HIGHMARK HEALTH OPTIONS

Quarterly Update for Providers

Fall 2022

In this newsletter:

Review the 2022 clinical practice guidelines.

2022 Member experience survey results.

Check out the updates on Bright Futures periodicity schedule.

Interpretation and translation services for patients.

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Contact us.

Highmark Health Options Provider Services is the first line of communication for providers' questions and inquiries. Provider Services is available Monday–Friday, 8 a.m.–5 p.m., and can be reached by calling 1-844-325-6251 or emailing hho-depsresearch2@highmark.com.

Review the 2022 clinical practice guidelines.

To support providers, Highmark Health Options (HHO) monitors industry changes that affect clinical practice guidelines. These guidelines outline appropriate health care for specific clinical conditions that may be relevant to patients. However, when it comes to taking care of patients, provider judgment and knowledge of an individual patient supersedes clinical practice guidelines.

The Quality Improvement and Utilization Committee reviews clinical practice guidelines before distributing them to providers. The committee reviews to see if these guidelines are:

- Developed using evidence-based clinical practice guidelines from recognized sources in the profession and industry.
- Provided to improve health care quality by promoting peer-reviewed standards of care and best practices.

Find a complete listing of HHO clinical practice guidelines online.

Colorectal cancer screening and early detection are important.

Regular screenings can help prevent many colorectal cancers. Screenings can find precancerous polyps so that they can be removed before they turn into cancer. The best screening test available for colorectal cancer is a colonoscopy. It is the only screening test that can detect many colorectal cancers.

When performing a colonoscopy:

- Ensure patients have received instructions on what to eat and how to empty their bowels.
- Examine the lining of the entire colon to check for polyps or tumors. Remove any found polyps.

Recommend patients start having colonoscopies at age 45, regardless of gender. Patients with an increased risk of colorectal cancer may have a screening earlier.

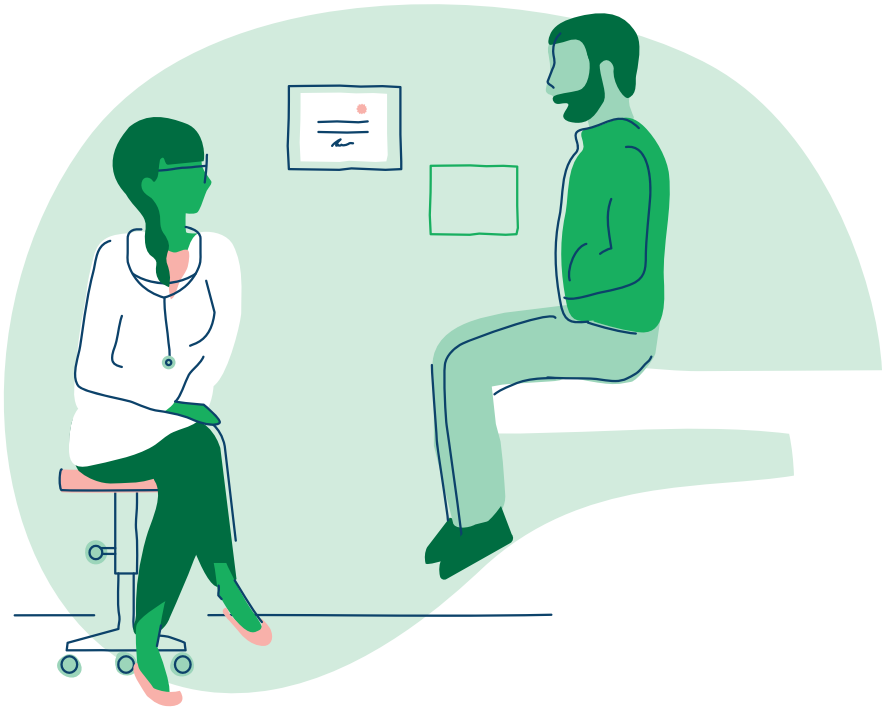
Colorectal cancer is caused by an uncontrolled division of abnormal cells in the colon or rectum. It is the third most common cancer in the United States, and it occurs most often in people age 50 and older. Screening is important because colorectal cancer is highly treatable when found early.

