HIGHMARK Delaware HEALTH OPTIONS

November 2018

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: Hospital Discharge Day Management Services

Hospital Discharge Day Management Services
Hospital Discharge Day Management Services should be billed using the following CPT codes:

- **99238 -** Hospital discharge day management; 30 minutes or less
- **99239 -** Hospital discharge day management; more than 30 minutes

Hospital Discharge Day Management Services is a face-to-face evaluation and management (E/M) service between the attending physician and the patient. The E/M discharge day management visit should be reported for the date of the actual visit by the physician or qualified non-physician practitioner even if the patient is discharged from the facility on a different calendar date. Only one hospital discharge day management service is payable per patient per hospital stay.

Only the attending physician of record reports the discharge day management service. Physicians or qualified non-physician practitioners, other than the attending physician, who have been managing concurrent health care problems not primarily managed by the attending physician, and who are not acting on behalf of the attending physician, should use Subsequent Hospital Care (CPT code range 99231 - 99233) for a final visit. The discharging physician may not bill for both a hospital visit and hospital discharge management for the same date of service.

Hospital discharge day management codes are to be used to report the total duration of time spent by a physician for final hospital discharge of a patient. The codes include:

- final examination
- discussion of the hospital stay
- all time spent by the discharging physician, even if the time is not continuous
- instructions for continuing care to all relevant caregivers
- preparation of discharge records
- prescriptions
- referral forms

POLICY SOURCES
American Medical Association, *Current Procedural Terminology (CPT)*
CMS, *Medicare Claims Processing Manual, Chapter 12 – Physicians/Non-physician Practitioners, 30.6.9.2*
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

Medications to Require Medical Prior Authorization

As a part of our continuous efforts to improve the quality of care for our members, Highmark Health Options will implement a prior authorization process for the following medications effective with dates of service listed below. Failure to obtain authorization will result in a claim denial.

The prior authorization process will apply to **all Highmark Health Options Members**. Medical necessity criteria for each of the medications listed below are outlined in the specific medication policies available online. To access Highmark Health Options' medical policies, please paste the following link in your internet browser: **https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy**.

PROCEDURE CODES REQUIRING AUTHORIZATION

AUTHORIZATION REQUIRED AS OF 3/5/2018			
Procedure Code	**Description**	**Procedure Code**	**Description**
J1300	Soliris	**J1745**	Remicade
J1322	Vimizim	**J9042**	Adcetris
J1459	Privigen	**J9228**	Yervoy
J1556	Bivigam	**J9271**	Keytruda
J1557	Gammaplex	**J9299**	Opdivo
J1561	Gamunex-C/Gammaked	**J9305**	Alimta
J1566	Immune globulin, powder	**J9355**	Herceptin
J1568	Octagam	**J3490**	Unclassified drugs
J1569	Gammagard	**J3590**	Unclassified biologics
J1572	Flebogamma	**J9999**	Not otherwise classified, antineoplastic drugs
J1599	IVIG, non-lyophilized		
AUTHORIZATION REQUIRED AS OF 9/3/2018			
Procedure Code	**Description**	**Procedure Code**	**Description**
J0585	Botox	**J2357**	Xolair
J1442	Neupogen	**J9035**	Avastin
J2505	Neulasta	**J9047**	Kyprolis
J2820	Leukine	**J9055**	Erbitux
J1447	Granix	**J9306**	Perjeta
Q5101	Zarxio	**J9395**	Faslodex
J9310	Rituxan	**J2323**	Tysabri
AUTHORIZATION REQUIRED AS OF 10/1/2018			
Procedure Code	**Description**	**Procedure Code**	**Description**
J2469	Aloxi	**J0490**	Benlysta
J1786	Cerezyme	**J0221**	Lumizyme
J0178	Eylea	**J2778**	Lucentis
J2796	Nplate	**J2562**	Mozobil
J1428	Exondys	**J9295**	Portrazza
J2350	Ocrevus	**J2326**	Spinraza
AUTHORIZATION REQUIRED AS OF 12/3/2018			
Procedure Code	**Description**	**Procedure Code**	**Description**
J2182	Nucala	**J1439**	Injectafer

