



FINDING A BETTER PROCESS

Butler-Area Practice Invests Time, Taps EMR to Succeed in Highmark's UDC Program

Everyone needs a Roger.

Roger Percy, a certified registered nurse practitioner at Butler Health System (BHS) Primary Care, Nallathambi Medical Associates, decided there had to be a better way to handle the Unconfirmed Diagnosis Code (UDC) program forms Highmark sends to the practice's office periodically.

Highmark launched the program in 2015 to work proactively with primary care practices so Highmark Medicare Advantage members' chronic conditions are addressed annually and to improve the quality and continuity of care.

Like some practices participating in the UDC program, Nallathambi Medical Associates experienced challenges in getting the diagnosis information to its doctors in a timely manner.

Before Roger's initiative, the UDC forms sat on a desk. When a Highmark member came for an office visit, someone searched the stack for the member's form. If the form was found before the end of the office visit, it was given to the doctor to review with the patient. Then the form

Butler Health System (BHS) Primary Care, Nallathambi Medical Associates

Office locations: Butler and Cabot, Butler County

Services: Complete primary care services

Staff: 3 PCPs, 1 PA, 1 CRNP, 2 RNs, 7 CMAs, 7 clerical/medical support staff

went back in the pile for final processing.

Because of the labor-intensive process, some UDCs were going unchecked, and not all members were being evaluated annually for all of their chronic conditions. Also, the practice was missing an opportunity to earn program compensation that's available for returning accurate, complete forms to Highmark.

People Notice a Good Thing

Initially, Roger handled the UDC forms for Dr. Nallathambi. He was so appreciative of Roger's time and efforts that the other doctors in the practice noticed and asked Roger to handle the UDC forms for their patients as well.

So Roger created a new process.

The practice manager, Tammi Chamberlain, reviews the next day's patient appointments with the UDC forms on hand. When she finds a match, she makes a copy of the UDC form and passes it on to Roger.

He researches the diagnosis information in the patient's electronic medical record (EMR), updating any diagnosis with clinical and lab results. He then adjusts the problem list to include any suspected, but unconfirmed, diagnoses.

He adds the information to the assessment portion of the patient's record, so the doctor has quick and easy access to the summary. This new process saves more time for the doctor and improves the quality of care the patient receives. Chamberlain says, "It makes it so much easier for the doctors, and we have a more accurate health record, including test results."

Since there is more information on the form now than in prior years, the initial prep work with the patient's electronic medical record does take time. "But, putting this information in front of physicians is worth the effort, especially when it translates into better patient care," said Lisa Percy, quality manager.

For example, the forms note patients with a persistent diagnosis, but Highmark also alerts PCPs about patients with a suspected diagnosis. These are based on claims data like lab results, radiology information, pharmacology data, and other clinical data that may indicate a patient has a specific undiagnosed condition.

By entering the data in the patient's health records and adding a note to alert the doctor of the UDC information, practice staff enable the doctor to address the chronic conditions, persistent or suspected, with the patient.

And, at Nallathambi Medical Associates, these efforts are indeed bearing fruit.

Hard Work Pays Off — for Patients and the Practice

In 2017, the practice evaluated and responded to more than 1,400 unconfirmed diagnoses. Of that number, more than 1,100 diagnoses were either confirmed or resolved, providing for better patient care.

Lisa Percy recalls that one of the doctors, after reviewing a condition from the UDC form with the patient, called a specialist who diagnosed the patient. This conversation gave the doctor a more complete picture of the patient's overall health, allowing for better clinical decisions.

Under Nallathambi Medical Associates' old process, out of 10 UDC forms the practice submitted, about three or four were not eligible for program compensation. Now, out of hundreds submitted to Highmark, only one or two are returned. That's a tremendous time savings because forms don't have to be corrected, reprocessed, and resubmitted.

Percy and the doctors consider the new process to be a success. "It's not hard. It does take a little bit of time, but if you have someone prep the medical records, it's definitely worthwhile," she said.

Through Highmark's UDC program, providers can earn:

- \$125 per member form if they return less than 60 percent complete and accurate
- \$150 per member form if they return between 60 and 74.99 percent complete and accurate
- \$165 per member form if they return 75 percent or more complete and accurate

"The incentive is important to every office financially. It's easy money, really. And, we're saving a lot of time by not having to go back and do the forms again like we did under our old process," Percy said.

Tips for Success

The practice offered these tips for success in the UDC program:

- Check the UDC member roster against the daily patient schedule.
- Prepare ahead of time — front-loading the UDC information into the patient's medical record.
- Flag the information so the doctor sees it during the patient visit.
- Attend all the UDC webinars and rely on other training resources.

Keeping up with the Program

To increase the effectiveness of the UDC efforts, Percy participates in all program webinars and other Highmark training resources. She said that helps her to stay on top of quality initiatives and also works toward improving the practice's CMS Stars ratings and HEDIS[®] scores.