Colorectal risk factors

- Age
  - Colorectal cancer is more common in people age 50 and older.
- Personal and family history
  - Patients at an increased risk of colorectal cancer include those who:
    - Have a parent, sibling, or child with colorectal cancer, especially if the family member was diagnosed before age 60.
    - Have had colorectal cancer are higher risk of recurrence.

- Race
  - Black and African American individuals are at higher risk. The reasons for this are not fully understood.
  - Jewish people of eastern European descent are at higher risk. About 6% have DNA changes that increase their risk of colorectal cancer.
- Inflammatory bowel disease (IBD)
- IBD, which includes ulcerative colitis and Crohn's disease, puts patients at a higher risk of developing colorectal cancer
- Lifestyle
  - Being overweight, having an inactive lifestyle, eating a diet high in red meat and processed meat, smoking and drinking alcohol can increase the risk of colorectal cancer.

Providers with questions on colorectal screenings can contact Quality at 1-844-325-6251.



2022 Member experience survey results.

The 2022 Consumer Assessment of Healthcare Providers and Systems (CAHPS) results have arrived. Every year, Highmark Health Options members are selected at random and surveyed about their health care experience. The survey results highlight what members find most satisfying about their health care and offer insights into opportunities for improvement.

For the 2022 CAHPS survey, respondents reported being most satisfied with:

- How well doctors communicate (adult and child population)
- Customer service (adult and child population)
- Rating of health care (child population)
- Rating of specialist (child population)

The CAHPS survey also reported areas for improvement, such as:

- Rating of health care (adult population)
- Rating of specialist (adult population)

Providers can do the following to maintain and improve the CAHPS score for 2023:

- Gather and analyze patient feedback on their recent office visits.
- Regularly analyze appointment scheduling time frames rather than types of office visits.
- Advise members of available alternative methods of care, such as telehealth, urgent care, and follow-up care.
- Consistently review and discuss care plans with members and specialists.

Thank you for your continued collaboration to make our members happier and healthier.

Providers with any questions about the CAHPS results can contact the Quality team at 1-844-325-6251.

CAHPS® survey season is coming.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is a tool that collects information about patients' health care experiences. The survey allows patients to disclose their thoughts about their health plan, which includes various aspects of care from doctors, provider practices, and health care facilities. Survey results are used to:

- Elevate the standards of patient-provider relationships.
- Identify key areas to provide better clinical care.
- Improve the delivery of services.

Highmark Health Options members will be surveyed during March and April. The results will be available by late summer.

Care teams can partner with the Case Management team to provide collaborative care.

Providers are encouraged to work with Highmark Health Options to provide collaborative care for patients. Primary care physicians are required to work with Case Managers to ensure proper care is being provided and case status remains up-to-date. Case Managers can help:

- Assess a patient's situation and needs.
- Provide ongoing coordination to see that a patient's care needs are being met.
- Work with patients and their families to develop care plans to map out what kind of services they need, how often they are needed, and more.

Providers should work with Case Managers to provide the care patients need. Contact Case Management with any questions at **1-844-325-6251**.

Remind patients when to use urgent care centers.

Providers should take time to explain to patients the main difference between urgent care and emergency departments:

- If the condition is life-threatening, go to an emergency department.
- If the condition is a minor illness or injury, go to a local urgent care center or walk-in clinic.

Use the information below as a reference for when patients should go to the emergency department, urgent care, or their PCP.

Emergency Department

Visit 24/7 or call 911 immediately for:

- Broken bone out of place
- Chest pain
- Difficulty speaking
- Eye injury
- Head injury or unconscious
- Overdose or poisoning
- Shortness of breath
- Weakness on one side (face or limbs)

Urgent Care

Visit outside doctor office hours for:

- Allergic reaction
- Broken bone with no broken skin
- Cuts needing stitches
- Most conditions listed under primary care

Primary Care Doctor

Visit during regular office hours for:

- Checkups, ongoing care
- Flu shots, other vaccines
- Medicine refills or changes
- Referrals to a specialist
- Animal or insect bite
- Back pain
- Cold and flu-like symptoms
- Headaches, migraines
- Minor burns
- Nausea, vomiting, diarrhea
- Rash
- Sore throat
- Sprains, strains
- STD, urinary tract infection

Evaluation and management updates for 2023.

