed medical condition or the effects of the condition of the member, in all settings for normal activities of daily living (ADLs), but will not be solely for the convenience of the member, the member's family, or the member's provider;
- Be timely, considering the nature and current state of the member's diagnosed condition and its effects, and will be expected to achieve the intended outcomes in a reasonable time;
- Be the least costly, appropriate, available health service alternative, and will represent an effective and appropriate use of program funds;
- Be the most appropriate care or service that can be safely and effectively provided to the member, and will not duplicate other services provided to the member;
- Be sufficient in amount, scope and duration to reasonably achieve its purpose;
- Be recognized as either the treatment of choice (i.e., prevailing community or Statewide standard) or common medical practice by the practitioner's peer group, or the functional equivalent of other care and services that are commonly provided; and

- Be rendered in response to a life threatening condition or pain, or to treat an injury, illness, or other diagnosed condition, or to treat the effects of a diagnosed condition that has resulted in or could result in a physical or mental limitation, including loss of physical or mental functionality or developmental delay.

And will be reasonably determined to:

- Diagnose, cure, correct or ameliorate defects and physical and mental illnesses and diagnosed conditions or the effects of such conditions; or
- Prevent the worsening of conditions or effects of conditions that endanger life or cause pain, or result in illness or infirmity, or have caused or threaten to cause a physical or mental dysfunction, impairment, disability, or developmental delay; or
- Effectively reduce the level of direct medical supervision required or reduce the level of medical care or services received in an institutional setting or other Medicaid program; or
- Restore or improve physical or mental functionality, including developmental functioning, lost or delayed as the result of an illness, injury, or other diagnosed condition or the effects of the illness, injury or condition; or
- Provide assistance in gaining access to needed medical, social, educational and other services required to diagnose, treat, or support a diagnosed condition or the effects of the condition.
- In order that the member might attain or retain independence, self-care, dignity, self-determination, personal safety, and integration into all natural family, community and facility environments and activities.

PROVIDER NETWORK CONTACT INFO

Below is a listing of the various contacts within Provider Networks:

Provider Relations Account Liaisons:

Paula Victoria
LTSS providers statewide
PVictoria@Highmarkhealthoptions.com
302-502-4083

Andrea Thompson
New Castle County
AThompson@Highmarkhealthoptions.com
302-502-4024

Chandra Freeman
Kent County and City of Newark
CFreeman@Highmarkhealthoptions.com
302-502-4067

Tracy Sprague
Sussex County
TSprague@Highmarkhealthoptions.com
302-502-4120

Senior Provider Contracting Executive:
Chanel Bailey
CWalker-Bailey@Highmarkhealthoptions.com
302-502-4154

Ancillary Strategy:

Elaine Yakich
Provider Contract Analyst
Vision; SNF; ICF/MR; LTAC/Rehab; Ambulance
EYakich@gatewayhealthplan.com
412-255-4349

Shawn Smith
Provider Contract Analyst
Home Health/PDN; Hospice; Home Infusion
SSmith@gatewayhealthplan.com
412-255-1195

Katrina Tillman
Provider Contract Analyst – Behavioral Health
KTillman@Gatewayhealthplan.com
302-528-4871

Laura Gudenburr
Provider Contract Analyst – Free Standing PT/OT/ST; Free Standing Radiology; Urgent Care; Ambulatory Surgery Center; Walk-In Clinics
LGudenburr@Gatewayhealthplan.com
412-420-6465

Rick Madey
Provider Contract Analyst – DME
RMadey@Gatewayhealthplan.com
412-918-8554

Julia Donohue
Provider Contract Analyst – Dialysis; Lab and Audiology
JDonohue@Gatewayhealthplan.com
412-420-6467

ENROLLMENT AND ELIGIBILITY DETERMINATION

Highmark Health Options is offered to those recipients who are enrolled in the State of Delaware’s Medical Assistance program and who are eligible for enrollment into a Managed Care program. The Department of Health & Social Services (DHSS) determines recipient eligibility.

Role of the Health Benefit Manager (HBM)

DHSS employs a Health Benefit Manager (HBM) who performs Outreach, Education, Enrollment, Transfer, and Disenrollment of clients/members. The HBM explains the benefits offered by Highmark Health Options and other Managed Care Organizations (MCOs) and helps the recipient choose an MCO that meets their needs. Potential members are encouraged to select a primary care practitioner from a list of participating practitioners.

