HIGHMARK Delaware HEALTH OPTIONS

May 2018

PROVIDER UPDATE

An Update for Highmark Health Options Providers and Clinicians

PROGRAM AND BENEFIT NEWS

CLINICAL UPDATES

POLICY 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

Anesthesia Billing Guidelines

Anesthesia Services

Providers are reminded of the anesthesia billing guidelines below. Highmark Health Options requires that all anesthesia services must be submitted with one of the following pricing modifiers in the first modifier position.

Required Anesthesia Modifiers	Modifier Description	Reimbursement Percentage
AA	Anesthesia Services performed personally by an anesthesiologist	100%
AD	Medical supervision by a physician for more than four concurrent anesthesia procedures	100%
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals	50%
QX	Qualified non-physician anesthetist with medical direction by a physician	50%
QY	Medical direction of one qualified non-physician anesthetist by an anesthesiologist	50%
QZ	CRNA service without medical direction by a physician	100%

Anesthesia claims must be billed with appropriate modifiers.

- AA Modifier denotes the Anesthesiologist did the actual procedure.
- QY/QX modifiers denotes the CRNA rendered the service alone or under the Anesthesiologist guidance.

Anesthesia Billing Guidelines, continued

Additional anesthesia billing guidelines to consider:

- Highmark Health Options processes anesthesia services based on anesthesia procedure codes only.
- All services must be billed in minutes. Fractions of a minute should be rounded to whole minutes (30 seconds or greater: round up; less than 30 seconds: round down).
- Physical status modifiers, P1-P6, will not allow any additional payment. These are informational modifiers only and should be submitted after the pricing modifier.
- The claim should include ONLY the primary anesthesia code except when there is an add-on code that should be reported along with the primary anesthesia service.
- If you provide pain management services, continue to bill with surgical codes.
- If you provide medical procedures such as Swan Ganz, Laryngoscopy Indirect with Biopsy, Venipuncture Cutdown, Placement of Catheter or Central Vein, then continue to bill with the medical procedure code.
- When billing anesthesia for all obstetrical procedures, use the anesthesia procedure codes as defined in the Anesthesia section of the CPT4 manual.

Should you have any questions about this communication please contact your Provider Relations Representative or Highmark Health Options Member Services Department at 1-844-325-6251.

Coding Corner: Proper Uses of Modifier 25

Preventative Medicine and Sick Visits

As per AMA CPT Guidelines, Highmark Health Options shall allow reimbursement for a medically necessary sick visit Evaluation and Management (E/M) Service at the same visit as a Preventative Medicine Service (CPT 99381 – 99429) when it is clinically appropriate. Providers shall use CPT codes 99201 – 99215 to report a sick visit E/M with CPT modifier 25 to indicate that the E/M is a significant, separately identifiable service from the Preventative Medicine code reported. If modifier 25 is not appended, the sick visit will deny.

Please verify with the Medicaid Fee Schedule for reimbursable Preventative Medicine Service codes.

Modifier 25 vs Modifier 57

As per AMA CPT Guidelines, Highmark Health Options will reimburse E/M Services on the same day as a global surgical procedure for the following circumstances:

Modifier 25 – Significant evaluation and management service by same physician on date of global procedure

- E/M Service that is significant and separate on the day of a procedure with a 0 or 10-day global surgical period

Modifier 57 – Decision for surgery made within global surgical period

- E/M Service that is the decision for surgery on the day of or on the day before a procedure with a 90-day global surgical procedure

The modifiers should be appended to the E/M Service. Absence of the modifiers will cause the E/M Service will deny as global to the procedure.

References

American Medical Association, *Current Procedural Terminology (CPT)*
CMS, *Medicare Claims Processing Manual, Chapter 12 – Physicians/Nonphysician Practitioners, 30.6.6*
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

CMS, *Medicare Claims Processing Manual, Chapter 18 – Preventative and Screening Services*
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf

Warning to Providers about Fraudulent Prescription Scam

Recently, the Highmark Health Options Payment Integrity department has been made aware of a new scam involving fraudulent prescriptions being faxed to physicians for their signature. We've received complaints from members who have received unrequested large quantities of medications and supplies. These complaints prompted us to conduct numerous investigations into these suspected fraudulent prescriptions. We've learned that telemarketing companies are contacting members and obtaining their primary care physician's contact information. Then, the companies fax prescriptions to the physician's office to obtain his or her authorization.