Medical decision-making

Starting Jan. 1st, 2023, providers may select the level of inpatient, observation, discharge, and consultation evaluation and management (E/M) services based on either time or medical decision-making, apart from encounters in the emergency department.

The medical decision-making elements associated with evaluation and management services comprises three components:

- Problems: The number and complexity of problems addressed.
- Data: The amount and/or complexity of data to be reviewed and analyzed.
- Risk: The risk of complications and/or morbidity or mortality of patient management.

To select the level of an E/M service, two of the three elements of medical decision-making must be met or exceeded.

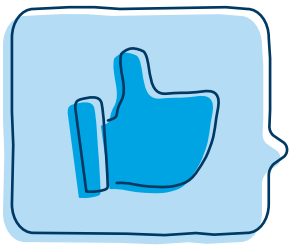
New COVID-19 vaccine codes

The American Medical Association (AMA) established a website that features timely updates of the Panel's actions to assist CPT code users in differentiating and appropriately reporting:

The medical decision-making elements associated with evaluation and management services comprises three components:

- The available vaccine product codes.
- Their affiliated immunization administration codes.

Find additional details on the new vaccine coding structure and other pertinent information provided in multiple special editions of the CPT® Assistant for COVID-19 guidance are available.



Providers must verify HHO members

There are many instances encountered where an HHO member has the same common name and date of birth as a Highmark commercial member. This has created issues where claims are billed to the incorrect plans or members, causing providers to retract and reissue claims.

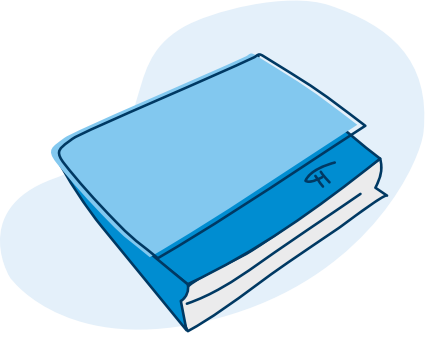
Verify the following when billing:

- Member address
- Member insurance ID card
- Member photo ID
- Overall verification with the member when multiples are returned in a patient search with the same name and date of birth

Reference:

CPT® Evaluation and Management

Medical record requests reminders.



Providers are required to respond to all medical record requests in a timely manner. Each request should be reviewed thoroughly. In addition, providers must submit all documentation requested. If additional clarification is needed, providers can contact the individual who sent the request.

Providers must include the following information with the medical records:

- Member-identifying information (e.g., photo ID, member ID card)
- Consent to treat
- Privacy practices disclosure
- Release of information for payment
- Notes and documentation for service dates

Providers can contact Payment Integrity at 1-844-325-6251 to request an extension if they need more time to gather information for the submission.

Submit medical records by mail to:

Highmark Health Options
120 Fifth Avenue
FAPHM-052C
Pittsburgh, PA 15222

The provider's role in the Care Management program is important.

The Highmark Health Options Care Management team can partner with providers to reduce the number of a patient's visits to the emergency department, help the patient avoid going back to the hospital, and support a personal plan of care for the patient. A team of nonclinical and clinical staff is available to:

- Address a patient's health issues.
- Link patients to services, such as helping them make appointments.
- Remind patients to go to their annual physicals.
- Review a patient's medications with them.

Providers can call Care Management at 1-844-325-6251.

Note these prior authorization changes.

Providers must follow the prior authorization process for a subset of medications. Failure to obtain an authorization for these medications will result in a claim denial. Providers can view the most recent prior authorization reminder communication and most current list of impacted medications online.

