HIGHMARK. Delaware HEALTH OPTIONS

Summer 2020

PROVIDER UPDATE

An Update for Highmark Health Options Providers and Clinicians

THIS ISSUE

Page

PROVIDER UPDATES

Important Phone Numbers

CULTURAL COMPETENCY TRAINING AND TOOLKIT

Highmark Health Options understands that to improve the quality of life of our members, we must be cognizant of their cultural and linguistic differences. A collaborative and trusting patient-provider relationship is the key to reducing the gaps in healthcare access and outcomes. Highmark Health Options has assembled a list of resources and web-based tools that are intended to help build sensitivity to the cultural and linguistic differences and foster improved understanding and communication.

If you or your staff would like to gain a better understanding of how cultural issues can impact healthcare and healthcare outcomes, please use our Cultural Competency Toolkit as a jumping off point. We have done the research for you and have a wealth of information that will help you gain a better understanding of cultural competency and health equity.

Please take ten minutes to review our Cultural Competency Training Power Point.

Next, learn more by visiting our Resource Center to learn more about health care disparities, office assessment tools, downloadable communication tools and continuing medical education courses.

Once you've checked out our resources, please complete the Cultural Competency Attestation, and we will acknowledge your cultural competency training in our provider directory. If you've already completed a Cultural Competency Training Course, please let us know by completing the Cultural Competency Attestation and we will acknowledge your training in our provider directory.

CODING CORNER

Use of CMS NCDs and LCDs

When no applicable State or Highmark Health Options policy, guidance or regulation exists for determining the coverage criteria for procedures and services, Highmark Health Options follows Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and LCD articles when determining medically necessary diagnoses. These determinations define coverage criteria with a list of CPT, HCPCS, and/or ICD-10-CM codes that are approved.

If a procedure or service is submitted without an appropriate diagnosis code on the claim, then the procedure or service will be denied. Likewise, if a DME HCPCS code is submitted without an appropriate diagnosis code on the claim, then the DME HCPCS code will be denied.

The CMS Coverage Data Base and Advanced Search for NCD, LCD, and Articles may be found at this link: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx

Durable Medical Equipment (DME) related LCDs may be found in the same place on the Noridian website: https://med.noridianmedicare.com/web/jadme/policies/lcd/active

CMS Medicare National Coverage (NCD) Coding Policy Manual and Change Report for Clinical Diagnostic Laboratory Services is updated quarterly and may be found at this link: https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/LabNCDsICD10

MEDICAL RECORD REVIEW PROCEDURE

Medical Record Review (MRR) Standards have been adopted by the Highmark Health Options Quality Improvement/Utilization Management (QI/UM) Committee. Medical Record Review Standards have been developed for:

- PCPs
- Specialists, and
- Behavioral Health Providers.

The importance of having standards is to verify that providers are:

- Aware of the expected level of care and associated documentation;
- Aware of the requirements for maintenance of confidential medical information and record keeping; and
- Assured that medical records are being evaluated in a consistent manner.

The QI/UM Committee has established the scoring standard of 80% for the MRR Standards. If the score of 80% has not been met for MRR, a follow-up review will be scheduled to assess improvement. Providers are notified of their results and any areas of deficiency by letter within forty-five (45) calendar days of the review. Repeatedly failing to meet a performance score of 80% may lead to initiation of corrective action, up to and including termination from the Plan.

Medical records for this review are obtained directly from the provider and may be reviewed at the provider's location (on-site review) or sent to Highmark Health Options for a desk-top review. If you have been chosen for an MRR, someone from Highmark Health Options will reach out to you this summer.

EPSDT NEWS AND UPDATES

Referral Tracking

Federal requirements mandate that all State Medicaid plans ensure that their members are provided "healthcare, treatment and other measures to correct or ameliorate any defects and chronic conditions discovered."

Highmark Health Options is committed to ensure that our members have timely evaluation and any necessary treatment as a result of positive screening and/or assessment by a physician. In order to accomplish this, we require the coding of any referrals made during a visit on the claim submitted for office visit.

What is needed?

Below are the appropriate codes to indicate a referral to another provider.

Vision	Hearing	Dental	Medical	Behavioral	Other
YV	YH	YD	YM	YB	YO

Where does the code get recorded?