HOW TO AVOID THE FAXED PRESCRIPTION SCHEME

Highmark Health Options urges you to pay attention to any prescriptions or certificates of medical necessity (CMN) received through fax from pharmacies or suppliers indicating that the patient has requested the medication or supplies. Be on the alert especially for the following types of requests:

- Acid reflux or GERD medication (omeprazole sodium bicarbonate)
- Braces – knee, neck, back, or wrist
- Compound creams
- Diabetic supplies: blood glucose meters, alcohol pads, test strips, lancet devices, and control solutions
- Non-steroidal anti-inflammatory drugs such as mefenamic acid or fenoprofen calcium
- Scar and skin creams (Urevaz or fluocinonide)
- TENS units and associated supplies, such as electrodes, leads, and batteries
- Topical pain creams (lidocaine, diclofenac sodium, Vanatol LQ, and combination packs)
- Vitamins

RED FLAGS

- The prescription or CMN typically will be completed with the medication or supplies and SIG (label or directions) already filled in, including the number of refills.
- The quantity of the medication may be unusually high. Most ointments, gels, and creams are dispensed in grams. Most tubes and jars come in sizes of 35.4, 50, or 100 gram sizes. The questionable prescriptions may request a quantity of 250 grams and up.
- The requesting pharmacy will usually be out of state.
- The prescription could list multiple diagnoses as checked off, or multiple options in the following categories: topical pain therapy; wellness; scar or dermatitis; eczema; general or diabetic neuropathy; inflammatory pain; arthritis; acid reflux; or GERD.

The list of medications can change. Please review any prescription carefully that your office did not initiate. If you are not sure that the patient actually requested and needs the medication, please do not approve the request. If you believe your office has received questionable prescriptions, you may contact the Highmark Health Options Fraud Hotline at 1-844-325-6256.

The Five A's of Tobacco Cessation

Begin the Conversation: Help Your Patients Quit for Good

Did you know that 7 out of every 10 smokers want to quit, but only 20% of them will do it on their own, or ask for help? With your help, your patients can begin to live tobacco-free.

Starting that conversation can be difficult, but it's crucial to be consistent and talk to your patients about cessation during every encounter. To help you start the conversation, we'd like to remind you of the five A's, a proven effective strategy to help you and your patient work toward a tobacco-free life. It allows you to assess your patient's willingness to quit and provide them with the most effective tools to help them quit for good. The five A's are:

1) **Ask** about and document tobacco use status at EVERY visit.
2) **Advise** in a clear, direct, personalized manner that tobacco users stop smoking.
3) **Assess** willingness to quit at this time. For former tobacco users, ask how recently they stopped and what challenges they may still have trouble dealing with.
4) **Assist** by prescribing NRT, unless medically contraindicated.
5) **Arrange** follow up, including counseling.

For more information on how you can help your patients quit smoking, go to https://www.cdc.gov/tobacco/campaign/tips/partners/health/index.html

Black, J. 2010. Evidence base and strategies for successful smoking cessation. *Journal of Vascular Surgery*. Volume 51 Number 6. Pg 1529-1537.

Chronic Obstructive Pulmonary Disease

Chronic Obstructive Pulmonary Disease (COPD) is a major cause of morbidity and mortality in the United States and is currently the fourth leading cause of death in the world. There are many causes for COPD; however, the strong correlation between low socioeconomic status and developing COPD is striking. This social determinant of health is one important characteristic of many patients who suffer from COPD.

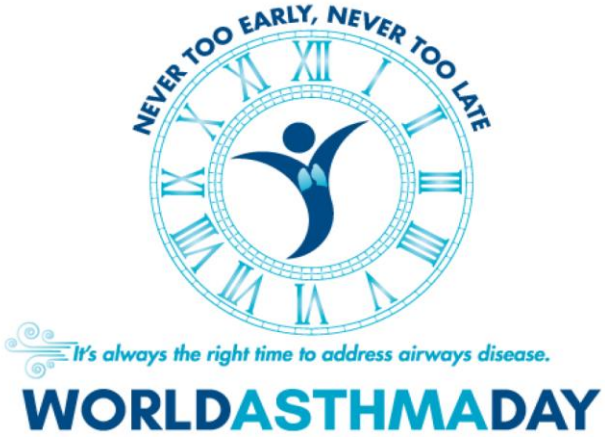
Goals to improve COPD outcomes include enhancing early detection through the required use of spirometry by primary care physicians in outpatient clinics for patients with symptoms and history that suggest the possibility of COPD. Utilizing spirometry can optimize the usage of short-and long-acting bronchodilators and potentially decrease the use of inhaled corticosteroids.

If a patient with COPD has trouble with their activities of daily living, they will likely be a candidate for Pulmonary Rehabilitation. Pulmonary Rehabilitation is known to improve symptoms, quality of life, as well as physical and emotional participation in everyday activities. It has also been shown to be the most effective therapeutic strategy to improve shortness of breath and exercise tolerance.

