PROVIDER NEWS
A newsletter for the Highmark Blue Shield providers in central Pennsylvania, the Lehigh Valley, northeastern Pennsylvania, and southeastern Pennsylvania
HIGHMARK
Issue 3, 2020

Interview with Jason Renne

Jason Renne
Senior Vice President of Provider of Partnerships and Contracting

In March of this year, Highmark Inc. welcomed Jason Renne as the new Senior Vice President of Provider of Partnerships and Contracting. Renne has over 20 years of experience working in the managed care industry including organizations such as Banner | Aetna, Geisinger Health Plan, XLHealth and Kaiser Permanente. His experience has allowed him to work in the for-profit and nonprofit sectors of health care both regionally and nationally, which has shaped his unique view of how health care should be managed most effectively.

How have your prior experiences in health care shaped the way you approach the payer-provider relationship?

My philosophy on how payers and providers can best work together to serve our communities has been formed by my experiences with highly evolved integrated health organizations that are committed to fundamentally changing the way health care is both delivered and financed. I believe that this is achieved by ensuring that the mission, economics and shared resource allocation between payer and provider are fully aligned towards making health care affordable while improving the quality and experience for both patients and members when accessing the system.

The fundamental key to achieving success is through full organizational commitment to delivering meaningful value to the communities served. This requires recognition that the antiquated fee-for-service payment model is not sustainable and ultimately will not reverse the trend of rising health care costs to employers and families across the country. My experience has taught me that both the payer and provider must embrace this strategy to see significant change.

What was it about Highmark's mission/vision that attracted you to the organization?

I'm most energized by the "getting health care right" segment of our mission. It emphasizes the unique position to leverage our Integrated Delivery and Finance System (IDFS) and external provider partnerships to truly transform health care through a spirit of collaboration. When we are committed to creating as little abrasion as possible so that the providers can focus on providing high quality affordable health care, our members are better served. We are continuously trying to find the balance between not forcing our providers to jump through hoops that aren't valuable and at the same time, being responsible with the dollars we earn from our customers.

I'm most energized by the "getting health care right" segment of our mission.

What are your top priorities over the next few years?

1. Increase the cross-functionality of the Provider Partnership and Contracting teams to create a best-in-class/ differentiated provider and member experience. Everything that occurs in provider network workflows is circular in nature and affects all other aspects of the department, so it is important that every member of our team is continually looking for ways to bring greater efficiency and value to our providers & members.
2. Become a national example of how high functioning IDFS platforms can effectively avert the trend of rising health care costs.
3. Create a differentiated relationship with the providers across our network by partnering with them to treat each of our members like VIPs when they access care within our delivery systems. The better the services that we provide, the more our providers will want to work with us and become ambassadors for our brand. My goal is to have providers look at patients that are members of other health care organizations and say, "Why aren't you a Highmark member? They are a true partner and help us provide even better care with the information and tools that they provide."

How do you see Highmark changing payer-provider partnerships in the future?

We are evolving differently than the general industry. Even though every health insurer has some form of pay-for-performance program in place, many have become stale and redundant. They are not as effective as they once were. However, Highmark has pioneered its value-based platform in a way that goes above and beyond a lot of the off-the-shelf versions by committing to sharing risk with as many providers as possible. While we will never get to a place across our entire

network where every provider is in a downsized risk- sharing position with us, Highmark is committed to moving our providers in that direction. We want to align incentives with our providers so that the cost of care decreases while the quality of care can increase.

When you joined Highmark back in March, the country was just starting to tackle the Covid-19 crisis. How has the current crisis affected Highmark's health strategy going forward?

Deep relationships with providers remains core to our strategy. These provider relationships ensure network viability, enable the transition to value-based care, improve patient and clinician experience, and lower total cost of care. However, the current environment has created new challenges and opportunities that we need to also consider and address.

Members are accessing health care through virtual care more now than ever before. Providers who were already advanced in virtual care and telehealth are moving to the next level. Others who were only dabbling in virtual care and telehealth made great strides in a short amount of time to maintain a level of economic stability.

