

# Physicians Helping Highmark's True Performance Program to Succeed

## Highmark's True Performance Program Avoided More than \$260 Million in Health Costs in 2017

When PCPs helped Highmark launch its True Performance program in January 2017, the goal was to improve health care quality outcomes for members, reduce annual increases in total health care costs, and help physicians engage in patient care coordination and population health management.



True Performance is a value-based reimbursement program for PCPs focused on affordability and quality of health care for Highmark members. The program evaluates a PCP's ability to deliver the right care at the right time and in the most appropriate setting, and it rewards PCPs for their performance on quality and cost/utilization measures.

Highmark's claims data through the end of 2017 are now showing the results of the True Performance program, and they have exceeded expectations — with more than \$260 million in avoided health costs to date.

"PCPs have an enormous influence on our members' health — from routine visits to prescribing medications to referrals to specialists — and that is why the True Performance program focuses on PCPs," said Charles DeShazer, MD, senior vice president and chief medical officer, Highmark Health Plan. "And we have seen great success in the first year."

According to Dr. DeShazer, Highmark members who are seeing a PCP in the True Performance program had 11 percent fewer ER visits in 2017 than members seeing a PCP who is not in the program.

“True Performance helps physicians focus on prevention and wellness — they are evaluated on meeting nationally recognized quality measures, such as ensuring members receive appropriate screenings and vaccinations,” Dr. DeShazer said. “Those prevention and wellness efforts are helping to keep our members out of the ER, and we estimate that potentially avoided costs were over \$38 million in just the first year of the True Performance program.”

Additionally, members seeing a PCP in the True Performance program had 16 percent fewer inpatient admissions in 2017 compared to members seeing a PCP who is not in the program — at a potentially avoided cost of \$224 million.

“True Performance also evaluates physicians on how they help members manage chronic illnesses such as diabetes, heart disease, and asthma,” Dr. DeShazer added. “When those conditions are properly managed, costly inpatient hospital stays related to chronic illnesses can be avoided.”

While cost savings and better health are certainly good for patients and members, PCPs are also seeing benefits from True Performance. Through collaboration with Highmark, they receive the support and information needed to thrive in the new environment of value-based care.

“The True Performance program is a ‘true’ collaboration between the provider and Highmark that recognizes our commitment to quality and also provides us with data tools, plus personalized support, to help us provide better care for our patients,” said Bill Johnjullo, MD, chair of the Allegheny Health Network (AHN) Primary Care Institute in Pittsburgh. “True Performance also provides a new payment model that helps us fund reinvestments to support the transformation in how we provide a higher level of personalized care. It truly is a win-win-win situation for our patients, providers, and Highmark.”



# Freespira to Help Highmark Members Manage Panic Attacks

A pounding heart. Sweating. Nausea. Trembling. And fear of losing control.

Patients suffering those symptoms may or may not know what's happening to them. But health care professionals can quickly pinpoint the cause: a panic attack.

Panic attacks are excruciating for anyone who suffers from them. And successfully treating them can be challenging.

Highmark members and their network care providers now have a new ally to help fight panic attacks. Select Highmark members, in collaboration with their physicians or behavioral health specialists, have access to Freespira.

Freespira is a new FDA-cleared treatment that can significantly reduce or eliminate debilitating panic symptoms, according to the therapy's creator, Palo Alto Health Sciences (see "How does Freespira work?" below).

## What is Freespira?

Freespira is an at-home, medication-free, one-month treatment that addresses the underlying physiological causes of panic: chronic hyperventilation and/or other dysfunctional respiratory patterns.



Though they may not realize it, many people experiencing panic attacks breathe differently than others, and not only during a panic attack. Freespira teaches them to adjust their exhaled CO<sub>2</sub> level and breathing rhythm to normal patterns. Doing so




helps reduce or eliminate panic symptoms and panic attacks, sometimes in as little as two weeks.

With an authorization from their network physician or behavioral health specialist, Highmark members will receive a tablet computer containing the Freespira app. Members also get a highly advanced sensor that measures their breathing rate and exhaled CO<sub>2</sub> level.

## How does Freespira work?

The sensor transmits data on the user's breathing to the Freespira app. Real-time breathing information is then displayed on the tablet. And the patient receives personalized guidance in addition to visual and audio instructions on how to adjust his or her breathing.

