HIGHMARK Delaware
HEALTH OPTIONS

October 2018

PROVIDER UPDATE

An Update for Highmark Health Options Providers and Clinicians

Program 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: DME Modifiers

Modifiers Required for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

KX Modifier

The KX modifier is required on all DME claims. The KX modifier indicates that the supplier has ensured coverage criteria for the DMEPOS billed is met and the documentation does exist to support the medical necessity of the item. Documentation must be available upon request

Common Modifiers

- NU – New durable medical equipment purchase
- RR – Rental (Use this "RR" modifier when DME is to be rented)
- UE – Used durable medical equipment purchase

DME Rental Modifiers

- BP – The beneficiary has been informed of the purchase and rental options and has elected to purchase the item
- BR – The beneficiary has been informed of the purchase and rental options and has elected to rent the item
- BU – The beneficiary has been informed of the purchase and rental options and after 30 days has not informed the supplier of his/her
- KH – DMEPOS item, initial claim, for first month rental
- KI – DMEPOS item, second or third month rental
- KJ – DMEPOS item, fourth to the thirteenth months of rental

Use modifiers KH, KI, and KJ in addition to modifier RR

Modifiers appropriate for oxygen and oxygen equipment

- RR – Rental
- QE – Prescribed amount of oxygen is less than 1 liter per minute (LPM)
- QF – Prescribed amount of oxygen exceeds 4 liters per minute (LPM) and portable oxygen is prescribed
- QG – Prescribed amount of oxygen is greater than 4 liters per minute (LPM)
- QH - Oxygen conserving device is being used with an oxygen delivery system

Repair and Replacement

Repair and replacement of DME equipment which the beneficiary owns, has purchased, or is a capped rental item is covered in certain cases of loss, irreparable damage, or wear. When filing a claim to for the replacement or repair of equipment prior to the reasonable useful lifetime (RUL) of five years, the modifiers below are added to the HCPCS:

- RA – Replacement of a DME, Orthotic, or Prosthetic Item
- RB – Replacement of a part of a DME, Orthotic, or Prosthetic Item furnished as part of a repair

Coding Corner: DME Modifiers (cont.)

Prosthetics and Orthotics

- K0 – Lower limb extremity prosthesis functional Level 0 - Does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.
- K1 – Lower extremity prosthesis functional Level 1 - Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulatory.
- K2 – Lower extremity prosthesis functional Level 2 - Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs, or uneven surfaces. Typical of the limited community ambulatory.
- K3 – Lower extremity prosthesis functional Level 3 - Has the ability or potential for ambulation with variable cadence. Typical of the community ambulatory who has the ability to transverse most environmental barriers and may have vocational, therapeutic or exercise activity that demands prosthetic utilization beyond simple locomotion.
- K4 – Lower extremity prosthesis functional Level 4 - Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

Osteogenesis Stimulators

E0747, E0748 and E0760 are Class III Devices that must be submitted with a KF modifier. The KF modifier indicates a FDA Class III Device.

Surgical Dressings

Modifiers A1 through A9 are used with surgical dressings to indicate the number of wounds. If modifier A9 (dressing for nine or more wounds) is used, information must be submitted in Item 19 on a paper claim, or the electronic equivalent, indicating the number of wounds.

Medication modifiers

- BA – Item furnished in conjunction with parenteral nutrition (PEN) services
- BO – Orally administered nutrition, not by feeding tube
- EA – ESA, anemia, chemo-induced
- EB – ESA, anemia, radio-induced
- EC – ESA, anemia, non-chemo/radio
- KO – Single drug unit dose formulation
- KP – First drug of a multiple drug unit dose formulation
- KQ – Second or subsequent drug of a multiple drug unit dose formulation
- JB – Administered subcutaneously
- JW – Drug amount discarded/not administered to any patient

Coding Corner: DME Modifiers (cont.)

EY Modifier

The EY modifier indicates a supplier does not have a doctor's order for an item or service. Claims with the EY modifier will deny as not reasonable and necessary.