Medications to Require Medical Prior Authorization

PROCEDURE CODES REQUIRING AUTHORIZATION - continued

AUTHORIZATION REQUIRED AS OF 12/3/2018			
Procedure Code	**Description**	**Procedure Code**	**Description**
J2786	Cinqair	**Q0138**	Feraheme
J3590*	Fasenra*	**J9226**	Supprelin LA
J2507	Krystexxa	**J9225**	Vantas
J2278	Prialt	**J2353**	Sandostatin LAR depot
J3590*	Luxturna*	**J1930**	Somatuline depot
J9600	Photofrin	**J0740**	Cidofovir
J3590*	Brineura*	**J1950**	Lupron
J9041	Velcade		

*These medications will be reviewed under procedure code J3590 until a permanent code is assigned

What if the medication not on the list?
If the medication you are prescribing for your patient is not on this list that means it does not require a pre-service prior authorization. The process for obtaining this medication (that 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://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy

Diagnosis Required for Female Hormone Prescriptions

In response to an HHS Office of Inspector General (OIG) pharmacy audit, Highmark Health Options will be requiring diagnosis codes on female hormone prescriptions. The Federal government matches state funds with a higher rate when these medications are used for family planning. Therefore, the State must track the actual reason for the hormones being prescribed.

Effective **December 3, 2018** Highmark Health Options will require a diagnosis to be submitted on the claim for female hormone prescriptions. Below is a list of possible diagnosis codes, but the list is not all inclusive. **Please include the appropriate diagnosis on all of your Highmark Health Options member prescriptions for female hormone products.** Otherwise, the retail pharmacy will need to contact you for a member diagnosis in order to process the prescription. We have also notified our network pharmacies of this requirement.

Diagnosis Code	Diagnosis
Z30.01	oral contraceptive agent
E28.2	polycystic ovaries
N80	endometriosis
N92, N93	menstrual abnormalities
N94	menstrual cramps
E28	primary ovarian insufficiency
N91	amenorrhea
N94	premenstrual syndrome
L70	disease of sebaceous gland (acne)

Follow-Up After Hospitalization for Mental Illness

Highmark Health Options members should see an outpatient psychiatric or behavioral health specialist within 7 to 30 calendar days of discharge after hospitalization for mental illness. Proper follow-up care is associated with lower rates of pre-hospitalization and with a greater likelihood that gains made during hospitalization are retained. Hospitalization may stabilize individuals with acute behavioral conditions, but timely and appropriate continued care is needed to maintain and extend improvement outside of the hospital. The period immediately following discharge from inpatient care is recognized as a time of increased vulnerability. Ensuring continuity of care by increasing compliance to outpatient follow-up care helps detect early post-hospitalization medication problems and provides continuing support that improves treatment outcomes and reduces readmissions.

Coordinating Follow-up Care after Psychiatric Admissions

When members are admitted to the hospital for mental health needs, Highmark Health Options Behavioral Health is notified by the admitting hospital of the admission. A Highmark Health Options Single Point of Contact Care Coordination staff (SPOC) will then follow-up with the admitting hospital social work department, hospital, collaterals or providers, and as necessary, meet face to face with the member prior to discharge to develop a solid discharge plan.

Collaboration by Highmark Health Options Care Coordination

- SPOC will assist with setting up follow-up appointment with a mental health provider within 7 days of discharge.
- SPOC will refer member to Care Coordination for increased/ongoing follow-up care after hospitalization.
- SPOC will provide Medication Reconciliation to assure medications are on the Delaware Preferred Drug List (DPL).
- SPOC will coordinate Pharmacy delivery if appropriate.
- SPOC will coordinate transportation assistance when necessary.
- SPOC will identify and address any other potential barriers that may impact independence in the community.
- SPOC will provide member with discharge packet that includes community resources such as local food banks, community shelters, and other resources to ensure member has access to services post discharge.

