A Newsletter for
Highmark Health Options
Providers and Clinicians

PROVIDER UPDATE

Highmark Delaware
HEALTH OPTIONS

INSIDE THIS ISSUE

JUNE 2018

PROVIDER UPDATE

HIGHMARK. Delaware HEALTH OPTIONS

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QUALITY PROGRAM EVALUATION

Highmark Health Options Quality Improvement/Utilization Management (QI/UM) Program's primary goal is to ensure the excellent provision of health care and services for our members. Our program is designed to positively impact the health and safety of members through a health care delivery system that provides access to high-quality medical, behavioral health care, pharmaceutical and other covered health services in a cost-effective manner.

Highmark Health Options conducts an annual review of its QI/UM Program to see how well we've met the health care and service needs of our members.

An evaluation of the 2017 Quality Program was conducted which revealed the program's achievements last year including:

- Preparation for our first NCQA Accreditation Survey to take place in 2018
- Expansion of the department to include a Quality Manager, four additional Clinical Quality Management Analysts, two Community Health Workers and two additional Member Advocates
- Creation of initiatives to study and improve continuity and coordination of medical and behavioral healthcare
- First annual Experience of Care and Health Outcomes (ECHO) survey of the membership
- Formation of the CAHPS/ECHO Workgroup with a primary focus on improvement of member satisfaction and outcomes
- Development of a comprehensive HEDIS dashboard to track, trend, and improve annual performance
- First distribution of the PCP Portfolio Reports to qualifying practitioners for profiling and performance monitoring

We met many of the QI/UM Program goals, implemented new and innovative programs, identified areas for improvement and are developing plans to address improvement opportunities in 2018.

To request a copy of Highmark Health Options Annual Evaluation, please contact the Provider Services Department at 1-844-325-6251.

MEMBER RIGHTS AND RESPONSIBILITIES

Our members have certain rights and responsibilities that are a vital part of membership with Highmark Health Options. These rights and responsibilities are included in the member handbook and are published annually in the Highmark Health Options member newsletter.

The Highmark Health Options Member Rights and Responsibilities are available online for our network providers to help maintain awareness and support your relationship with your Highmark Health Options members.

You'll find the Member Rights and Responsibilities in Chapter 2, Unit 2, of the *Highmark Health Options Provider Manual*. The Provider Manual is available on the Highmark Health Options website under **Providers > Provider Manual.** A hard copy of the Member Rights and Responsibilities is available upon request by calling your Provider Relations representative.

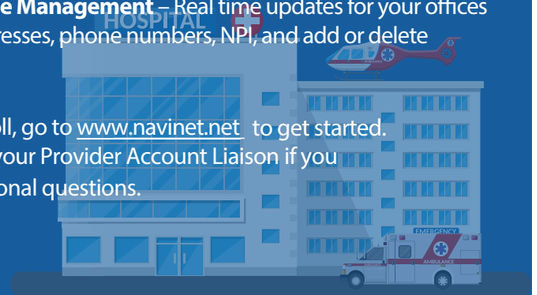
JOIN NAVINET TODAY

Highmark Health Options strongly encourages all providers to enroll in Navinet, which is a free technology resource for providers that can be accessed 24 hours a day, 7 days a week.

There are numerous benefits to joining Navinet.

- **Highmark Delaware Branded NaviNet** – Your single access point for both Highmark Delaware commercial members AND Highmark Delaware Health Options Medicaid members.
- **Eligibility and Benefits** – Verify member eligibility. Should the member not have their ID card with the Unique Member ID – Medicaid ID searches are supported as are name/exact DOB.
- **EOB/Remittance Inquiry** – Access EOBs/Remittances
- **Authorizations** – Submit and review authorizations. When submitting authorizations for Medicaid members you will need to choose the Highmark Health Options categories and services.
- **Claim State Inquiry** – Find additional detail on your claim.
- **Provider File Management** – Real time updates for your offices e.g. update addresses, phone numbers, NPI, and add or delete providers.

It is easy to enroll, go to www.navinet.net to get started. Please contact your Provider Account Liaison if you have any additional questions.



CONTINUITY AND COORDINATION OF CARE

The seamless sharing of information between healthcare providers, such as between primary care physicians (PCPs) and specialists, presents many challenges to the continuity of care and treatment of our members. Highmark Health Options membership includes some of the most vulnerable individuals who may suffer from severe or chronic illnesses. Enhanced communication among and between all those who participate in providing care to a patient is imperative in ensuring that all decisions about the patient's care are informed and contribute to the patient's overall well-being. Continuity of care issues can result in suboptimal outcomes, increased costs, and medical errors.