Additional Modifiers

- AU – Item furnished in conjunction with a urological, ostomy or tracheostomy supply
- AV – Item furnished in conjunction with a prosthetic or orthotic device
- AW – Item furnished in conjunction with a surgical dressing
- AY – Item or service furnished to an ESRD patient that is not for the treatment of ESRD

Informational Modifiers

- GA – Waiver of Liability statement on file, ABN required (Medicare claims)
- GK – Reasonably and necessary item/service associated with a GA or GZ modifier
- GL – Medically unnecessary upgrade provided instead of non-upgraded item, no charge, no ABN
- GY – Item or service statutorily excluded or does not meet the definition of any Medicare benefit (May be placed on a claim as information but not as a primary modifier)
- GZ – Item or service expected to be denied as not reasonable or necessary (Items submitted with GZ are automatically denied and not subject to complex medical review) (Medicare claims)
- LT – Left side (Used to items provided for the left side of the body)
- MS – Six month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty
- RT – Right side (Used to items provided for the right side of the body)
- TW – Back-up Equipment

POLICY SOURCES

American Medical Association, *Coding with Modifiers: A Guide to Correct CPT and HCPCS Level II Modifier Usage*

American Medical Association, *Current Procedural Terminology (CPT)*

CMS, *Medicare Claims Processing Manual, Chapter 20* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c20.pdf

Noridian, *Modifiers* https://med.noridianmedicare.com/web/jddme/topics/modifiers

Medical Drug Management

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

Procedure Codes Currently Requiring Authorization

*** Authorization required as of March 3, 2018 ***		
JCODE	**DRUG NAME (brand)**	**DRUG NAME (generic)**
J1300	Soliris	Eculizumab injection
J1322	Vimizim	elosulfase alfa injection, 1mg
J1459	Privigen	IVIG privigen injection 500 mg
J1556	Bivigam	Imm Glob Bivigam injection, 500mg
J1557	Gammaplex	Gammaplex injection (5%, 10%)
J1561	Gamunex	Gamunex-C/Gammaked
		Immune globulin, powder
J1568	Octagam	Octagam injection
J1569	Gammagard	Gammagard liquid injection
J1572	Flebogamma DIF	Flebogamma injection
		IVIG, non-lyophilized
J1745	Remicade	Infliximab injection
J9042	Adcetris	Brentuximab vedotin injection
J9228	Yervoy	Ipilimumab injection
J9271	Keytruda	Pembrolizumab injection
J9299	Opdivo	Nivolumab injection
J9305	Alimta	Pemetrexed injection
J9355	Herceptin	Trastuzumab injection
J3590	Unclassified biologics	
J3490	Unclassified drugs	
J9999	Misc Antineoplastic Drugs	
*** Authorization required as of September 3, 2018***		
J0585	Botox	onabotulinumtoxinA injection
J1442	Neupogen	filgrastim injection
J2505	Neulasta	Pegfilgrastim injection
J2820	Leukine	Sargramostim injection
J1447	Granix	tbo-filgrastim injection
Q5101	Zarxio	filgrastim-sndz injection (biosimilar)
J9310	Rituxan	Rituximab injection
J2357	Xolair	Omalizumab injection
J9035	Avastin	Bevacizumab injection
J9047	Kyprolis	Carfilzomib injection
J9055	Erbitux	Cetuximab injection
J9306	Perjeta	Pertuzumab injection
J9395	Faslodex	Fulvestrant injection
J2323	Tysabri	Natalizumab injection

Medical Drug Management (cont.)

