Q2 2025

Provider Newsletter

for Highmark Health Options | Highmark Health Options Duals (HMO SNP) | DELAWARE

FEATURED ARTICLES:

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Contact Us

Highmark Health Options and Highmark Health Options Duals 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 the following numbers:

HHO Provider Services: **1-844-325-6251** HHO Duals Provider Services: **1-855-401-8251**

Practitioner Excellence Program is Launching August 2025

Highmark is offering a new incentive in August 2025.

The Highmark Health Options Practitioner Excellence (HHOPE) Program supports Highmark's mission to improve the health and wellness of the individuals and the communities we serve by providing access to integrated, superior health care. The program is available for both Highmark Health Options and Highmark Health Options Duals D-SNP providers.

Providers must acknowledge that they are opting in to the core HHOPE program. Please contact your Clinical Transformation Consultant directly or email us at: **DePET@Highmark.com** for information on the opt-in process.

By opting-in, the provider also acknowledges the intent to participate in the program. Providers will be enrolled in the programs based on provider specialty, eligibility criteria outlined in the HHOPE Incentive Provider Guide, and network participation. The HHOPE Incentive Program Guide can be found on our website: **highmarkhealthoptions.com**.

The HHOPE Provider Experience (PE) team is offering multiple hour-long webinars to provide an overview of the 2025 HHOPE Program now through September:

- Thursday, July 10 at 10 a.m.
- Monday, July 28 at 2 p.m.
- Tuesday, Aug. 19 at 10 a.m.
- Thursday, Sept. 25 at 10 a.m.

Keep an eye on upcoming provider newsletters and PE team email blasts for additional information.

Enhanced Community Care Management Program is Now Live

The Enhanced Community Care Management (ECCM) program is now available to Highmark Health Options (HHO) Medicaid and Highmark Health Options Duals (HHO Duals) Medicare D-SNP members.

The ECCM program provides comprehensive support for members, facilitating better health management, improved access to care, and collaborative care team engagement.

What is ECCM?

- Supportive and palliative care for high-risk populations, providing care coordination and specialty medical expertise that collaborates closely with the member's primary care provider (PCP) and focuses on leading patients to live their best lives.
- ECCM's interdisciplinary care team includes physicians, advanced practice providers, registered nurses, licensed social workers, and care coordinators. It provides team-driven care directed by whole-person centered outcomes, such as self-management of patient's chronic conditions, improved quality of life, symptom burden alleviation, emotional well-being improvement, increased communication, stronger continuity of care, and decreased caregiver burden.
- ECCM care is provided both virtually and in the community.
- The ECCM team ensures it is meeting patients where they are and matching them with the appropriate resources based on the patients' changing needs.
- The ECCM model is flexible, reducing disruption for the patient, family, and caregiver by providing care during the most complex parts of the care continuum. The ECCM care team is the extra set of eyes and hands in the home to monitor patients more closely when they need it the most.

Please refer appropriate patients to ECCM through any of these channels:

- Phone: **844-438-3226 (844-GET-ECCM)**
- Email: **eccmreferrals@highmark.com**
- Fax: **844-978-2756**

For questions or information regarding this active program, contact Highmark Health Options Provider Services at **1-844-325-6251** (Medicaid) or Highmark Health Options Duals at **1-855-401-8251** (D-SNP), Monday–Friday, 8 a.m.–5 p.m.

Virtual Behavioral Health through HHO on the GO

Highmark Health Options offers a convenient option for members who are age 18 and older to receive virtual mental health care with a licensed therapist with HHO on the Go.

Our dedicated therapists provide online counseling for various concerns such as anxiety, depression, stress, LGBTQ topics, and life transitions. Additionally, our experienced psychiatrists offer diagnosis and medication management services for ongoing conditions like bipolar disorder, eating disorders, depression, insomnia, OCD, panic attacks, and PTSD. We also provide online doctor visits for individuals seeking treatment for addiction.

With our HHO on the Go feature, members can easily connect with a doctor directly from their cell phone. Booking an online doctor visit can be done quickly through our user-friendly app or website. We are proud to offer these visits at no cost to Highmark Health Options members.