Potential clients submit enrollment applications to the State Service Centers or online via the ASSIST website. DHSS electronically notifies Highmark Health Options that a recipient will be enrolled in Highmark Health Options. Recipients approved by DHSS are added to Highmark Health Options’ information system with the effective date assigned by the State. Newly enrolled members receive a new Member Handbook and a Highmark Health Options identification card.

PCPs role in Verifying Eligibility

Primary care practitioners verify eligibility by consulting their panel listing in order to confirm that the member is part of the practitioner’s panel. The panel list is distributed on or about the first of every month. The primary care practitioner should check the panel list each time a member is seen in the office. If a member’s name is on the panel list, the member is eligible with Highmark Health Options for that month. If members insist they are effective but do not appear on the list, the practitioner should call the Highmark Health Options Provider Services Department at 1-844-325-6251 for help in determining eligibility.



FRAUD AND ABUSE

Highmark Health Options will make every effort to prevent, detect, investigate and report violations of fraud, waste and abuse (FWA). It is the Highmark Health Options policy to investigate any actions by members, employees or providers that affects the integrity of Highmark Health Options and the Medical Assistance Program.

Highmark Health Options defines FWA as follows:

- Fraud:** An intentional deception or misrepresentation made by a person with the knowledge that deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.
- Abuse:** Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to health care benefit program, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care.
- Waste:** The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs.

Participating providers and their staff are required to comply with Highmark Health Options’ policies and procedures for the detection, prevention and reporting of potential FWA.

Examples of provider prohibited acts include but are not limited to:

- Billing or charging Medical Assistance recipients for covered services
- Billing for services not rendered
- Billing separately for services in lieu of an available combination code (Unbundling)
- Submit a claim for a service at a fee which is higher than the usual and customary charge to the general public for the same service or item (Up coding)
- Billing more than once for the same service
- Falsifying records
- Performing inappropriate or unnecessary services
- Misrepresenting locations of service
- Soliciting, offering or receiving a kickback or bribe

Examples of prohibited acts for Highmark Health Options members may include but are not limited to:

- Forging prescriptions for pharmacy or medical services
- Members getting identical prescriptions from different doctors
- A person using an insurance card that is not theirs
- A member using transportation service for something other than medical services
- A member in collusion with a provider (example: provider pays a patient a kickback for participating in fraud)

If fraud or abuse is suspected it is your responsibility to contact Highmark Health Options’ Fraud Hotline at 1-844-325-6256. The fraud hotline answers 7 days a week, 24 hours a day. It allows for confidential and anonymous reporting.

Detailed information regarding the Federal False Claims Act and Provider Prohibited Acts can be found on the Highmark Health Options website at www.highmarkhealthoptions.com

IMPORTANT NEWS ABOUT YOUR PROVIDER NEWSLETTER

The Highmark Health Options (Delaware) *Provider News* (six issues per year) version is moving toward a monthly and quarterly edition and will be titled Highmark Health Options *Provider Update*.

Eight Monthly issues (Jan., Feb., April, May, July, Aug., Oct. and Nov.) will be an online HTML version designed to accommodate timely articles.