Procedure Codes Requiring Authorization as of October 1, 2018

*** NEW - Authorization required as of October 1, 2018***		
JCODE	**DRUG NAME (brand)**	**DRUG NAME (generic)**
J2469	Aloxi	Palonosetron injection
J0490	Benlysta	Belimumab injection
J1786	Cerezyme	Imiglucerase injection
J0221	Lumizyme	Alglucosidase alfa injection
J0178	Eylea	Aflibercept injection
J2778	Lucentis	Ranibizumab injection
J2562	Mozobil	Plerixafor injection
J2796	Nplate	Romiplostim injection
J9295	Portrazza	Necitumumab injection
J1428	Exondys 51	Eteplirsen injection
J2350	Ocrevus	Ocrelizumab injection

What if the medication is 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. This claim might be subject to post-service, pre-payment edits, but no pre-service authorization is required.

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 auto fill 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 1-855-412-8001.

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: HighmarkHealth Options

Opioid Prescription Prior-Authorization

Beginning **October 1, 2018**, Highmark Health Options launched a phased implementation of changes affecting opioid prescriptions. The initial change involves prior authorization requirements for opioid prescriptions exceeding the limits listed below. The prior authorization limit will apply to any member presenting to a pharmacy with a prescription that results in the member at or exceeding 90 morphine milligram equivalents of opioids per day from both new and existing prescriptions. The second phase of this initiative, beginning **November 5, 2018,** limits the duration of therapy for members receiving prescriptions for all short acting opioid prescriptions.

A PRIOR-AUTHORIZATION will be required for:

Cumulative opioid doses > 90 milligram morphine equivalents (MME)/day
Scripts for children (<21) with a duration of therapy longer than 7 days in a 30 day period
Scripts for adults (≥21) with a duration of therapy longer than 14 days in a 30 day period

We know that providing adequate pain control while mitigating potential risks can be challenging. In an effort to support our members and providers with the highest quality care and to minimize unintentional overdose risk and other safety concerns associated with opioid use, we have included a link to CDC resources directly beneath the Opioid Analgesics authorization criteria on our website **https://highmarkhealthoptions.com/providers/priorauthorization** for assistance with MME calculation, tapering plans, and using the Prescription Drug Monitoring Program (PDMP).

Listed on the next page are some other ways Highmark Health Options is attempting to stem the terrible epidemic.

Opioid Prescription Prior-Authorization (cont.)

HIGHMARK HEALTH OPTIONS OPIOID INTERVENTION STRATEGIES

- Creating an active "lock in" program for members getting opioids from multiple providers or exhibiting drug seeking behavior.
- Providing robust communication to members, pharmacies and providers impacted by these changes
- Creating an interdisciplinary team to support members and their providers
- Preventing dependence and addiction by early intervention when members have high risk pharmacy utilization
- Providing support for members and their physicians in tapering off high-dose opioids, including an interdisciplinary team to help find the right resources to support tapering from high opioid doses
- Assuring easy access to naloxone, the drug used to treat an overdose
- Collaborating with Delaware MAOT program Leadership Teams to ensure smooth transition for members transferring from Rehabilitation Centers.
- Developing enhanced, embedded Care Coordination program at IMD facilities, D&A Centers, and Community providers to ensure member success and effective discharge planning and support post discharge.

We have notified all affected members and prescribers 30 days in advance of implementing these changes. We appreciate your help and collaboration in encouraging the safe and appropriate use of opioid medications. If you have questions, please contact us at 1-844-325-6251.

Member Satisfaction Survey Results

Every year, a sample of members are asked to complete a member satisfaction survey. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey asks members a variety of questions related to their experience with Highmark Health Options and their providers. Three separate CAHPS surveys are completed annually to assess member satisfaction for the adult, child, and CHIP populations. Survey questions are combined to form the following categories:

- Getting Needed Care
- Getting Care Quickly
- Customer Service
- How Well Doctors Communicate
- Coordination of Care
- Shared Decision-Making
- Health Promotion and Education

Members are then asked to rate their health care, health plan, personal doctor, and specialist on a scale from one to ten. The responses allow us to focus resources on underperforming areas and make improvements where needed.