Chamberlain also appreciates Highmark's UDC program for those reasons.

"More important than the financial incentives we earn is that the UDC program helps us to provide the best patient care," she said. "It alerts us to possible unconfirmed diagnoses and gives us an opportunity to address those concerns with our patients."

For more information about the UDC Program, visit Highmark's online Provider Resource Center via NaviNet[®]. Click on **Education/Manuals** and then **Risk Adjustment Programs**. The 2018 UDC Program materials will display and include slide presentations and webinars for PCPs and specialists, a program manual, and program instructions.

Note: The best practices and interventions are presented for your consideration only. The best practices and interventions are not required by Highmark but may be appropriate for your practice. You may find that other practices and interventions are more suitable. Please note that the successful implementation of any practice or intervention depends upon many factors and variables. Therefore, Highmark makes no representation with respect to the described practices and interventions.

What Is the UDC program?


- A proactive, clinically based effort between Highmark and providers to put persistent or suspected diagnoses in front of the doctor before the patient's visit; these diagnoses may be pertinent for annual evaluation or treatment during the patient's office visit
- Includes previously reported and/or suspected diagnoses that may not have been reported to Highmark in the current year
- Designed to improve continuity, quality, and timely coordination of care and to capture the complete and accurate health status of Highmark members





If health care had a crystal ball, a peek into it might show the industry's future looking something like this:

Patients will interact with physicians much more often, including through telehealth visits and smartphone apps. Structured clinical teams of physicians, nurses, pharmacists, dietitians, care navigators, and others will deliver more collaborative care and support patients even when they're well.

Employers who buy coverage for their employees will continue to demand quality, better results, and affordability — pushing the industry ever closer to [value-based care](#) .

Such predictions were among those of physicians, hospital executives, insurers, and employers who shared the stage at the Pittsburgh Business Group on Health's (PBGH) 16th Annual Health Care Executive Leadership Forum. Held March 13 in downtown Pittsburgh, the event attracted some 200 PBGH members and guests seeking a forecast on health care's future.

A panel discussion was held with four regional physician-health system leaders on the evolution of care delivery in the face of ever-increasing costs. A second panel discussion with representatives of four health insurers was held to discuss how coverage and payment are changing to keep care affordable.

After each talk, a panel of three employer purchasers of care took the stage to voice their reactions.

Care Delivery to Center Around Wellness and Technology

In the next decade, wellness and condition management will emerge as priorities to reduce hospital stays and manage costs, according to physician-health system panelists.

"Primary care will become the most critical asset of any health care system," said Susan Manzi, MD, chair of the Medicine Institute at Allegheny Health Network (AHN), who served on the provider panel. "We're going to see more team-based care, with physicians, nurses, advanced practitioners, behavioral health specialists, and pharmacists all managing patients, and not just for acute episodes. Rarely will you see one doctor in an office with only a nurse and a medical assistant."



Susan Manzi, MD

Telehealth visits and remote home monitoring of patients will become commonplace, and care delivery will move more toward "protocolized care," she added.

"Doctors don't like that term. But today, if you ask 10 doctors how to treat a patient, you might get 10 different approaches," Manzi said. "Care needs to move toward evidence-based protocols that minimize unwarranted variation."

Providers and Insurers Finding Common Ground

Care providers and insurers increasingly are seeing each other as partners, noted members of the insurer panel. And both parties agree that care and cost transformation begins with primary care.

"Last year, we launched our True Performance pay-for-value incentive program because PCPs impact a significant part of the health care premium — not only in terms of quality measures but also in managing costs," said Anthony Benevento, senior vice president of Regional Markets for Highmark.



Anthony Benevento

Conversations between insurers and PCPs start a data exchange that can speed up the transition to value-based care, he noted. "We've seen an incredible thirst from doctors to provide them with data on where cost and quality meet," Benevento said. "It's just the first step in changing the way we pay for care."

Members of the employer panel were:

- Jan Klein, chairperson of the Allegheny County Schools Health Insurance Consortium
- Carrie Rust, director of human resources for Ellwood Group Inc.
- Lisa Harris, director of benefits and compensation for Eat 'n Park Hospitality Group

“Highmark is grateful for organizations like the Pittsburgh Business Group on Health that foster frank discussion and help move the health care industry forward together,” Benevento said. “We look forward to continued dialog.”





HIGHMARK FURTHER ADDRESSING **OPIOID USE**

Coverage Measures Intended to Address Growing Opioid Crisis

Like you, Highmark sees the safe, effective use of prescription drugs by our members, your patients, as a main priority.

That is why, effective March 8, 2018, Highmark implemented opioid measures designed to assist the clinically appropriate use of these medications while proactively preventing the development of opioid use disorder.

There will be exceptions for members with cancer or other terminal illnesses.