Important changes: The following medications/HCPCS codes no longer require authorization:

- Celestone Soluspan (betamethasone acetate/betamethasone sodium phosphate) J0702
- Biosimilar products
- Oncology agents except for reference products, which require a trial of the biosimilar agent when clinically appropriate
    - Avastin (J9035), Neupogen (J1442), Neulasta (J2505), Remicade (J1745), Rituxan (J9312), Herceptin (J9355)

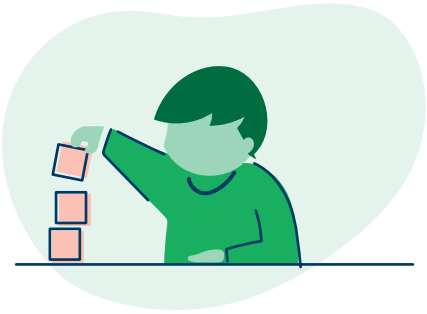
New authorization requirements as of Dec. 19, 2022:

- Skysona* (elivaldogene autotemcel) J3590
- Zynteglo* (betibeglogene autotemcel) J3590

*These medications will be reviewed under the applicable miscellaneous procedure code until a permanent code is assigned.

Providers with any questions can contact Pharmacy at 1-844-325-6251.

Reminder for pediatric lead screening.



There has been a significant decrease in childhood lead screenings due to the COVID-19 pandemic. A recent review of Delaware childhood blood lead testing data shows a significant decrease in childhood lead screenings. Lead testing rates dropped by an average of 54% in the first six months of 2020, compared to 2019. During the first six months of 2021, childhood lead testing rates in Delaware dropped by an average of 63%, compared to 2019.

The decrease in pediatric lead screenings is important because the pandemic has added to the risk of lead exposure. The Lead Poisoning Prevention Program encourages providers to order a blood lead-level test for children for these reasons:

- Children and families are spending more time in their homes during the pandemic, increasing their risk of lead exposure from paint and dust, the primary sources of lead poisoning.
- Many families and property owners in older homes are also using this time to initiate do-it-yourself home projects or renovations, further increasing the risk of lead exposure.

Children aged 6 and younger are most susceptible to lead poisoning because their brains and central nervous systems are still developing. Failure to detect lead poisoning has significant implications for children, such as damage to the brain and nervous system, slowed growth and development, and learning and behavior problems. Children with elevated blood lead levels:

- Have a lower chance of being on track for kindergarten.
- Are more likely to enter the juvenile justice system and be incarcerated as adults (ages 18–23).

Check out the updates on Bright Futures periodicity schedule.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

New updates include

- Assessing risk for hepatitis B virus for newborn to adults, age 21 years.
- Assessing risk for sudden cardiac arrest.
- Screening for suicide risk has been added to existing depression screening recommendations.

A PDF version of the schedule is available for providers to view.

Reminder about durable medical equipment requests.

If a patient has commercial or Medicare coverage in addition to Medicaid coverage, the other carrier is always the primary insurer. HHO is the payer of last resort for services provided to patients with dual-coverage. All authorization requirements must be met for payment to be issued.

To receive payment for services provided to patients with other insurance coverage, the provider must:

- First bill the patient's primary insurance carrier using the standard procedures required by the carrier.
- Upon receipt of the primary insurance carrier's EOB, the provider should submit a claim to Highmark Health Options.
    - Providers must bill within 60 days from the date of an EOB from the primary carrier when Highmark Health Options is secondary.
    - An original claim along with a copy of the EOB is required to process the claim.
- If HHO is primary, anything over $500 needs prior authorization.

Providers with any questions can call Payment Integrity at 1-844-325-6251.

Partnering with a patient's case management team.

All patients enrolled in Long-Term Services and Supports program are assigned a Case Manager who assists them in achieving health care goals, obtaining community resources, and authorizing services that are part of their benefit package.

Case Managers are required to collaborate with all service providers and include physician recommendations on their members' plan of care. The plan of care includes a summary of the services the member requires along with short- and long-term health care goals.

