HIGHMARK Delaware HEALTH OPTIONS

September 2018

PROVIDER UPDATE

An Update for Highmark Health Options Providers and Clinicians

Provider and Clinical Updates

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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

Highmark Health Options is an independent licensee of the Blue Cross and Blue Shield Association

Coding Corner: Global Surgical Package

The Global Surgical Package is single reimbursement for all care associated with a surgical procedure. The Global Surgical Package includes the pre-operative, intra-operative, and post-operative services routinely performed by the surgeon or members of the same group within the same specialty. Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician.

There are three types of Global Surgical Packages based on the number of post-operative days:

000 – endoscopies or some minor surgical procedures with zero day post-operative period

- No pre-operative period
- No post-operative days
- Visit on the day of procedure is generally not reimbursed as a separate service

010 – other minor procedures with 10-day post-operative period

- No pre-operative period
- Visit on the day of the procedure is generally not reimbursed as a separate service
- Total global period is 11 days. Count the day of the surgery and 10 days immediately following the day of surgery.

090 – major surgeries with 90-day post-operative period

- One day pre-operative included
- Day of the procedure is generally not reimbursed as a separate service
- Total global period is 92 days. Count 1 day before the day of the surgery, the day of the surgery, and the 90 days immediately following the day of surgery.

Additional Global Surgical Package abbreviations:

- XXX – global concept does not apply
- YYY – contractor-priced codes, for which MACs determine the global period
- ZZZ – add-on codes that must be billed with another service and are always included in the global period of the primary procedure

Coding Corner: Global Surgical Package (cont.)

Services included in the Global Surgical Package:
- Pre-operative visits after the decision is made for surgery.
- Intra-operative services that are normally a usual and necessary part of a surgical procedure.
- All additional medical or surgical services required of the surgeon during the post-operative period of the surgery because of complications, which do not require additional trips to the operating room.
- Follow-up visits during the post-operative period of the surgery that are related to the recovery from the surgery.
- Post-surgical pain management by the surgeon.
- Supplies, except for those identified as exclusions.
- Miscellaneous services, such as dressing changes, local incision care, removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

Services <u>not</u> included in the Global Surgical Package:
- Initial consultation or evaluation of the problem by the surgeon to determine the need for major surgeries. This is billed separately using the modifier 57 (Decision for Surgery). This visit may be billed separately only for major surgical procedures. Initial evaluation for minor surgical procedures and endoscopies is always included in the Global Surgical Package, unless a significant, separately identifiable services is also performed. Modifier 25 is used to bill a separately identifiable Evaluation and Management (E/M) service by the same physician on the same day of the procedure.
- Services of other physicians related to the surgery, except where the surgeon and the other physician(s) agree on the transfer of care. This agreement may be in the form of a letter or an annotation in the discharge summary, hospital record, or ASC record.
- Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of the surgery.
- Treatment for the underlying condition or an added course of treatment which is not part of the normal recovery from surgery.
- Diagnostic tests and procedures, including diagnostic radiology procedures.
- Clearly distinct surgical procedures that occur during the post-operative period which are not re-operations or treatment for complications. A new post-operative period begins with the subsequent procedure.
- Treatment for post-operative complications requiring a return trip to the operating room.
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is reimbursed separately.
- Immunosuppressive therapy for organ transplants.
- Critical care services (CPT 99291 and 99292) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician.

Coding Corner: Global Surgical Package (cont.)

Global Surgery Modifiers:

Modifier	Description
24	Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Post-operative Period
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service (use with minor procedures)
54	Surgical Care Only (use when one physician performs a surgical procedure and another provides pre-operative and/or post-operative management)
55	Post-operative Management Only (use when one physician performs the post-operative management and another physician has performed the surgical procedure)
57	Decision for Surgery (use with major procedures)
58	Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Post-operative Period
76	Repeat Procedure or Service Performed by the Same Physician
77	Repeat Procedure or Service Performed by Another Physician
78	Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Post-operative Period
79	Unrelated Procedure by the Same Physician or Other Qualified Health Care Professional During the Post-operative Period

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, *MLN Booklet, Global Surgery Booklet, ICN 907166, August 2017*
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GloballSurgery-ICN907166.pdf
CMS, *Pub 100-4 Medicare Claims Processing Manual, Chapter 12* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

Correct Coding for BMI

You're Already Doing it – Get Credit For It!

Did you know that many practitioners are providing services that never get billed to insurance companies? While many codes may not be necessary for reimbursement, they can help justify medical necessity should the need arise. Insurance companies can also compile this data to better evaluate the needs of their respective populations and adjust resources accordingly.