The Global Initiative for Chronic Obstructive Lung Disease (GOLD) Guidelines are available and contain well-defined recommendations for patients with COPD based on their risk for exacerbation and level of airway obstruction.

If you would like support in managing our members diagnosed with COPD, you can refer them to our *Lifestyle Management Program*. This program is a multidisciplinary, continuum-based holistic approach to health care delivery that proactively identifies and/or manages children and/or adults with chronic medical conditions. Members can call Highmark Health Options Member Services at 1-844-325-6251 and choose the option for Care Coordination.

Asthma Awareness



To improve asthma awareness and care around the world, World Asthma Day (an annual event first held in 1998), was created by the Global Initiative for Asthma (GINA).

The theme for this year's World Asthma Day is:

"Never too early, never too late. It's always the right time to address airways disease."

This year's theme hopes to increase awareness among healthcare providers and patients worldwide, to assess signs of asthma *at any time* in a patient's life, and control asthma by *taking action.*

As part of World Asthma Day, the global strategy includes talks, dialogue and campaigns organized to raise consciousness about risk factors pertaining to asthma (Credit: Global Initiative for Asthma; http://ginasthma.org/wad/).

Updated Medical Policy Notices (effective 5/15/2018)

New Highmark Health Options Medical Policies

Four new policies are listed below with summaries. Full descriptions of the new policies are available on the Highmark Health Options provider website at:
https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy

Fecal Transplant
Summary – Highmark Health Options may provide coverage under the medical-surgical benefits of the Company's Medicaid products for medically necessary fecal microbiota transplants in patients with recurrent Clostridium difficile infections.

Electrical Bone Growth Stimulators for Spinal Indications
Summary – Highmark Health Options may provide coverage under the medical-surgical and DME benefits of the Company's Medicaid products for medically necessary invasive and non-invasive electrical bone growth stimulators as an adjunct to lumbar spinal fusion procedures.

Genetic Testing Panels
Summary – Highmark Health Options may provide coverage under the medical-surgical benefits of the Company's Medicaid products for medically necessary genetic testing panels.

Transcranial Magnetic Stimulators
Summary – Highmark Health Options may provide coverage under the behavioral health benefits of the Company's Medicaid products for medically necessary repetitive transcranial magnetic stimulation. This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness or condition. Each person's unique clinical circumstances warrant individual consideration, based upon review of applicable medical records.

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Updated Medical Policy Notices (effective 5/15/2018)

Existing Medical Policies – Annual Review with Criteria Revisions

Twelve policies with criteria revisions resulting from annual review are listed below. Criteria changes are indicated. Full descriptions of the policies are available on the Highmark Health Options provider website at: https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy

Bariatric Surgery

- Added definitions;
- Criteria updates, including: Preoperative diet requirements and comorbidities, Moved surgeries from eligible section to non-covered surgeries;
- Added a contraindication;
- 2018 Coding updates;
- Added supporting literature to Summary of Literature; and
- Added references.

Oncotype DX

- Added a definition;
- Added non-coverage indications to #2; reformatted procedure section and summary of literature;
- Updated and revised summary of literature to meet current societal recommendations; and
- Added references.

Genetic Testing for Cystic Fibrosis

- Removed diagnosis code E84.1 from diagnosis code table;
- Deleted ICD-10 Diagnosis Code Z36;
- Added ICD-10 code Z84.81;
- Added coverage statement regarding infants under the Procedures-diagnostic section;
- New information on testing strategies added to literature; and
- Added detailed genetic counseling requirements.

Hyperbaric Oxygen Therapy

- Removed ICD-10 codes T07 and T14.8;
- 63 new 2018 ICD 10 codes added related to non-pressure chronic ulcers (Please see coding manuals for specifics related to coding updates);
- Added 2017 Hayes published evidence based reviews for *diabetes-related foot ulcers* and *Topical Oxygen Therapy for the treatment of Chronic Wounds* to the summary of literature; and
- Added updated references to Source(s).

BRCA 1 & 2

- Revised first-degree relative to include half-sibling; and
- Added letter C to address repeat testing under procedures section.

Continued on next page

Updated Medical Policy Notices (effective 5/15/2018)

Chromosomal Microarray

- Added Autism Spectrum to medically necessary criteria under procedure (section 1);
- Added HCPCS code S3870 to Procedure code table; and
- Deleted stillborn ICD-10 codes.

Negative Pressure Wound Therapy

- In Section 1 C, number 1: The >90 day requirement for chronic stage III and IV pressure ulcers has been changed to >30 days;
- Removed incorrect criterion from Section 3;
- Updated literature;
- Revised covered procedure codes-removed A9272 and added A6550, A7000, A7001 and E2402; and
- Updated reference sources.