Case Managers are contractually required to connect and coordinate with the following providers at the corresponding frequency:

- PCP – quarterly
- HCBS providers – annually
- Skilled care providers – every 60 days
- Behavioral health providers – quarterly

Providers should work with Case Managers to provide the care a patient needs. Providers can contact Case Management with any questions at 1-844-325-6251.

Reminder that LTSS level of care redeterminations are conducted annually.

HHO redetermines member LTSS eligibility annually. Members with home- and community-based services need to be re-evaluated by HHO staff. Members are required to redetermine their eligibility for LTSS annually; this includes a financial and a medical redetermination. HHO is responsible for redetermining medical eligibility for LTSS members. When the redetermination is complete, HHO staff will send a form to the member's PCP.

PCP's are required to sign off on and agree to the staff's redetermination. PCPs should return a document to HHO confirming they have agreed to and signed off on it.

Providers with any questions can call LTSS at 1-844-325-6251.

Providers can partner with HHO for wellness programs and linkage to services.

Highmark Health Options staff is available to partner with providers to provide comprehensive Care Management Services for all eligible Highmark Health Options members.

Nurses, social workers, and other health care staff are available to talk with providers to make sure patients receive the medical care and support they need.

A multidisciplinary team is available to address any issues patients may have such as:

- Chronic conditions (e.g., asthma, heart or lung disease, diabetes, high blood pressure)
- Mental health and substance use disorders
- Women's health

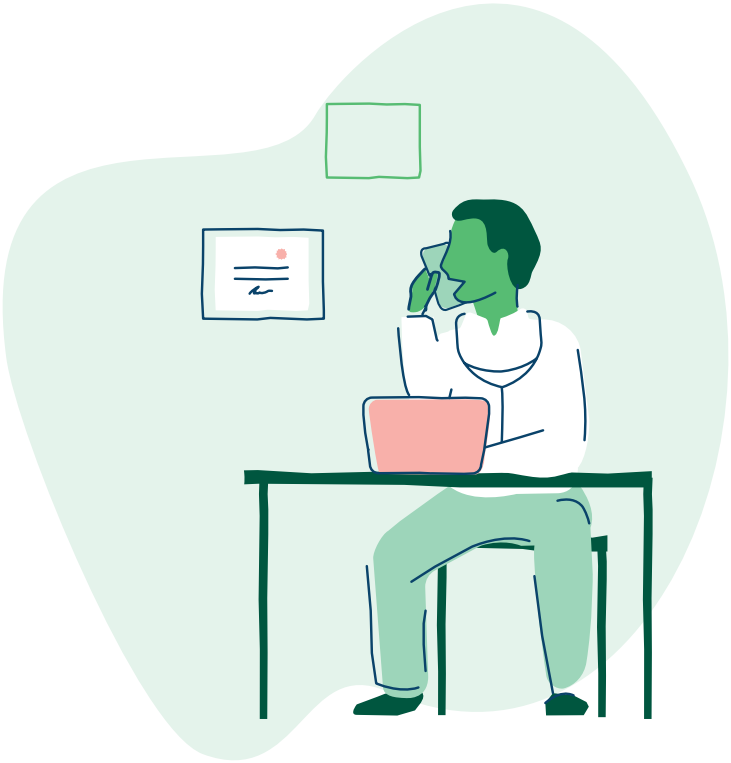
Community resources and programs are available to help patients stay well and manage their conditions. Highmark Health Options staff can provide patients with ongoing disease education and management with our Lifestyle Management/Wellness Programs. More Lifestyle Management/Wellness Program information is available online.

Work with Case Managers to coordinate minor home modifications for patients.

Providers can work with Case Managers to assist patients who need minor home modifications. The Home Modification Program pays for modifications to be made to the home of a person with a physical disability. The changes are made to allow a person to move around more freely in the home. Delaware residents age 18 or older who have a permanent or long-term physical disability are eligible.

Modifications are made to permanent residences only. Funds are used only when no other funding source is available or when there is not enough money from another source to pay for the needed modifications. Typical modifications include minor changes to existing bathroom and kitchen, wheelchair ramps and stairlifts.

Providers with any questions can call LTSS at 1-844-325-6251.