These measures follow CDC and Highmark guidelines:

- **Short-acting opioids:** For individuals new to therapy, initial prescriptions will be limited to seven days. Prior authorization applies. These patients will receive a maximum 14-day supply for short-acting opioids within a 30-day period without additional authorization, provided that each prescription does not exceed the seven-day limit.
- **Long-acting opioids:** Prior authorization is required, with confirmation of diagnosis, for new users to initiate therapy.


Highmark designed these measures with member safety as the primary goal.

“Even at low doses, taking an opioid for an extended period of time increases the risk of addiction,” said Sarah Marche, PharmD, vice president of Pharmacy Services for Highmark Inc. “The idea of this program is to stop inappropriate, long-term use at the outset. This policy is completely about the safety of our members and the

communities that we serve.

“Data from the CDC show that people who use opioids for just one day have a 6 percent chance of becoming addicted,” Marche added. “For those who use opioids for more than a week, the chances increase to more than 13 percent.”

She noted there are some exceptions to the program, including members who have a condition that causes chronic pain that can't be managed with other treatments or who may need opioids for acute or chronic pain associated with cancer or other malignant conditions.

Valuable resources can be found on the website for Pennsylvania's [Prescription Drug Monitoring Program](#)  (PA PDMP). These resources can assist you in identifying patients struggling with substance abuse disorder. The site also offers access to other expansive resources, including:

- Prescriber Q&A
- PDMP Tutorials & Policies
- Opioid Prescribing Guidelines
- Patient Education Materials
- Provider Resources on:
 - Talking with Patients About Their Drug Use
 - Identifying Red Flags for Addiction and Diversion
 - State Resources Available to You

You also can consult Highmark's Clinical Practice Guideline for opioid use that's available on our online Provider Resource Center. On the Resource Center, click on **Education/Manuals** and then on **Clinical Practice and Preventive Health Guidelines**. In the **2018 Clinical Practice Guidelines** section, click on **Prescribing Opioids for Chronic Pain Guideline and Key Points**.

Highmark will remain vigilant and continue to support you in addressing the opioid crisis to keep our members — your Highmark patients — safe. Watch *Provider News* for updates about these ongoing efforts.



You also can consult Highmark's Clinical Practice Guideline for opioid use that's available on our online Provider Resource Center.

axialHealthcare Program Succeeding, Expanding

As reported in recent issues of *Provider News*, Highmark has joined forces with

axialHealthcare, a national leader in safe and effective pain management and opioid therapy.

axialHealthcare's resources provide a more comprehensive view of patients' medication use, such as multi-prescriber activity, adverse drug interactions, overdose, and addiction. Highmark's collaboration with axialHealthcare began in West Virginia and expanded to Pennsylvania in February 2018.

"We are very confident that our work with axialHealthcare and doctors will drive meaningful change throughout our network," said Charles DeShazer, MD, chief medical officer for Highmark Inc. "We are going to need many tools to combat this terrible problem. That's why we are expanding the program to Pennsylvania. We expect positive results here, just as we've seen in West Virginia."

To date, the results in West Virginia are impressive:

- More than 250 providers received extensive, targeted clinical consultation on pain management.
- Patients receiving opioids from multiple prescribers dropped by more than 28 percent.
- Patients receiving opioids in addition to certain sedatives — a significant risk factor for opioid overdose — fell by more than 25 percent.

axialHealthcare has resources you can use that can be accessed directly from NaviNet[®]. Log into NaviNet, navigate to **My Health Plans**, and choose the appropriate Highmark health plan. Under **Workflows for this Plan**, select **Auth Inquiry and Reports** and then **Pain Management Program Portal**. Select the appropriate billing provider and click **Submit**.*

*Please note: Access is at the office and user level. It can be disabled for any user by your security officer.

Watch *Provider News* for updates on the axialHealthcare program and how it is helping Highmark to successfully address the opioid crisis.



VITAL Progress: Program Wins Innovation Award

Medical science and technology are evolving faster than ever. Researchers, physicians, and medical device makers are developing revolutionary new treatments and other patient care breakthroughs — including diagnostic tests, durable medical equipment, or new procedures or care processes.

Since its 2015 launch, Highmark Health's [VITAL](#) program has played a key role in supporting innovations that have commercial approval but do not yet have the widespread adoption of the medical community. That support helps clinicians and tech companies more quickly test their market-ready care solutions in real hospital environments and generate results so insurers may consider covering them.

And VITAL's efforts aren't going unnoticed.


In April, the Blue Cross and Blue Shield Association (BCBSA) announced that VITAL, a program of Highmark Health, won the organization's 2018 Brand Innovation Award.



David Holmberg, left, president and chief executive officer of Highmark Health, accepts the Blue Cross and Blue Shield Association's (BCBSA) 2018 Brand Innovation Award on behalf of VITAL at a recent BCBSA Board of Directors meeting.

