PROVIDER NEWS
A Newsletter for Highmark Blue Shield Providers in Central Pennsylvania, the Lehigh Valley, Northeastern Pennsylvania and Southeastern Pennsylvania
Issue 5, 2017

ALL PROVIDER TYPES

We recently unveiled a fresh new look for our online **Provider Resource Center (PRC)** — your one-stop source for provider manuals, medical policy, and all the information you need to do business with Highmark.

Whether you're visiting the PRC through NaviNet® or via **Helpful Links** on our website, you'll notice the PRC's exciting new design. You'll also see several navigational enhancements that will make your PRC user experience more efficient and productive.

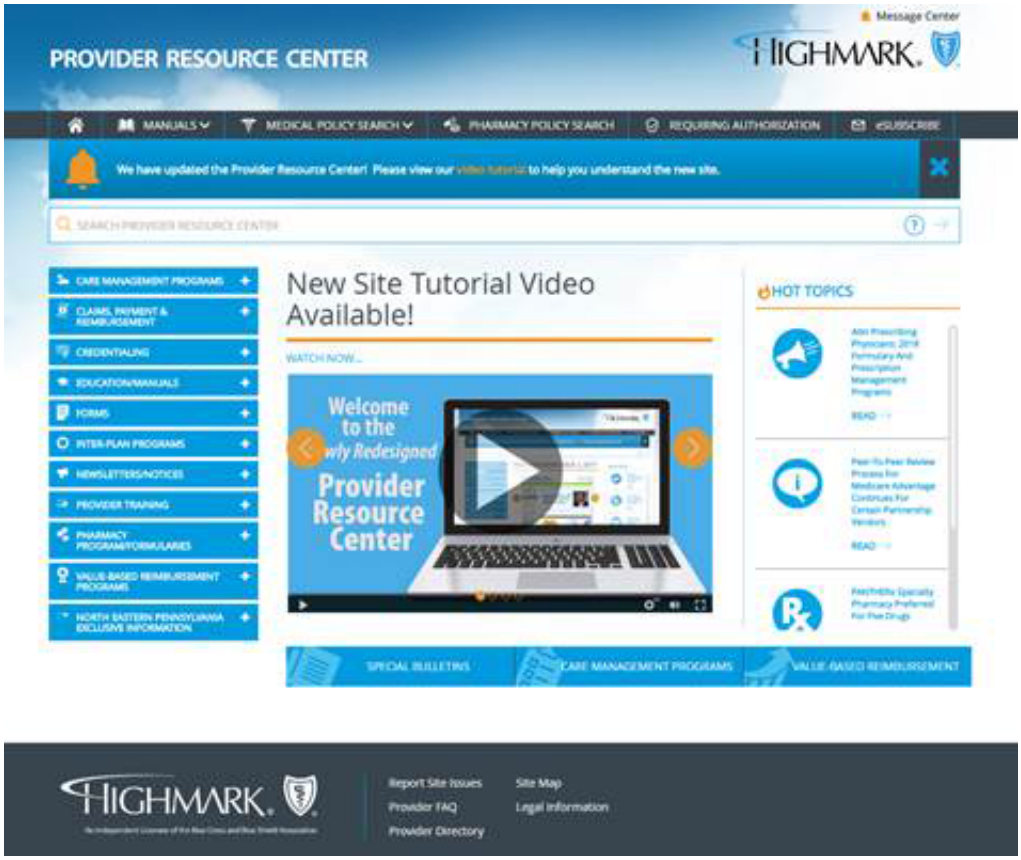
And we've created the new PRC with mobility in mind: the site view adjusts for use on smartphones and tablets, enabling you to access its tools and information on the go.

Less clutter

We've significantly condensed the number of links that were listed down the left side of the PRC home page. So that you no longer need to scroll down a lengthy list to find the link you need, we've created nine general information categories, each listed in blue bars at left.

Named as follows, each of the nine categories expands to reveal related sub-categories when you click the "+" symbol beside each one:

- **Care Management Programs** (including the Physical Medicine Management and Radiology Management programs)
- **Claims, Payment & Reimbursement** (including medical and reimbursement policies)
- **Credentialing**
- **Education/Manuals** (including the *Highmark Blue Shield Office Manual* and *Highmark Facility Manual*)
- **Forms**
- **Inter-Plan Programs** (including the BlueCard® Information Center)
- **Newsletters/Notices** (including *Provider News* and e-Subscribe)
- **Pharmacy Program/Formularies**
- **Value-Based Programs**



Easier to access Quicklinks

At the top of the home page, we've made several of the most popular Quicklinks available in gray buttons oriented horizontally across the page. These include **Manuals**, **Medical Policy Search**, and **Pharmacy Policy Search**.