The code should be recorded on the claim for service in which referral was made, box 19 on the paper claim form CMS-1500. If you are using electronic medical claims, you will need to check with your IT staff to find the equivalent on an electronic claim. If you have questions, please reach out to Kim York, EPSDT Coordinator, at 302-317-5944 or Kimberly.York@Highmark.com.

Next WebEx for Pediatric Providers

There will be a Pediatric Immunizations WebEx in Fall 2020. A Save the Date will be coming soon!

OVERCOMING THE STIGMA OF NALOXONE PRESCRIBING

Some patients with chronic pain benefit from opioid treatment, but these medications carry certain risks, including respiratory depression. Co-prescribing naloxone for patient safety is an important tool for physicians. How do you explain the safety benefits of naloxone to patients without the stigma that overdose carries? Dr. Philip Coffin, MD director of substance use research at San Francisco Department of Public Health has a few tips.

How to Talk to Your Patients About Naloxone

Routinely co-prescribing naloxone is important not just for patients that physicians think may overdose, but also for safeguarding others who may have access to these medications. So, it's important to frame the the conversation with patients and emphasize that opioid medications carry certain risks, not that the patient's themselves are risky. This helps reduce the stigma and helps make patients feel like they are not being targeted or somehow accused of being out of control with their medications.

Dr. Coffin considers these three important things when co-prescribing naloxone:

1. **Talking about overdose.**

   The word "overdose" to a patient and too many providers, means injecting heroin or taking a whole bottle of pills. But, that's not what the medical system means when talking about overdose with opioids. So, it's critical not to start out the conversation with the word "overdose". What the medical system means is that there are more opioids in the body at a given time than your body can handle. So, it may mean a patient has sleep apnea and if they stop using the C-PAP machine, the opioids they take may suppress their respiration too much for them to breath enough at night and patient could effectively overdose. It may also mean that a young family member may get into the medicine cabinet and accidentally take the medicine and overdose. Emphasis on the fact that these are risky medications and the importance of having an antidote nearby is key.

2. **The risks involved.**

   Many times, patients do not really hear risks involved with opioid use. When you pair the conversation with an actual prescription for naloxone and with an actual intervention, it helps to impress upon the patient that the physician's goal in working with patients with opioids is to maximize patient safety and well-being.

OVERCOMING THE STIGMA OF NALOXONE PRESCRIBING, *cont.*

3. **Who should get naloxone?**

   There are two contexts in the distribution of naloxone. One is distribution to users through the needle exchange programs. This is where it's most likely to be used to reverse overdose. The next is co-prescribing naloxone to patients. Many times these patients who are prescribed opioids perceive their risk of overdose to be low or non-existent. Many patients that do overdose perceive the event as an adverse drug reaction to their medications. When naloxone is co-prescribed, it helps the physician address the broader topic of opioid issues.

Training for Providers

CDC launched two (2) new opioid trainings that support providers in the safer prescribing of opioids for chronic pain. The modules are part of a series of interactive online trainings that feature recommendations from the CDC Guideline for Prescribing Opioids for Chronic Pain. The seventh module, Determining Whether to Initiate Opioids for Chronic Pain, helps providers identify and consider important patient factors when starting or continuing opioid therapy, while the eighth module, Implementing CDC's Opioid Prescribing Guideline into Clinical Practice, walks providers through a quality improvement (QI) process using a set of 16 clinical measures outlined in the Quality Improvement and Care Coordination: Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain. Both modules include clinical scenarios and tools, and a resource library to enhance learning.

These and all the modules in the series offer free continuing education, available on CDC's Training for Providers webpage: https://www.cdc.gov/drugoverdose/training/

References

1. Parks, T. (2016, June 3). *AMA*. Retrieved from AMA.org: https://www.ama-assn.org/delivering-care/opioids/antidote-3-things-consider-when-co-prescribing-naloxone

RECOGNIZING AND REPORTING QUALITY OF CARE AND QUALITY OF SERVICE CONCERNS

Highmark Health Options is committed to ensuring that our members receive safe, effective, and quality care and services. To achieve the best health outcomes for members, we monitor, investigate and track all quality of care concerns and issues.

A Quality of Care (QOC) concern may be related to quality of care as well as quality of services provided. A QOC issue occurs when care provided to a member places his/her health or life in jeopardy due to the action, or lack of action, by a provider or when care provided does not meet national or local standards of care, or is not consistent with current professional knowledge. Examples of a QOC concern include delay in treatment, equipment failure resulting in a negative outcome, and medication error.