Passive Oscillatory Devices

- Added related policy numbers to Page 1;
- Revised criteria in section 1.D., 1.F., 1.I, (Removal of trial period); and
- Deleted duplicate criteria statement in section 1.H.

Skin Replacement Therapy

- Added ABI to Definition section;
- Added The diabetic foot ulcer is free of infection;
- Wound must have adequate circulation and presence of acceptable peripheral pulses or as evidenced by ankle-brachial index (ABI) of 0.65 or greater in the limb being treated. Added on index of greater than 0.45 is needed to heal; and
- Added MariGen as a non-covered product.

Custom Made Oral Appliances

- Added HCPCS code E0485 to non-covered procedure table; and
- Added member age to criteria under Procedures section.

Continuous Glucose Monitoring of Interstitial Fluid

- The criteria for medical necessity has been updated for the following
  - Removal of 30-day requirement in Letter I
  - Deletion of table of FDA-approved CGM devices;
- Updated and revised CMS coverage position;
- Updated Professional Society table;
- Updated Summary of Literature and Reference Sources sections;
- Added new CGM HCPCS codes K0553 and K0554; and
- Added additional ICD-10 codes which include: E10.22-29, E10.3211-13, E10.3291-93, E10.3311-13, E10.3391-93, E10.3411-13, E10.3491-93, E10.3511-13, E10.3521-23, E10.3531-33, E10.354-43, E10.3551-53, E10.3591-93, E10.37X1-X3, E10.41-49, E10.52, E10.59, E10610, and E10.618 & Z79.4.

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Updated Medical Policy Notices (effective 5/15/2018)

Bronchial Thermoplasty

- Added definitions;
- 2018 Procedure code update: added 0016U; deleted 81401 & 81403;
- 2018 Diagnosis code update: Added ICD-10: C92.20, C92.21, C92.22, C92.90, C92.91 & C92.92; and
- Updated Reference Sources.

Existing Medical Policies – Annual Review with No Criteria Revisions (some have coding or formatting revisions)

The six policies without criteria revisions resulting from annual review are listed below. If any of the below policies had coding or formatting revisions, they are indicated. Full descriptions of the policies are available on the Highmark Health Options provider website at:
https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy

Wearable Cardioverter Defibrillator

- No revisions.

Noninvasive Positive Pressure Ventilation in Home

- 2018 Coding Revisions: New Diagnosis code R06.03 has been added.

Whole Exome and Whole Genome

- No revisions.

BCR ABL1 Testing in Chronic Myelogenous Leukemia and Acute Lymphoblastic Leukemia

- Added definitions;
- 2018 Procedure code update: added 0016U; deleted 81401 & 81403;
- Diagnosis code update: Added ICD-10: C92.20, C92.21, C92.22, C92.90, C92.91 & C92.92; and
- Updated Reference Sources.

Panniculectomy / Abdominoplasty / Lipectomy

- Removed Procedure code 00802 since isn't relevant to policy.

Implantable Cardioverter Defibrillator (ICD) / Subcutaneous ICD

- 2018 Coding revisions: Diagnosis code I50.1 has been updated.

Living Will / Advance Directives

The Omnibus Budget Reconciliation Act (OBRA) of 1990 included substantive new law that has come to be known as the Patient Self-Determination Act and which largely became effective on Dec 1, 1991. The Patient Self-Determination Act applies to hospitals, nursing facilities, providers of home healthcare or personal care services, hospice programs and health maintenance organizations that receive Medicare or Medicaid funds. The primary purpose of the act is to assure that the beneficiaries of such care are made aware of advance directives and are given the opportunity to execute them if they so desire. It is also to prevent discrimination in care if the member chooses not to execute advance directives.

As a participating provider within the Highmark Health Options network, you are responsible for determining if the member has executed an advance directive and for providing education when it is requested.

You can request a copy of a "Living Will" form from the Quality Improvement Department by calling Highmark Health Options Provider Services at 1-844-325-6252. There is no governmentally-mandated form.

A copy of the "Living Will" form should be maintained in the medical record. Highmark Health Options Medical Record Review Standards state that providers ask members age 21 and older whether they have executed advance directives and will document the response.

Providers will receive educational material regarding member's rights to advance directives upon entering the Highmark Health Options practitioner network.

Advance directive forms are made available by visiting the Highmark Health Options website at www.highmarkhealthoptions.com. Members can also be directed to their Member Handbook, or to contact Member Services at 1-844-325-6251, to obtain an advance directive form.

Provider Network Contacts

Provider Relations:

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Diane Thornberg – Sussex County
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Provider Contracting, continued

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412-255-1195

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

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 option)
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.