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Effective August 1, 2021, Highmark is expanding its Advanced Imaging and Cardiology Services program (managed by eviCore) to include Out-Of-Area (OOA)[1] and Out-Of-Network (OON)[2] providers/services serving Highmark members enrolled in its fully insured Commercial, Medicare Advantage, Affordable Care Act (ACA) plans, and members of select self-insured (Administrative Services Only) groups.

Highmark's prior authorization requirements ensure that our members receive the most appropriate care delivery in alignment with nationally accepted evidence-based guidelines.

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The program includes prior authorization for elective or non-emergency outpatient radiology or cardiac imaging services (Prior authorization does not apply to services that are performed in the emergency room or during an inpatient stay.) Services include:

Radiology	Cardiac Imaging
• Magnetic resonance imaging (MRI) • Magnetic resonance angiograms (MRAs)	• Cardiac CT • Cardiac MRI • Diagnostic heart catheterization

• Positron emission tomography (PET) scans • Positron emission tomography – computed tomography (PET-CT) • Computerized tomography (CT) scans • Computed tomography angiography (CTA) scans • Nuclear medicine	• Myocardial perfusion imaging (SPECT and PET) • Nuclear cardiac imaging • Stress echocardiogram • Stress testing • Transesophageal echocardiogram • Transthoracic echocardiogram

For more information on this change and for guidance on submitting a prior authorization for OOA or OON providers/services, see the AUTHORIZATIONS SOON REQUIRED FOR OUTOF-AREA AND OUT-OF-NETWORK ADVANCED IMAGING AND CARDIOLOGY SERVICES eBulletin published on the Provider Resource Center.

[1]OOA services are those performed by a provider outside of the Highmark health plan footprint of Pennsylvania, Delaware, and West Virginia and who is participating with their local Blue Plan.

[2]OON services are those performed by a provider who is not contracted with Highmark or any other blue plan or is excluded from certain benefit plans. These services can occur within Highmark's footprint or OOA.

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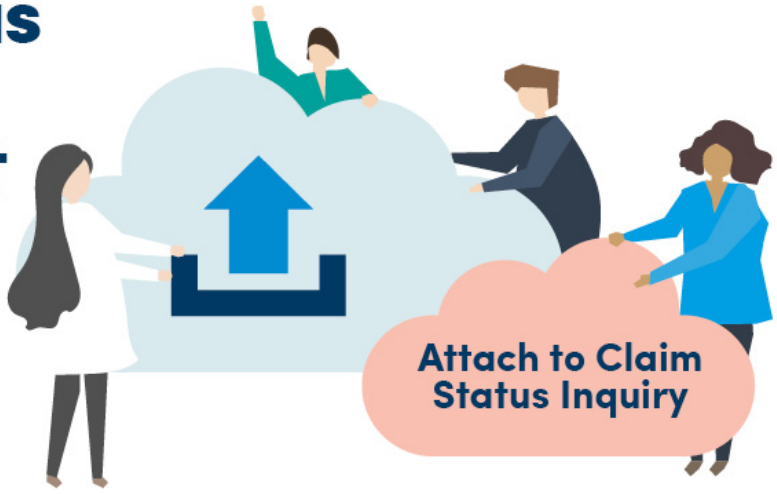
Claim Status Inquiry Attachment Feature Coming Soon to NaviNet®



Highmark is making it easier for our providers to submit supporting documentation to a Claim Status Inquiry.

Soon, providers will be able to attach those documents online through NaviNet®. This will streamline the claim status inquiry process and eliminate the need to fax supporting documents or print them out and send them through the mail.

The changes will help to ensure that Highmark receives the right supporting documentation to make more informed and timely claim decisions, simplify and expedite the overall process and reduce administrative burden.

Providers will be able to attach four types of documents to a claim status inquiry:

1. **PWK (additional documentation to support an electronic claim)**
2. **Out of Area Medical Records-Including Barcoded Request Letter (as coversheet)**
3. **Medical Record Request**
4. **General Provider / Facility Inquiry**

If you have not yet signed up for NaviNet, visit www.NaviNet.net and click the **Providers: Sign Up for NaviNet** tab.