By expanding our fee schedules and accepting hundreds of additional codes in the telehealth space, Highmark has enhanced the ability for providers to be reimbursed through this technology.

As the paradigm of care continues to change, Highmark's priority remains member access to high-quality and affordable health care.

Moving into the "new normal," we want to ensure that telehealth services provided to our members are of value and where possible, equivalent to being in a doctor's office (as far as the results are concerned). As the paradigm of care continues to change, Highmark's priority remains member access to high-quality and affordable health care.

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New IVR Prompt Option for Physical Therapy, Speech Therapy, and Spinal Manipulation Visit Limits

Effective May, 15, 2020, the interactive voice response (IVR) system on the Highmark Provider Service phone lines was enhanced to offer providers the ability to verify physical therapy (PT), spinal manipulation (SM), and speech therapy (ST) benefit visit limits.

Providers receive responses based on whether the member has benefits and if the member has utilized their benefits at the time of the call. Responses regarding utilization of visits are based on claims received and finalized for the member.

For more information and examples of how this works, please see the Plan Central Message posted on May 20, 2020.

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Teleretinal Autonomous Artificial Intelligence

Several national organizations, the American Diabetes Association (ADA), the American Academy of Ophthalmology (AAO), and the American Association of Clinical Endocrinologists (AACE) recommend annual comprehensive eye exams for all patient with diabetes beginning 5 years after diagnosis of Type 1 patients and at the time of diagnosis for Type 2 patients.[1]

Early intervention and prevention are key. Retinopathy is often asymptomatic and many patients are not aware of their condition until it is advanced.

In the United States, eighty percent of patients living with diabetes will eventually develop diabetes retinopathy. According to the National Institute of Health National Eye Institute,[1] from 2010 to 2050 the number of Americans with diabetes retinopathy is expected to nearly double from 7.7 million to 14.6 million.

Primary care physicians will refer patients with diabetes to an eye care specialist for a dilated retinal exam (DRE); however, half of the patients referred will not schedule an appointment. When patients are asymptomatic, they do not notice a problem and they do not feel it is necessary to have an eye examination completed. There are other barriers that prevent patients from seeking treatment. Some of the patient's barriers can be addressed with the use of teleretinal imaging in the provider's office or clinic.

Teleretinal imaging can help increase patient compliance with DRE by identifying patients with diabetes within the primary care setting and providing retinal imaging on site as part of the routine diabetes office visit.

Teleretinal imaging has existed and has been available for many years; however, it has not been widely used in the United States because of the following:

- Unavailability of qualified eye care specialists or trained readers
- Delay of hours or days to receive results
- Lack of meaningful imaging quality feedback resulting in undetected signs of eye disease

With new advances in teleretinal imaging technology, primary care providers can now administer an eye exam as part of their patient's diabetes care check list without a specialist to interpret the images.

In 2018, the FDA approved the IDx-DR autonomous artificial intelligence (AI) system and recently in 2020, the FDA approved Eyenuk to market EyeArt for detection of diabetes retinopathy:.[2,3] These systems can provide:

- Immediate imaging feed back to the operators
- Definitive diagnosis that provides results for physicians to discuss at the time of patient appointment

Patients report that the most common reason they obtained dilated retinal screening was due to strong recommendation from their PCP at the time of their routine diabetes office visit. Many patients have limited knowledge and understanding of the purpose of diabetes eye screening, however, they will still obtain screening when recommended by their PCP.

Office staff, at the time of the visit, can make ophthalmology appointments for patients that require dilated retinal examination follow-up. Most important is the patient does not wait for a call back or letter from their health care provider directing them to make an appointment.