Members complete two 17-minute sessions each day for four consecutive weeks in the privacy and comfort of their homes. With guidance from a therapist, Freespira has been shown to be safe and effective in several clinical studies, according to Palo Alto Health Sciences (see data below).

A Freespira Quality Improvement Program conducted through [VITAL](#) , Highmark Health, and Allegheny Health Network from 2015 through 2017 showed promising clinical outcomes for patients:

- 85% of patients reported they were free of panic attacks immediately after treatment ended
- 83% reported significant symptom reduction immediately after treatment concluded
- 81% said they were free of panic attacks 12 months after treatment
- 94% reported significant symptom reduction 12 months after treatment

The program also showed that Freespira delivered measurable cost reductions. For members completing the treatment, overall medical costs were reduced by 50% and ED costs dropped by 64%.

## How to refer your Highmark members

Freespira is a covered benefit for non-Medicare-Advantage Highmark members. Copays and coinsurance apply. Use NaviNet<sup>®</sup> or the applicable HIPAA electronic transactions to check member benefits and eligibility.

To refer an eligible Highmark member, call 1-800-735-8995 or send an email to [cs@freespira.com](mailto:cs@freespira.com).

You will be able to review records of your patients' Freespira breathing sessions through a secure website.

Watch *Provider News* for more information and updates on Freespira.

**Important note:** This article is informational only: Highmark does not recommend particular treatments or health care services. Members' access to Freespira is conditioned upon the authorization of a physician or health care professional. Coverage of Freespira is subject to the terms of each member's benefit plan. Please confirm that your patient who is a Highmark member has a benefit for Freespira. Additionally, state laws and regulations governing health insurance, health plans, and coverage may apply and will vary from state to state.



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# Highmark Introduces Upcoming Changes to Prior Authorization Program

- **New Musculoskeletal Surgery and Interventional Pain Management Services Prior Authorization Program Being Implemented Oct. 1, 2018**
- **Prior Authorization List to Be Updated Oct. 1, 2018**

Highmark is committed to working with health care providers to assure that our members, your patients, receive high-quality, medically necessary care in the most appropriate setting. Although there is no substitute for a physician’s professional opinion, the reality of today’s health care market is that in some instances, nationally accepted evidence-based guidelines are not followed, resulting in inappropriate or unnecessary care delivery.



Ensuring patients receive appropriate care based on well-established, evidence-based clinical guidelines will result in better outcomes, better experiences, and lower costs for our clients and our members. At the same time, Highmark is committed to trying to reduce unnecessary barriers to care and streamlining the patient experience.

In line with this approach, as announced in a [Special eBulletin](#)  dated and posted on July 16, 2018, we are making updates to our prior authorization program to verify that the elective or planned care our members receive is medically necessary, appropriate, and performed in the optimal setting. In accordance with evidence-based guidelines, we are adding additional procedures to our prior authorization list.

Simultaneously, to reduce the administrative burden on our network providers for less complex cases, and to safeguard timely care and a better patient experience, we are removing other procedures from our prior authorization list.

In addition, in keeping with our commitment of promoting continuous quality

improvement for services provided to our members, Highmark has entered into an agreement with eviCore healthcare to implement a musculoskeletal (MSK) surgery and interventional pain management (IPM) services program. The new program incorporates a comprehensive clinical review, including predictive intelligence, clinical decision support, and peer-to-peer discussions. This approach confirms our members receive only medically necessary and appropriate MSK surgical and IPM services in the least intensive setting to promote the best outcomes.

The eviCore MSK surgery and IPM program and prior authorization changes will go into effect on Oct. 1, 2018.

We appreciate your support and the high-quality, cost-effective care you provide our members, your patients. We look forward to your continued assistance in ensuring that Highmark members receive appropriate, medically necessary services in a quality, clinically appropriate fashion.

Watch for detailed information on the Highmark Provider Resource Center for everything you'll need to know. You'll find the new MSK/IPM page under **Care Management Programs**.

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# Reminder: Highmark’s Childhood Obesity Preventive Health Benefit

## September Is Childhood Obesity Awareness Month

Obesity in childhood and adolescence has become one of the most important pediatric chronic conditions over the past two decades. Many factors contribute to overweight and obesity; however, the primary factor is an imbalance between energy consumption and energy expenditure.