A specific launch date and step-by-step instructions on the new workflow will be communicated via Plan Central in NaviNet and Special Bulletins on the Provider Resource Center.

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Keep your Patients up to Date with their Preventive Exams and Screenings

The global pandemic has caused many patients to miss their preventive exams and screenings since March 2020. This problem has persisted into 2021 and could have long-term effects on your patients, but there is still time to catch your patients up.

To aid in this effort, Public-Health compiled a lifetime health care schedule organized by age and covering both vaccines and preventive exams and screenings as recommended by the National Institute of Health (NIH). You can find Highmark's recommended care schedule on the **Preventive Health Guidelines** page under **Education/Manuals** on the **Provider Resource Center**.

Why Keeping Your Patients Up To Date With Their Preventive Health Is Important

Early detection of health issues helps you to prevent diseases, gets your patients the care they need before conditions become life-threatening, and increases your patients' life expectancy.

According to the Centers for Disease Control (CDC), seven out of 10 U.S. deaths are caused by chronic disease, with roughly half of the country's population diagnosed with a chronic illness including: heart disease, cancer, diabetes, AIDS, or other conditions classified by the medical community as preventable. According to Healthy People 2020, a federal program administered by the United States Department of Health and Human Services:

- **Routine cardiovascular exams alone save tens of thousands lives each year**
- **Vaccines save the lives of roughly 42,000 children each year**

- **Preventive health screenings and primary care consultations have also been found to significantly increase life expectancy, particularly among 30-to-49 year olds.**

Disclaimer: You should determine the appropriate treatment and follow-up with your patient based on their current situation and health records. This informational article is based upon a search of literature, as such there may be other recommendations or suggested practices that you may find more suitable for your patients.

Footnotes:
Resources Used for This Article:
www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Clinical-Preventive-Services
www.healthypeople.gov/2020/About-Healthy-People
www.publichealth.org/public-awareness/preventive-care-schedule

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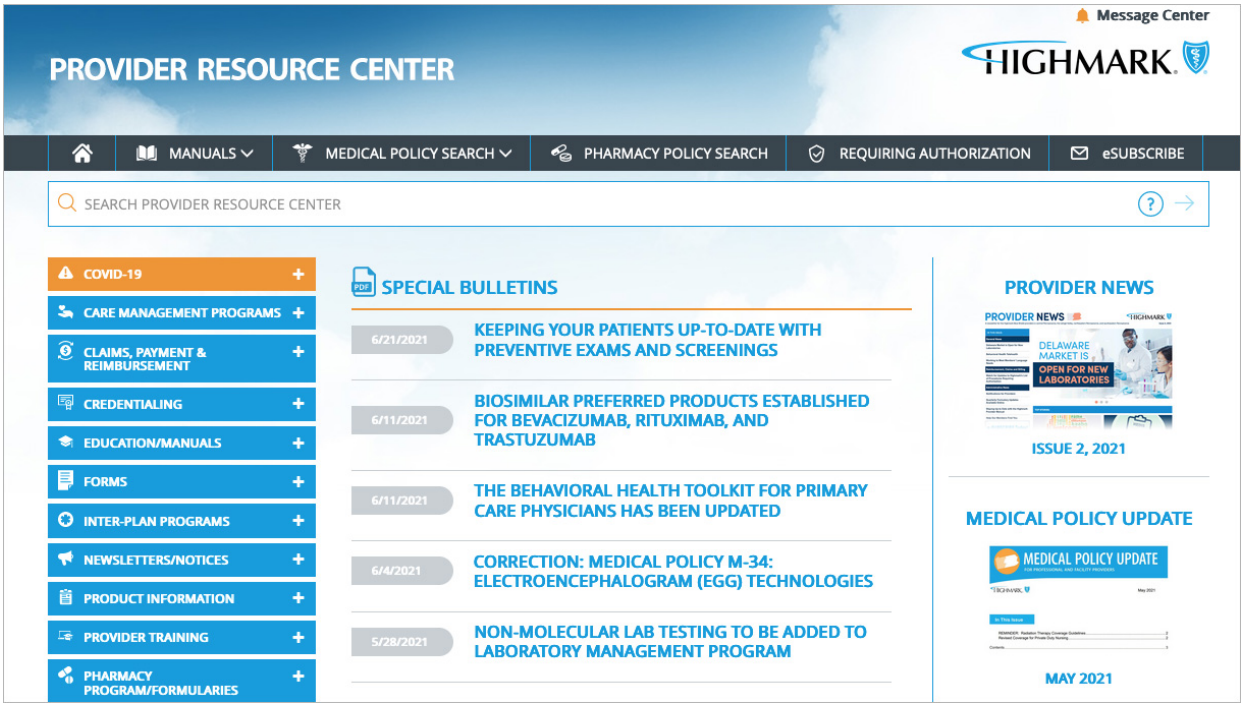
Provider Resource Center Home Page Changes