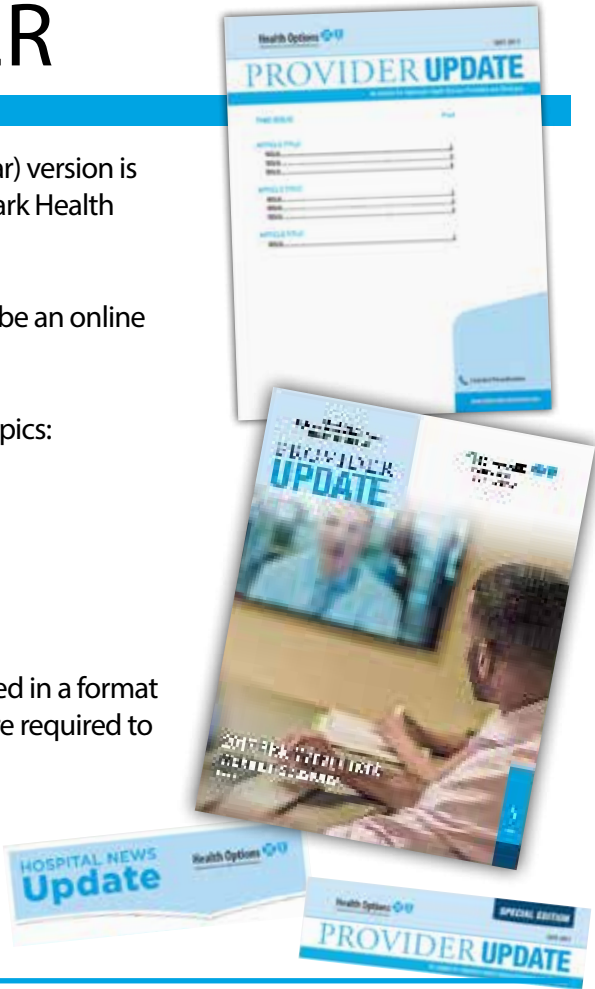
The monthly news (*Provider Update*) will be formatted by the following topics:

- Program and Benefit Updates
- New Product Updates
- Clinical and/or Behavioral Health
- Medical Policy Updates (Clinical and Drug)

Four Quarterly issues (March, June, Sept. and Dec.) will be a PDF designed in a format to accommodate longer articles and policy-related documents that we are required to inform you about on a yearly basis. Sections are broken out into:

- Office staff
- Clinical Updates

As needed, we’ll also have *Hospital News Updates* and *Special Bulletins*.



NOTICE TO PRIMARY CARE PROVIDERS REGARDING THE PHYSICIAN PORTFOLIO REPORTS

The Physician Portfolio reports will soon be distributed to PCP practices. By sharing the information in the “Physician Portfolio,” we partner with you to improve the quality of care of our members.

The “Physician Portfolio” consists of multiple measures, including utilization, pharmacy and preventive measures. This report compares you to your peers, and identifies opportunities where Highmark Health Options and your practice can work together to improve the health care of our members. The report will be made available through the NaviNet portal.

To get more information about the Physician Portfolio report or the NaviNet portal, please contact your Highmark Health Options Provider Account Liaison or Clinical Transformation Consultant.

Be sure to share this important information with all physicians in your practice.

MEDICAID REQUIREMENTS FOR PERINATAL CARE

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

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

Below is a brief list of additional perinatal screenings that are required for Medicaid recipients as recommended by the Delaware Division of Medicaid & Medical Assistance (DMMA):

- 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
- 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.



AFTER HOSPITAL DISCHARGE

Hospital discharges can be a confusing, stressful and challenging time for patients and their caregivers. In efforts to reduce readmissions and improve patient health, patients are encouraged to follow up with their primary care providers soon after discharge. During these post hospital discharge appointments it is important to review some key areas with patients. Some of these key areas include:

Medications

- **Complete a medication reconciliation** with the patient to help them understand which medications have been added, discontinued, or changed and why. Research indicates that the majority of patients do not understand the new dosing of medications they are taking or the reasons for medication changes while they were in the hospital.
- **Ensuring that the patient was able to obtain all of the medications prescribed at discharge.** Sometimes cost or transportation can be a barrier to obtaining new medications. Patients revert back to prior medications losing the health benefit of any medication changes that were made in the hospital.

Review Discharge Instructions

- Making sure that the patient understands all of the instructions that they were discharged with. This could include education and information regarding a new diagnosis, a new diet recommendation or any restrictions the patient should be following.
- Ensuring the patient has followed up with any therapies, testing and lab work that was ordered post-discharge.
- Provide education about signs and symptoms that the patient should make you aware of that could be indicators that their health is beginning to worsen again. Also develop a self-care plan and/ or sick day plan.

