PROVIDER NEWS

A Newsletter for Highmark Blue Shield Providers in Central Pennsylvania, the Lehigh Valley, Northeastern Pennsylvania and Southeastern Pennsylvania
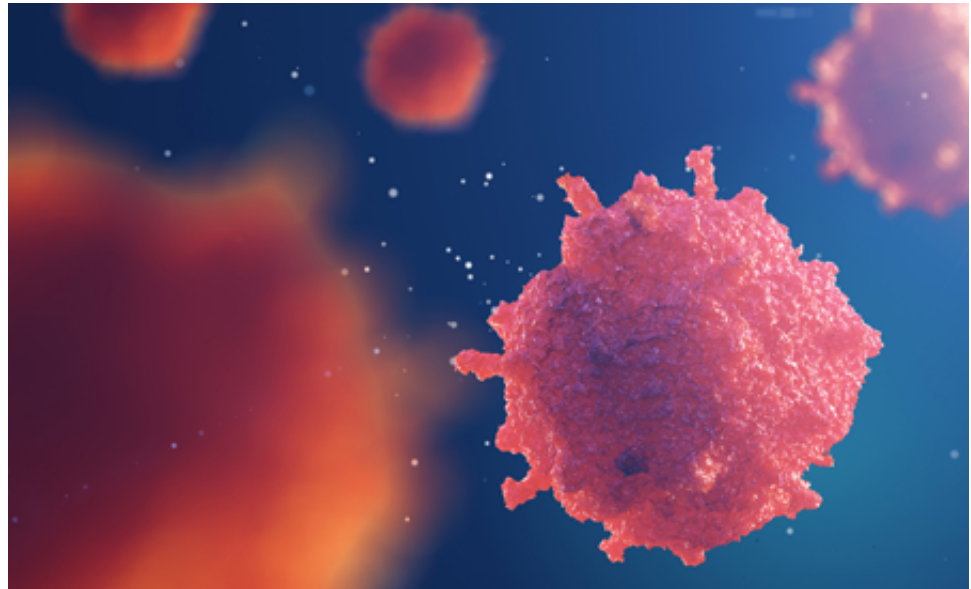
HIGHMARK

Issue 3, 2018

A Major Lift for Cancer Care and Research

A $25 Million Grant to Penn State Health Will Bolster Care for Central PA Residents

Efforts to provide specialized cancer care and conduct innovative research got a significant lift this past spring when Highmark Health announced a $25 million grant to Penn State Cancer Institute.

The grant will help the institute develop new cancer treatment drugs and establish clinical trials to test promising new therapies, making them accessible to all patients. The funding also will boost recruitment of leading researchers with expertise in specific cancer disciplines.

The funding is the latest component of a **larger, long-term collaboration** that Highmark Health and Penn State Health announced in December 2017. That collaboration includes a $1 billion joint investment that will enable Penn State Health to develop a high-value, community-based health care network designed to expand local access to primary and specialty care and enhance cooperation with community physicians.

Highmark Health's support for Penn State Cancer Institute further demonstrates its commitment to central Pennsylvania residents and communities and its belief that patients should have access to exceptional care close to home.

"As we said last year, we believe very strongly in the team at Penn State and the clinical expertise at the Milton S. Hershey Medical Center," said David Holmberg, president and chief executive officer of Highmark Health. "Today, through this $25 million investment in Penn State Cancer Institute, we are affirming our commitment

to a collaboration between the two strongest health care brands in Pennsylvania who share a passion for providing our members and patients with unsurpassed service and quality."

Based on the Penn State Health Milton S. Hershey Medical Center campus, Penn State Cancer Institute is the region's leading cancer care provider.

Penn State Cancer Institute's clinical services are offered in Hershey; in State College, PA, through an alliance with Mount Nittany Health; and in Reading, PA, at Penn State Health St. Joseph. With a research presence in Hershey and at the University Park campus, the institute is the centerpiece of Penn State's efforts to prevent, treat, and find cures for cancer.

Opening doors to cancer breakthroughs

The grant will enable Penn State Cancer Institute to invest immediately in research operations and science to transform cancer care.

One area of focus will be growing research lab services through new shared scientific resources, which will be available to all institute staff. Examples include an Absorption, Distribution, Metabolism and Excretion Laboratory — where the effects of potential new cancer drugs can be studied. A developmental therapeutics laboratory also will be developed to manage Phase 1 clinical trials.