When a concern arises, Highmark Health Options conducts a medical record review and analyzes our findings prior to determining a resolution. We refer suspected or actual QOC findings to our Medical Director for actions which may include gathering a provider response, provider education, corrective action plan, or peer review. We may need to notify other areas as needed such as the Credentialing and Fraud and Abuse departments, or the State.

We carefully track and trend our QOC concerns, identify process improvements, and report confirmed findings to the QI/UM Committee and the Committee's Board of Directors.

It is important for providers to report their QOC concerns to Highmark Health Options. Anyone can report a QOC concern by contacting Provider Services at 1-844-325-6251 or fax your QOC concern to our QI department. A QOC reporting form is available at: https://www.highmarkhealthoptions.com/Provider/Provider-Resources/Forms-and-Reference.

FDA: SINGULAIR TO GET 'BLACK BOX' WARNING

THURSDAY, March 5, 2020 — Asthma and allergy drug montelukast - sold as a generic and under the brand name Singulair - received a "boxed warning" over potential ties to neuropsychiatric effects, the U.S. Food and Drug Administration announced Wednesday.

The drug has long carried a warning that it has been linked with an increased risk for "agitation, depression, sleeping problems, and suicidal thoughts and actions," the FDA said in a statement. The agency's move Wednesday elevates that advisory to its most prominent boxed warning. The new warning advises healthcare providers to "avoid prescribing montelukast for patients with mild symptoms, particularly those with allergic rhinitis." Added to the boxed warning, patients who are prescribed montelukast will also get a special medication guide outlining potential risks.

The first such warning added to montelukast labeling came in 2008 after reports of suicide and other serious psychiatric events were reported in users. The agency has since tracked and compiled data linking mental health issues with use of the drug, and a summary was presented at an FDA advisory committee meeting last year. Based on the committee's assessment, "the FDA determined the risks of montelukast may outweigh the benefits in some patients, particularly when the symptoms of the disease are mild and can be adequately treated with alternative therapies," the agency said.

Data accumulated since then prompted the upgrade, the agency said; these were reviewed in a separate safety communication posted Wednesday. Analysis of the FDA's ADVERSE Event Reporting System from 1998 (when the drug was first approved) to 2019 identified 82 cases of completed suicide in patients using the drug. In 64 of these for which the patient's age was known, 19 were in children and teens younger than 18.

Yet data from the FDA's Sentinel System from 2010 to 2015 did not support increased risks of psychiatric events when use of montelukast was compared to inhaled corticosteroids. Among some 450,000 asthma patients older than six, there were no significant increases in risks for inpatient depressive disorder or self-harm. The analysis also showed decreased risk for treated outpatient depressive disorder with montelukast versus inhaled steroids (HR 0.91, 95% CI 0.89-0.93). The Sentinel study did have a number of limitations, however.

Still, the anecdotal reports plus animal studies indicating that montelukast crosses the blood-brain barrier persuaded the FDA that a stronger warning is needed.

FDA: SINGULAIR TO GET 'BLACK BOX' WARNING, *cont.*

"Due to the wide availability of alternative safe and effective allergy medicines with long histories of safety, we have reevaluated the risks and benefits of montelukast and have determined it should not be the first-choice treatment particularly when allergic rhinitis symptoms are mild," the agency stated. "In addition, many healthcare professionals and patients/caregivers are not aware of the risk of mental health side effects despite the existing warnings in the prescribing information." The agency is also requiring manufacturers to provide new patient medication guides.

To help FDA track safety issues with medicines, report adverse events involving montelukast or other medicines to the FDA MedWatch program:

Contact FDA For More Info
855-543-DRUG
(3784) and press 4
druginfo@fda.hhs.gov

References

1. Gever, J. (2020, March 4). *Medpage Today*. Retrieved from Medpage Today: https://www.medpagetoday.com/allergyimmunology/allergy/85239

2. Richards, M. (2020, March 4). *FDA*. Retrieved from FDA: https://www.fda.gov/news-events/press-announcements/fda-requires-stronger-warning-about-risk-neuropsychiatric-events-associated-asthma-and-allergy

RECOMMEND TARGET STATIN DOSES AND CONSIDER LDL AFTER A STROKE

New evidence will spark questions about **whether to aim for an LDL goal in patients with a prior ischemic stroke or TIA.**

For several years, it's been recommended to use target DOSES of statins shown to reduce CV risk, rather than titrating to an LDL goal.