The results of the 2018 CAHPS surveys were largely positive with high ratings received in a number of categories. On a national scale, several categories are performing in the 90th percentile. Members are happy with their personal doctors and how they are communicating with them. Members are also satisfied they are getting care quickly. A CAHPS workgroup has been formed to identify barriers and develop interventions for under-performing measures such as health promotion and education, shared decision making and getting needed care. Highmark Health Options is actively working toward improving these areas and increasing member satisfaction.

While the CAHPS surveys are reflective of Highmark Health Options as a plan, they also measure your performance as a provider. You can help by considering the following suggestions:

- Include members in the decision-making process
- Use active listening techniques such as paraphrasing what was said and incorporate "teach back" strategies
- Ensure staff engage in effective and respectful communication with members
- Explain things in an understandable way
- Utilize appointment reminder calls to prompt patients to bring their medications to review during their appointments.

Together, we can make members happier and healthier!

Lead Screening as a Part of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Highmark Health Options EPSDT Program is based upon the federally-mandated EPSDT Program for Medical Assistance-eligible children under the age of 21 years. Through the EPSDT Program, children are eligible to receive medical, dental, vision, and hearing screens to assure that they receive all medically necessary services without regard to Medical Assistance covered services.

Each 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, as well as communicating demographic information (e.g. telephone number, address, alternate address) with the staff to assist with scheduling, locating, and addressing compliance issues.

One of the required screen tests within the EPSDT program is lead screening. It is important for all members to be tested for lead exposure at age 1 and again at age 2. This will help to keep children safe from lead poisoning. Children are at highest risk for lead poisoning because they put objects in their mouth during the crucial brain development period. Lead poisoning leads to learning disabilities and slowed growth and development. Educate your patients about items that may contain lead, such as, old paint chips or paint dusting, dirt, and pipes. Children who have been lead poisoned may not look or act sick, so it is important to for all children to be tested.

Other required screenings and tests are outlined in the provider section of the Highmark Health Options website at www.highmarkhealthoptions.com. Primary care practitioners are required to follow this schedule to determine when the necessary screens and tests are to be performed.

Appropriate Treatment for Children with Upper Respiratory Infection

As winter approaches, children with upper respiratory infections (URIs) will be on the rise. Most URIs, also known as the common cold, are caused by viruses that require no antibiotic treatment.

According to the CDC, antibiotic resistance is presenting a major threat to the public's health. Antibiotic resistance occurs when bacteria develop the ability to defeat the drugs designed to kill them. Each year in the United States, at least 2 million people get infected with antibiotic-resistant bacteria, and at least 23,000 people die as a result.

About 30 percent of antibiotics, or 47 million prescriptions, are prescribed unnecessarily in doctors' offices and emergency departments in the United States, which makes improving antibiotic prescribing and use a national priority.

Recent efforts to decrease unnecessary prescribing have resulted in fewer children receiving antibiotics in recent years. Increased awareness of appropriate treatment for URIs can reduce the dangers of antibiotic-resistant bacteria.

References

1. Centers for Disease Prevention and Control. 2013. "Antibiotics Aren't Always the Answer." http://www.cdc.gov/features/getsmart/

Improving Compliance with Asthma Controller Medications in the Pediatric Population

The problem of getting children to follow a treatment regimen is widespread and is frustrating for physicians. The extent to which any patient adheres to a medical regimen is an essential determinant of clinical success. Improved patient adherence may lead to improvements in asthma control and quality of life. For caregivers and children, the daily hassles of living, stress, and typical family conflict can be some of the biggest barriers to medication adherence. Reasons why children do not take their medications also include caregivers' lack of understanding of the diagnosis, concerns about drug therapy effectiveness, frequency of the regimen, fear of medication side effects, taste, peer-pressure surrounding the use, and lack of trust with the physician. The role of the clinician is to adequately inform the patient and the caregiver about the prescribed regimen and to discuss the importance of adherence even in the absence of symptoms. In the patient who subsequently manifests non-adherence, the clinician should explore with the patient and caregiver, barriers to adherence and methods to overcome these barriers.