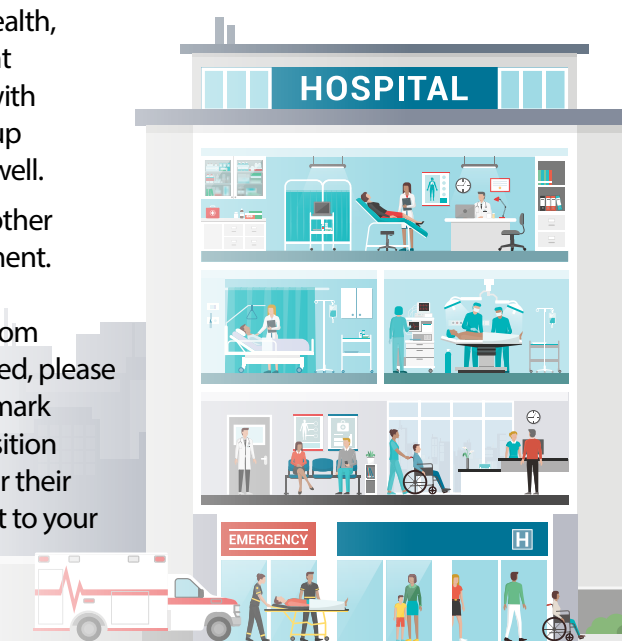
Home Health Services and Medical Equipment

- **Ensure that your patient is receiving any necessary home health services ordered upon hospital discharge.**
- If the patient was ordered new medical equipment when they were discharged ensure that the patient has received it and is using it properly.

Behavioral Health Discharges

- If the patient was discharged from the hospital for mental health, develop a plan with your patient regarding the management of their mental health needs. Offer to coordinate their care with their behavioral health provider as well. They should follow up with a mental health provider within 7 days of discharge as well.
- If the patient has been newly diagnosed with an alcohol or other drug dependence diagnosis support them in seeking treatment.

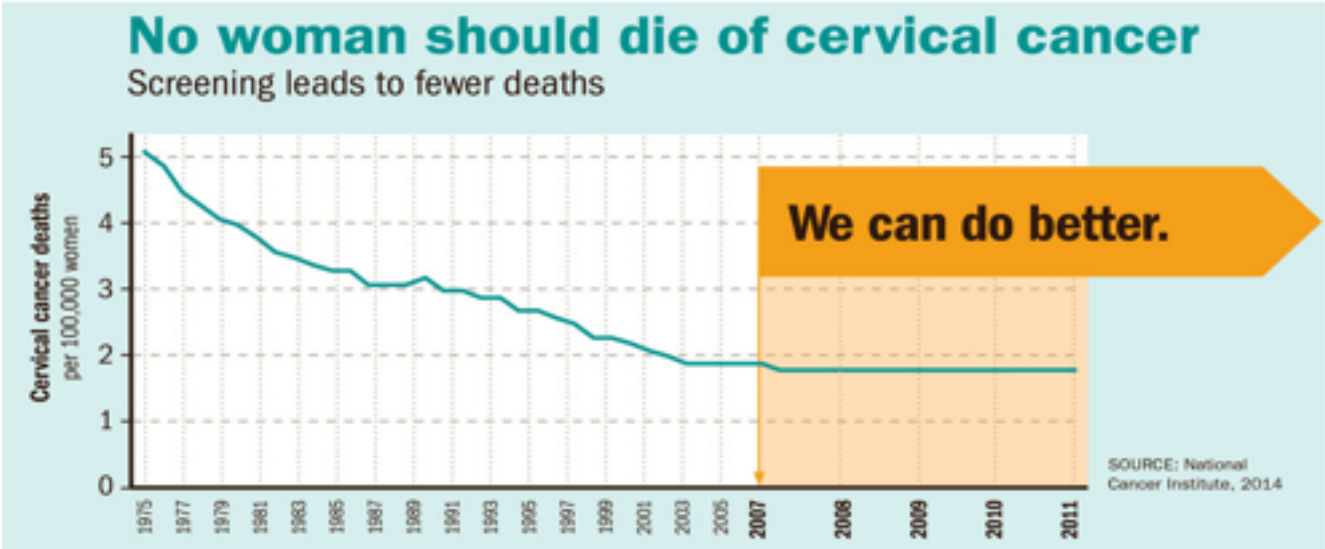
If you are working with a patient that you feel could benefit from additional support and education in meeting their health care need, please feel free to refer them to the Care Management program at Highmark Health Options. In addition, Highmark Health Options has a Transition Management team that may be also supporting your patient after their recent hospital discharge. This Care Manager may be reaching out to your office for assistance in managing your patient's needs.