Now data suggest treating to an LDL below 70 mg/dL instead of about 95 mg/dL prevents a recurrent CV event in about 1 in 42 ischemic stroke or TIA patients treated for 3.5 years.

This is in patients on statins, plus ezetimibe if needed to reach their LDL target.

Consider this evidence more support for recent cholesterol guideline changes that bring back some emphasis on LDL for high-CV-risk patients.

Continue to recommend a high-intensity statin (atorvastatin 80 mg/day, etc) for most stroke patients.

But don't advise a "fire and forget" approach. Advise checking an LDL 4 to 12 weeks after starting the statin and then about annually.

Evaluate adherence to lifestyle changes and statins if LDL stays above 70 mg/dL since many patients need help sticking with a statin.

Recommend adding a non-statin if that's not enough especially in stroke patients with CV risks, such as high BP, diabetes, or smoking.

References:

1. N Engl J Med Published online Nov 18, 2019; doi:10.1056/NEJMoa1910355
2. J Am Coll Cardiol 2019;73(24):e285-e350
3. Stroke 2014;45(7):2160-236

UNDERSTANDING GAPS IN CARE FOR LTSS MEMBERS

A "gap in care," also referred to as a gap in in-home services, is defined as "the difference between the number of hours of in-home services approved in a member's plan of care services and the number of hours of the in-home service that are actually delivered to the member" (MCO Master Service Agreement 3.7.2.4.21). In short, a gap in care is when a member is without an approved service due to the provider not being available or when a member goes without care.

Methods used to ensure service delivery include educating the member about his or her role around service expectations, establishing clearly defined responsibilities of the Case Manager and providers, and monitoring providers for timely and appropriate delivery of services. Additionally, LTSS members are required to have a back-up plan for each LTSS service identified on the Plan of Care. The backup plan is developed to address any gaps in care in the event a provider reports an interruption in the service plan such as missed or late services. This backup plan identifies an alternate informal caregiver who will provide care when a provider is unable to.

Providers should report an identified interruption in services to the member, to the LTSS Support Center Member Associate, and/or to the member's Case Manager as soon as possible. This allows the Case Manager and/or Member Associate to work closely with the member to provide an explanation for the service interruption in a timely manner, to ensure the backup plan is implemented to avoid a gap in care, and to prevent any negative impact to the member if a gap in care occurs. If an unforeseeable service interruption occurs, the member can choose to receive the service at an alternative date/time from the regular provider.

The following situations are not considered gaps in care:

- Member is not home to receive care when the provider arrives at the scheduled time.
- Member refuses to allow the provider in the home.
- Member refuses services.
- Provider/agency is able to find a replacement.
- Member and provider/agency agrees to re-schedule all or part of services in advance.
- Provider/employee refuses to return to the member's home due to unsafe or threatening environment.

Case Managers and Member Associates are responsible for tracking gaps in care for reporting purposes. When a gap in care is reported or identified, the approved total weekly service hours and the total number of hours missed is documented in the member's electronic medical record and reported to DMMA on a monthly basis.

PREVENTING AND MANAGING HYPOGLYCEMIA IN PATIENTS WITH DIABETES

Hypoglycemia is a serious concern in patients with diabetes. Hypoglycemia can cause irreversible cognitive impairment, dementia, falls, vehicular accidents, other injuries, and death. The table below addresses common clinical questions about hypoglycemia in patients with diabetes.

Abbreviations: ADA = American Diabetes Association; IM = intramuscular; SC = subcutaneous