Part of the BCBSA's annual Brand Excellence Awards, the Brand Innovation Award is given for enhancing the position of the Blue brand by delivering new programs, products, and/or initiatives. Entries were judged on their brand- and business-building impact, originality, and potential for adoption across the BCBSA system of Blue plans.

“We’re very honored and thrilled to receive the BCBSA’s 2018 Brand Innovation Award,” said Eileen Rodgers, director of the VITAL program. “VITAL has made great strides and established many impactful clinical and technology projects in a very short time. We have more than 40 new ideas under evaluation, and we’re excited to help fast-track these potential care solutions for those who can benefit the most — patients.”

[HeartFlow](#)  is an example of new patient care technology that is blossoming with VITAL’s help.

What VITAL’s Support Means


When doctors or other industry leaders identify a potential new treatment, technology, or procedure, VITAL offers support that helps them gain insights and collect the needed data to demonstrate the effectiveness of the innovation.

VITAL collects evidence of clinical quality, financial feasibility, and patient experience to make a case for adopting the new solution within the care delivery system. That information can help to expand opportunities for enhanced care management programs and changes to coverage and reimbursement policies. And that can give patients faster access to new, promising treatments.*

Currently, testing occurs at Allegheny Health Network (AHN) facilities in Pittsburgh for AHN patients who also are eligible Highmark members in order to obtain a full picture of clinical and cost data.

As of April 2018, VITAL:

- Has 13 active projects with 40+ in the pipeline
- Is focused on cardiology, oncology, women’s services, chronic conditions (COPD and diabetes), precision medicine, and other areas of clinical transformation
- Anticipates supporting testing and validation of 10+ projects per year by 2020

VITAL is seeking to work with clinicians and technology leaders who have market-ready innovations that are ready for testing and evaluation to spur broader adoption. For more information or to begin an application, visit VITAL’s newly redesigned website at vitalinnovation.com  or send an email to VITAL@highmarkhealth.org.

*The coverage of any medical service or treatment is subject to the terms of the member’s benefit plan. Please be sure to use NaviNet[®] or the applicable HIPAA electronic transactions to check member benefits and eligibility prior to ordering or providing services.





NaviNet Provider File Management: We've Listened to Your Concerns and Made Improvements

As you know, Provider File Management is a data management tool within Highmark's NaviNet[®] system that providers use to update their directory information and make sure it's current and correct. Until now, this function proved to be difficult to use, especially for providers who have multiple locations and staff.

In response to your concerns, Highmark has updated Provider File Management and made it easier than ever to ensure your directory information remains valid. With this valuable resource, you can easily update practitioners' information and their office addresses, request credentialing, update and maintain your patient acceptance panel, and add new accreditations.

While the Centers for Medicare & Medicaid Services (CMS) requires providers to update their directory information at least quarterly, we suggest you make updates as soon as changes occur, for the benefit of your patients. Highmark members who are looking for a PCP or specialist expect that the online provider directory presents information that is accurate and current. Without your help, this service may not provide the best access to care for these members.

Reminder: Protect Your Network Status

It's essential that your practice information on file with Highmark remains up to date and is attested to on a quarterly basis.

Providers who don't validate and attest that their data is accurate will be immediately removed from the directory, and their status within Highmark's networks may be impacted.

CMS requires Highmark to conduct a quarterly outreach to validate provider information. We use this information to populate our provider directory and to help ensure correct claims processing. Each review confirms:

- **The practitioner name is correct.** For example, we must ensure the practitioner's name in the directory matches the name on his/her medical license.
- **The practice name is correct.** For example, is there a difference between the practice name that is being used when phones are answered versus the practice name listed in the directory?
- **The practitioner's practicing specialties are correctly listed.** Is there more than one specialty listed in the directory? Are both specialties being practiced?
- **Practitioners are not listed at practice locations where they don't actually schedule appointments and see patients.** Practitioners listed must be affiliated with the group. Practitioners who cover on an occasional basis are not required to be listed. Practitioners who do not see patients on a regular basis at a location should not be listed at that location.
- **The practitioner is accepting new patients — or not accepting new patients — at the location.**
- **The practitioner's address, suite number (if any), and phone number are correct.**

Note: Your up-to-date information must include your current address, phone number, fax number, and any and all required data elements set forth in the provider contract(s) with Highmark.

It's vital that all providers review and update their information in Provider File Management within NaviNet. Information should be updated as soon as a change occurs. All data should be reviewed at a minimum of once a quarter to ensure it's accurate. Detailed instructions are available in the **Provider File Management NaviNet Guide**, which is available on the Provider Resource Center under **Education/Manuals**.



Providers who don't validate and attest that their data is accurate will be immediately removed from the directory, and their status within Highmark's networks may be impacted.

Highmark and its designated agent, Atlas, are currently making outreach calls to providers to verify the accuracy of provider data. If you receive a call, please provide our agent with the requested information.



Shingrix Added to Preventive Schedule

Highmark maintains a Preventive Schedule* for members that is intended to help them get the most out of their preventive care benefits — everything from regular physicals to specific screenings for members who are at risk of certain chronic or serious health conditions.