Highmark's Provider Resource Center Home Page has a new look to make it easier for health care professionals, facilities, and staff to find the latest news and updates. Special Bulletins are now front-and-center on the homepage allowing easy access to some of the most recent changes and communications. Our latest Provider News and Medical Policy Update publications are also featured on the homepage.

Hot Topic articles are discontinued, and the information formerly posted as a Hot Topic will now be posted as a Special Bulletin. You may search past Hot Topics under Newsletters/Notices in the left menu.



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Is Your PROMISe ID Up To Date?

If you render, order, refer, or prescribe items/services to Children's Health Insurance Program (CHIP) patients, you must have an active Provider Reimbursement and Operations Management Information System Identification (PROMISe™ ID) on file with the Commonwealth of Pennsylvania Department of Human Services (DHS) and Highmark. The information you have on file must include your provider type and each service location where you see CHIP enrollees.

Highmark is required to deny claims if we are unable to match your NPI reported on the claim to a PROMISe enrollment record for the service location where the services were performed.

Additionally, you are required to select a PROMISe ID-enrolled provider when submitting any authorization requests for referrals in NaviNet®.

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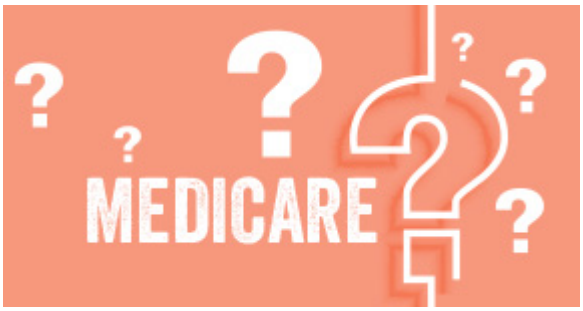
Key FAQs About Medicare Compliance and Fraud, Waste, and Abuse (FWA) Training



If your practice or facility cares for Medicare-eligible patients, 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 Every individual who is associated with your practice or facility and works with Highmark's Medicare Advantage and/or Medicare Part D Prescription Drug Plan (PDP) members 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:

- At the beginning of their employment, contract, or appointment: **Within 90 days**
- During employment, contract, or appointment: **Between Jan. 1 and Dec. 31 every 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 the General Compliance Training and Fraud, Waste, and Abuse Training offered by your practice or facility
    - **IMPORTANT DISCLAIMER:** This training must include all 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 present one of the following acceptable forms of evidence:

- 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).**

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Attention Medicare Advantage PPO Contracted Providers:

Medicare Advantage PPO Network Sharing Provides In-Network Access to Out-Of-Area Blue Plan Medicare Advantage PPO Members

All Highmark Blue Cross Blue Shield, Highmark Blue Shield, and/or Highmark West Virginia Blue Cross Blue Shield Medicare Advantage PPO Plans participate in reciprocal network sharing. This allows all Blue Plan Medicare Advantage PPO patients to obtain in-network benefits when traveling or living in the service area of any other Blue Medicare Advantage PPO Plan if the patient sees a contracted Blue Medicare Advantage PPO provider.

If you have a Medicare Advantage PPO contract with Highmark, you should provide the same access to care for patients of other Blue Medicare Advantage PPO Plans as you do for Highmark's Medicare Advantage PPO patients. Below are answers to questions you may have about Medicare Advantage PPO Network Sharing.