Expected/Desired Outcomes

Follow-up appointment with a mental health provider within 7 days of discharge.
Increased/Ongoing follow-up care after hospitalization.
Reduced readmissions and ER visits.

Tips for Providers and/or staff when talking to the member

Remember, when physicians and other providers recommend follow-up care, most patients comply. After a patient in your primary care practice is hospitalized for a behavioral health diagnosis, it is important to ask whether a follow-up behavioral health appointment is scheduled. If so, encourage the patient to schedule and keep that appointment. Encourage your patient that there is no stigma for having a mental health diagnosis and that consistent follow-up care is very important.

QI/UM Program

The purpose of the Highmark Health Options Quality Improvement/Utilization Management (QI/UM) Program is to assure quality, safety, appropriateness, timeliness, availability, and accessibility of care and services provided to Highmark Health Options members. The comprehensive evaluation and assessment of clinical, demographic, and community data in conjunction with current scientific evidence is paramount to meet the identified needs.

The goal of the QI/UM Program is to ensure the provision and delivery of high quality medical and behavioral health care, pharmaceutical, and other covered health care services and quality health plan services. The QI/UM Program focuses on monitoring and evaluating the quality and appropriateness of care provided by the Highmark Health Options health care provider network and the effectiveness and efficiency of systems and processes that support the health care delivery system. The QI/UM Program is assessed on an annual basis to determine the status of all activities and identify opportunities that meet the QI/UM Program objectives.

As a participating provider, Highmark Health Options asks that you cooperate with Quality Improvement activities to improve the quality of care and services members receive. This may include the collection and evaluation of data, participation in various Quality Improvement initiatives and programs, and allowing the plan to use and share your performance data.

Implementation and evaluation of the QI/UM Program is embedded into Highmark Health Options daily operations. The QI/UM Program has available and uses appropriate internal information, systems, practitioners, and community resources to monitor and evaluate use of health care services, the continuous improvement process, and to assure implementation of positive change.

The scope of the Program includes the following, but not all:

- Enrollment
- Members' Rights and Responsibilities
- Network Accessibility and Availability, including those related to Special Needs
- Network Credentialing/Recredentialing
- Medical Record Standards
- Claims Administration
- Clinical Outcomes
- Patient Safety
- Preventive Health, Disease Management, Long-Term Services and Support (LTSS)
- Continuous Quality Improvement using Total Quality Management Principles

To request a copy of the complete Quality Improvement Program, Work Plan, or Annual Evaluation, please contact Highmark Health Options Provider Services Department at 1-844-325-6251.

Lifestyle Management Program's Cardiac Program

Overview
Highmark Health Options helps members with certain chronic diseases by providing additional educational benefits and health support for their condition through the Lifestyle Management Program.

Cardiac conditions are one of the chronic health disorders included in the Lifestyle Management Program. The Cardiac Program emphasizes patient education and support to help members with cardiac conditions take an active role in their well-being by adopting a heart healthy lifestyle, by taking medications as prescribed, and by understanding how to avoid sudden flare-ups of their condition.

Eligibility
All adult Highmark Health Options members, age 21 or older, with a diagnosis of heart failure, myocardial infarction, or coronary artery disease are eligible for the program. Members are automatically enrolled once they are identified with one of these cardiac conditions; however, they are able to opt out if they choose.

Program Benefits
The program will help your patient:
- Learn the meaning of specific cardiac symptoms to prevent further cardiac damage.
- Understand the importance of lab tests for lipid testing and medications.
- Understand how other conditions play a part in worsening a cardiac condition.
- Understand when to call the physician and the key words to tell the office.

For more information on the Lifestyle Management Program, including inquiring about the other chronic conditions included in the program, or to refer a patient to the Cardiac Program, call Highmark Health Options at 1-844-325-6251.