The 2020 American Diabetes Association new set of clinical standards recognizes the use of autonomous artificial intelligence (AI). The new ADA 2020 Standard of Medical Care includes language noting that "AI systems that detect more than mild diabetes retinopathy and diabetes macular edema authorized for use by the FDA represent an alternative to traditional screening approaches."[4]

The IDx-DR system is a small tabletop operation which guides trained operators through the process using a robotic fundus camera to capture two images per eye and sends the images to the IDx-DR analysis system on a nearby computer. The images are sent to a cloud-based server that utilizes software and algorithm to detect retinal findings based on autonomous comparison with a large dataset of representative fundus images. That system takes about 20 seconds to determine if signs of diabetes

retinopathy are present. The process does not require a trained ophthalmologist to be present. It requires minimal training and takes only four hours to educate staff on using the system.[5]

Health systems that are using autonomous AI have experienced significant improvements in accessibility, efficiency, and compliance rates.

[1]Diabetic Retinopathy Data and Statistics, NIH National Eye Institute @ https://www.nei.nih.gov/learn-about-eye-health/resources-for-health-educators/eye-health-data-and-statistics/diabetic-retinopathy-data-and-statistics, accessed 6/8/2020

[2] Endocrineweb for Healthcare Professionals, First In-Office Screening for Diabetic Retinopathy Cleared by FDA @ https://www.endocrineweb.com/professional/diabetes-complications/office-screening-diabetic-retinopathy-under-fda-review

[3] FDA Clears Eyenuk's Diabetic Retinopathy Screening System @ https://www.fdanews.com/articles/198392-fda-clears-eyenuks-diabetic-retinopathy-screening-system accessed 8.12.2020

[4]American Diabetes Association. 11. *Microvascular complications and foot care:* Standards of Medical Care in Diabetes – 2020. *Diabetes Care 2020;43(Suppl.1):S135-S151 @ https://care.diabetesjournals.org/content/43/Supplement_1/S135, accessed 8/12/2020*

[5]Growing IDx, Innovation IOWA @ https://innovationia.com/2019/05/30/growing-idx/

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Telemedicine in the Spotlight During COVID-19

Telemedicine has taken on a critical role during the COVID-19 public health emergency as health care providers have had to turn to alternative ways of providing health care to limit exposure to the virus. Highmark recognizes the importance of telemedicine at this time to ensure our members are able to access the right care in the right setting to assure safety for all. “Our number one priority – especially during this crisis – is to make sure that our members receive the care that they need,” said Deborah Rice-Johnson, President, Highmark Inc.

To help ensure members can continue to safely receive care, Highmark expanded access to telehealth services for all members and waived out-of-pocket costs such as deductibles, coinsurance, and copayments on all telehealth covered services from March 13, 2020, through September 30, 2020.

Highmark has also expanded access, without out-of-pocket costs, to both in- and out-of-network teleaddiction services for members in Pennsylvania, West Virginia, and Delaware who are in addiction treatment and need immediate help.

To support provider practices and system viability during this time, Highmark has eliminated member cost-sharing for in-network telemedicine services through September 30, 2020, greatly expanded the types of services that are covered via telemedicine, and relaxed the technology standards in our policies for providing telemedicine during the COVID-19 pandemic. “By doing so, Highmark is attempting to make it easier to provide services, eliminate some administrative costs, and potentially

avoid the need for investment in technology," said Robert Wanovich, Vice President, Ancillary Provider Strategy and Management, Highmark Inc.

As Highmark plans for the future of health care beyond the pandemic, we will also continue to evaluate our telemedicine policies, fee schedules, and allowable telemedicine codes. We want to ensure our providers can continue to offer valuable virtual services to our members that are, or will be in the future, equivalent to the standard of care for in-person office visits.

The information below provides a quick overview for providing virtual visits to Highmark members during the COVID-19 public health emergency.

Member Benefit Options

Highmark provides benefit enhancements that give members the option for "virtual visits" with their trusted primary care providers and specialists using real-time interactive audio and video telecommunications technology. These enhancements for virtual visits apply to the PCP/physician office visit, specialist office/outpatient visit and consultation, outpatient mental health, and retail clinic benefits, as applicable, under a member's benefit plan.

In addition, Highmark also offers a telemedicine benefit through which our members can receive services from one of our approved vendors when they are unable to receive care from their primary care physician or specialist when needed. Services are available through the vendor's telecommunications platform and performed by practitioners contracted with these vendors.