SAVE LIVES WITH CERVICAL CANCER SCREENING

Cervical cancer is a largely preventable gynecologic cancer. Through regular screening pre-cancer cells can be detected early enough that the disease can be treated before it becomes a problem. In fact, research has shown that women who do not receive regular screenings make up the majority of new cervical cancer cases each year¹.

Since the Pap test was introduced in the 1950s, the number of women screened for cervical cancer has gone up, while the death rate has decreased. The table below from the CDC² illustrates the decrease in the death rate since 1975. However, screening rates have plateaued in recent years and, as a result, the rate of women in the United States who die from this disease has plateaued as well.



There are a number of ways you can help to increase the screening rate for women in your practice. Make sure that they are aware of the current United States Preventive Services Task Force recommendation:

- Women 21-64 years of age should be screened by Pap test every three years
- Women 30-64 years of age can be screened every five years by a combination of Pap and HPV testing

Also, be sure that women know the difference between a pelvic exam with and without a Pap test. Many women believe that they are up to date on cervical cancer screening even when they have only had a pelvic exam. Lastly, include a reminder in your patient's chart to discuss screening at her next check-up. You can make a big difference in a woman's willingness to get screened and save her life in the process.

¹ Vesco KK, Whitlock EP, Eder M, Lin J, Burda BU, Senger CA, et al. Screening for cervical cancer: a systematic evidence review for the U.S. Preventive Services Task Force. Evidence Synthesis No. 86. AHRQ Publication No. 11-05156-EF-1. Rockville, MD: Agency for Healthcare Research and Quality; 2011

² "Cervical Cancer Is Preventable Infographic." Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, 05 Nov. 2014. Web. 09 May 2017.

PREVENTIVE DENTAL CARE FOR IMPROVED OVERALL HEALTH

Tooth decay, also called a cavity, is the most common chronic disease in children and adolescents (ages 6-19 years)¹. If left untreated, tooth decay can become a serious health issue such as an abscess or other infection. Untreated tooth decay also causes pain that can result in trouble with eating or a loss of self-confidence.

It is unfortunate that tooth decay is so common since it is a disease that is very preventable. Brushing twice a day with fluoridated tooth paste and flossing, visiting the dentist regularly, and eating a diet full of fruits and vegetables are a few ways to help prevent tooth decay. You can make a difference, too. Speak to your patients about good oral hygiene and make the recommendation to see an area dentist. This recommendation from you is an important step for a patient who does not currently have a dentist.

There is another step that you can take in your office to help prevent tooth decay. In many cases decay occurs over time and is the result of habits formed when a child is young. One treatment that can strengthen a child's teeth is topical fluoride varnish application. Providers can get certified to apply fluoride varnish in an office setting quarterly for children under age 5 years. This service is reimbursable in Delaware for Medicaid recipients if applied by a physician and it can be worked into the time that you have for a check-up with your patient. This step can go a long way to improving your patient's overall health.

If you are not currently certified to apply fluoride varnish and you are interested, then please choose one of the following ways to get certified:

- On-site training offered by AAP – DE Chapter's Healthy Teeth Healthy Children Collaboration. Call to schedule a presentation at 484-446-3059.
- Online training offered by Smiles for Life. Visit www.smilesforlifeoralhealth.org to access the training. Course 6 – Caries Risk Assessment, Fluoride Varnish, and Counseling provides information on applying fluoride varnish.

¹ National Center for Health Statistics. "Health, United States, 2014: With Special Feature on Adults Aged 55–64." Hyattsville, MD. 2015.



DOMESTIC VIOLENCE AWARENESS & RESOURCES BROCHURE



promote equality
coalition of agencies
and individuals
Prevention
healthy relationships
justice
stop domestic violence
join us
Social Change
partnership
awareness
1 in 4 women affected
Advocacy
alter the social conditions that
allow violence to occur

Visit our website for
information and resources:
www.dcadv.org

About Domestic Violence

Domestic violence is a pattern of abusive behaviors used by one partner in an intimate relationship to control the other.

It can include physical, psychological, verbal, sexual, and/or financial abuse. It is always about power and control.