It is to the benefit of both the patient and healthcare professional to communicate any reports, therapies, medications, and concerns identified by providers across treatment settings. Please contact your Provider Relations Representative with questions about how you can help improve patient care between settings.

CODING CORNER: NATIONAL DRUG CODE 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, Highmark Health Options 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 be considered reimbursement.

Converting NDCs from 10-digits to 11-digits

NDCs 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	9999-9999-99	5-4-2	99999-0999-99
5-4-1	9999-9999-9	5-4-2	99999-9999-09

NDC Resources

Resources for accurate NDC reporting include:

- CMS NDC-HCPCS Cross Walk
- FDA National Drug Code Directory
- Drug packaging

As of June 30, 2018, Highmark Health Options 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.

SOURCES

CMS, ASP Drug Pricing Files https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2018ASPFiles.html

CMS, Medicare Claims Processing Manual, Chapter 17 – Drugs and Biologicals https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf

CMS, MLN Matters, Important Information Concerning the Medicare Crossover Process and State Medicaid Agency Requirements for National Drug Codes (NDCs) Associated with Physician-Administered Part B Drugs, SE1234 https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1234.pdf

FDA, National Drug Code Directory https://www.fda.gov/Drugs/InformationOnDrugs/ucm142438.htm

Federal Register, Medicaid Program; Announcement of Medicaid Drug Rebate Program National Rebate Agreement https://www.federalregister.gov/documents/2018/03/23/2018-05947/medicaid-program-announcement-of-medicaid-drug-rebate-program-national-rebate-agreement

PROVIDER SELF AUDITS/OVERPAYMENTS

Overview

Highmark Health Options, its providers and its members are responsible for the identification and return, regardless of fault, of overpayments. In the event that Highmark Health Options makes an overpayment to a provider, the full amount of that overpayment must be recovered. Additionally, if a provider identifies an overpayment from Highmark Health Options, the provider is responsible for returning the overpayment in full at the time of discovery.

Provider Self-Audit (Self-Identified Overpayment)

Federal and State regulations require providers to routinely audit claims for overpayments. Highmark Health Options has a process in place for our network providers to report the receipt of a self-identified overpayment.

Providers must notify Highmark Health Options in writing of the reason for the self-identified overpayment, and should provide payment within sixty (60) calendar days. If the claim is over two years old a check is preferred, however; retraction is preferred for claims that are less than two years old. It is imperative that providers include the explanation of the Self-Audit and the claims they represent. ***If a listing of claims is not provided, Highmark Health Options cannot guarantee that the claims will not be included in separate audits, for the same reason.*** Please provide a listing of claims as requested on the Provider Self-Audit/Overpayment Form (see next page). Conversely, if providers use an extrapolation calculation to determine payment, a description of that methodology and the calculation should be included with your submission.

Deposit of a provider check or retraction of the requested claims does not constitute complete agreement to the submitted self-audit results or overpayment amount. Highmark Health Options Payment Integrity Department may contact the provider to discuss self-audit results as necessary. The overpayment letter and check (if applicable) should be sent directly to:

Highmark Health Options
Attention: Payment Integrity Department
Four Gateway Center
444 Liberty Avenue, Suite 2100
Pittsburgh, PA 15222-1222

Information to Submit for Self-Identified Overpayment

When submitting information for an identified overpayment, please include the following:

- Provider Information (i.e.; Name, NPI, TIN, Contact information, etc.)
- Self-Audit / Overpayment Information
- Period of claims
  - For claims two years old or more, please provide a check
  - For claims less than two years old, retraction of claims is preferred
- List of affected claims and/or extrapolation calculation used to determine overpayment amount
- Other information (as required)

Provider Self Audit/Overpayment Form

Instructions for providers: Highmark Health Options (HHO) cannot accept verbal requests to retract claim(s) overpayments. Providers may complete and submit this form for any self-identified overpayments to the HHO Payment Integrity Department.

PLEASE COMPLETE ALL SECTIONS

I. Provider Information

Date_____ Practice Name_____ Provider Number_____
Practitioner Name_____ Phone Number_____
Tax Identification Number_____ NPI Number_____
Contact Person at Provider's Office_____
Contact Phone Number_____ Contact E-mail Address_____

II. Self-Audit/Overpayment Information

A. Reason for Refund: (please check one)

Identified through Audit/Review	_____
Duplicate Payment Identified by Provider	_____
Provider Billing Error	_____
Multiple Payments Identified by Provider	_____
Secondary Health Insurance Identified	_____

B. Type of Refund: (please check one)

Retraction Requested (Claims less than 2 years old)	_____
Check Provided (Claims 2 years old or more)	_____