Q How does Medicare Advantage PPO Network Sharing work?

A If you are a contracted Medicare Advantage PPO provider with Highmark and you see Medicare Advantage PPO patients from another Blue Plan, you must give them the same contractual access to care as other Highmark patients and you will be reimbursed in accordance with your negotiated rate under your Highmark contract. Your patients will receive in-network benefits in accordance

with their benefit plan. If you are not a contracted Medicare Advantage PPO provider with Highmark and you provide services for out-of-area Blue Medicare Advantage PPO patients, you will receive the Medicare allowed amount for covered services based on where the services were rendered and according to the patient's out-of-network benefit level. For emergency and urgent care, you will be reimbursed at the patient's in-network benefit level.

Q **How do I recognize an out-of-area patient from one of the Plans participating in this program?**

A The "MA" in the suitcase on the patient's Blue Plan Medicare Advantage PPO ID card indicates a patient who is covered under the Medicare Advantage PPO Network Sharing Program. Patients should be asked to show their Blue Cross and/or Blue Shield ID card when receiving services (and not their standard Medicare ID card).

Q **Do I have to provide services to Medicare Advantage PPO patients from other Blue Plans?**

A If you are a contracted Medicare Advantage PPO provider with Highmark, you should provide the same access to care as you do for Highmark Medicare Advantage PPO patients.

If you are not a contracted Medicare Advantage PPO provider with Highmark, you may see other Blue Plan Medicare Advantage PPO patients; however, you are not required to do so.

Q **What if my practice is closed to new local Medicare Advantage PPO patients?**

A If your practice is closed to accepting new Highmark Medicare Advantage PPO patients, you are not required to provide care for out-of-area Blue Plan Medicare Advantage PPO patients.

Q **How do I verify eligibility and benefits?**

A You can verify eligibility and benefits for Medicare Advantage PPO patients from other Blue Plans via Highmark's NaviNet® provider portal. Select **BlueExchange® (Out-of-Area)** under **Workflows for this Plan**, and then click on **BX Eligibility and Benefits Inquiry**. You can also call the BlueCard® Eligibility

line at **1-800-676-BLUE (2583)** and provide the patient's 3-character prefix located on the patient's ID card.

Q **Where do I submit the claim?**

A Submit the claim to Highmark under your current billing practices. Once you submit the claim, Highmark will work with the out-of-area patient's Blue Plan to determine benefits, and then Highmark will send you the payment.

Please **do not** bill traditional Medicare for any services rendered to a Medicare Advantage member.

Q **What is the member cost-sharing level and copayments?**

A When out-of-area Blue Plan Medicare Advantage PPO patients see Medicare Advantage PPO contracted providers in Highmark's service areas, covered services and copayments will be at the patient's in-network level of benefits. You may collect the copay amounts at the time of service.

Q **May I balance bill the out-of-area patient the difference between my charge and the allowance?**

A No, you may **not** balance bill the out-of-area patients for this difference. Patients may be billed for any applicable deductibles, coinsurance, and/or copays.

Q **What if I disagree with the reimbursement amount that I received?**

A If there is a question concerning the reimbursement you received, please contact Highmark Freedom Blue PPO Provider Services.

Q **Who do I contact if I have a question about Medicare Advantage PPO Network Sharing?**

A If you have any questions about the Medicare Advantage PPO Network Sharing Program, please contact Highmark Freedom Blue PPO Provider Services at **1-866-588-6967**.

Information on the Medicare Advantage PPO Network Sharing Program is available in the *Highmark Provider Manual*. Please see Chapter 2.2: Medicare

Advantage Products & Programs and Chapter 2.6: The BlueCard Program.

Disclaimer: BlueCard is a registered mark of the Blue Cross Blue Shield Association. Health benefits or health benefit administration may be provided by Highmark Blue Cross Blue Shield, Highmark Blue Cross, Highmark Blue Cross Blue Shield West Virginia, or Highmark Senior Solutions Company, which are independent licensees of the Blue Cross and Blue Shield Association.