If you encounter members who require behavioral health services that are not linked with a behavioral health provider or face difficulties in securing appointments, we encourage you to refer them towards our services.

Patients can access the website at **HHOontheGo.com** and follow the instructions to set up their account.

For other questions, reach out to your provider account liaison or call Provider Services at **1-844-325-6251**, Monday–Friday, 8 a.m.–5 p.m.

Vaccine Reminder: Disease Prevention with Childhood and Adolescent Immunizations

Recent outbreaks of measles, pertussis (whooping cough), and other vaccine-preventable diseases presents an opportunity to remind your Highmark Health Options patients about the importance of childhood and adolescent immunizations.

According to data from the **Centers for Disease Control and Prevention (CDC)**, 95% of measles cases are in individuals with an "unvaccinated or unknown" vaccine status with many of these cases clustered in areas with low vaccination rates.

The **CDC** and the **American Academy of Pediatrics (AAP)** recommend that children stay on track with their well-child appointments and routine vaccinations. On-time vaccination is critical for providing protection against potentially life-threatening disease. The CDC's Immunization Schedules for **birth through age 6** and **children ages 7–18** can assist you and your patients with creating a vaccination plan.

Best Practices

To help your Highmark patients stay on track with childhood and adolescent vaccines, consider the following:

- Create standing vaccine orders within the Well-Child Visit templates.
- Create Electronic Medical Record (EMR) alerts when members are due for immunizations.
- Incorporating an "immunization catch-up day" into your office workflow to allow patients to get vaccinated and close gaps in immunization records.

Additionally, Highmark's Care Coordination team will reach out to your office and offer assistance for members who may have immunization care gaps.

Thank you for your dedication to keeping our members and communities healthy by prioritizing childhood and adolescent immunizations.

Coding Corner: ICD-10 Specificity and Medical Necessity

ICD-10 codes are fundamental in substantiating the medical necessity of a service.

Each code corresponds to a specific diagnosis or condition that a health care provider is treating. When submitting claims to insurance companies or Medicare, providers must correctly include these codes to justify the need for certain treatments or procedures.

An authorization is not a guarantee of payment, and providers are required to adhere to the coding and billing reporting guidelines.

Please see the example below for a scenario in which ICD-10 codes are reported as the ONLY diagnosis on a claim (the primary diagnosis on a professional claim or principal diagnosis on a facility claim).

- **Example:** First code the underlying disease, such as, Pachydermoperiostosis (M89.4). L62 (this ICD-10 code describes Nail disorders in diseases classified elsewhere) is not accepted as a primary diagnosis because instructions require the underlying condition to be coded first.

The residual or late effect of an injury generally requires two codes. The primary diagnosis must describe the nature of the sequela. The secondary diagnosis describes the original injury and usually has an "S" in the 7th position to indicate sequela. (Sequela of cerebrovascular disease is an exception.)

See the example below:

- **Primary Diagnosis:** Treatment of ankle instability following a sprain: M24.271 (this is the ICD-10 code for Disorder of ligament, right ankle).
- **Secondary Diagnosis:** S93.411S - Sprain of calcaneofibular ligament, right ankle, sequela S93.411S is not accepted as a primary diagnosis because instructions require the residual condition be coded first.

Below are some additional diagnoses and their definitions:

- **External Causes Diagnosis:** These codes are supplements to the principal or primary diagnosis code indicating the nature of the condition.
- **Manifestation Diagnosis:** ICD-10-CM convention requires the underlying condition sequenced first followed by the manifestation.

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- **Secondary Diagnosis:** A "secondary only" ICD-10-CM code refers to a diagnostic code that can only be used as a secondary diagnosis and cannot be listed as the primary diagnosis on a claim; meaning it should always be accompanied by another primary diagnosis code when billing medical services.
- **Sequela Diagnosis:** According to the ICD-10-CM Manual guidelines, a sequela (seventh character "S") code is not appropriate as a primary, first listed, or principal diagnosis on a claim.
- **Laterality Policy:** Laterality is a unique attribute to the ICD-10-CM code set built into certain ICD-10-CM code descriptions.