It is estimated that 1 in 4 women will be victimized in her lifetime. Domestic violence is a public health, criminal, and social issue that affects us all.

We all have a role in preventing and ending domestic violence.

How to Get Help

If you or someone you know is in an abusive relationship, contact your local domestic violence hotline to learn about available options and services. Their trained advocates help victims create confidential, personalized safety plans.

24-Hour Hotlines & Shelters
New Castle County
302.762.6110 (bilingual)

Kent & Sussex Counties
302.422.8058 or
302.745.9874 (bilingual)

Who We Are

DCADV is the statewide, nonprofit **coalition of agencies and individuals** working to **stop domestic violence** in Delaware.

We **work in partnership** with direct service providers, government officials, and business and community partners to **promote equality** in relationships as we strive to **alter the social conditions** that allow violence and abuse to occur.

We invite you to **join us** in these efforts.

KEY AREAS OF FOCUS
Public Awareness
Public Policy and Systems Advocacy
Training and Certification
Prevention
Economic Justice
Mental Health, Trauma, and Disabilities

What We Do

- Inform the public about the effects of domestic violence on our communities.
- Assist in the planning and coordination of services for victims and their families.
- Provide training and technical assistance to service providers and professional and community groups that serve victims and survivors.
- Encourage safe and respectful relationships for individuals of all ages, races, genders, sexual orientations, and abilities.
- Act as an information and resource center on domestic violence, bringing local, regional, and national expertise to Delaware.
- Advocate for policy and legislative issues that impact victims.
- Offer Domestic Violence Specialist Certification for advocates working with victims and perpetrators.
- Focus on specific populations, including teens, women of color, LGBTQ individuals, immigrants, and people with disabilities and mental health conditions.

Learn More and Join DCADV's Mailing List
www.dcadv.org
www.facebook.com/DelawareCoalition

What You Can Do


- Join the Delaware Coalition Against Domestic Violence as a Supporting Member.
- Raise awareness by talking with your friends, neighbors, and co-workers.
- Volunteer in a local domestic violence program.
- Encourage employers to institute human resource policies that support victims.
- Make your voice heard. Let your legislators know where you stand on this important issue. Join DCADV's Action Alert list.
- Don't ignore signs of domestic violence. Call a local hotline to find out how to help.
- Hold abusers responsible for their behavior. Let them know there is no excuse for violence, ever.
- Ask your employer to support DCADV or to match your membership donation.
- Encourage programs in your community to teach children how to handle conflict without violence.
- Hold a cell phone drive to raise funds for DCADV.

Supporting Membership

Supporting membership is open to individuals, organizations, and businesses who would like to help prevent and end domestic violence. Your tax deductible contributions support DCADV's public information, advocacy, and policy reform efforts on behalf of victims of domestic violence and their children.

In addition to financial support, Supporting Membership shows the community and policy makers that there is wide support for the Coalition's mission and programming.

Visit our Members and Partners webpage for an online membership form and a printable form. Various forms of payment are accepted.

Contact Us


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Wilmington, DE 19801

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www.facebook.com/DelawareCoalition

October 2016

CLINICAL BEHAVIORAL HEALTH

Highmark Health Options ensures high quality behavioral health services encompassing substance recovery care and mental health treatment within the least restrictive environment through contractual relationships with behavioral health providers able to support the member's behavioral care needs across the continuum of care. Highmark Health Options partners with providers, community-based stakeholders, appropriate State-based case management services, and the member to develop care plans that support the member's behavioral wellness. Health Options supports the member's behavioral health wellness through care management support and oversight of behavioral health utilization to ensure quality of care and member engagement within the process.

A Health Options provider can refer a member to the Behavioral Health Program for assessment of possible behavioral health need and assistance with behavioral health coordination of care. Providers can call 1-844-325-6251 and select the Clinical Care Coordination option. A complete list of available services, including appointment standards, coordination between physical health and behavioral health, as well as resources for crisis intervention centers throughout Delaware is available beginning in Chapter 3 of the Highmark Health Options [Provider Manual](#).



EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit is a federal program which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT ensures children and adolescents receive appropriate preventive, dental, mental health, and developmental and specialty services without regard to Medical Assistance covered services.