Highmark Health Options has identified a decline in the number of provider offices submitting claims containing codes for evaluation of body mass index (BMI). Most offices measure a patient's height, weight, and BMI at every visit. However, they often forget to bill for the service.

An increased BMI is a contributing factor to a wide range of medical conditions. Highmark Health Options needs your help to identify patients that need assistance with improving their health. When you see a patient, ask your staff to bill the applicable ICD-10 codes for BMI. They range from Z68.1 – Z68.45. Doing so will help us better serve the population and care for our members.

Clinical Obesity Assessments in Children and Adolescents

At a minimum, health care providers should perform an annual assessment of weight status in all children and adolescents under their care. Assessment should include the following components:

Medical and Family History

- Identify familial risks (e.g., overweight/obesity, type 2 diabetes, high blood pressure, heart disease, high cholesterol).
- Identify underlying syndromes or secondary complications of overweight and obesity (e.g., hypothyroidism, polycystic ovarian syndrome, Prader-Willi syndrome, diabetes, sleep apnea).

Physical Examination

- Measure height and weight, calculate BMI and plot on standard growth charts (e.g., CDC BMI for Age Percentiles grids).
- Measure blood pressure.
- Inspect and examine body systems to identify underlying syndromes or secondary complications of overweight and obesity (e.g., hirsutism, dysmorphic features, slipped capital femoral epiphysis, leg bowing, acanthosis nigricans).

Dietary Assessment

- Identify eating behaviors, food intake and preferences.

Physical Activity Assessment

- Identify daily activities and exercise patterns.

Psychosocial Assessment

- Screen for depression, if indicated.
- Assess family support and readiness to change.

Laboratory Testing

Examples include, but are not limited to, fasting lipid profile, liver function tests, fasting plasma glucose and insulin levels and are based on history or exam findings. For patients 2 years of age and older, if the BMI for age and sex is:

- 5th-84th percentile (healthy weight) with no risk factors: Obtain non-fasting lipid profile for all children between the ages of 9-11 and again between 18-21.
- 85th-94th percentile (overweight) with no risk factors: Obtain fasting lipid profile.
- $\geq 95^{th}$ percentile (obese), even in the absence of risk factors: Obtain fasting lipid profile, AST, ALT, and fasting glucose.
- Any BMI with risk factors in history or physical examination: Obtain fasting lipid profile, AST, ALT, and fasting glucose.

Clinical Obesity Assessments in Children and Adolescents

Coding Guidelines

Use the following codes to bill for BMI assessment, nutrition counseling and physical activity counseling.

Component	ICD-10-CM	
BMI Percentile	BMI < 5%	Z68.51
	BMI 5% -<85 %	Z68.52
	BMI 85%-<95%	Z68.53
	BMI ≥ 95%	Z68.54

Component	ICD-10-CM	CPT®	HCPCS
Nutrition Counseling	Z71.3	97802, 97803, 97804	G0270, G0271, G0447, S9449, S9452, S9470
Physical Activity Counseling	Z02.5, Z71.82		G0447, S9451

Material adapted from the American Academy of Pediatrics Institute for Healthy Childhood Weight "Algorithm for the Assessment and Management of Childhood Obesity in Patients 2 Years and Older." 2015.

Breast Cancer Screening

Each October, we are reminded of the impact that breast cancer has in the United States, for both victims and their families. According to the American Cancer Society, breast cancer is the most common type of cancer in the United States and the fourth leading cause of cancer death[1]. In fact, it is estimated that one in eight American women will be diagnosed with breast cancer at some point in their lives[1].

Despite being so prevalent and receiving nationwide attention, many women still worry about screening for breast cancer. Notably, there is concern about false positives that lead to unnecessary biopsies - a topic that has been in the news recently. To complicate matters further, a review of available research has shown that estimates of over-diagnosis ranges from zero to 54 percent[2]. As a result, it is difficult to truly understand women's chances of receiving a false positive when discussing risks with patients.

One thing that is certain, however, is that there is a small, but real, chance of saving a woman's life through regular breast cancer screening. That benefit must be weighed against any risk of a false positive and the decision to screen should be discussed with your patient. Regular screening is a great way to improve your patients' lives.

Breast Cancer Screening is also a measure that impacts HEDIS rates. It's defined as the number of women 52 - 74 years of age as of December 31st of the measurement year who have received one or more mammograms since October 1st two years prior to the measurement year. Women who have had both breasts surgically removed are excluded from the measure.