Vaccine

Highmark has added the Shingrix vaccine (Procedure Code 90750) as a preventive benefit for individuals age 50 and older.

Members who received the Zoster vaccine are eligible for Shingrix as long as it has been two months or more since they received Zoster.

Note: For Medicare Advantage members, Shingrix is covered under their Medicare Part D (prescription drug) benefits.

For the Current Guidelines

To access the preventive health guidelines, visit the Provider Resource Center via NaviNet® or through our main website under **Helpful Links**. Choose **Education/Manuals** and **Clinical Practice and Preventive Health Guidelines**.

We encourage you to consult our preventive health guidelines when planning care for your patients with Highmark coverage, and we thank you for your support in addressing their health needs!

*Please note that most, but not all, of our customer groups follow the Highmark Preventive Schedule, meaning not all members may have coverage for services on the schedule. Therefore, when providing services for our members, please remember to check the member’s benefits via NaviNet or by using the

appropriate HIPAA electronic transactions to determine if services are covered and if any associated member cost sharing applies. (If you do not have access to NaviNet, please call Provider Service to obtain benefits and eligibility information.) The administration of any vaccination is subject to the recommendation of the physician or other health professional. The Preventive Schedule only recommends procedures and testing.





Highmark Seeking New Members for Medical Review Committee for 2019-2020 Term

Highmark is seeking new members to serve on its Medical Review Committee for the next two-year term of 2019-2020.

Highmark's Medical Review Committee resolves disputes between Highmark and Pennsylvania-contracted health service practitioners. These disputes may involve billing disputes and quality-of-care issues, as well as alleged violations of participating provider agreements, credentialing denials, and appeals regarding network terminations. The Committee also considers and reviews appeals for providers who have been denied privileges to provide imaging services.

Nine doctors of medicine, one doctor of osteopathy, one doctor of chiropractic, one physical therapist, and two consumer representatives now serve on the Committee. The Medical Review Committee Selection Committee appoints the members to a two-year term. Members may be reappointed.

The Medical Review Committee generally meets three to four times a year, or as needed based on cases and schedules. The meetings are held at the Highmark campuses, both in Camp Hill and Pittsburgh, Pa. Members receive an honorarium from Highmark for attending the meetings and are also reimbursed for reasonable travel expenses.

Considerable preparation time for the meetings may be required. Members are expected to attend all meetings and be prepared to participate in each case discussion.

Committee Member Requirements and How to Apply

All potential candidates must be a Pennsylvania-licensed health care provider who is a party to one or more professional provider contracts with Highmark.

If you are interested in being considered for membership by the Medical Review Committee Selection Committee, please send a copy of your current resume or curriculum vitae by June 29, 2018, either through email to earl.bock@highmark.com, or through U.S. mail to:

Earl Bock
Secretary, Medical Review Committee
Highmark Blue Shield
1A-L3
P.O. Box 890089
Camp Hill, PA 17089



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Medicare Advantage News

Key FAQs About Medicare Compliance and FWA Training

If your practice or facility cares for Medicare-eligible patients, please read this important notice and share it with your colleagues.



What kind of training is required by the Centers for Medicare & Medicaid Services (CMS)?



CMS requires Highmark's Medicare First-tier, Downstream, and Related (FDR) Entities to complete two trainings:

- Medicare Parts C&D General Compliance Training
- Combatting Medicare Parts C&D Fraud, Waste, and Abuse (FWA) Training



Who must complete these trainings?



Individuals associated with your organization who work with Highmark's Medicare Advantage and/or Medicare Part D Prescription Drug Plan (PDP) patients and who fall into one of these categories:

- Employee
- Governing-body member
- Temporary worker
- Contractor
- Subcontractor
- Volunteer



Why does CMS require these individuals to complete these trainings?



CMS expects Highmark and its other Medicare-plan sponsors to ensure that all organizations receiving Medicare dollars understand how to comply with the laws, regulations, guidelines, and policies that come with the Medicare program and how to prevent, detect, and correct Medicare fraud, waste, and abuse.



When does CMS require these individuals to complete these trainings?



Both trainings must be completed:


- Within 90 days of hire, contracting, or appointment
- Annually thereafter (between Jan. 1 and Dec. 31 of any given contract year)



Where can individuals go to access these trainings?



Individuals have three options for completing these training requirements. They can:

- Complete both trainings online via the [CMS Medicare Learning Network](#) .
- Complete Highmark's General Compliance Training and Fraud, Waste, and Abuse Training, which includes the CMS Medicare Learning Network Training. The course is located on the Highmark **Provider Resource Center**. To access the training, search using the keyword "Fraud."
- Complete your organization's General Compliance Training and Fraud, Waste, and Abuse Training as long as it includes all of the content included in CMS's trainings, without any modifications.



What proof must be provided that the trainings were completed?