"Penn State College of Medicine has a rich history in cancer research, from our work decades ago that contributed to the development of the world's first cervical cancer vaccine to the many vital studies underway today that are helping us to understand how different cancers form, spread, and can be effectively prevented and treated," said Dr. A. Craig Hillemeier, dean, Penn State College of Medicine; chief executive officer, Penn State Health; and senior vice president for health affairs, Penn State. "This grant is a demonstration of Highmark's confidence in our ability to continue to advance discoveries that

Additional Expansions to Benefit Cancer Care

In April, Penn State Health announced other service enhancements to provide comprehensive cancer care in central Pennsylvania. These include:

- Expansion of Penn State Health St. Joseph's **Medical Office Building in Bern Township** ⎘ to incorporate a new linear accelerator to treat solid tumor cancers
- Development of a new **Department of Radiation Oncology** ⎘ at Penn State College of Medicine to enhance recruitment of cancer treatment and research experts and train

improve the lives of people with cancer."

More effective, affordable cancer care close to home

One of Penn State Cancer Institute's greatest needs is recruiting highly trained personnel to help manage projects and develop protocols for research and clinical trials.

"This grant will help us continue to pursue the best scientists in the world to be part of the Penn State Cancer Institute team," said Dr. Raymond J. Hohl, director of Penn State Cancer Institute. "This means we improve our knowledge about the disease, and that ultimately benefits our patients."

The grant also will support clinical researchers developing investigator-initiated trials, enabling "Highmark Scholars" to bring their research ideas into the clinic. That will enable cancer patients in central Pennsylvania, including Highmark members, to participate in original clinical trials without traveling far from home.

"I am so pleased that Highmark is part of this innovative provider-payor collaboration, which is going to change and improve lives," said Deborah Rice-Johnson, president of Highmark Inc. "This type of financial commitment also provides significant stability for Penn State Cancer Institute and helps ensure that our members and everyone in the community will continue to have access to high-quality, affordable care."

Keeping cancer care close to patients' homes, families, and support systems is extremely important, Rice-Johnson noted. She added that it is one of the great benefits of these types of provider collaborations that have resulted from the Highmark and Penn State alliance.

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VITAL Innovation Program to Evaluate Mobile App for Diabetes Patients

WellDoc's BlueStar Offers FDA-Cleared Digital Coaching Program

Highmark Health's **VITAL** innovation program will evaluate the BlueStar® mobile app developed by WellDoc®.

BlueStar is a digital health coach that engages with individuals who have type 2 diabetes. It delivers personalized, real-time feedback, as well as diabetes education tailored to meet each patient's specific needs and appropriate to their care plan. Initially, the app is being offered solely to Highmark members. Testing will be done through Allegheny Health Network, its physicians, and patients who enroll in the app.
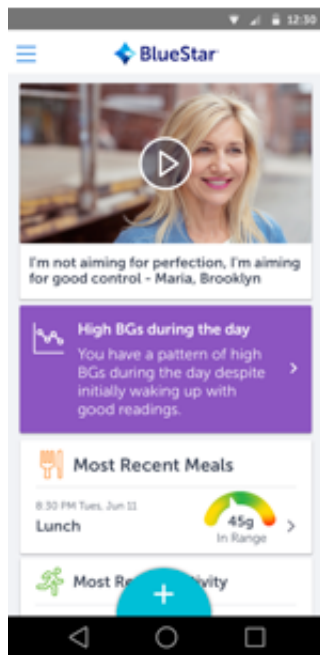
"According to the CDC, over 30 million Americans are living with type 2 diabetes," said Sarah Ahmad, senior vice president of Innovation and Transformation for Highmark Health. "Finding better ways to offer patients support and guidance in the fight against chronic disease is a priority of the VITAL program.

"WellDoc's BlueStar app is demonstrating promise as a therapy that can help control diabetes, making it well suited for further testing through VITAL, which can help accelerate the adoption of important new technologies, making them available to patients sooner," she said.

More than 150 patients will participate in the evaluation of BlueStar over a period of six months, ending in December of this year.

For more information on BlueStar, read this **press release** .