According to the Centers for Disease Control and Prevention (CDC), children ages 2-19 years with a BMI at the following percentile are considered to fall into these categories:

BMI percentile	Category
85 to 94	Overweight
95 or higher	Obese



Counseling parents and patients regarding nutrition and physical activity should be part of all well-child visits to prevent or treat overweight and obesity.

Despite the publicity about “body shaming,” weight stigma continues in this age group, expressed primarily by teasing and bullying. Instead of motivating positive change, this stigmatization contributes to behaviors like binge eating, social isolation, avoidance of health care services, decreased physical activity, and increased weight gain. Weight-based bullying is among the most frequent forms of peer harassment that students report.

## Highmark’s Childhood Obesity Preventive Health Benefit



Children 2 to 18 years of age who have a BMI in the 85th percentile or higher are eligible for:

- Four preventive health office visits (an annual preventive visit and three follow-up visits)
- Unlimited nutritional counseling visits specifically for obesity
- One set of recommended lab work annually that includes:
  - Cholesterol screening
  - Hemoglobin A1c **or** fasting glucose
  - AST and ALT

### Childhood obesity at a glance

- Nationally, one in five school-age children (6 to 19 years old) is obese.
- In Pennsylvania, more than one in four children is overweight or obese.



You can help combat childhood obesity by talking to parents and children about:


- Eating plenty of fruits, vegetables, and whole-grain products; low-fat or fat-free dairy products; and lean meats, poultry, fish, lentils, and beans for protein
- Giving age-appropriate portions
- Avoiding or reducing calorie-dense foods and beverages
- Encouraging 60 minutes of physical activity a day
- Limiting screen time (TV, video games, computer) to two hours or less daily.

Questions addressing their children's weight may not be comfortable for parents or caregivers to hear. But having these conversations early in a child's life helps to minimize health concerns later in life.

To support you in these discussions, Highmark offers helpful tools and resources in our [Childhood Obesity Physician Tool Kit](#) , which is available under **Education/Manuals** on our online Provider Resource Center.


#### Sources:

- Alliance for a Healthier Generation.
- American Heart Association. "Addressing your child's weight at the doctor." Updated Aug. 4, 2014.
- Centers for Disease Control & Prevention, Childhood Obesity section.
- *CHILDHOOD OBESITY*. April 2013. Volume 9, Number 2. "Innovative Tools Help Counselors Discuss Childhood Obesity with Parents."
- Agency for Healthcare Research and Quality (AHRQ), National Quality Measures Clearinghouse. "Weight assessment and counseling for nutrition and physical activity for children/adolescents: percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation during the measurement year."
- American Academy of Pediatrics. "Stigma Experienced by Children and Adolescents with Obesity." Pont, S. Published online, Nov. 20, 2017.
- American Heart Association (Endorsed by American Academy of Pediatrics). *Dietary Recommendations for Children and Adolescents: A Guide for Practitioners*, retrieved from [aappublications.org/news](http://aappublications.org/news) .
- American Academy of Pediatrics. "Recommendations for Treatment of Child and Adolescent Overweight and Obesity," retrieved from [aappublications.org/news](http://aappublications.org/news) .

- American Academy of Pediatrics. "Policy Statement – Children, Adolescents, Obesity, and the Media," retrieved from [aapublications.org/news](https://aapublications.org/news) .



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# News for Northeast PA Providers: PCP Auto-Assignment Program for HMO ACA Members

## Effective for 2019 Open Enrollment

One of Highmark’s primary concerns is supporting our members’ overall good health. The Patient Protection and Affordable Care Act of 2010 (ACA) has enabled more Americans to purchase quality, affordable health care coverage from insurers like Highmark.



Highmark understands that a key to our members’ overall care coordination is selection of a PCP. We encourage members to make this selection at enrollment. While many members make this selection immediately, Highmark has identified some health maintenance organization (HMO) ACA members who didn’t initially select a PCP.

That’s why Highmark is implementing a new program called PCP Auto-Assignment for HMO ACA members, effective with the 2019 open enrollment period. The new program will ensure members select a PCP at enrollment. Or, for members who do not select a PCP immediately, one will automatically be assigned.