Individuals must review the training programs in their entirety, and there must be some form of evidence that each individual completed the training. Acceptable forms of evidence include:

- Sign-in sheets
- Individual employee attestations
- Electronic certifications

The records must include:

- Time
- Attendance
- Topic
- Certificates of completion (if applicable)
- Test scores (if applicable)

Proof of training completion must be provided to Highmark upon request. Training records must be maintained for the period of the provider's contract with Highmark, plus an additional 10 years.



Are there any exceptions to these guidelines?



Yes. FDRs who have met the FWA training and education certification requirements through enrollment into Parts A or B of the Medicare program or through accreditation as a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) are deemed to have met the training and educational requirements for fraud, waste, and abuse. However, these individuals are **not** exempt from the general compliance training requirement.





Medicare Advantage News


New Medicare Cards Coming Soon

What to Expect and How to Help Your Patients

Beginning in April 2018, the Centers for Medicare & Medicaid Services (CMS) will start mailing new Medicare cards with new identification numbers to all active Medicare beneficiaries. The new cards will have a Medicare Beneficiary Identifier (MBI)




instead of the beneficiary's Social Security number to prevent fraud and medical identify theft.

The CMS card distribution schedule indicates that Medicare beneficiaries in Pennsylvania and West Virginia are first on the list to receive their new cards starting in May 2018. You can view the entire mailing schedule at [cms.gov/Medicare/New-Medicare-Card/NMC-Mailing-Strategy.pdf](https://www.cms.gov/Medicare/New-Medicare-Card/NMC-Mailing-Strategy.pdf) .

Communicate With Your Medicare Patients Now

Patients may be confused as to which card to present or why their Social Security number is no longer the same as their Medicare number. Asking patients if they have additional Medicare Advantage or Medigap coverage at the time of service may be beneficial and may help alleviate misunderstandings.

You play an important role in educating your Medicare patients about their new cards. To help prepare your patients for this change, CMS has provided a variety of

tools for you to use to remind patients of their new Medicare card. Please review the following website for items that are printable, such as posters, tear-offs, and fliers, which can be helpful when discussing the new Medicare card and number with your patients: [cms.gov/Medicare/New-Medicare-Card/Partners-and-Employers/Partners-and-employers.html](https://www.cms.gov/Medicare/New-Medicare-Card/Partners-and-Employers/Partners-and-employers.html). These items may be displayed in your office; however, this is not a requirement. CMS also launched its own educational campaign around the new card in March of 2018.





Locum Tenens Process Change to Take Effect June 1, 2018



Effective June 1, 2018, Highmark will no longer accept locum tenens forms.

This change is being implemented to ensure Highmark's compliance with Centers for Medicare & Medicaid Services (CMS) billing requirements (Medicare Claims Processing Manual, Chapter 1, Section 30.2.11). Those requirements outline the specific payment conditions that must be met when a physician retains a locum tenens (substitute physician).

Compliance Requirements

Physicians may retain substitute physicians to take over their professional practices when they are absent for reasons such as:

- illness
- pregnancy/maternity leave
- vacation
- continuing medical education

Billing Requirements

A physician may bill and receive payment for a substitute physician's "covered visit services" as though he/she performed them. In such situations, "covered visit services" include not only those services ordinarily characterized as a covered physician visit, but also any other covered items and services furnished by the substitute physician or by others as "incident to" the physician's services.

A physician may submit a claim and (if assignment is accepted) receive payment for covered visit services of a substitute physician if:

- The regular physician is unavailable to provide the services.

- The member has arranged or seeks to receive the services from the regular physician.
- The regular physician pays the substitute for his/her services on a per diem or similar fee-for-time basis.
- The substitute physician does not provide the services to patients over a continuous period of longer than 60 days subject to the following exception:
 - A physician called to active duty in the Armed Forces may bill for services furnished under a fee-for-time compensation arrangement for longer than the 60-day limit.

In these cases, the physician indicates that the services were provided by a substitute physician under a fee-for-time compensation arrangement meeting the requirements of this section by entering **HCPCS code modifier Q6** after the procedure code.

(Modifier Q6 — Service furnished under a fee-for-time compensation arrangement by a substitute physician or by a substitute physical therapist furnishing outpatient physical therapy services in a health professional shortage area, a medically underserved area, or a rural area).

If the only services a physician performs in connection with an operation are post-operative services furnished during the period covered by the global fee, these services need not be identified on the claim as services furnished by a substitute physician.

Please note: Claims submitted with a Q6 modifier will be subject to ongoing monitoring and audit for fraudulent billing activity.