About VITAL

VITAL supports medical innovations that have commercial approval but do not yet have the widespread adoption of the medical community. With VITAL's support, tech companies and clinicians can test their care solutions more quickly and in real patient care environments. Insurers are then able to make informed coverage decisions.

Provider News, Issue 3, 2018 | © 2018 Highmark Blue Shield

Introducing the *Highmark Provider Manual!*

We are pleased to announce that the new *Highmark Provider Manual* is now available!

We have consolidated the information from the *Highmark Blue Shield Office Manual* and the *Highmark Facility Manual* into one manual to serve as the primary online resource for all providers — professional, facility, and ancillary — in all of our service areas in Pennsylvania, Delaware, and West Virginia. Although the information is the same, we've organized it in a way that will help you find the information you need more easily.

The *Highmark Provider Manual* is available under **Education/Manuals** on the Provider Resource Center (PRC). It can also be accessed quickly by selecting **Manuals** on the dark gray Quicklinks Bar at the top of the PRC homepage.

The *Highmark Provider Manual* is comprised of six chapters based on key categories of content: General Information, Product Information, Provider Network Participation, Provider Responsibilities and Guidelines, Care and Quality Management, and Billing and Payment.

Unit titles identify if the unit is specific to professional or facility providers or, in some cases, a particular provider type (for example, Chapter 4.4: Ancillary Providers). Also, look for the icon on the first page of each unit to identify whether the unit is intended for Professional Providers, Facility Providers, or All Provider Types.

Along with our traditional chapter/unit format, we've also kept other features from the former manuals that can be accessed from **Additional Resources** at the bottom of the manual's home page.

You can still access all tip sheets from throughout the manual in one location — the Tip Sheet Index. And all of the manual's units are available as a single PDF document that lets you search the entire manual by keyword if you're not able to determine which unit contains the information you're seeking.

Also in this location are the archived versions of the former professional and facility manuals for historical reference, if needed.

As in the previous manuals, blue italic text will still be used to identify new or updated information. The **_Why blue italics?_** icon will be placed wherever there are blue italics.

What's new?

We've added a new feature, the **Quick Reference**, at the top of the manual's homepage. This is a one-page reference for the Highmark phone numbers you need the most — the Provider Service Center and Clinical Services. If you need another phone number, you'll find a link on the document that will take you to the manual unit that contains additional contact information.

We've also created a Quick Reference icon that you'll see throughout the manual to provide easy access to these important phone numbers from within the manual.

As always, we welcome your feedback so that we can make the manual as helpful as possible. If you would like to comment on or make suggestions for additional improvements to the _Highmark Provider Manual,_ please email your comments to **HPMeditor@highmark.com**.

If you haven't signed up for e-Subscribe yet, be sure to do so to receive our end-of-the-month "Highmark Provider Manual Updates" emails describing all updates and additions to the manual during the month. You'll also receive other information by signing up for e-Subscribe — _Provider News_ and _Medical Policy Update_ newsletters and the In Case You Missed It notifications telling you about important messages you may have missed.

To subscribe, select **Newsletters/Notices** from the main menu on the PRC, and then **E-Subscribe For Publications And Notifications**.

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Member ID Prefix to Include Numbers

As announced recently on the Provider Resource Center (PRC), the Blue Cross and Blue Shield Association (BCBSA) was to begin issuing prefixes containing alpha-numeric characters as early as April 2018 and moving forward.

This change is a result of diminishing options for solely alphabetical character combinations. The alpha prefixes, now called "Prefixes" due to inclusion of numeric characters, are used to appropriately route claims across the BlueCard® network to the correct home plan and are primarily visible on member ID cards.

Although April 2018 was the effective timeframe for new BCBSA prefixes, you may not begin seeing the alpha-numeric prefixes until later in 2018 or even 2019.

Transition Details:

- No existing member prefixes will change.
- The change will occur only when health plans, like Highmark, request new prefixes. These prefixes will then be assigned to new client accounts throughout the year or during open enrollment.

As noted in the PRC announcement, Highmark wants to ensure you and your trading partners are prepared to submit and accept this new prefix on electronic transactions and that documentation and communications reflect "Prefix" instead of "Alpha-Prefix." (**Note**: This includes the 837I and 837P Health Care Claim and the 835 Electronic Remittance Advice transactions.)