PCP Auto-Assignment will work as follows:

- **Existing members:** Highmark systems will review the existing member history. If the member previously had a PCP, he/she will be confirmed as in-network for the member’s current network. If yes, this physician will be the member’s current PCP. If no PCP was selected previously, Highmark’s systems will locate a PCP in the closest geographic region where the PCP indicates acceptance of new patients.
- **New members:** Highmark’s systems will locate a PCP in the closest geographic region where the PCP indicates acceptance of new patients.

Highmark appreciates the quality care you provide to our members, and we believe this integrated program will assist in better achieving more effective patient care.

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# Medicare Advantage News: Reminders About Important Medicare Exams and Visits

The Centers for Medicare & Medicaid Services (CMS) provides an annual wellness visit (AWV) and health risk assessment (HRA) benefit for Medicare beneficiaries, including Medicare Advantage members. Following are some important reminders for network physicians who see Medicare-eligible patients.



## **AWV doesn't replace IPPE**

The AWV does not replace the Initial Preventive Physical Examination (IPPE) — also known as the “Welcome to Medicare Visit” — that new beneficiaries receive within 12 months of enrolling in Medicare.



The AWV is not covered during the first 12 months of a beneficiary's initial enrollment in Medicare.

## **AWV includes Health Risk Assessment**

The AWV requires a Health Risk Assessment (HRA) and a customized wellness or personal prevention plan.

## **Medicare Advantage medical policy outlines coverage criteria for AWV**

Highmark Medicare Advantage Medical Policy N-98 provides comprehensive details regarding coverage and billing guidelines for the AWV, including Personalized Prevention Plan Services.

For more information, visit [cdc.gov](https://www.cdc.gov)  or the [Provider Resource Center](#) . The Annual Wellness Visit Member Checklist meets CMS-required components for the HRA, and the checklist is available on the Provider Resource Center.

## Use correct coding to ensure proper claims processing and reimbursement

The IPPE, AWW first visit, and AWW subsequent visit each have a distinct procedure code. To avoid claim rejections and ensure proper reimbursement, the procedure codes to use when billing are:

- G0402 — Initial Preventive Physical Exam (IPPE)
- G0438 — Annual Wellness Visit, First (AWV)
- G0439 — Annual Wellness Visit, Subsequent (AWV)

We thank you for the quality care you provide to all your Highmark patients, including our Medicare-eligible members.

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**CHIP News**

# Required Lead Blood Test Reimbursable

## Safeguarding Children Is Easier Than You Think

Pennsylvania's Children's Health Insurance Program (CHIP) requires that all members ages 9 months to 2 years have at least one lead blood test that can be performed during the routine wellness and developmental screening visits. These are preventive, reimbursable benefits with no out-of-pocket costs for these members.

### Did you know?

Completing the lead blood test is easy! It can be completed with the routine hemoglobin test performed at 12 months for anemia, per Bright Futures™. Even better news: No blood draw is required. Simply complete one finger stick for both the hemoglobin and lead tests. Finally, the lead blood test and developmental screening test are reimbursable if submitted using procedure codes 83655 and 96110, respectively.

We understand that since symptoms may not be readily identifiable in infants and those under 1 year of age, parents may be hesitant to request or permit the test, even if you discuss it with them. However, lead poisoning is a serious matter, with potential mental and physical symptoms not showing up until several years later. These symptoms, which may be more difficult to treat later in the child's life, include:

- Developmental delay (testing discussed below)
- Learning difficulties
- Seizures
- Hearing loss
- Irritability
- Weight loss
- Sluggishness and fatigue
- Loss of appetite
- Abdominal pain
- Vomiting



Next, a developmental screening is also recommended. It can assist in early detection of autism, learning disabilities, and developmental delays. As stated, this test is also reimbursable, with no out-of-pocket member costs, if billed using procedure code 96110.






## Quality care — tying the testing together

- **Lead blood test:** Lead poisoning isn't simply a paint-related issue that occurs only from old houses. Lead poisoning can come from other places where children play, like around old water pipes, soil that is tracked into the house, or even from the child's favorite toys.
- **Developmental screenings:** Subsequently, the Centers for Disease Control and Prevention (CDC) recently encouraged pediatricians and PCPs to follow American Academy of Pediatrics guidelines for screening children 3 years of age and younger for developmental disabilities. This occurred due to 2014 findings that 17 out of every 20 children in the Autism and Developmental Disability Monitoring Network had a developmental concern by the age of 3. Of this number, only eight of every 20 children had undergone a developmental evaluation by that same age.