C. Other Information:

Period of Claims (based on dates of service) _____
Detailed Description of Overpayment _____

Mail To:
Highmark Health Options
Attention Payment Integrity Department
Four Gateway Center
444 Liberty Avenue, Suite 2100
Pittsburgh, PA 15222-1222

III. Member/Claim Information: (Please use a separate sheet for additional Member/Claim Information)

Member Name	HHO ID #	DOS	Claim Number	Refund Amount

IV. Other Required Information: (as necessary for Provider Self Audits)

Extrapolation Used? _____
Extrapolation Method & Calculation: _____

If a listing of claims is not provided, HHO cannot guarantee that the claims will not be included in separate audits, for the same reason.

THE APPEAL

If your patient received a denial for a service or item that was requested, you can ask us to reconsider our decision on behalf of the patient. The appeal process can either follow a standard or expedited review timeframe. You may call Member Services to help you file an appeal, or, find the Member Appeal Form on our website at www.highmarkhealthoptions.com. If a standard review is requested, the member's written signature will be needed before your request can be processed. To help with our review, medical records supporting your request should accompany your request. After the member's signature is received, the standard review timeframe is thirty (30) days.

Our expedited process is provided only when the member's life, health or ability to regain maximum function would be placed in jeopardy if the request is reviewed using the standard timeframe. Expedited requests require a physician written certification stating the clinical rationale or facts supporting the need for an urgent review period. Decisions for expedited appeals will be made within 72 hours of the appeal request. The member's signature is not required for expedited requests. If you request an expedited appeal, please fax us your request certifying the need option as the review timeframe and medical records supporting the appeal request.

If you do not agree with our appeal decision, you may ask for a State Fair Hearing. This is an appeal process provided by the State of Delaware. More information on how to apply for a State Fair Hearing can be found in the Provider Manual.

MEMBER BILLING BY PROVIDERS

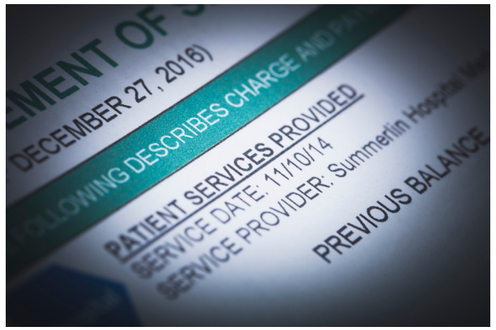
Payment by Highmark Health Options is considered payment in full. Under no circumstances, including but not limited to, non-payment by Highmark Health Options for approved services, may a provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from or have any recourse against a Highmark Health Options member.

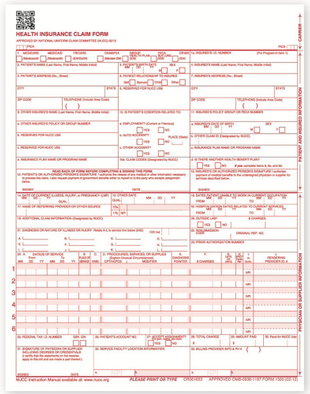
Practitioners may directly bill members for non-covered services provided; however, prior to the provision of such non-covered services, the practitioner must inform the member:

- of the service(s) to be provided;
- that Highmark Health Options will not pay for or be liable for said services;
- of the member's rights to appeal an adverse coverage decision as fully set forth in the Provider Manual; and
- if an appeal occurs and member is unsuccessful, that the member will be financially liable for such services.

Please contact your Provider Account Liaison if you have any additional questions or concerns.

Important Billing Reminder:
Paper claims must be submitted on the original red lined HCFA Claims1500 or UB form with red ink. Complete information is available in Chapter 7 of the Highmark Health Options Provider Manual.





IMPROVING PATIENTS' HEALTH LITERACY

Low health literacy can prevent patients from understanding their health care services.

Health Literacy is defined by the National Health Education Standards[1] as *"the capacity of an individual to obtain, interpret, and understand basic health information and services and the competence to use such information and services in ways which are health-enhancing."*

This includes the ability to understand written instructions on prescription drug bottles, appointment slips, medical education brochures, doctor's directions and consent forms and the ability to negotiate complex health care systems. Health literacy is not the same as the ability to read and is not related to year of education. A person who functions adequately at home or work may have marginal or inadequate literacy in a healthcare environment.

Possible Signs of Low Health Literacy

Your patients may frequently say:

- I forgot my glasses.
- My eyes are tired.
- I'll take this home for my family to read.
- What does this say? I don't understand this.