Clinical Question	Suggested Approach or Resource
Which patients are at highest risk of hypoglycemia?	**Patients with Type 1 diabetes (highest risk)** • Risk factors for severe hypoglycemia include prior episode of severe hypoglycemia, A1C <6%, hypoglycemic unawareness, long duration of diabetes, autonomic neuropathy, younger age (i.e., too young to recognize and self-treat mild hypoglycemia, or adolescent), intensive glycemic control Patients with type 2 diabetes using insulin or **sulfonylurea** (lower risk), especially with: • Severe cognitive impairment, older age, low health literacy, food insecurity, poor glycemic control, hypoglycemic unawareness, long duration of insulin therapy, chronic kidney disease, or neuropathy, intensive glycemic control, bariatric surgery **Certain medications may affect perception or response to hypoglycemia:** • Beta-blockers, especially non-cardioselective agents: may blunt adrenergic symptoms (e.g., anxiety, palpitations, sweating, shaking) and impair counter regulatory response. Patients can still feel faint, dizzy, confused, sleepy, weak or irritable, or have problems with speech or vision. They might also have a headache. • SSRIs may alter perception of hypoglycemic symptoms
What are the symptoms of hypoglycemia?	**Symptoms can be classified as autonomic (neurogenic) or neuro-glycopenic:** • Autonomic: shakiness, tachycardia, sweating, anxiety, hunger, nausea, tingling • Neuro-glycopenic: difficulty concentrating or speaking, confusion, weakness, dizziness, drowsiness, headache, vision changes

PREVENTING AND MANAGING HYPOGLYCEMIA IN PATIENTS WITH DIABETES, *cont.*

Clinical Question	Suggested Approach or Resource
What resources are available to help educate patients about hypoglycemia?	**From the American Diabetes Association:** • Hypoglycemia (Low Blood Sugar): https://www.diabetes.org/diabetes/medication-management/blood-glucose-testing-and-control/hypoglycemia
How can hypoglycemia be prevented?	Patients should be educated to manage situations that put them at risk of hypoglycemia: fasting, delayed meals, alcohol use, exercise, or sleep. For example: • Patients should be educated about adjusting insulin use and carbohydrate intake for exercise. • Patients on intensive insulin should periodically check nighttime finger sticks at a time corresponding to peak overnight insulin effect, to identify need for regimen change. In at-risk patients, ask about hypoglycemia at each visit. Choose a pre-prandial glucose target that balances glycemic control and risk of hypoglycemia: 80 to 130 mg/dL (4.4 to 7.2 mmol/L) [Evidence level B-3]. Re-think the treatment regimen if the patient experiences hypoglycemia unawareness or level 3 hypoglycemia. For insulin-treated patients with hypoglycemia unawareness, or an episode of level 2 hypoglycemia, target glucose should be increased to avoid hypoglycemia for several weeks to three months to help restore awareness. Prescribers, the patient, and caregivers should monitor cognitive function. Consider continuous glucose monitoring for appropriate patients. Be watchful for medications that might cause hypoglycemia (e.g., quinolones, tramadol).

PREVENTING AND MANAGING HYPOGLYCEMIA IN PATIENTS WITH DIABETES, *cont.*

Clinical Question	Suggested Approach or Resource
What is the general approach to treatment of hypoglycemia?	If the patient is conscious, give glucose 15 to 20 g (20 g if severe) if blood glucose <70 mg/dL (4 mmol/L). Repeat glucose 15 g in 15 minutes if blood glucose still <70 mg/dL (4 mmol/L). If the patient is unconscious, or unwilling to cooperate with oral intake, give glucagon. If intravenous access is available, give 20 to 50 mL of D50W (i.e., 10 to 25 g of glucose) over one to three minutes. • It may take five to 15 minutes for the patient to regain consciousness after glucagon administration. Turn the patient on their side; they may vomit. Call 911. Glucagon may be repeated while waiting for emergency help. Once hypoglycemia is reversed, the patient should eat their usual meal, or snack if the usual mealtime is >1 hour away.2 The snack should consist of 15 g carbohydrate plus protein (e.g., seven crackers plus a piece of cheese, or a slice of bread plus two tablespoons of peanut butter). Patients taking acarbose (Precose [U.S.]) or miglitol (Glycet) must use glucose tablets, one cup of non-fat milk, or one tablespoon honey.
Which patients should have glucagon on hand?	All patients at risk of level 2 hypoglycemia should have unexpired glucagon on hand. • The patient's caregiver or frequent contacts (e.g., family, friends, school personnel, roommate, coworker, and correctional officer) should be told where it is and how to use it.

Severity of Hypoglycemia

American Diabetes Association
Level 1: glucose <70 mg/dL (4 mmol/L) but ≥54 mg/dL (3 mmol/L). Considered clinically important, even if asymptomatic.
Level 2: glucose <54 mg/dL (3 mmol/L]
Level 3: severe episode with impaired mental or physical function requiring assistance. Risk of seizures, unconsciousness, and death.