Early screenings are among the best resources to rule out or expedite treatment if an issue is identified. As mentioned, there is minimized pain since no secondary blood draw is required for the lead blood test. Highmark does understand parents may choose to shelter their children from painful situations if they don't see obvious signs of health-related concerns.

For this reason, Highmark is providing the following CDC web resources. This information may prove to be beneficial when discussing these topics with parents during testing visits and/or in preparation for upcoming appointments. Parents who understand potential health concerns are better equipped to make informed decisions related to the welfare of their children.

- [What Do Parents Need to Know to Protect Their Children?](#) 
- [Blood Lead Levels in Children Fact Sheet: What Do Parents Need to Know to Protect Their Children?](#) 
- [Prevention Tips](#) 

Highmark appreciates the quality care you provide to our members, your patients. Working together, we can achieve more effective patient outcomes.

**Source:**

Healio. May 8, 2018. "CDC: PCPs need to conduct more pediatric development screenings." [healio.com/family-medicine/pediatrics/news/online/%7B0522d7f8-3a91-4fb2-b281-e581ab3b7b1e%7D/cdc-pcps-need-to-conduct-more-pediatric-development-screenings](https://healio.com/family-medicine/pediatrics/news/online/%7B0522d7f8-3a91-4fb2-b281-e581ab3b7b1e%7D/cdc-pcps-need-to-conduct-more-pediatric-development-screenings) 



**CHIP News**

# Reminder — CHIP Providers Required to Enroll with DHS

Effective Jan. 1, 2018, the Pennsylvania Department of Human Services (DHS) requires all care providers and practitioners to be enrolled to order, refer, or prescribe items or services for the state’s Children’s Health Insurance Program (CHIP) members. This requirement follows a Centers for Medicare & Medicaid Services (CMS) provision.



Providers who don’t meet this requirement and don’t have a valid PROMISe™ ID will have their claims denied for services provided to CHIP members.

CHIP providers must complete an enrollment application for their provider type for each location (office address) and submit all required documents to DHS.

You can sign up as a CHIP-only provider. And, most providers aren’t required to pay the application fee.


Other reminders:

- If you have already enrolled in the Pennsylvania Medical Assistance (MA) Program, you **don’t** need to re-enroll as a CHIP provider.
- If you are part of another state’s Medicaid or CHIP program, or are enrolled in Medicare, you **must enroll** with DHS to be a CHIP provider.
- If you see patients from multiple CHIP managed care organizations, you are **only required to enroll once** with DHS as a CHIP provider.
- If your practice has multiple locations, **include each address** on your application.

**Note:** If you have a PROMISe ID and you include any of the following providers on


your request who **don't have a valid ID** (National Provider Identifier – NPI), the claims will be denied:

- Billing provider
- Performing provider
- Referring provider

More information is available on the [DHS's website](#) .



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**CHIP News**

# New CHIP Preventive Care Outreach Campaign

Pennsylvania's Children's Health Insurance Program (CHIP) requires preventive care services, including annual well-child exams, annual developmental screenings for children ages 1 to 3 years, and lead blood screenings ([see story in this issue](#)) once between age 9 months and 2 years.



Highmark has launched a new monthly outreach to families of CHIP-enrolled children to assist them in obtaining these required preventive services. Our representatives will be contacting your office to schedule well-child exams, developmental screenings, and/or lead blood testing for your Highmark-enrolled CHIP patients.