Please talk to your clearinghouse, vendor, or billing service immediately so that you don't experience electronic payment or transaction delays.

It's important to note:

- "0" and "1" will not be used in the prefixes
- "2" through "9" will be used in the prefixes
- A prefix will never include all numeric values (For example, "111").
- R22 – R99 will not be used, as that number sequence overlaps with the Federal Employee Program

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Medicare Advantage News

CT Colonography Screening to Be Preventive Benefit for Medicare Advantage Members, Effective July 1, 2018

The United States Preventive Services Task Force (USPSTF) recognizes computed tomography (CT) colonography (virtual colonoscopy) as an acceptable screening option for detecting colorectal cancer.

At this time, the Centers for Medicare & Medicaid Services (CMS) does not mandate Medicare Advantage (MA) plans to cover CT colonography as a colorectal cancer screening test. However, Highmark has decided to fully cover CT colonography with no copay for its MA members under our Preventive Schedule beginning July 1, 2018, because of the test's high efficacy rate and affordability.

Who Will Be Covered?

All MA members ages 50 to 75 who are at average risk of developing colorectal cancer will be covered. If providers believe CT colonography is the most appropriate colorectal cancer screening test, our members will be able to obtain this service without any out-of-pocket cost.

This may not be the most appropriate screening for everyone. Colonoscopy remains the gold standard for detecting colorectal cancer and should remain the screening of choice for those who are considered to be at high risk.

Diagnosis Requirements

CT colonography screening (CPT code 74263 — Computed tomographic [CT] colonography, screening, including image postprocessing) will be covered once every five years for eligible MA members when billed with any one of the following ICD-10-CM codes:

- Z12.10 – Encounter for screening of malignant neoplasm of intestinal tract, unspecified

- Z12.11 – Encounter for screening for malignant neoplasm of colon
- Z12.12 – Encounter for screening for malignant neoplasm of rectum
- Z80.0 – Family history of malignant neoplasm of digestive organs
- Z80.8 – Family history of malignant neoplasm of other organs or systems
- Z80.9 – Family history of malignant neoplasm, unspecified
- Z83.71 – Family history of colonic polyps

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Attention: Medicare Advantage Prescribing Physicians and Credentialing Personnel

Prescriptive Prescriber Authority Enhancements Coming in September

As previously announced on the Provider Resource Center, effective Sept. 11, 2018, Express Scripts®, the company that processes Highmark drug claims, implemented state prescriptive authority logic within their pharmacy claim processing system.

This implementation is phase one of the three-phased initiative that will ensure all applicable Highmark regions, as well as all states, are in compliance with Federal law and applying specific prescriptive state authority.

What this Means for Prescribing Providers

Effective Sept. 11, 2018, if the prescriber does not meet the criteria determined by state law regarding assignment of correct taxonomy code(s) to their National Provider Identifier (NPI), Express Scripts will leverage the *National Council for Prescription Drug Programs* state-level prescriptive authority rejection reason code, 876.

This implementation also may mean that your patient's prescription will not be filled at the pharmacy if your NPI is not within compliant taxonomy code requirements.

If you haven't yet done so, Highmark recommends you review and, if necessary, update taxonomy codes assigned to your NPI. Highmark also suggests you review this information annually and make updates as frequently as required.

Express Scripts **Prescriber Taxonomy FAQ** ⬈ is included for your convenience. This comprehensive FAQ summarizes the compliance logic of this implementation and includes instructions regarding how to update taxonomy codes assigned to prescribers' NPI(s), if required.

This FAQ is available on the Provider Resource Center under **Pharmacy Program/Formularies** > **Pharmacy Information**.

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Five Tips for Faxing Pharmacy Prior Auth Requests

Tip Sheet Clarifies Pharmacy Prior Auth Requirements

One of Highmark's primary concerns is our members' safe, effective, and timely receipt of prescription drugs that provide required treatment and pain management.

We understand there may be valid reasons why patients require medications that deviate from Highmark's programs, policies, and contractual parameters. In these cases, prior authorizations are required. Highmark wants to work with you to ensure that prior authorizations are completed accurately and processed in a timely manner.