Sources:

1. **Centers for Medicare and Medicaid Services. (2024, October 1). ICD-10-CM Guidelines FY25. Retrieved from CMS.gov**
2. **Novitas. (2021, December 10). Medically Necessary Services and Prior Authorization. Retrieved from Novitas Solutions**

Invitation to Participate: ICP and ICT for Highmark Health Options Duals Providers

We care about the whole health and well-being of our members, so we want to help our providers keep Highmark Health Options Duals members as healthy as possible.

As a valued member of the Interdisciplinary Care Team (ICT), you are the first step to the success of our members' care. Each Medicare member has an Individualized Care Plan (ICP), which they have access to on the member portal or by mail upon request. You have access to the ICPs for your panel, available on the provider portal. We encourage you to review the member's care plan with them during their next visit.

We also invite you to participate in ICT meetings regarding your patients. The purpose of ICT meetings is to focus on our members and their specific needs to help achieve their overall health care goals. Each ICT meeting results in an updated ICP, so your input is critically important.

Please call the Care Coordination Department to schedule an ICT meeting for any of your Highmark Health Options Duals patients at **1-855-401-8251 (TTY 711)** for Care Coordination. Our hours of operation are Monday–Friday, 8 a.m.–5 p.m.

Important Reminder: Obtaining Patient Consent to Treatment Form

Highmark Health Options and Highmark Blue Cross Blue Shield ("Highmark") require providers to have medical records that comply with Centers for Medicare and Medicaid Services (CMS), American Medical Association (AMA), National Council on Compensation Insurance (NCCI), National Committee for Quality Assurance (NCQA), Health Insurance Portability and Accountability Act (HIPAA) Transactions and Code Sets, Medicaid regulations, Medicare Manuals, and all other applicable professional guidance.

"Properly executed informed consent forms" are required documentation (42 CFR § 482.24). Consent forms are part of the minimum required documentation that providers must maintain for each individual that is evaluated or treated; and should include:

- Dates of service
- Identifying information for the patient
- Signature and date of the patient
- Signature, date, and credentials of the clinician
- Types of services or treatments
- Benefits or potential risks
- Alternative services or treatments
- Easy to read and legible documentation

When Highmark requests medical records for Fraud, Waste, and Abuse (FWA) reviews, Consent to Treatment Forms must be included. Failure to obtain and maintain this documentation by a provider may result in corrective actions that may include pre-payment review, payment suspension, recovery of overpayments, and potential network termination.

Please refer to the resources below for additional information:

- **CFR Title 42**
- **Delaware Code Title 16**
- **AMA Code of Medical Ethics**

Interactive Care Management for Highmark Health Options and Highmark Health Options Duals Members

Highmark Health Options provides comprehensive Interactive Care Management to support the health and well-being of your Highmark Health Options and Highmark Health Options Duals patients.

Our Care Management Programs feature three distinct services tailored to meet diverse patient needs:

- **Maternity**
- **Complex Case Management:** For individuals with multifaceted comprehensive physical and behavioral health needs.
- **Disease Management:** For patients with:
  - Chronic Kidney Disease (CKD)
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Congestive Heart Failure (CHF)
  - Diabetes
  - Hyperlipidemia
  - Hypertension
  - Inflammatory Bowel Disease (IBD)
  - Prediabetes

All patients with these diagnoses or conditions qualify for personalized support. Each program offers evidence-based health education, self-management tools, and ongoing care coordination to improve outcomes. A dedicated clinician will collaborate with you to develop personalized health plans and assist patients with medication management, specialist referrals, and appointment scheduling.

These programs are offered at no cost, with flexible opt-in and opt-out participation.

Refer eligible patients today by calling **Highmark Health Options Provider Services at 1-844-325-6251 (TTY: 711)** or **Highmark Health Options Duals Provider Services at 1-855-401-8251 (TTY: 711)**, Monday–Friday, 8 a.m.–5 p.m.

Empowering Patients with Hypertension: Effective Strategies for Teaching Blood Pressure Control

Empowering patients with hypertension to actively participate in their blood pressure control is crucial for achieving optimal outcomes. By adopting effective teaching strategies, physicians can foster patient understanding, promote adherence to treatment plans, and ultimately improve patient health and well-being.