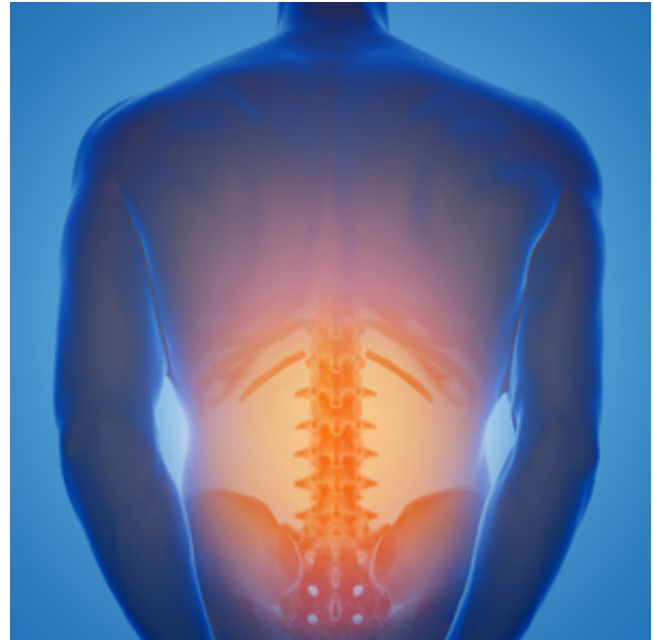
Please review the *Highmark Blue Shield Office Manual* or *Highmark Facility Manual* for more information on how to fully credential your providers.



Patient Education About Overuse of Imaging Studies for Low Back Pain

Studies have shown that low back pain is one of the most common reasons for visits to a PCP. And, based on the severity of their pain, patients may perceive the need for advanced imaging scans as a first step in their diagnosis.

However, nationally accepted best practice guidelines (see Evidence-Based Guidelines, below) offer treatment alternatives that may help patients manage pain appropriately and avoid the high out-of-pocket costs of unnecessary advanced imaging scans.



Please share the following guidelines with the physicians in your practice or facility and ask them to discuss the guidelines with patients to help them better understand the costs and potential health risks associated with unnecessary advanced imaging procedures.

Evidence-Based Guidelines

The American College of Physicians' Current Clinical Practice Guideline for the Diagnosis and Treatment of Low Back Pain offers viable treatment alternatives.¹ And the Academy of Family Physicians has endorsed this guideline for best practice, which recommends managing initial acute, chronic, or sub-acute low back pain in these ways:

- Non-pharmacological treatments
 - superficial heat
 - massage
 - acupuncture
 - spinal manipulation
 - exercise
 - multidisciplinary rehabilitation


- tai chi
- yoga
- motor control exercise
- progressive relaxation
- biofeedback
- low laser therapy
- cognitive behavior therapy
- Pharmacological treatments
 - nonsteroidal anti-inflammatory drugs (NSAIDs) (can substitute Tramadol or Duloxetine when NSAIDs contraindicated)
 - skeletal muscle relaxants
 - opioids only when other treatments are unsuccessful and benefits outweigh the risks (See [Highmark Further Addressing Opioid Use](#) in this issue of *Provider News*.)

Barriers to Guideline Adherence

According to the Institute for Clinical and Economic Review (ICER), several perceived barriers may prevent clinicians from following the recommendations listed above in the practice guidelines, including the following²:

- clinicians' lack of agreement with specific recommendations
- lack of time to talk with patients and lack of resources to engage patients on potential harm of over-imaging use
- desire to reassure and keep patients happy
- linking physician bonuses and quality scoring to patient satisfaction
- concerns about malpractice
- number of tests recommended before being seen by specialist
- clinicians' awareness of guidelines at the point of care
- payment models that reward volume of service
- insurance coverage that masks the cost of procedures and patients not responsible for cost of imaging tests


The National Committee for Quality Assurance (NCQA) recommends that imaging for low back pain should be avoided for at least 28 days in the outpatient setting, unless there are clear indications requiring more aggressive interventions.

Highmark supports this best practice and promotes the use of evidence-based care to ensure that our members receive high-quality, appropriate, and safe treatment at an affordable cost. Highmark also maintains a [Radiology Management Program](#)  to ensure appropriate use of outpatient, non-emergency diagnostic imaging procedures for our members.



Physicians also can consult Highmark's Clinical Practice Guideline for opioid use that's available on our online Provider Resource Center. On the Resource Center, click on **Education/Manuals** and then on **Clinical Practice and Preventive Health Guidelines**. In the **2018 Clinical Practice Guidelines** section, click on **Prescribing Opioids for Chronic Pain Guideline and Key Points**.

Note: The coverage of any medical service or treatment is subject to the terms of the member's benefit plan. Additionally, the physician and patient will determine the appropriate course of treatment for the patient.