Who can provide virtual visits to Highmark members?

Virtual visits may be provided by any network participating provider whose services are eligible to be delivered virtually. In general, any provider is eligible to provide covered services within the scope of their license, deemed appropriate using their medical judgment, and delivered within the definition of the code that will be billed. Due to differences in state regulations, certain requirements may vary by state.

The provider can make the determination whether a virtual visit is the right course of

treatment for their patient. The standard of care applicable to an in-person patient encounter also applies to a virtual patient encounter. All telemedicine encounter documentation in the medical record is expected to meet the same minimum standards as required for face-to-face visit documentation.

Technology Requirements

Providers can conduct virtual visits following Highmark's recommended service and security guidelines using real-time, interactive telecommunications hardware and software that are HIPAA and HITECH compliant. Highmark is not responsible for the security of virtual visits and does not validate the safeguards of any equipment and software used on either side of the virtual transmission.

The U.S. Department of Health and Human Services' Office of Civil Rights (OCR) announced that it would exercise enforcement discretion and waive potential HIPAA penalties for consumer communication applications if used for telehealth during the COVID-19 nationwide public health emergency.

The OCR's discretion applies to widely available communications apps, such as FaceTime or Skype, when used in good faith for any telehealth treatment or diagnostic purpose, regardless of whether the telehealth service is directly related to COVID-19. Through the OCR temporary lift on some restrictions, a provider may use audio and video OR audio only to provide virtual visits to patients using any non-public facing remote communication product that is available.

In line with the OCR's decision, Highmark is temporarily relaxing its current telemedicine policy requirements as they relate to the specific communication applications used.

Services Eligible for Delivery via Virtual Visits

Highmark has made modifications to policies and procedures that are in effect through the public health emergency, including allowing some additional services via virtual visits temporarily as part of our response to the COVID-19 crisis. Highmark currently considers the following procedure codes eligible for reimbursement for dates of service from March 13, 2020, through September 30, 2020: **Telehealth Code Set**.

Please note that, in accordance with the Families First Coronavirus Response Act (FFCRA), Highmark will continue to cover member cost share for COVID-19 related outpatient visits as well as associated services and testing through the end of the public health emergency.

Billing Reminders to Help Avoid Claim Denials

When billing professional (1500/837P) claims, please remember to use the Telehealth

Place of Service code 02 for virtual visits using both audio and video components OR audio only. Attach the GT or 95 modifier (whichever best represents the visit) to the procedure code(s) to indicate that the visit was performed via telemedicine using both audio and video components.

On facility claims (UB-04/837I), the facility should use the standard revenue code and CPT/HCPCS codes for the service (service must be listed on the approved telemedicine code list) AND the appropriate 95 or GT modifier should be used to indicate telehealth delivery of services. The use of the 78X revenue code is not required for hospital outpatient telehealth services unless billing Q3014.

Taking Telemedicine Beyond COVID-19

Highmark's virtual visit options were available prior to the public health emergency and will remain as an option for care delivery after the COVID-19 public health emergency ends.

Additional information on virtual visits and the telemedicine benefit is available in the *Highmark Provider Manual's* **Chapter 2.5: Telemedicine Services**. Billing information is detailed in Highmark Reimbursement Policy Bulletin **RP-046: Telemedicine Services**.

Resources to Answer Your Questions

To stay informed, please visit the dedicated **COVID-19** section on the Highmark Provider Resource Center regularly for the most up-to-date information related to the COVID-19 public health emergency.

A recorded version of the "Telemedicine and Virtual Visit During COVID-19" webinar presented in May can also be found there.

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Highmark Seeking New Members for the Medical Review Committee (2021–2022 Term)

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

Four 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 four times a year at the Highmark campuses, both in Camp Hill and Pittsburgh, Pennsylvania. Members receive an honorarium from Highmark for attending the meetings and are also reimbursed for 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.