Beyond the Prescription: The Importance of Patient Education

Simply prescribing medication is insufficient for achieving optimal blood pressure control. Patients need to understand the condition, its potential complications, and the importance of lifestyle modifications. Educating patients empowers them to adhere to treatment, make informed decisions, and take ownership of their health.

Effective Strategies for Patient Education:

- **Start with the Basics:** Clearly explain what high blood pressure is, its potential complications, and the importance of achieving target blood pressure levels. Use simple language and visuals to enhance understanding.
- **Tailor the Approach:** Consider the patient's individual needs, health literacy, and cultural background.
- **Engage in Active Listening:** Encourage patients to ask questions and address their concerns. Listen attentively and provide clear, concise answers.
- **Emphasize Lifestyle Modifications:** Discuss the importance of diet, exercise, stress management, and limiting alcohol and smoking.
- **Demonstrate Blood Pressure Monitoring:** Teach patients how to use a home blood pressure monitor and record their readings while explaining the importance of regular monitoring.
- **Utilize Technology:** Leverage mobile apps, online resources, and telehealth platforms to provide ongoing support and education.
- **Promote Self-Management:** Encourage patients to track their blood pressure, medication adherence, and lifestyle changes.

Strategies to Increase Asthma Medication Ratio Performance

The Asthma Medication Ratio (AMR) quality measure assesses patients ages 5–64 with both persistent asthma and a ratio of controller medications to total asthma medications of 0.50 or greater.

The goal of this measure is to increase compliance with asthma controller medications. Appropriate medication management for patients with asthma can help reduce:

- Asthma-related hospitalizations.
- Emergency room visits.
- The need for dangerous acute asthma exacerbations and rescue medications.

If a patient has an AMR less than 0.50, it is interpreted that they are filling more rescue medications than controller medications. This would require a follow-up to optimize their asthma regimen.

The following strategies can help providers increase AMR performance:

- Assess barriers (e.g., cultural, financial, social support, health beliefs, access to care, language).
- Evaluate and track disease activity to adjust medication regimen as needed.
- Provide asthma education and self-management for patients with AMR < 0.50, such as accountability on the possibility of nonadherence to controller medication and triggers leading to frequent use of rescue medication.
- Reconcile medications (e.g., assess for effectiveness, number of prescription refills).
- Refer chronic case management.
- Review the patient's knowledge about medication and symptom exacerbation.

Important Policy Notification: Medicare Parts A and B Cost-Sharing

All members enrolled in Highmark Health Options Duals D-SNP also have Medicaid (Medical Assistance) or receive some assistance from the state.

Some members will be eligible for Medicaid coverage to pay for cost-sharing deductibles, copayments, and coinsurance. They may also have coverage for Medicaid covered services, depending on their level of Medicaid eligibility.

As a reminder, our dual-eligible Medicare and Medicaid members shall not be held liable for Medicare Parts A and B cost-sharing when the appropriate state Medicaid agency is liable for the cost-sharing.

Providers further agree that upon payment from Highmark Blue Cross Blue Shield, providers will accept the plan payment as payment in full or bill the appropriate state source. Please make sure to follow Medicaid coverage and claims processing guidelines. Balance billing a dual-eligible member for a deductible, coinsurance, or copayment is prohibited by federal law.

Our organization and provider network are also prohibited from excluding or denying benefits to or otherwise discriminating against, any eligible and qualified individual regardless of race, color, national origin, religious creed, sex, sexual orientation, gender identity, disability, English proficiency, or age.

Highmark Health Options Duals D-SNP plan members have certain rights and responsibilities as members of our plans. To detail those rights and responsibilities in full, we maintain a Member Rights and Responsibilities statement which is reviewed and revised annually.

The Member Rights and Responsibilities statement can be found in either the Member Handbook for Medicaid members or the Evidence of Coverage for Highmark Health Options Duals members.

Providers are encouraged to contact us if you have questions about this Provider Update or need additional member-specific information.