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Notifications for Providers

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

Reimbursement, Claims & Billing

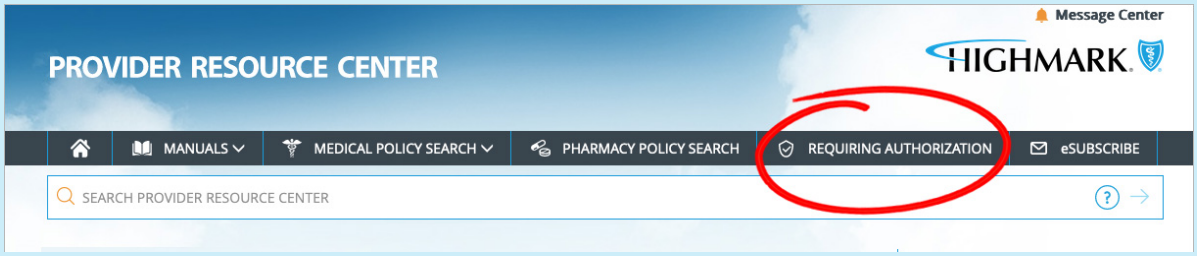
New and updated reimbursement policies

Highmark regularly issues new or updated reimbursement policies. Keep an eye on the Provider Resource Center Home Page for eBulletins announcing new policies and the Reimbursement Policy page for policy updates.

To access Highmark reimbursement policy bulletins, select **CLAIMS, PAYMENT & REIMBURSEMENT** from the Provider Resource Center main menu, and then click on **Reimbursement Policy**.

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

During the year, Highmark adjusts the List of Procedures and Durable Medical Equipment (DME) Requiring Authorization, which includes outpatient procedures, services, DME, and drugs that require authorization for our members. These changes are announced in the form of Special eBulletins that are posted on Highmark's Provider Resource Centers (PRC). To view the List of Procedures/DME Requiring Authorization, click Requiring Authorization in the gray bar near the top of the PRC homepage.



Please note that the Highmark member must be eligible on the date of service and the service must be a covered benefit for Highmark to pay the 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 are not signed up for NaviNet or do not have access to the HIPAA electronic transactions, please call Clinical Services to obtain an authorization for services:

- Highmark Delaware Contact Information for Providers
- Highmark Contact Information for Pennsylvania Providers
- Highmark West Virginia Contact Information for Providers

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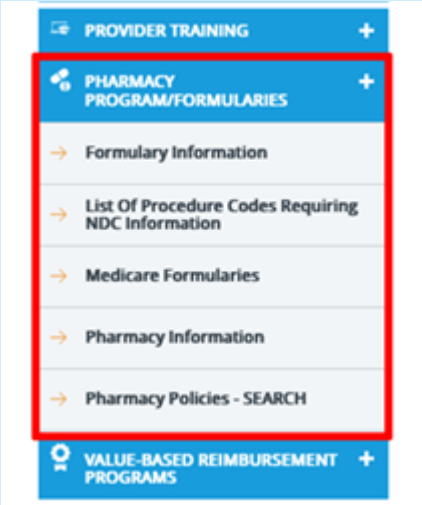
Quarterly Formulary Updates Available Online

Highmark regularly updates 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 that can be found on the home page of Highmark's Provider Resource Center.

Providers who do not have internet access or do not use 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 refer to the **Pharmacy Program/Formularies** pages, accessible from the main menu on the Provider Resource Center (PRC).



This page includes information on:

- Providing information for exception requests
- The process for generic substitutions
- Explanations of limits/quotas, therapeutic interchange, and step-therapy protocols

Federal Employee Program (FEP) Drug Formularies and Pharmaceutical Management Procedures

The FEP specific drug formularies are available online. Providers who don't have internet access may obtain formulary information via phone by using the below toll-free numbers and following the prompts for *Pharmacy*:

- Delaware: 1-800-721-8005
- Pennsylvania: 1-866-763-3608
- West Virginia: 1-800-535-5266

To learn more about the FEP exception request processes for non-formulary drugs, click here.

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Staying Up to Date with the Highmark Provider Manual

Ensure you are regularly reviewing the Highmark Provider Manual for our most recent guidance on:

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

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