Strategies to improve adherence in children include using simplified drug regimens (e.g., once-daily dosing), pleasant-tasting medicines, liquid or other non-pill formulations, regular phone contact between parents and physicians, reminders, information counseling, self-management plans, and other forms of individualized supervision or attention, such as reinforcement of the information by the pharmacist. Physicians also can encourage adherence by providing a clearly written explanation or patient information sheets that list generic and brand names, dosage, schedule, duration, and common side effects and practical ways of coping with them. Physicians, children, and caregivers should develop a mutually agreed-upon treatment plan. Having the child participate in devising the plan can also help improve adherence.

Highmark Health Options and the State of Delaware offer a variety resources for patients with asthma. One such resource is the Delaware Asthma Consortium, which offers an Over-the-Phone Home Asthma Assessment (link below). The program is designed to help Delaware families who have children with asthma learn about potential asthma triggers in the home. Health Options members of any age with asthma can also utilize the plan's care coordination services by calling 844-325-6251.

http://www.deasthma.org/delaware-over-the-phone-home-asthma-assessment-program/

Social Determinants of Health and Community Repository

What is Health? As defined by the World Health Organization, it is a "State of complete physical, mental, and social wellbeing, and not merely an absence of disease or infirmity." Influences on health include availability of and access to: Education, healthy, nutritious food, safe and affordable housing, reliable public transportation, health insurance, safe water and non-polluted air and culturally sensitive health care providers.

These *Social Determinants of Health* (SDOH) are conditions in which people are born, grow, live, work and age and are defined by the distribution of resources, and help create health disparities. Empowering patients is one key to help address SDOH and health disparities.

As a provider you can educate your patients about social determinants of health and refer them to Care Coordination * for assistance. The Highmark Health Options Community Repository * is a resourceful tool that is full of support and guidance through a list of public agencies. The categories that define this tool focus on all aspects of life including health and dental, food support, utility assistance, maternal care, housing assistance, mental health and more. You can also refer the member to Highmark Health Options Member Services by calling 1-844-325-6251 or TTY (711 or 1-800-232-5460).

Lifestyle Management Programs

The Lifestyle Management Program includes population-based disease management programs that focus on improving the health status of Highmark Health Options members with chronic conditions. The Lifestyle Management Program provides patient education and self-empowerment for medication, diet, and lab adherence to reduce inpatient and emergency room utilization.

	Asthma	Cardiac	COPD	Diabetes	Maternal Outreach Management and MOM Options
Eligibility	Ages 2 and older with a diagnosis of asthma	Ages 21 and older with CAD, MI or HF	Ages 21 and older with COPD	All ages with Type 1 or Type 2 diabetes	Pregnant women
Contact Referrals and Information	Highmark Health Options Provider Relations 1-844-325-6251				
Description	• The programs provide patient education and self-empowerment for treatment plan adherence, as well as tools to reduce inpatient utilization and emergency room utilization • Education is aimed at delaying or preventing the onset of disease specific complications • The programs support the provider's plan of care				This prenatal program offers care coordination to reduce low birth weight, pre-term deliveries, and NICU admissions
Provider Benefits and Support	Highmark Health Options Lifestyle Management Programs aim to: • Enhance patient-provider communication • Decrease inpatient and emergency room utilization • Increase treatment plan adherence including immunizations such as flu and pneumonia • Improve patient satisfaction The MOM Options Maternity program has a proven record of decreasing the number of premature deliveries The 24/7 Nurse Line can help your patients achieve better outcomes and decrease ED visits				

Lifestyle Management Program

	Asthma	Cardiac	COPD	Diabetes	Maternal Outreach Management and MOM Options
Enrollment	Members are identified through claims: Highmark Health Options utilization management, pharmacy and member services departments; member self-referrals; and provider referrals. Your referrals are welcome.				Provider submission of the ONAF helps identify high-risk women in need of interventions.
Coordination of Care	Care Coordinators assist you and your patients with coordination of care for specialist visits, home health, behavioral health, and DME and community referral needs.				
Web-Based Tools	Go to the provider pages at www.highmarkhealthoptions.com and choose *Providers* and select the *Training* tab.				
Referral Source to Help Members Quit Tobacco	Refer patients to the toll-free Delaware Tobacco Quitline at 1-866-409-1858.				