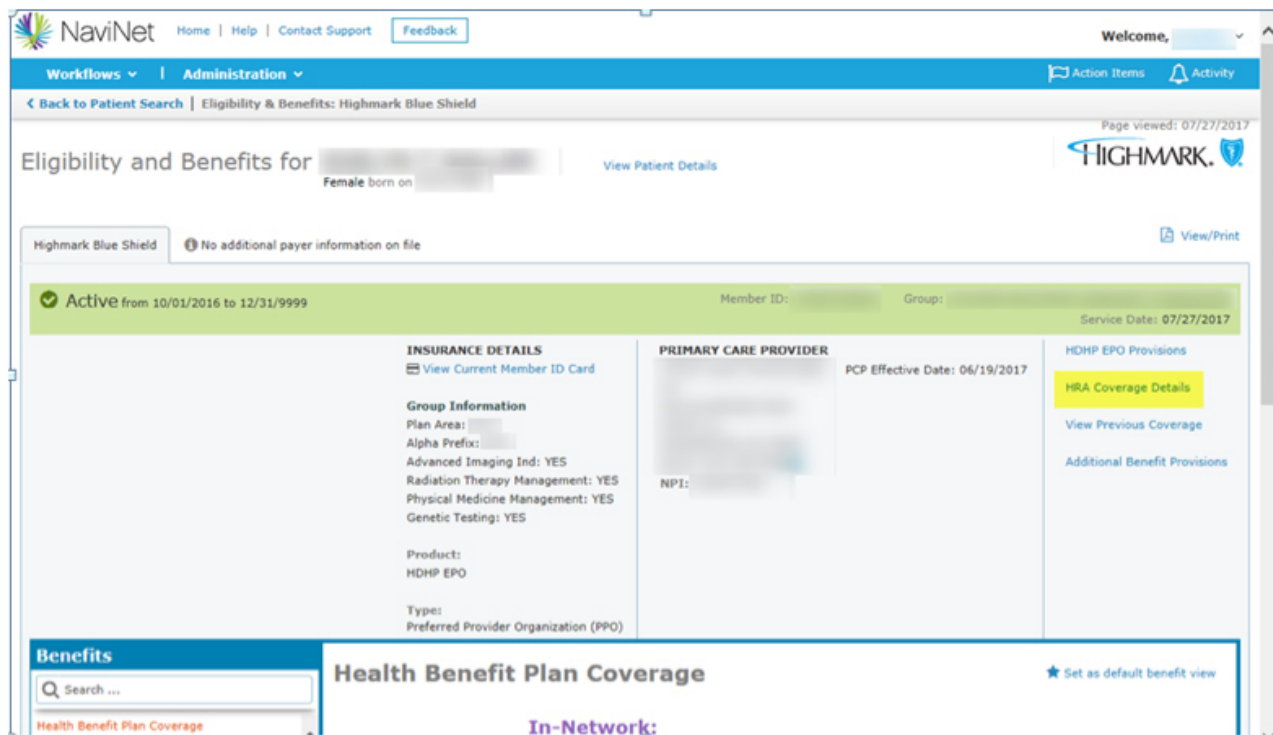
These calls began in mid-July 2018 and will continue monthly.



# NaviNet Puts Information on Members' HRAs at Your Fingertips

Many Highmark members now have health plans with high deductibles that are tied to corresponding health reimbursement arrangements (HRAs). You can easily tell if a member has an available HRA and access that information using NaviNet®.

To retrieve a member's HRA information, select **HRA Coverage Details** (highlighted in yellow in the screen capture below) from the **Eligibility and Benefits Details** page.



The HRA Coverage Details page shows the amounts for both the Individual and Family Annual Election. If the HRA is partially funded by the member's employer, this page will show any amount that the member (employee) is required to pay. Please note that you will have to contact Highmark to determine if the member has met any of the HRA amounts listed.

# HRA Coverage Details

## Patient Information

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**Patient Name:**  
**Member ID Number:**

**Benefit Effective Date:** 01/01/2017  
**Benefit Term Date:** 00/00/0000

## Contributions

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<b>Individual Annual Election:</b>	\$ 1250
<b>Employee &amp; Child Annual Election:</b>	\$
<b>Employee &amp; Children Annual Election:</b>	\$
<b>Employee &amp; Spouse Annual Election:</b>	\$
<b>Family Annual Election:</b>	\$ 2500

## Participant Deductibles

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<b>Special Plan Design:</b>	Employee Pays First
<b>Individual Deductible Amount:</b>	\$ 250
<b>Employee &amp; Child Deductible Amount:</b>	\$
<b>Employee &amp; Children Deductible Amount:</b>	\$
<b>Employee &amp; Spouse Deductible Amount:</b>	\$
<b>Family Deductible Amount:</b>	\$ 500
<b>Embedded Deductible:</b>	Yes
<b>Embedded Deductible Amount:</b>	\$ 250


## Expense Types

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<b>Coinsurance:</b>	No
<b>Copay:</b>	No
<b>Deductible:</b>	Yes

If a member's HRA has been set up as "Direct Pay to Provider," payment will be made directly from the HRA to the provider if the HRA has an account balance.