Our Provider Services Department can be reached at one of the following numbers, Monday–Friday, 8 a.m.–5:00 p.m.:

Highmark Health Options Duals (D-SNP): 1-855-401-8251 (TTY: 711)

Highmark Health Options Medicaid: 1-844-325-6251 (TTY: 711)

2025 Model of Care Training Summary

Provider Training Requirement: If you have not already done so, please complete the Model of Care training before Dec. 31, 2025.

As a Special Needs Plan (SNP), Highmark Health Options Duals Dual-Eligible Special Needs Plan (D-SNP) members are required by the Centers for Medicare and Medicaid Services (CMS) to administer a Model of Care (MOC). In accordance with CMS guidelines, Highmark's SNP MOC is the basis of design for our care management policies, procedures, and operational systems that will enable our Medicare Advantage Organization (MAO) to provide coordinated care for special needs individuals. Our network providers are expected to complete and attest to MOC training on an annual basis.

The SNP MOC is divided into four sections:

1. Description of the SNP Population
2. Care Coordination
3. SNP Provider Network
4. Quality Measurement & Performance

The annual provider training focuses on the SNP Provider Network section and outlines what Highmark Health Options Duals expects from our providers in maintaining an effective MOC. The MOC ensures that the SNP Provider Network is comprehensive and able to care for the unique and specific needs of the population by implementing the following elements throughout the SNP provider network:

1. Specialized Expertise
2. Use of Clinical Practice Guidelines
3. Care Transition Protocols
4. Annual Model of Care Training

The training also includes common MOC terms and definitions as well as Highmark's contact information.

Review the Model of Care Provider Training found on our website **here**. Once you have completed this training, please submit an attestation indicating that you have completed and comprehend the Model of Care training by clicking **here**.

The Importance of Preventive Screenings

Regular preventive screenings are crucial for improving the health and well-being of your Highmark Health Options and Highmark Health Options Duals patients. By focusing on early detection and proactive care, you can significantly impact their quality of life and help them stay healthy.

Breast Cancer Screenings

Early detection of breast cancer can significantly impact your patient's life. Regular screenings can lead to earlier preventive measures. Breast cancer screening is also a measure that impacts HEDIS rates.

It's defined as the number of women ages 40-74 as of Dec. 31 of the measurement year who have received one or more mammograms since Oct. 1 two years prior to the measurement year. Women who have had both breasts surgically removed are excluded from the measure.

How to improve screening and HEDIS rates:

- Create alerts or flags in the medical record to remind staff who interact with patients 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 of the results to include in their medical record.
- Use other preventive appointments, including 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. Breast Cancer Awareness Month 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 patient's life.

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Colorectal Cancer Screenings

Regular screenings can help prevent many colorectal cancers. Still considered the preferred screening method, colonoscopies detect the most colorectal cancers. It is recommended that patients should start having colonoscopies at age 45, regardless of gender. Patients with an increased risk of colorectal cancer may have to screen sooner.

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 an immediate family member with colorectal cancer.
  - Have had colorectal cancer and a 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.
- **History of Inflammatory Bowel Disease (IBD)**
- **Lifestyle:** Being overweight, having an inactive lifestyle, eating a diet high in red and processed meat, smoking, and drinking alcohol can increase risk.

Thank you for your dedication to keep our members healthy.

Highmark Health Options Member Outreach Navigators Empower Patients and Providers Alike

Highmark Health Options offers our members access to our Care Coordination staff that can help them better understand their health care benefits and appropriately access services within a managed health care plan.

Highmark Health Options providers can request support from a Care Coordination team member to help educate members who need more information about their care. This includes topics like appropriate emergency room usage.

Providers are invited to refer Highmark Health Options members for additional guidance adhering to their treatment plan, assistance with keeping scheduled appointments, understanding their benefits, and resources available by completing the appropriate Member Outreach Form:

- For members age 20 and younger: **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Member Outreach Form**
- For members age 21 and older: **Member Outreach Form**

A Highmark Health Options representative will contact the member and follow up with the provider at the provider's request.

Providers must complete their missed appointment outreach prior to sending in the Member Outreach Form for a missed appointment. Missed Appointment Outreach includes three attempts with at least one telephone call per missed appointment.

For more information or to request member outreach, please call Highmark Health Options at **1-844-325-6251**. You can also fax the Member Outreach Form to the Case Management Department at **1-833-581-1864**.