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 **October 1, 2020** to Earl.Bock@Highmark.com or the following address:

Earl Bock
Secretary, Medical Review Committee
Financial Investigations and Provider Review
Highmark Inc.
CH1AHM-033H
PO Box 890089
Camp Hill, PA 17089

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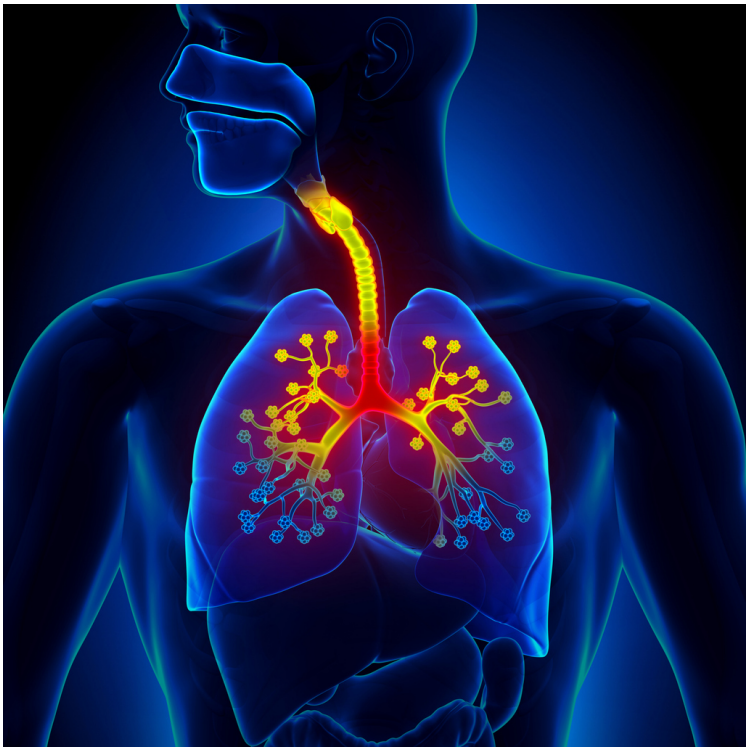
Reminding Your Patients About Upper Respiratory Infections and Bronchitis



We are nearing the time of the year that sneezing, runny noses, and coughing begins. It is important to educate your patients on when these illnesses are viral and can be treated with supportive measures and may need antibiotics.

Remind your patients that viruses (such as the common cold) are frequently the cause of upper respiratory infections and bronchitis. According to the Centers for Disease Control, you should have your patients come in for a check-up when the following symptoms are present:

- Temperature 100.4 F (38 C) or higher
- Coughing with bloody mucus
- Shortness of breath, difficulty breathing, or fast breathing
- Symptoms lasting more than three weeks
- Symptoms such as cough or runny nose that get better then worsen
- Infants under three months of age with a fever 100.4 F (38C) or higher
- Dehydration
- Worsening of any chronic medical conditions
- Repeated episodes of symptoms

Since overprescribing antibiotics can lead to antibiotic resistance, it is important to know that antibiotics are not always needed when treating patients with these symptoms.

For more information about treatment for upper respiratory infections, bronchitis, and

antibiotic usage, please visit the Centers for Disease Control Antibiotic Prescribing and Use website at https://www.cdc.gov/antibiotic-use/.

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Metabolic Monitoring in Children and Adolescents On Antipsychotics – Best Practices

Antipsychotic medications offer the potential for effective treatment of psychiatric disorders in children and adolescents (such as childhood schizophrenia, bipolar disorder, psychosis, or severe conduct problems that are resistant to other types of treatment, including behavioral symptoms associated with Tourette's syndrome and autistic disorders); however, they pose an increased risk for the child developing serious health concerns, including metabolic health complications. These medications being prescribed for off-label use (such as attention deficit hyperactivity disorder) is increasing these risks in children and adolescents.[1]

There are new medications (atypical antipsychotics/second generation antipsychotics) that have fewer side effects - especially extrapyramidal symptoms - than first generation antipsychotics; however, there are still inherent risks which must be weighed against the benefits of taking these medications. Studies have shown that metabolic monitoring rates associated with second generation antipsychotics are well below optimal levels, especially for lipid monitoring.[2] Early interventions can decrease the possibility of long term sequelae associated with this class of drugs, especially cardiac disease, type 2 diabetes, and obesity.