## How to sign up for NaviNet

If you don't have NaviNet, we strongly encourage you to visit [navinet.net](http://navinet.net)  and gain access to the system. Current NaviNet users who have questions about the system may call 1-888-482-8057 to speak with a NaviNet representative.

In addition to using NaviNet to look up members' HRA information, you can use the



system to quickly locate eligibility and benefit information, to check your allowances for the services you're providing, to request needed authorizations, to submit and check the status of claims, and much more.



# Reminder About PSA-Based Screening in Older Men

The goal of prostate cancer screening is to identify the high-risk, localized disease that can be successfully treated. Doing so can prevent the morbidity and mortality associated with advanced or metastatic prostate cancer in asymptomatic men.

The prostate-specific antigen (PSA) screening test is the most common method used to screen for prostate cancer. Whether to perform the test is one of the most important issues in men's health. And it's one of the most controversial.

The controversy is over the widespread use of the PSA test to screen for prostate cancer in men who are free of signs and symptoms of the disease.

PSA screening cannot diagnose cancer. A biopsy is necessary to tell the difference between slow growing, harmless prostate cancer and less common, aggressive, and potentially deadly tumors.

In the United States, about one in nine men will be diagnosed with prostate cancer in their lifetime. And this year, nearly 165,000 men will be diagnosed with prostate cancer.

The harm of PSA-based screening includes:

- False-positive results
- Complications from prostate biopsies
- Over-diagnosis (in 20% to 50% of cases)
- Psychological harm

The harm of treatment includes:

- Urinary/fecal incontinence
- Erectile dysfunction
- Pain
- Fever



- Hematospermia

On May 8, 2018, the United States Preventive Services Task Force (USPSTF) released its final recommendation statements for PSA-based screening specifically in older men:

- Grade C – with moderate certainty that net benefit of PSA-based screening for prostate cancer in men aged 55 to 69 years is small for some men. How each man weighs specific benefits and harms will determine whether the overall net benefit is small.
- Grade D – with moderate certainty that potential benefits of PSA-based screening for prostate cancer in men 70 years and older do not outweigh the expected harm.

The American Urological Association and the American Cancer Society recommend shared decision-making between patient and physician before prostate cancer screening is ordered. Men should address their concerns and priorities with their doctors to facilitate informed decisions about prostate cancer screening and improve patient satisfaction and outcomes.

It is beneficial for health systems to ensure that providers and their communities understand the risks and benefits of PSA screening. Organizations can develop screening guidelines that align with their communities' needs and providers' preferences. It is important to provide decision-support tools for providers and patients to guide informed decision making.

Coverage for PSA screening varies among Highmark's benefit plans. Please use NaviNet or the applicable HIPAA electronic transactions to check member benefits and eligibility. Also, visit our online Provider Resource Center to view the age-appropriate Highmark Preventive Health Guidelines for screening recommendations. (On the Resource Center, choose **Education/Manuals** and **Clinical Practice and Preventive Health Guidelines**.)


If your patients who are Highmark members have questions about coverage, please direct them to call the Member Service number on the back of their Highmark ID card to verify coverage.

**Sources:**

American Urological Association: [auanet.org/guidelines/early-detection-of-prostate-cancer-\(2013-reviewed-and-validity-confirmed-2015](http://auanet.org/guidelines/early-detection-of-prostate-cancer-(2013-reviewed-and-validity-confirmed-2015) 

American Cancer Society: [cancer.org/cancer/prostate-cancer/early-detection/acs-recommendations.html](http://cancer.org/cancer/prostate-cancer/early-detection/acs-recommendations.html)



Urology Care Foundation: [urologyhealth.org](http://urologyhealth.org) 



## Make Sure Patients Can 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<sup>®</sup> to check these fields:

- Current address
- Phone number
- Fax number

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.

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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 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 eBulletins.

These Special eBulletins are available [online](#) . Additionally, notices are placed on the Provider Resource Center's **Hot Topics** page to alert physicians when new quarterly formulary update Special eBulletins are available.

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

### Pharmaceutical Management Procedures


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




## About This Newsletter

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

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

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

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

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

### Comments/Suggestions Welcome


Joe Deemer, Copy Editor

Adam Burau, Editor

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



## Contact Us

Providers with internet access will find helpful information online at [highmarkblueshield.com](http://highmarkblueshield.com) . NaviNet<sup>®</sup> 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<sup>SM</sup> 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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