Accessibility Standards

Highmark Health Options (HHO) Delaware maintains standards and processes for ongoing monitoring of access to health care. To help ensure our members receive services in a timely manner, practice sites are contractually required to follow these standards.

Please take a few minutes to **review the accessibility standards** and share with your office staff that schedule member appointments, including off-site central scheduling and call center staff.

These standards and additional resource information related to accessibility are available on our HHO provider website.

Continuity of Care Across Settings

Open communication among and between all those who participate in providing care to a patient, such as primary care physicians (PCPs) and specialists, is imperative in ensuring that all decisions about a patient's care are informed and contribute to overall well-being.

When information is not shared between health care providers, it can present many challenges to the continuity of care and treatment of our members. Highmark membership includes some of the most vulnerable individuals who may suffer from severe or chronic illnesses. Continuity of care issues can result in sub-optimal outcomes, increased costs, and medical errors.

Both members and health care professionals benefit when documentation on communication between PCP or specialist care, notes from consultations, follow-up plans for significantly abnormal lab or imaging results, ER discharge summaries, and records from transferred care or SNFs/home care agencies, are shared across treatment specialties. Please contact your Provider Relations Representative with questions about how you can help improve patient care between settings.

Member Rights and Responsibilities

Highmark Health Options Medicaid and Medicare Duals members have certain rights and responsibilities as members of Highmark. To detail those rights and responsibilities in full, Highmark maintains a Member Rights and Responsibilities statement, which is reviewed and revised annually.

Highmark and its provider network do not and are prohibited from excluding or denying benefits to, or otherwise discriminating against, any eligible and qualified individual regardless of race, color, national origin, religious creed, sex, sexual orientation, gender identity, disability, English proficiency or age. Some additional rights and responsibilities include:

Members have the right to:

- Receive information from Highmark in a way that works for them (in languages other than English, in Braille, in large print, or other alternate formats, etc.).
- Be treated with fairness and respect at all times.
- Receive timely access to covered services and drugs.
- Have personal health information kept private and confidential.
- Receive information from Highmark about the Plan, its network of providers, covered services, and rights.
- Have Highmark support their right to make decisions about their care.
- Issue a complaint or ask Highmark to reconsider decisions the Plan has made by filing an appeal.
- Make recommendations regarding the organization's member rights and responsibilities policy.
- Receive a written explanation in the event a medical service or Part D drug is not covered, or if their coverage is restricted in some way.
- Receive a copy of their medical records free of charge upon request. Know their treatment options and risks in a way they can understand.
- Participate in decisions about their health care, including the right to refuse any recommended treatment.
- Be given instructions about what is to be done if they are not able to make decisions for themselves. This includes maintaining an advance directive, such as a living will or a power of attorney for health care.
- Contact the Department of Health and Human Services' Office for Civil Rights if they believe their rights have not been respected due to their race, color, national origin, religious creed, sex, sexual orientation, gender identity, disability, English proficiency, or age.

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- To request and/or participate in a scheduled Interdisciplinary Care Team (ICT) meeting which may include your assigned Highmark Case Manager, your PCP, caregiver, and any other pertinent personnel directly included in your care.
- To access and have direct input into your individualized care plan (ICP). Your care plan is available on your portal page or can be mailed to you upon request.

Members are responsible for:

- Getting familiar with their covered services and the rules they must follow to get these covered services.
- Informing Highmark if they have any other health insurance coverage or prescription drug coverage in addition to our plan.
- Telling their doctor and other health care providers that they are enrolled in our plan.
- Helping their doctors and other providers care for them by providing needed information, asking questions, and following through on their care.
- Respecting the rights of other patients and acting in a way that helps the smooth running of their doctor's office, hospitals, and other offices.
- Paying Medicare premiums and any applicable copayments or late enrollment penalties.
- Notifying Highmark if they move, regardless of whether it is outside or inside of Highmark's service area.
- Follow plans and instructions for care that they have agreed to with their practitioners.
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

*If a minor becomes emancipated, or legally freed from control by his or her parents (over the age of sixteen), or marries, he or she shall be responsible for following all Highmark Health Options member guidelines set forth above.