PREVENTING AND MANAGING HYPOGLYCEMIA IN PATIENTS WITH DIABETES, *cont.*

References:

1. Standards of medical care in diabetes – 2019. *Diabetes Care* 2019;42(Suppl 1):S1-193.
2. Diabetes Canada Clinical Practice Guidelines Expert Committee. Diabetes Canada 2018 practice guidelines for the prevention and management of diabetes in Canada. *Can J Diabetes* 2018;42(Suppl 1):S1-S325.
3. Wei N, Zheng H, Nathan DM. Empirically establishing blood glucose targets to achieve HbA1c goals. *Diabetes Care* 2014;37:1048-51.
4. American Diabetes Association. Hypoglycemia (low blood sugar). https://www.diabetes.org/diabetes/medication-management/blood-glucose-testing-and-control/hypoglycemia. (Accessed September 1, 2019).
5. Diabetes Canada. Hypoglycemia low blood sugar in adults. https://www.diabetes.ca/diabetescanadawebsite/media/managing-my-diabetes/tools%20and%20resources/hypoglycemia-low-blood-sugar-in-adults.pdf?ext=.pdf (Accessed September 1, 2019).

LINKS TO WELLNESS PROGRAMS AND SERVICES

Highmark Health Options has links to our Lifestyle Management Programs and Wellness Services. Tell your patients about our website or click on the image below for a sneak peek to learn how we are supporting our members.

Also, search our Community Resource Connection page. This list can help you and/or your patients find local services for wellness, screenings, domestic violence, food banks, housing, legal aid, you name it. You can also make suggestions! Go to the Highmark Health Options Community Resource Connection and check out the helpful resources around the state, or around the corner. This page is password protected within the member portal, so your patients (our members) will need to create a member account if they don't already have one.

Partnering in Care Management

Did you know we are here to partner with you to provide comprehensive Case Management Services for all eligible members? Our goal is to work with you to assist our members, your patients, achieve optimal healthcare outcomes. Our multidisciplinary team is available to address member issues in specialty areas such as women's health, chronic conditions, i.e., asthma, congestive heart failure, diabetes, Crohn's Disease, COPD, hypertension, etc., as well as mental health and substance abuse.

We utilize a team of non-clinical and clinical staff to address our member's issues, whether it is linkage to services, community resources, ongoing disease education and/or management. Our clinicians provide Lifestyle Management/Disease/Condition specific education, address preventative health issues, and complete medication reconciliations. Our Care Management Team can partner with you to reduce Emergency Department usage, impact re-hospitalizations, improve adherence with medication compliance, and support a plan of care for your patients, bridging them to healthy outcomes.

The Care Coordinators and members communicate and work in partnership toward achieving the member's heathcare goals via the Highmark Health Options *Patient Self-Management Guide*. This guide promotes Care Coordinator/member discussion and helps establish a collaborative relationship.

Your role as a provider in the Care Management Program is *imperative*. If you identify a member that may benefit from this program, you may make a referral by contacting our Care Coordination Department at: **1-844-325-6251.**

Highmark Health Options welcomes all referrals to this program; we will stratify each member based on the member's unique needs. Your patient will be assigned to our designated staff who will follow-up in an effort to impact the member's health and well-being as proactively as possible.

LIFESTYLE MANAGEMENT/WELLNESS PROGRAMS

Highmark Health Options' Lifestyle Management/Wellness Programs include population-based disease management/lifestyle programs that focus on improving the health status of Highmark Health Options members with health issues and/or chronic conditions. Our Lifestyle Management/Wellness Programs provide patient education and self-empowerment for medication, diet, and lab adherence to reduce inpatient and emergency room utilization.