To assist you in expediting prior authorizations, Highmark has created a tip sheet titled **Five Tips for Faxing Pharmacy Prior Auth Requests** . This printable poster offers directions for submission of these critical prior authorizations that will drive consistency and improve approval timeframes.

Following are five keys to successfully completing a pharmacy prior authorization:

1. Include only one patient per prior authorization request. Limiting each fax to a single patient eliminates the risk of improper PHI disclosure.
2. Include only one prescription per prior authorization request. Limiting your request to one prescription reduces errors.
3. Include all required/supporting clinical information per request. Doing so ensures reviewers receive required information.
4. Prior to faxing, confirm all information is entered and completed accurately.
5. Finally, fax the prior authorization to 1-866-240-8123.

We hope you find this tip sheet, which is suitable for printing and hanging by your fax machine, to be valuable in expediting your authorizations.

In addition to accessing the tip sheet from the above link, you can easily locate the tip sheet on the Provider Resource Center by selecting **Pharmacy Program/Formularies** > **Pharmacy Information**. The tip sheet is located on the Pharmacy Information web page.

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Safeguard Your Network Status

What are patients seeing when they look at your information in the Highmark provider directory?

Is your practice name correct? Are all practitioners listed?

We want Highmark members to have the most reliable information about your practice, so they are able to make informed decisions on where to seek care. That's why it's essential that the practice information you have 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.

The Centers for Medicare & Medicaid Services (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.

> We want Highmark members to have the most reliable information about your practice, so they are able to make informed decisions on where to seek care.

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.

It's vital that all providers review and update their information in Provider File Management within NaviNet®. All fields should be completed with your up-to-date information, including your current address, phone number, and fax number. 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**.

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.

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Working to Meet Patients' Language Needs

Our quality improvement efforts are designed to ensure quality care and member satisfaction. To achieve these goals, we continually review the aspects of our plan that affect member care and satisfaction and look for ways to improve them. One way to do that is to share details with network practitioners about the languages patients in their area may speak and to provide information on available interpreting services.

Highmark annually assesses languages spoken by population in our service area and compares them to the data that practitioners report on their network applications. Our 2018 analysis concluded that the following counties had greater than 1,000 residents speaking the following primary languages:

Language:	Counties in which language is spoken, *and* PCPs are available who speak the language:	Counties in which language is spoken, *and there are no* PCPs available who speak the language:
African Languages	—	Lancaster
Arabic	Dauphin, Lehigh	—
French-(incl. Patois,	Berks, Dauphin, Lancaster, Lehigh, Monroe, York	—

Cajun)		
German	Berks, Cumberland, Lancaster, Lehigh, Northampton, York	—
Hindi	Lehigh	—
Italian	Berks, Lackawanna, Luzerne, Northampton	—
Other Asian Languages	Cumberland, Lehigh	—
Other Indic Languages	Dauphin, Lancaster, Northampton	Lackawanna
Other Indo-European	—	Berks
Other West Germanic Languages	—	Berks, Centre, Clinton, Cumberland, Dauphin, Juniata, Lancaster, Lebanon, Mifflin, Northumberland, Snyder, Union
Polish	Luzerne, Monroe	—
Russian	—	Lancaster
Spanish	Adams, Berks, Carbon, Cumberland, Dauphin, Franklin, Lackawanna, Lancaster, Lebanon, Lehigh, Luzerne, Lycoming, Monroe, Northampton, Northumberland, Pike, Schuylkill, Union, Wayne, York	—
Vietnamese	Berks, Dauphin, Lancaster, Lehigh	—

- The above data are from the 2011-2015 U.S. Census -American Community Survey Five-Year Estimates.
- This information is based on county population and not Highmark membership population.

In addition, our telephone translation vendor provided a breakdown of all calls Highmark customer service representatives received during the year (in all of Highmark's and its insurer affiliates' service areas) that required interpreter services. In 2017, Member Service received 39,799 calls (a 16.7 percent decrease from 2016) from members speaking 77 different languages. The largest percentage of calls (88.3 percent) was from members speaking Spanish. The total number of calls serviced for Spanish was 34,970.

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Reminder: Highmark Seeking New Members for Medical Review Committee

Highmark continues to seek 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.

Highmark's Medical Review Committee resolves disputes between Highmark and Pennsylvania-contracted health service practitioners.