Cervical Cancer Screenings Create Healthier Outcomes

Women lead busy lives and may need to be reminded often to adhere to preventive screenings for their health. In the United States, there are over 8 million women who have not followed through with getting screened for cervical cancer (American Cancer Society, 2014.) Based on these numbers, women and providers are missing the opportunity for preventive education, early detection and early treatment of cervical cancer. Cervical cancer is preventable but to ensure a woman's healthy outcome, it takes a multidisciplinary team approach and dedicated patient education to reduce the care gaps.

Cervical cancer screenings are essential for women in the prevention and identification of cervical cancer. Most cervical cancer is caused by the human papillomavirus (HPV) infection and requires a Pap test to detect. According to the National Cancer Institute (n.d.), there are greater than 13,000 estimated new cases of cervical cancer in 2018. Although the 5-year survival rates for women diagnosed with cervical cancer is high at 66.2%, it is still critically important to encourage patients to have their regular Pap screenings to determine if they have cervical cancer, stage of cervical cancer, and to initiate the most appropriate treatment options for healthier outcomes.

As a provider, you can help change these statistics by utilizing each patient visit or contact as an opportunity to encourage them to see the value of getting cervical cancer screenings in a timely fashion as stated below:

- Women aged 21–29 years should get a Pap test every 3 years; HPV testing is not recommended.

- Women aged 30–65 years should preferably get co-testing of a Pap test and an HPV test every 5 years. A Pap test can also be done alone every 3 years.

References:

American Cancer Society. (2014). CDC: Millions of Women Not Getting Cervical Cancer Tests. Retrieved from https://www.cancer.org/latest-news/cdc-millions-of-women-not-getting-cervical-cancer-tests.html

National Cancer Institute. (n.d.). Surveillance, Epidemiology, and End Results Program. *Cancer Stat Facts: Cervical Cancer*. Retrieved from https://seer.cancer.gov/statfacts/html/cervix.html

Stopping Elderly Accidents, Deaths and Injuries (STEADI)

Falls are a common and serious health threat to adults 65 and older. Every year, more than 1 in 4 older adults fall, but more than half of those who fall don't tell their healthcare provider. The ***Stopping Elderly Accidents, Deaths, and Injuries (STEADI***) https://www.cdc.gov/steadi/about.html initiative was developed in response to this growing health threat. STEADI offers training and resources to help healthcare providers put fall prevention strategies into practice.

As a healthcare provider, you are already aware that falls are a serious threat to the health and well-being of older patients. Over 3 million older adults are treated in emergency departments annually for fall injuries. As a provider you play an important role in caring for older adults and you can help reduce these devastating injuries.

The STEADI Initiative offers a coordinated approach to implementing the American and British Geriatrics Societies' Clinical Practice Guideline for fall prevention. STEADI consists of three core elements: **Screen** patients for fall risk, **Assess** modifiable risk factors, and **Intervene** to reduce risk by using effective clinical and community strategies. Combined, these elements can have a substantial impact on reducing falls, improving health outcomes, and reducing healthcare expenditures.

CDC developed the STEADI initiative which includes educational materials and tools to improve fall prevention for providers, pharmacists, older adults and their caregivers.

Reference:
Centers for Disease Control, STEADI Stopping Elderly Accidents, Deaths & Injuries
https://www.cdc.gov/steadi/materials.html

Health Literacy

According to the Institute of Medicine, Health Literacy is defined as "the capacity individuals have to obtain, process and understand basic health information and services needed to make appropriate health decisions." Health literacy refers to the skills necessary for an individual to participate in the health care system and to maintain good health. These skills include reading and writing, calculating numbers, communicating with health care professionals and using health technology such as electronic diabetes monitoring devices.

According to the Centers for Disease Control and Prevention (CDC), 9 in 10 individuals have difficulty using everyday health information that is routinely available in health facilities, retail outlets, in the media and in their communities.

An estimated 90 million Americans have low health literacy. Demographics likely to experience limited health literacy:

- Age 65 of older
- Incomes at or below poverty level
- Limited education; no high school diploma/GED
- Individuals with low English proficiency and/or non-native speakers of English

To stay healthy individuals must know how to read the labels on food and medicine, locate the nearest health center, report symptoms to health professionals, understand insurance paperwork and pay medical bills.