	Asthma	Cardiac	COPD	Diabetes	Healthy Weight Management & Diabetes Prevention	Maternal Outreach Management (MOM) Options
Eligibility	Ages two and older with asthma	Ages 21 and older with primary cardiac condition which may include: CAD, MI, IVD, A-Fib or CHF, HF and/or stroke	Ages 21 and older with COPD	All ages with Diabetes: Type 1 or Type 2	Adults and children - Body Mass Index (BMI): *Adults >25 *Children 3 or older: > 85th% *Learn if your patient may be able to partticipate in our Diabetes Prevention Program (18 & older) YMCA Partnership*	Pregnant women
Contact Referrals and Information	Highmark Health Options Care Coordination **1-844-325-6251**					

LIFESTYLE MANAGEMENT/WELLNESS PROGRAMS, *cont.*

	Asthma	Cardiac	COPD	Diabetes	Healthy Weight Management & Diabetes Prevention	Maternal Outreach Management (MOM) Options
Description	• These 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				*"My Healthy Weight Pledge"* This program provides education & access for preventative and treatment services for adults and children in an effort to improve individual healthy weight & ongoing weight management	This prenatal program offers care coordination to reduce low birth weight, pre-term deliveries, and neonatal intensive care unit (NICU) admissions
Provider Benefits and Support	Highmark Health Options' Lifestyle Management/Wellness 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 emergency department (ED) visits					
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!*				Identified through claims, utilization management, pharmacy, care management, member self-referrals and provider referrals	Provider submission of the Obstetrical Needs Assessment Form (ONAF) helps identify high-risk women in need of interventions

LIFESTYLE MANAGEMENT/WELLNESS PROGRAMS, *cont.*

	Asthma	Cardiac	COPD	Diabetes	Healthy Weight Management & Diabetes Prevention	Maternal Outreach Management (MOM) Options
Coordination of Care	Care Coordinators can assist you and your patients with coordination of care for specialist visits, home health, behavioral health, durable medical equipment and community referral needs.					
Web-Based Tools	Go to: www.highmarkhealthoptions.com					
Referral Source to Help Members Quit Tobacco	Refer patients to the toll-free Delaware Tobacco Quitline at **1-866-409-1858** or have them visit https://www.quitnow.net/mve/quitnow?qnclient=delaware					

STATEMENT OF MEMBERS' RIGHTS AND RESPONSIBILITIES

The organization's member rights and responsibilities statement specifies that members have:

1. A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.

2. A right to be treated with respect and recognition of their dignity and their right to privacy.

3. A right to participate with practitioners in making decisions about their health care.

4. A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.

5. A right to voice complaints or appeals about the organization or the care it provides.

6. A right to make recommendations regarding the organization's member rights and responsibilities policy.

7. A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.

8. A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.

9. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

IMPORTANT ANNOUNCEMENT – APPEALS AND GRIEVANCES DEPARTMENT

Effective July 5th, 2020 there will be changes to the contact information for both Member Appeals & Grievances and Clinical Appeals submissions. The changes are as follows:

	CURRENT CONTACT	*NEW CONTACT – EFFECTIVE 7/5/2020*
Member Appeals & Grievances Fax Number	412-255-4503	833-841-8074
Provider Clinical Appeals Fax Number	855-501-3904	833-841-8075
Mailing Address	PO BOX 22278, Pittsburgh, PA 15222	PO BOX 106004 Pittsburgh, PA 15230

The phone numbers to speak with a representative will not change. Please continue to use the following methods to reach an agent with questions or to initiate a request:

- Member Services (Non-LTSS): 1-844-325-6251
- Member Services (LTSS): 1-855-401-8251
- Provider Services: 1-844-325-6251
- Member Advocates: 1-855-430-9852

There will be no changes to the processing times or exchange of information. If you have any questions or concerns about these changes, please reach out to Provider Services or your Provider Network Contact.

PROVIDER NETWORK CONTACTS

Provider Relations:

Desiree Charest - Sussex County
Provider Account Liaison
**includes servicing of LTSS Providers*
Desiree.Charest@highmark.com
302-217-7991

TBD - All Counties
Provider Account Liaison
Ancillary Strategy
Contact Provider Services at 844-325-6251

Nikki Cleary- All Counties
Provider Account Liaison for Hospitals and Ambulatory Surgery Centers
Nikki.Cleary@highmark.com
302-502-4094

Chandra Freeman – Kent County and City of Newark
Provider Account Liaison
**includes servicing of LTSS Providers*
Chandra.Freeman@highmark.com
302-502-4067

Christina Hales – New Castle County Provider Account Liaison
**includes servicing of LTSS Providers*
Christina.Hales@highmark.com
302-421-2542

Tracy Sprague
Provider Account Liaison/Provider Complaints
Tracy.Sprague@highmark.com
302-502-4120

Paula Victoria
Manager, Provider Relations, LTSS
Paula.Victoria@highmark.com
302-502-4083

Provider Contracting:

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