Appointment Standards

Behavioral Health Practitioners

Appointment Type	Example	Appointment Standard
Care for a non-life-threatening emergency	An acute dystonic reaction to antipsychotic medication (drug-induced involuntary muscle spasms). Antidepressant-induced hypomania (drug-induced manic mood without functional impairment). Intrusive thoughts (significant, severe, distressing).	Within 6 hours
Care for immediate life-threatening emergencies	Immediate requests for behavioral health practitioner services include potentially suicidal individuals and include mobile response teams.	Within 1 hour
Urgent care	Acute major depression and acute panic disorder.	Within 24 hours
Initial visit for routine care	Routine outpatient behavioral health services include requests for initial assessments, requests for members discharged from an inpatient setting to a community placement and requests for members seen in emergency rooms or by a behavioral health crisis provider for a behavioral health condition.	Within 7 calendar days
Non-emergent or follow-up routine care	Marital problems, tensions at work and general anxiety disorder.	Within 3 weeks

All Behavioral Health Practitioners are responsible for providing 24 hour 7 day a week coverage for urgent or emergent care. Members should be instructed to call 911 or go directly to the emergency room in the case of a true emergency. In addition, there should be a provider on call to assist members in obtaining urgent or emergent care in a timely manner, following the guidelines outlined above.

Important News About Flu and Pneumonia Vaccination

Influenza Vaccination

Flu season is just around the corner. Since 2010, the CDC estimated that there have been up to 35.6 million influenza cases and up to 56 thousand deaths due to influenza annually.

You can help stop the flu from spreading by encouraging your patients to get a flu vaccine! The flu vaccine is the best way to prevent the flu. It is recommended that everyone aged 6 months and older should receive a flu vaccine around the time flu season starts (October), especially individuals who are at an increased risk for developing serious flu complications. People who interact with these individuals or care for infants less than 6 months should also receive the vaccine. Those at increased risk for developing flu complications include:

- Children aged 5 years and younger
- Adults aged 65 years and older
- Pregnant women
- People with chronic health conditions like heart and lung diseases, diabetes, and asthma

Help do your part in preventing the spread of the flu and discuss flu vaccine benefits and risks with your patients!

More information on the flu vaccine can be found at:
https://www.cdc.gov/flu/index.htm

Pneumococcal Vaccination

Thousands of pneumococcal infections, including meningitis, bacteremia, pneumonia, and ear infections occur annually. It is recommended that older adults (aged 65+ years) be vaccinated against pneumococcal diseases because they are at an increased risk for developing pneumococcal infection and death. There are two types of pneumococcal vaccines recommended for adults:

- Pneumococcal Conjugate Vaccine (PCV13): Prevents against 13 types of pneumococcal bacteria
- Pneumococcal Polysaccharide Vaccine (PPSV23): Prevents against 23 types of pneumococcal bacteria

More information on specific recommendations for pneumococcal vaccines can be found at:
https://www.cdc.gov/vaccines/vpd/pneumo/index.html

Centers for Disease Control and Prevention. Influenza (Flu). Accessed August 8, 2017 from https://www.cdc.gov/flu/index.htm
Centers for Disease Control and Preventions. Pneumococcal Disease. Accessed August 8, 2017 from https://www.cdc.gov/pneumococcal/vaccination.html

Recommendations for Perinatal Care

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

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

Below is a brief list of additional recommended perinatal screenings:

- 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; and
- 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.

Provider Network Contacts

Provider Relations:

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302-502-4083

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Shawn Smith
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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.