Interpretation and translation services for patients.

Per the Highmark Health Options (HHO) contract, providers are required to address, arrange, and coordinate interpreter services for patients. Reasonable steps should be taken to provide meaningful access to services, including translator services for patients with limited English proficiency.

HHO offers the Member Handbook and other materials in large print, in Braille, or on cassette tape at no cost to members. Providers may obtain copies of documents that explain legal requirements for translation services by contacting Provider Services at 1-844-325-6251.

Use these strategies to identify patients' health-related social needs.

Health-related social needs (HRSNs) are environmental conditions that can affect a person's health, well-being, and quality of life. Prioritizing early identification and mitigation of HRSN can help improve a patient's quality of life.

HRSN embraces a prevention framework to recognize and address a person's social, economic, and environmental needs that have been previously overlooked.

HRSN encompasses:

- Education (e.g., English as a Second Language [ESL], General Education Development [GED], or other education programs affecting HRSN)
- Employment and income
- Family and social supports (e.g., prenatal support services, childcare, social isolation, respite services, or caregiver support)
- Food insecurity
- Housing instability and quality (e.g., homelessness, poor housing quality, or inability to pay mortgage or rent)
- Interpersonal violence (e.g., intimate partner violence, elder abuse, or child maltreatment)
- Transportation needs beyond medical transportation
- Utility needs (e.g., difficulty paying utility bills)

Providers can use certain strategies to address the HRSN of patients. These strategies were developed by the National Academies' Committee on Integrating Social Needs Care into the Delivery of Healthcare to Improve the Nation's Health.

5A's to address health-related social needs:

- Awareness: Identify social risks specific to the patient and their population.
- Adjustment: Adjust clinical care to meet patients' needs, such as providing a language line, educational literature in an easy-to-understand format, and off-hour visits or telehealth services.
- Assistance: Connect patients with local community and government resources for short-term and long-term assistance.
- Alignment: Assess the patient's social care assets in the community. This is a great way to collaborate with the patient's LTSS or Care Coordination Case Managers, as they are available to provide continuous support and resources to patients.
- Advocacy: Form alliances with local social care organizations to advocate for policies that promote resources and address health-related social needs.

The PCP Portfolio Report promotes quality and safety of care.

The PCP Portfolio Report helps identify ways we can work together to improve care quality and safety through information sharing. This report is available on NaviNet. The report is updated quarterly in January, April, July, and October.

The report compares providers to others in their peer groups and contains key utilization, pharmacy, and quality measures. Quality of care and services provided to our members is evaluated based on these measures. When outliers are found, we send a letter to providers to explain these findings.

Provider feedback is incorporated into these reports.

Note: The PCP Portfolio Report is not tied to any reimbursement or incentive and is designed exclusively to improve quality and safety of care.

For more information, contact Su-Linn Zywiol, Strategy Program Manager.

Provider network contacts.

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Provider Complaints
(not claims related)

HHO-ProviderComplaints@highmark.com
Phone: 1-844-228-1364
Fax: 1-844-221-1569

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.

Check out this useful information.

Atlas Systems Inc. continues to conduct quarterly outreach to verify provider data on Highmark Health Options' behalf.

Balance billing: Payment by Highmark Health Options is considered payment in full. Under no circumstance may a provider bill; charge; collect a deposit from; seek compensation, remuneration, or reimbursement from; or have any recourse against a member.

Medical records: Highmark Health Options may request copies of medical records from providers. If medical records are requested, the provider must supply copies at no cost within 30 calendar days of the request.

Taxonomy: Highmark Health Options requires that credentialed taxonomy be included for all billing, rendering/performing, and attending providers on an inbound claim.

Check out these tools.

Cultural Competency Toolkit: Highmark Health Options has assembled a list of resources and tools to assist you in providing care that is sensitive to the cultural and linguistic differences of our members.

Community Support offers a way to free or reduced-cost services in the community. Search for local support resources to access food, housing, transportation, utility assistance, medical care, job training and more.

Visit the Highmark Health Options website for more resources and the latest updates.