Because these antipsychotic medications are most often associated with risk of weight gain, hyperlipidemia, and diabetes, the American Academy of Child and Adolescent Psychiatry (AACAP) guidelines recommend that children and adolescents, who are taking antipsychotic medications, should be routinely monitored for blood glucose and cholesterol levels, as well as BMI percentile documentation.[3]

In an effort to ensure that our members are receiving the best care possible, Highmark Health will be periodically reviewing the trends in metabolic monitoring for those pediatric/adolescent members taking antipsychotic medications.

In an effort to ensure that our members are receiving the best care possible, Highmark Health will be periodically reviewing the trends in metabolic monitoring for those pediatric/adolescent members taking antipsychotic medications. If gaps in care are identified, prescribing providers will receive a letter identifying the gaps associated with their attributed Highmark patients, including non-compliance for blood glucose testing and lipid profiles.

NOTE: Highmark does not recommend particular treatments or health care services. This informational article is not intended to be a substitute for professional medical advice, diagnosis, or treatment. The member's provider should determine the appropriate treatment and follow-up with his or her patient. This informational article is based upon a search of literature. There may be other recommendations or suggested practices that may be suitable in the care of patients. Coverage of services is subject to the terms of each member's benefit plan. Additionally, state laws and regulations governing health insurance, health plans, and coverage may apply and will vary from state to state.

References:

[1]Sohn, Minji et al. "National trends in off-label use of atypical antipsychotics in children and adolescents in the United States." Medicine vol. 95,23 (2016): e3784. doi:10.1097/MD.0000000000003784

[2]Jennifer D. Hayden, Libby Horter, Taft Parsons, III, Matthew Ruble, Sabrina Townsend, Christina C. Klein, Rodrigo Patino Duran, Jeffrey A. Welge, Stephen Crystal, Nick C. Patel, Christoph U. Correll, and Melissa P. DelBello. "Metabolic Monitoring Rates of Youth Treated with Second-Generation Antipsychotics in Usual Care: Results of a Large US National Commercial Health Plan" Journal of Child and Adolescent Psychopharmacology.Mar 2020.119-122.http://doi.org/10.1089/cap.2019.0087

[3]American Academy of Child and Adolescent Psychiatry. AACAP practice parameter for the use of atypical antipsychotic medications in children and adolescents. 2011 Retrieved from https://www.aacap.org/App_Themes/AACAP/docs/practice_parameters/Atypical_Antipsychotic_Medications_Web.pdf

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Important CHIP Updates

The following communications regarding the Children's Health Insurance Program (CHIP) have been published recently:

- Important: Timely Filing Requirements For Claims For Chip Enrollees
- Chip Developmental Screening Requirements And Billing Guidelines
- Important Reminder About Chip Preventive Care Immunizations

Please remember to regularly check the **Provider Resource Center and NaviNet Plan Central for communications on CHIP updates and reminders.**

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

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

Please note that 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.

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

To view the List of Procedures/DME Requiring Authorization, click **Requiring Authorization** in the gray bar near the top of the PRC homepage. To search for a specific procedure code within the list, 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 NaviNet® or under **Helpful Links** on our website.

Please note that 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 an authorization for services.

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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.