Resources:

1. Qaseem A., Wilt T.J., McLean R.M., Forciea M.A. Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline from the American College of Physicians. *Ann Intern Med.* 2017;166:514–530. doi: 10.7326/M16-2367
2. Reed, J., and Pearson, S. Choosing Wisely® Recommendation Analysis: Prioritizing Opportunities for Reducing Inappropriate Care (Imaging for Nonspecific Low Back Pain). [choosingwisely.org/wp-content/uploads/2015/05/ICER_Low-Back-Pain.pdf](https://www.choosingwisely.org/wp-content/uploads/2015/05/ICER_Low-Back-Pain.pdf) 

Additional Resources:

aafp.org/patient-care/clinical-recommendations/all/cw-back-pain.html  (accessed Jan. 10, 2018)
ncbi.nlm.nih.gov/pmc/articles/PMC5264674/  (accessed Jan. 10, 2018)



Notifications for Providers

Several times annually, Highmark notifies providers of important policies and guidelines. The following notification is for your information and reference.

Quality Program Information Available Online

The Quality Program has been designed to improve the quality, safety, and equity of the clinical care and services provided to our members. To do this, we continually review the aspects that affect member care and satisfaction and look for ways to improve them.

We work closely with the physician community in our efforts to address both the clinical care and service our members receive, as well as plan management to address the services provided by the organization (i.e., authorizations, claims handling, appeals, etc.). We also use member satisfaction surveys and other tools to get feedback on how we're doing. These results are used to guide our future clinical, service, network, member safety, health equity, and quality improvement activities.

For more information about the Quality Program, including information about program goals and a report on progress toward meeting those goals, please visit our online Provider Resource Center via NaviNet[®] or through our main website under **Helpful Links**. On the Resource Center, select **Education/Manuals**.

Professional providers should select **Highmark Blue Shield Office Manual**, and see "Chapter 4: Health Care Management, Unit 5: Highmark Quality Program" to view the Quality Program information.

Facility providers should select the **Highmark Facility Manual** and see "Chapter 4: Care Management and Quality Improvement Manual, Unit 8: Quality Improvement."




We work closely with the physician community in our efforts to address both the clinical care and service our members receive, as well as plan management to address the services provided by the organization.



Quarterly Formulary Updates Available Online

We regularly update our prescription drug formularies and related pharmaceutical management procedures. To keep our in-network physicians apprised of these changes, we provide quarterly formulary updates in the form of Special eBulletins.



These Special eBulletins are available [online](#) . Additionally, notices are placed on the Provider Resource Center's **Hot**

Topics page to alert physicians when new quarterly formulary update Special eBulletins are available.

Providers who don't have internet access or don't yet have NaviNet[®] may request paper copies of the formulary updates by calling our Pharmacy area toll-free at 1-800-600-2227.

Pharmaceutical Management Procedures


To learn more about how to use pharmaceutical management procedures — including providing information for exception requests; the process for generic substitutions; and explanations of limits/quotas, therapeutic interchange, and step-therapy protocols — please refer to the **Pharmacy Program/Formularies** page, which is accessible from the main menu on the Provider Resource Center.




About This Newsletter

Provider News is a newsletter for health care providers who participate in our networks. It contains valuable news, information, tips and reminders about our products and services.

- *Classic Blue*
- *Direct Blue*
- *EPO Blue*
- Freedom Blue PPO
- *PPO Blue*
- *PPO Plus*
- *Advance Blue*
- *Simply Blue*
- *Community Blue*

Do you need help navigating the *Provider News* layout? View a [tutorial](#)  that will show you how to access the stories, information and other links in the newsletter layout.

Important note: For medical policy and claims administration updates, including coding guidelines and procedure code revisions, please refer to the monthly publication [Medical Policy Update](#) .

Note: This publication may contain certain administrative requirements, policies, procedures or other similar requirements of Highmark (or changes thereto) which are binding upon Highmark and its contracted providers. Pursuant to their contract, Highmark and such providers must comply with any requirements included herein unless and until such item(s) are subsequently modified in whole or in part.

Comments/Suggestions Welcome


Joe Deemer, Copy Editor

Adam Burau, Editor

We want *Provider News* to meet your needs for timely, effective communication. If you have any suggestions, comments or ideas for articles in future issues, please write to the editor at adam.burau@highmarkhealth.org.



Contact Us

Providers with internet access will find helpful information online at highmarkblueshield.com . NaviNet[®] users should use NaviNet for all routine inquiries. But if you need to contact us, below are the telephone numbers exclusively for providers.

HIGHMARK
1-866-731-8080

Convenient self-service prompts available.

1-866-588-6967 — Freedom BlueSM PPO Provider Service Center

1-866-675-8635 — Freedom Blue PFFS Provider Service Center

1-866-634-6468 — Requests for Medical Management and Policy peer-to-peer conversations

1-800-992-0246 — EDI Operations (electronic billing)

1-800-600-2227 — Option 2 — Pharmacy (prescription authorizations)



Legal Information

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Note: This publication may contain certain administrative requirements, policies, procedures or other similar requirements of Highmark (or changes thereto) which are binding upon Highmark and its contracted providers. Pursuant to their contract, Highmark and such providers must comply with any requirements included herein unless and until such item(s) are subsequently modified in whole or in part.