Your patients' behaviors may include:

- Not getting their prescriptions filled or not taking their medications as prescribed.
- Consistently arriving late to appointments.
- Returning forms without completing them.
- Requiring several calls between appointments to clarify instructions.

Barriers to Health Literacy

- The ability to read and comprehend health information is impacted by a range of factors including age, socioeconomic background, education and culture.
- A patient's culture and life experience may have an effect on their health literacy.
- An accent, or a lack of accent, can be misread as an indicator of a person's ability to read English.
- Different family dynamics can play a role in how a patient receives and processes information.
- In some cultures it is inappropriate for people to discuss certain body parts or functions leaving some with a very poor vocabulary for discussing health issues.
- In adults, reading skills in a second language may take 6-12 years to develop.

IMPROVING PATIENTS' HEALTH LITERACY

Tips for Identifying and Addressing Health Literacy Issues

- ✓ Use simple words and avoid jargon
- ✓ Never use acronyms
- ✓ Avoid technical language (if possible)
- ✓ Repeat important information – a patient's logic may be different from yours
- ✓ Ask patients to repeat back to you important information
- ✓ Ask open-ended questions
- ✓ Use medically trained interpreters familiar with cultural nuances
- ✓ Give information in small chunks
- ✓ Articulate words
- ✓ "Read" written instructions out load
- ✓ Speak slowly (don't shout)
- ✓ Use body language to support what you are saying
- ✓ Draw pictures, use posters, models or physical demonstrations
- ✓ Use video and audio media as an alternative to written communications

Additional Resources

Use Ask Me 3®[2]. Ask Me 3® is a program designed by health literacy experts intended to help patients become more active in their healthcare. It supports improved communication between patients, families and their healthcare providers.

Patients who understand their health have better health outcomes. Encourage your patients to ask these three specific questions:

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

Asking these questions is proven to help patients better understand their health conditions and what they need to do to stay healthy.

For more information or resources on Ask Me 3® and to view a video on how to use the questions, please visit http://www.npsf.org/?page=askme3. Ask Me 3® is a registered trademark licensed to the National Patient Safety Foundation (NPSF).

American Medical Association (AMA)

The AMA offers multiple publications, tools and resources to improve patient outcomes. For more information, visit: http://www.ama-assn.org/ama/pub/about-ama/ama-foundation.page.

[1]Joint Committee on National Education Standards, 1995

[2]National Patient Safety Foundation, Ask Me 3®. http://www.npsf.org/?page=askme3

MY DIABETES REPORT CARD

Highmark Health Options recognizes the important role that medical practices play in providing quality healthcare to members. We also know the critical role members play in their own health. For that reason, we want to empower them with the best tools and resources to increase the likelihood of healthy outcomes.

With this in mind, we would like to notify you that the **"My Diabetes Report Card"** was mailed recently to our diabetic members meeting the HEDIS criteria.

The **"My Diabetes Report Card"** is an educational tool providing information on medication, as well as dates and results for diabetes-related labs/exams. The report card was sent to about 5,000 identified members (ages18-75 years of age), English or Spanish language.

Included in the **"My Diabetes Report Card"** is education on how often A1C, LDL-C, dilated retinal eye exam, urine screen, blood pressure and BMI should be checked, but also the members' date of last diabetes screening test along with most recent result of A1C and LDL-C. The **"My Diabetes Report Card"** also informs about medications often part of a diabetes management plan, along with the members' last medication fill date. We'd like you to be familiar with the information shared with members on their report card, should one of your patients receive it and follow up with you.

The following additional resources were also included in the mailing:

- Care4Life Diabetes Texting Program (www.care4life.com Code: Options Text #: 300400 word: JOIN reply: Options)
- Websites-diabetes.org and cdc.gov/diabetes
- Highmark Health Options resources:
  - Lifestyle Management Program
  - Member Services
  - Website (www.highmarkhealthoptions.com)
  - Member Portal & Community Repository (access to resources)

We appreciate your continued support of Highmark Health Options mission to deliver quality programs that positively impact the health and wellness of our members. If you have any questions or suggestions, please contact Provider Services at 1-844-325-6251.

LOWERING "BAD CHOLESTEROL"

Over 100,000,000 Americans have high levels of cholesterol. Of those, deaths due to coronary disease number over 400,000.

To reach lower levels of low-density lipoprotein ("LDL") cholesterol (i.e., "bad cholesterol" that clogs arteries with deposits of fat), an innovative combination of drugs can help.

For patients who took statins along with a newer class of drugs to lower cholesterol (PCSK9 inhibitors), studies indicate a twenty percent (20%) reduction of stroke, myocardial infarction and cardiovascular death (Credit: Cleveland Clinic/Cleveland Business/October 25, 2017).