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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Notifications for Providers

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

See *Highmark Provider Manual* for Participation Rules; Credentialing/Recredentialing Criteria and Procedures; Medical Record Criteria; Provider Responsibilities; and 24/7 Coverage Requirements

In-network providers should consult the ***Highmark Provider Manual*** ☑ for information outlining the health plan's network participation rules; credentialing/recredentialing criteria and procedures; medical record criteria; provider responsibilities; and 24/7 coverage requirements. The manual is available under **Education/Manuals** on Highmark's online Provider Resource Center, which is accessible via NaviNet® or under Helpful Links at **highmarkblueshield.com** ☑.

Information on these vital topics can be found in the following chapters and sub-units:

Provider network participation (including credentialing/recredentialing criteria and procedures, along with 24/7 coverage requirements:

> In-network providers should consult the *Highmark Provider Manual* for information outlining the health plan's network participation rules; credentialing/recredentialing criteria and procedures; medical record criteria; provider responsibilities; and 24/7 coverage requirements.

- Chapter 3: Provider Network Participation, Unit 1: Network Participation Overview
- Chapter 3: Provider Network Participation, Unit 2: Professional Provider Credentialing
- Chapter 3: Provider Network Participation, Unit 3: Professional Provider Guidelines
- Chapter 3: Provider Network Participation, Unit 4: Organizational Provider Participation (Facility/Ancillary)

Provider responsibilities and guidelines:

- Chapter 4: Provider Responsibilities and Guidelines, Unit 1: PCPs and Specialists
- Chapter 4: Provider Responsibilities and Guidelines, Unit 2: Behavioral Health Providers
- Chapter 4: Provider Responsibilities and Guidelines, Unit 3: Facility-Specific Guidelines

Medical record criteria:

- Chapter 3: Provider Network Participation, Unit 3: Professional Provider Guidelines

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Watch for Updates to Highmark's List of Procedures Requiring Authorization

During the year, Highmark makes adjustments to the List of Procedures/DME Requiring Authorization, which includes outpatient procedures, services, durable medical equipment (DME), and drugs that require authorization for our members.

These changes are announced in the form of Special Bulletins that are posted on our online Provider Resource Center (PRC). These Special Bulletins are communicated as Hot Topics on the PRC and are archived under **Newsletters/Notices** > **Special Bulletins & Mailings**.

The list includes services such as:

- Potentially experimental, investigational, or cosmetic services
- DME
- Select injectable drugs
- Oxygen
- Not Otherwise Classified (NOC) procedure codes
- Certain outpatient procedures, services, and supplies

To search for a specific procedure code within the List of Procedures/DME Requiring Authorization, press the Control and "F" keys on your computer keyboard, enter the procedure code, and press Enter.

For up-to-date information on procedures that require authorization or to view the current list of procedure codes, visit the PRC, accessible via Highmark NaviNet® or under **Helpful Links** on our website.

Remember, the Highmark member must be eligible on the date of service, and the service must be a covered benefit in order for Highmark to pay your claim.

You may use NaviNet or the applicable HIPAA electronic transactions to:

- Check member benefits and eligibility
- Verify if an authorization is needed
- Obtain authorization for services

If you don't have NaviNet or access to the HIPAA electronic transactions, please call Clinical Services to obtain authorization for services.

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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 *e*Bulletins.

These Special *e*Bulletins 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 *e*Bulletins 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.

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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**.

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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 Blue^{SM} 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)

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Legal Information

Highmark Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association. Highmark Blue Shield serves the 21 counties of central Pennsylvania and the Lehigh Valley as a full-service health plan. BlueCard, Blue Distinction, Blue Distinction Center and the Federal Employee Program are registered marks and Blues On Call is a service mark of the Blue Cross and Blue Shield Association.

Highmark Senior Health Company and Highmark Benefits Group are service marks of Highmark Inc. NaviNet is a registered trademark of NaviNet, Inc., which is an independent company that provides a secure, web-based portal between providers and health care insurance plans. Highmark Health is the parent company of Highmark Inc.

The Blue Cross Blue Shield Association is an association of independent, locally operated Blue Cross and Blue Shield companies.

Express Scripts is a separate and independent company that processes Highmark drug claims. Atlas Systems, Inc. is a separate and independent company that conducts physician outreach for Highmark.

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