Low health literacy can result in:

- Medication errors
- Low rates of treatment compliance due to poor communication between providers and patients;
- Reduced use of preventive services and unnecessary emergency room visits
- Ineffective management of chronic conditions due to inadequate self-care skills
- Longer hospital stays and increased hospital re-admissions

How health care professionals can help:

- Identify patients with limited literacy levels
- Use simple language, short sentences and define technical terms
- Supplement instruction with appropriate materials (videos, models, pictures, etc.)
- Reflect the age, cultural, ethnic and racial diversity of patients
- Offer assistance with completing forms

References:

Center for Health Care Strategies, Inc. "What is Health Literacy"
http://www.chcs.org/media/What_is_Health_Literacy.pdf

Centers for Disease Control, "Health Literacy Basics"
https://www.cdc.gov/healthliteracy/index.html

Privacy Notice

Highmark Health Options makes protecting the privacy and security of member health information a priority!

Highmark Health Options understands that there are times when we need to share information with health care professionals to enable proper care, timely payment, and reimbursement.

Understand that in some instances, HIPAA guidelines do permit health care providers to use or give out member medical information without the need for written authorization from the member. A few examples include:

- For public health activities (such as disclosing an outbreak)
- Student immunization records (can be released to the school when required by law or if written or oral agreement is documented)
- Release of a deceased member's personal health information (PHI) to coroners, medical examiners, funeral directors and for organ donations
- For judicial proceedings (such as court orders)

When a request is received for another purpose, Highmark Health Options will provide PHI in situations when the member has given authorization or consent to release information to the requesting party. In the event the member does not give authorization or consent to release their information, we will follow the parameters defined in 45 CFR 164.512 (uses and disclosures for which an authorization or opportunity to agree or object is not required), to determine if the information can be released.

Highmark Health Options employees are trained to avoid inappropriate disclosures and to provide minimum necessary information when responding to inquiries.

To learn more about how Highmark Health Options uses or discloses member information or to view our "Privacy Statement," please visit us online at www.highmarkhealthoptions.com. To request a paper copy of Highmark Health Options "Privacy Statement," please call Member Services at 1-844-325-6251.

Highmark Health Options takes great pride in protecting member information and looks forward to working with providers to manage our members' health care needs.

Resolving New EHS Processing Platform Issues

On January 1, 2018, Highmark Health Options transitioned to its new processing platform (EHS), supported by Highmark Health Solutions. While we have completed the release and implementation of our new interface, regrettably, the transition has not been as seamless as anticipated. Over the course of this year, we have tried to keep our customers and community partners updated by issuing and publishing communications, open forums and working directly with the individuals in our Provider community toward resolve.

We would like to let you know that we absolutely hear your frustrations and are truly sorry for the inconveniences this has caused to your daily operations.

Highmark Health Options is committed to you, our valued customers, in taking immediate and ongoing corrective actions to regain your confidence in us.

CONTACT US:

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. You may utilize NaviNet for the following services:

- Eligibility and Benefits
- EOB/Remittance Inquiry - Access EOBs/Remittances
- Authorizations
- Claim Status Inquiry
- Provider File Management
- Appeals/claim disputes can be requested, view LTSS authorizations, access the NIA RadMD portal and secure messaging.

In addition to NaviNet, you may reach Provider Services phone queue at **1-844-325-6251.** This team may also assist with general claims inquiries. For additional assistance, you may also reach out to your Network Liaison (found on the Highmark Health Options site or provided by Provider Services team).

For claims research and analysis, please submit your claims spreadsheet to: depsresearch@gateway.com

Again, we are confident that as a result of these actions, Highmark Health Options will be restored to standard operational functionality aligned to consistent and timely payments and services.

Thank you for your continued patience and diligence as we work together to resolve ALL of your issues. We appreciate your shared commitment to the members we serve and all of our community partners.

Provider Network Contacts

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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.