PHARMACY UPDATE: NEW ZIKA VIRUS WARNING

Zika is a virus that is spread though the bite of an infected mosquito and has been gathering significant media attention in recent years due to its potential risks for birth defects in pregnant females. Common symptoms of the Zika Virus include fever, rash, headache, joint pain, red eyes and muscle pain. Currently, there is no vaccine to prevent the Zika Virus, but the Centers for Disease Control (CDC) has advised that the best way to prevent Zika Virus is to use insect repellants. The CDC currently recommends the use of Environmental Protection Agency (EPA) registered insect repellents with one of the following active ingredients: DEET, Picaridin, IR3535, Oil of Lemon Eucalyptus (OLE), para-menthane-diol (PMD) or 2-undecanone. EPA registered products, when used as directed, are safe for use in females who are pregnant or breastfeeding.

For best results when applying insect repellant to those of any age, follow these few tips:

- Always read the full packaging directions before use.
- Reapply when directed on the packaging.
- Do not apply insect repellant to the skin that is covered by clothing.
- If you are also using sunscreen be sure to apply the sunscreen first then use the repellant.

Follow these tips when using insect repellant for a baby or child:

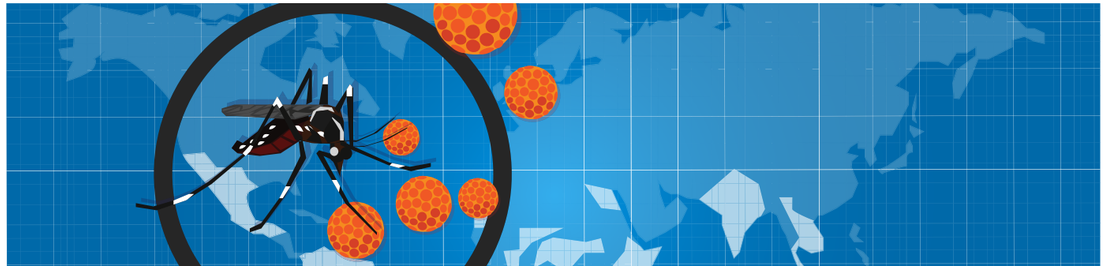
- Always read the full packaging directions before use.
- Do not apply insect repellant to children under the age of two months old.
- Avoid the child's hands, mouth, eyes and broken skin such as cuts or currently irritated skin.
- Spray the repellant onto your hands and then apply safely to the child's face.
- Do not use the products Oil of Lemon Eucalyptus (OLE) or para-menthane-diol (PMD) on children under three years old.

The efficacy of Non-EPA registered insect repellants has not been studied. Another way to protect against mosquito bites is to wear long sleeve clothing or pants and to cover baby strollers or carriers in netting. Certain items, such as long sleeve clothes, pants, socks, boots or tents, can be treated with Permethrin to reduce the risk of mosquito exposure. Read the packaging on Permethrin products before use, and avoid direct use with the skin. To protect your home, make sure all window screens or screen doors are intact. It is also recommended to empty weekly any objects holding water and clean them. These water containing objects could be anything from pots, buckets, children's toys, birdbaths or trash containers.

The following over-the-counter products are covered under our pharmacy benefit and contain the EPA registered ingredients to prevent the spread of Zika Virus:

- Cutter Skinsations Insect Repellant
- OFF! FamilyCare Insect Repellant I Smooth & Dry
- OFF! Active Insect Repellant I
- OFF! Deep Woods Insect Repellant V
- OFF! Deep Woods Insect Repellant VIII Dry
- Cutter Backwoods Insect Repellant
- Repel Sportsmen 25% Spray
- Repel Sportsmen Max 40% Spray
- Natrapel 20% Continuous Spray
- Sawyer Premium Insect Repellant
- Amerisource Lice Bedding Spray
- CVS Lice Bedding Spray
- Good Neighbor Lice Bedding Spray
- Leader Bedding 0.5% Spray
- Perrigo Lice Bedding Spray
- RID Home Lice Control Spray
- Rite Aid Lice Bedding Spray

For more information regarding the transmission, symptoms, prevention and treatment of Zika Virus, visit the CDC's website at www.cdc.gov/zika.



PROVIDER NETWORK CONTACTS

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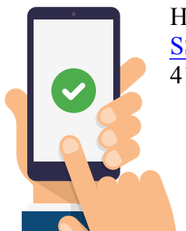

Provider Contracting, continued

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HIGHMARK. Delaware
HEALTH OPTIONS

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 NaviNet Portal.

TELEPHONE NUMBERS AND HOURS OF AVAILABILITY		
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.