Each Highmark Health Options primary care practitioner and primary care/specialist is responsible for providing the health screens for Highmark Health Options members and reporting the results of the screens to Highmark Health Options.

Your office may already be performing EPSDT during office visits with your patients. This is a **federally mandated program** and as such Highmark Health Options wants to make sure that your office is reporting the information correctly. Here are the claim requirements:

CMS-1500 Paper Format Requirements

The following format requirements apply when submitting CMS-1500 paper claims for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screens:

- All EPSDT screening services must be reported with the age-appropriate evaluation and management code (99381-99385, 99391-99395, 99341, and 99345) along with EP modifier.
- The EP modifier must follow the evaluation and management code in the first line of Box 24D on the claim form. Use CPT Modifier (52 or 90) plus CPT codes when applicable.
- The appropriate diagnosis codes Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, and Z00.129 must be noted in Box 21.
- Report visit code 03 in Box 24(h) of the CMS-1500 when providing EPSDT screening service.
- Report 2-character EPSDT referral code for referrals made or needed as a result of the screen in Box 10(d) on the CMS-1500. Codes for referrals made or needed as a result of the screen are:

YO - Other	YV - Vision	YH - Hearing
YM - Medical	YD - Dental	YB - Behavioral

EDI Format Requirements

Electronic data interchange (EDI) requirements for EPSDT claims are as follows:

- All EPSDT screening services must be reported with the age appropriate evaluation and management code (99381-99385, 99391-99395, 99431 and 99435) along with the EP modifier.
- The EP modifier must follow the evaluation and management code in the first position on the claim form. Use CPT Modifier (52 or 90) plus CPT code when applicable.
- The appropriate diagnosis codes Z00.00, Z00.01, Z00.110, Z00.111, Z00.121 and Z00.129 must be noted in Box 21.
- Populate the SV111 of the 2400 loop with a “yes” for an EPSDT claim (this is a mandatory federal requirement).
- Populate the Data Element CLM12 in the 2300 Claim Information Loop with “01” (meaning EPSDT).
- Populate NTE01 of the NTE segment with “ADD”. This means that the additional information is available in ‘field’ NTE02 (see below).
- Populate NTE02 with the NTE segment of the 2300 Claim Information Loop with the appropriate referral codes:

YO - Other	YV - Vision	YH - Hearing
YM - Medical	YD - Dental	YB - Behavioral

Timely Filing for EPSDT Claims is 120 days from the Date of Service

All Submissions must utilize ICD 10 Codes

Highmark Health Options requires primary care physicians who are treating pediatric patients to be enrolled in the Vaccine for Children (VFC) program. This program provides vaccines at no cost to providers so they can be given to those patients who are eligible for the program. The VFC website provides an overview of the program and includes information regarding eligibility requirements. Highmark Health Options will only reimburse an administrative fee for any covered VFC vaccine and the actual vaccine codes along with the appropriate NDC #s must be billed in order to receive reimbursement.

If you have questions, please contact Highmark Health Options Provider Services at 1-844-325-6251 or your Provider Account Liaison.

If you would like more information on EPSDT or VFC, please consult the following websites:

Bright Futures/AAP Periodicity Schedule:
<https://www.highmarkhealthoptions.com/sites/default/files/PeriodicitySchedule.pdf>

CDC Immunization Schedule:
<https://www.highmarkhealthoptions.com/sites/default/files/0-18yrsSchedule.pdf>

DHSS Immunizations – Infants & Children:
<http://www.dhss.delaware.gov/dph/dpc/immunize-children.html>

CDC Vaccine for Children Program:
<https://www.cdc.gov/vaccines/programs/vfc/index.html>

HIGHMARK HEALTH OPTIONS CONTACT INFORMATION

Our website, www.highmarkhealthoptions.com, provides up-to-date information.

IMPORTANT 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 22188 Pittsburgh, PA 15222-0188

TELEPHONE NUMBERS AND HOURS OF AVAILABILITY		
DEPARTMENT	CONTACT NUMBER	HOURS
Provider Services	1-844-325-6251	Mon. – Fri., 7 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 Support (LTSS)	1-844-325-6251	Mon. – Fri., 8 a.m. to 5 p.m. (after hours support accessible through the Nurse Advice 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.