Midyear Preventive Schedule Changes 2020

The preventive schedule is updated twice a year: once in January and once in July. The following changes have been made for the July Update:

- Expansion of HPV vaccine from 26 to include ages 27–45 for those at risk as published in MMWR August 2019. This change will take effect **September 1, 2020.**
- The TDAP vaccine can be given as a booster every 10 years instead of just using the TD booster.
- The United States Preventive Services Task Force (USPSTF) released an updated B level recommendation that clinicians offer to prescribe risk-reducing medication aromatase inhibitors (AI), to the existing drugs tamoxifen, raloxifene, to asymptomatic women who are 35 years or older and at increased risk for breast cancer and at low risk for adverse medication effects beginning on **October 1, 2020.** AIs are not FDA approved for breast cancer prevention, therefore, the drugs will be offered as second line drugs when prescribed by a physician indicating there is a contraindication or the other drugs are not tolerated.
- The USPSTF released a new A level recommendation that clinicians offer preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons

who are at high risk of HIV acquisition, effective **July 1, 2020**.

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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 by providers to our members. To do this, we continually review the aspects that affect the quality of the member care experience and satisfaction and look for ways to improve them.

We work closely with the physician community in our efforts to address both the quality of the clinical care and service our members receive, as well as plan management to address the services provided by Highmark (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 quality improvement activities and programs supporting such focuses as the clinical care and service received by our members, the provider network, member safety, and health equity.

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. Once on the Provider Resource Center, from the black navigation bar at the top, select **MANUALS > HIGHMARK PROVIDER MANUAL**. See Chapter 5, Unit 6: Quality Management.

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Formulary Updates Available Online

We regularly update our prescription drug formularies and related pharmaceutical management procedures. To keep our 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 (PRC) **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 (PRC).

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Staying Up to Date with the Highmark Provider Manual

Ensure you are regularly reviewing the provider manual for our most recent guidance on:

- Participation Rules
- Credentialing/Recredentialing Criteria & Procedures
- Medical Record Criteria
- Requirements for 24/7 Coverage

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Key FAQs

About Medicare Compliance and Fraud, Waste, and Abuse (FWA)Training

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

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

A 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

Q Who must complete these trainings?

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

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

Q Why does CMS require these individuals to complete these trainings?

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

Q When does CMS require these individuals to complete these trainings?

A 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)

Q Where can individuals go to access these trainings?

A 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 the General Compliance Training and Fraud, Waste, and Abuse Training offered by your practice or facility as long as it includes all of the content included in CMS's trainings, without any modifications.

Q What proof must be provided that the trainings were completed?

A 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.

Q Are there any exceptions to these guidelines?

A 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 (the training is still required).

PROVIDER NEWS
A newsletter for the Highmark Blue Shield providers in central Pennsylvania, the Lehigh Valley, northeastern Pennsylvania, and southeastern Pennsylvania
HIGHMARK
Issue 3, 2020

Help Your Patients Find You

The sign in front of your office helps patients find their way to you. So does your contact information in the online Highmark provider directory — if you keep it up to date and accurate.

If you want Highmark members to be able to find you, make sure your practice name, physician team, locations, and contact information are correct in the Highmark provider directory. These are the facts members use 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 is up to date and is attested to on a quarterly basis.

Reviewing data is vital for you

The Centers for Medicare & Medicaid Services (CMS) requires Highmark to reach out to you every quarter and ask you to validate your provider information. We use this information to populate our provider directory and to help ensure correct claims processing.

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

Your thorough review of your directory information confirms:

- Each practitioner's name is correct and matches the name on his/her medical license.
- The practice name is correct and matches the name used when you answer the phone.
- All specialties are correctly listed and are, in fact, currently being practiced.
- Practitioners listed at a location actually see patients and schedule

appointments at that office on a regular basis. All practitioners listed must be affiliated with the group. (Practitioners who cover on an occasional basis are not required to be listed.)
- 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.

Change happens

It's vital that you review and update your information as soon as a change occurs. Go to Provider File Management within NaviNet® to check these fields:

- Current address
- Phone number
- Fax number

Remember to review data at least once a quarter to ensure it's accurate.

Remember to review data at least 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 help our agent to gather the right information.

Atlas is an independent company that performs outreach to physicians on behalf of Highmark.

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

Arielle Reinert, 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 Arielle.Reinert@highmark.com.

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℠ 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

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

Atlas Systems, Inc. is a separate and independent company that conducts physician outreach for Highmark.

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