There are several ways that you can get more patients screened and improve your HEDIS rates:

- Create alerts or flags in the medical record that remind staff who interact with a patient to discuss breast cancer screening.
- Ask your patients if they have already had a mammogram that was ordered by another physician and get a copy to include in their medical record.
- Use other preventive appointments, such as well visits or annual flu shots, as an opportunity to discuss breast cancer screening.
- Offer scheduling or referral assistance to patients. You can even have standing referrals created for staff to provide patients while they are in the office.
- Come up with a schedule for screening that you can share with the patient. Having a schedule can help the patient plan for future appointments.

October is Breast Cancer Awareness Month. This is a good time to evaluate processes in your practice to determine what is and isn't working. In the end, small changes could make a big difference in your patients' lives.

1. American Cancer Society. Cancer Facts & Figures 2017. Atlanta: American Cancer Society; 2017.
2. Nelson HD, Pappas M, Cantor A, Griffin J, Daeges M, Humphrey L. Harms of breast cancer screening: systematic review to update the 2009 U.S. Preventive Services Task Force recommendation. *Ann Intern Med.* 2016.

Appointment Standards

PCP or Specialist		
Appointment Type	**Example**	**Appointment Standard**
Emergency Care	High temperature, persistent vomiting or diarrhea or symptoms which are of sudden or severe onset but which do not require emergency room services.	Available the same day
Urgent Care	Persistent rash, recurring high-grade temperature, non-specific pain or fever.	Seen within 2 calendar days
Routine Care	Psoriasis, treatment of chronic conditions such as chronic back pain.	Seen within 21 days
Appointment standards below apply to OB/GYNs or PCPs who provide prenatal care		
First trimester visit	Initial visit	Within 3 weeks
Second trimester visit	Initial visit	Within 7 calendar days
Third trimester visit	Initial visit	Within 3 calendar days
High risk pregnancy	Initial visit	Within 3 calendar days
	Emergency Exists	Immediately
Additional Office Standards for PCP or Specialist		
Wait time in waiting room for routine care	Providers will not make a patient wait longer than one hour. Office visits can be delayed when a provider "works in" urgent cases, when a serious problem is found, or when a patient had an unknown need that requires more services or education than was described at the time the appointment was made. If a physician or provider is delayed, patients must be notified as soon as possible so they know the delay. If the delay results in more than a 90 minute wait, the patient must be offered a new appointment.	

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**" will be sent to about 5,000 diabetic members meeting the HEDIS criteria.

The "**My Diabetes Report Card**" is an educational tool providing information on medications, as well as dates and results for diabetes-related labs/exams. The report card will be sent to about 5,000 identified members (ages 18-75 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 the most recent result of A1C and LDL-C. The **"My Diabetes Report Card"** also informs about medications that are 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.

2018 Provider Satisfaction Survey

Highmark Health Options continually strives to meet and exceed the needs of our provider network. Please let us know how we can better serve you by completing the Provider Satisfaction Survey you will soon receive. Your feedback and recommendations will be used to develop future improvement.

Oral Health Care for Attendant Care Providers

According to a collaborative study between the Division of Public Health, Bureau of Oral Health and Dental Services, and the University of Delaware (Center for Disabilities Studies), poor oral health and periodontal disease are correlated to: diabetes, respiratory infections, pneumonia, and cardiovascular disease. Many members in the Long Term Services and Supports (LTSS) Case Management program at Highmark Health Options receive assistance with ADLs through an attendant care agency. The care provided by an attendant helps to ensure that patients receive adequate oral healthcare thereby decreasing serious dental problems and risks to overall health.

What you can do to help:
Assess whether or not a member needs assistance with oral health. This can include set-up of utensils, supervision and queuing, or hands on assistance.

Document on the plan of care that oral healthcare assistance is an intervention.

Make sure the member has a copy of their plan of care and that it is kept in a convenient location.

How we can help:
The Highmark Health Options LTSS Case Managers conduct quarterly home visits and review the attendant care provider's plan of care. They are specifically looking to see if there are any oral health interventions.

If you notice any issues please feel free to reach out to our case managers. We are here to help and to ensure that our members get the very best care possible!

Highmark Health Options is committed to providing the best possible care to your patients, our members. During 2018, we will continue to educate our providers on the importance of oral care and its benefits. Informational provider forums will be scheduled in the fall to discuss more about this initiative. We encourage you to attend one of these important sessions.

Provider Network Contacts

Provider Relations:

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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.