The Member Rights and Responsibilities Statement can be found in the Medicaid Member Handbook, the Evidence of Coverage, or on our website at Medicaid Member Resources and Medicare Member Resources.

For more information, please call Provider Services at:

- Medicaid: **1-844-325-6251**
- Medicare Duals: **1-855-401-8251**

Ensuring Quality Care and Service through our QI/UM Program

Ensuring the excellent provision of health care and services for our members is the primary goal of the Highmark Health Options Duals (HHO Duals) QI Program.

To help achieve this, Highmark continuously monitors how well we're helping our members:

- Get preventive care.
- Receive care for long-standing health problems.
- Understand the medicines they take.
- Stay out of the hospital.
- Have appropriate access to providers.
- Make and keep doctor appointments.
- Share health information with their doctors.
- Receive care in a culturally competent manner.

The Quality Program leverages results from member surveys, medical record reviews, the Healthcare Effectiveness Data Information Set (HEDIS®), and other tools to measure how we are doing and to help set goals for future quality activities. We also work closely with you, our network providers, to monitor the care and services our members receive and determine what we can do to better serve them.

Highmark maintains a QI Workplan to analyze activities conducted as part of its QI Program. This Work Plan is evaluated every three months to identify issues and ensure that actions have been taken to address them.

Highmark also conducts an annual review of its QI Program to see how well we've met the health care and service needs of our members.

Please call Provider Services if you would like to request more information about our Quality Program at **1-855-401-8251**.

Clinical Practice and Preventive Health Guidelines

Highmark adopts clinical practice and preventive health guidelines to assist practitioners in providing appropriate health care for specific clinical conditions relevant to our members. These guidelines are developed using evidence-based clinical practice guidelines (CPGs) from professionally and industry-recognized sources, or through the experience of board-certified practitioners from appropriate specialties when guidelines from recognized sources are not available. The use of guidelines is intended to increase practitioner consistency with current standards in diagnosis and treatment.

General CPG Limitations

Guidelines may not apply to every patient or clinical situation; some variation from guidelines is expected. Provider judgment and knowledge of an individual patient replaces clinical practice guidelines. In addition, guidelines do not determine insurance coverage of health care services or products. Coverage decisions are based on member eligibility, contractual benefits, and determination of medical necessity.

Before distribution, the guidelines are reviewed and approved by Highmark's Quality Improvement and Utilization Management Committee.

Examples of some of the guidelines include:

- Adult and Child Preventive Care
- Asthma (Adult and Child)
- Attention Deficit Hyperactivity Disorder (Child and Adolescent)
- Bipolar (Adult, Adolescent, and Child)
- Cardiovascular Disease
- Childhood Obesity
- COPD
- Diabetes
- HIV (Adult and Adolescent)
- Hypertension
- Major Depression
- Opioid Prescribing for Chronic Pain
- Palliative Care
- Routine and High Risk Prenatal Care
- Schizophrenia (Adult, Adolescent, and Child)
- Substance Use Disorder

A complete listing of Highmark Health Options guidelines is **viewable online** at HHO Clinical Practice Guidelines. Physical copies are available upon request. For a paper copy, please contact the Government Quality and Health Equity Department at **1-844-325-6251**.

Participating Providers Should Not Balance Bill Patients

Highmark Health Options (HHO) continues to receive numerous complaints about participating providers who have inappropriately balance billed HHO patients for services.

As a reminder, reference the below language from page 19 of the Highmark Health Options Provider Manual Billing Responsibilities section.

Billing patients for covered services

Under no circumstance may a provider bill; charge, collect a deposit from, seek compensation, remuneration, or reimbursement from; or have any recourse against a patient for nonpayment by Highmark Health Options for covered services.

Contact Provider Services at **1-844-325-6251** to learn more about balance billing.

Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross Blue Shield Association. Highmark Health Options Duals is offered by Highmark Blue Cross Blue Shield. Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield offers HMO plans with a Medicare Contract. Enrollment in these plans depends on contract renewal.

Highmark Health Options is an independent licensee of the Blue Cross Blue Shield Association, an association of independent Blue Cross Blue Shield Plans.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

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