Since these Quicklinks are among the most popular clicks on the PRC, we wanted to make them even easier for you to access on the new site.

Helpful new features

Message Center

Under the Quicklinks bar, provider alerts from our new Message Center will display in a blue banner with an orange bell icon — noting important Highmark news and other key information. A link to the Message Center also is available above the Highmark logo at the top right. Just look for the orange bell icon. These provider alerts will appear only periodically to notify you of important information, so please click on them when they are visible.

Hot Topics

Listed down the right side of the home page is a new Hot Topics section. Replacing the Today's Messages page, the Hot Topics section links you to Special Bulletins and other announcements regarding recent or upcoming fee changes, formulary updates, and other changes you should know about. Archived messages will be filed in the Hot Topics Library once they are removed from the Hot Topics section.

New search functions

You can still search the entire PRC by using the search window at the top of the home page. But now you can conduct an advanced search by clicking the question mark at the far right of the search window, helping you find what you need more quickly. The medical and pharmacy policy searches are still available from those individual pages. But the new site also lets you search within our provider manuals and in our Special Bulletins & Mailings archive. Simply visit the ***Highmark Blue Shield Office Manual***, ***Highmark Facility Manual***, and **Special Bulletins & Mailings** pages and use the search window provided on each page.

PRC tutorial

Within the Message Center, we've added a helpful online tutorial to lead you through navigating the new site and its many great tools and features. Watch the tutorial today and encourage your colleagues to do the same, so you'll all be up to speed on the great features of our newly redesigned PRC!

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Highmark Cancer Collaborative's New Model for Colorectal Cancer Care Adopted on a Wider Scale

Health care is an endless pursuit of excellence — in improving care quality, enhancing the patient experience, and extending lives.

To that end, the Highmark Cancer Collaborative made great strides in its inaugural year toward revolutionizing care delivery for cancer patients. In 2017, one such accomplishment was the development of a new colorectal cancer care model, an approach to care that Highmark is supporting on a wider basis.

Implemented initially at Collaborative partner Allegheny Health Network (AHN), the new model promises to improve teamwork among physicians and help ensure the most appropriate and safest treatment for colorectal cancer patients. The model also aims to create a better overall patient experience (from diagnosis through final treatment and beyond), improve outcomes, and lower costs.

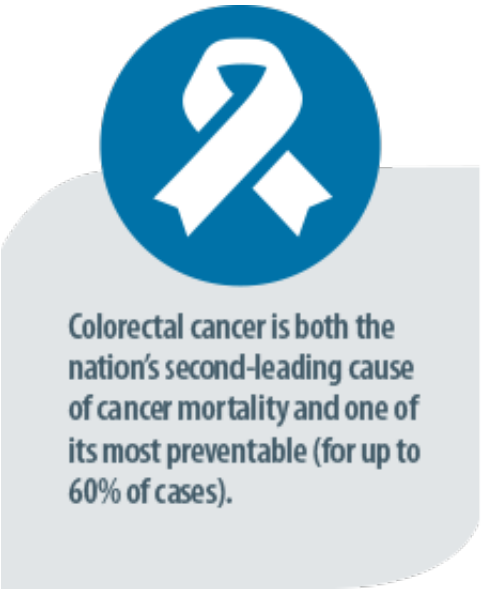
The strength of the model lies in providers adopting evidence-based, colorectal cancer clinical pathways recommended by leading national cancer experts and specialty societies. In addition to those care improvements, the model is based around innovative changes on the insurance-coverage side; these enhancements include reimbursing providers in a way that supports provider adherence to the new care pathways.*

And those pathways are powered by advanced information technology systems that participating physicians use to guide patient care.

Published studies have shown that adherence to such pathways translates into

higher care quality; safer, more effective treatment; fewer hospital admissions; and more cost-effective care for cancer patients.**

Why target colorectal cancers?



Cancer has exacted a heavy toll on patients and their families, both in terms of lives affected and personal financial cost.

Colorectal cancer is both the nation's second-leading cause of cancer mortality and one of its most preventable (for up to 60% of cases).

Additionally, the average cost of care per episode to treat a colon cancer patient was around $77,000 in 2015. For rectal cancer patients, the cost per case was $64,500. And, within those overall costs, chemotherapy was a major expense — $40,000 for colon cancer and $29,000 for rectal cancer.+

How does the new model work?

The Collaborative looked at colorectal cancer treatment from start to finish. Cancer physicians, clinicians, and researchers sought ways to improve everything from how patients and physicians communicate, to how oncologists diagnose colorectal cancers and order treatments, to how patients navigate through their course of care.

As a result of initial implementations, the model's new clinical pathways were adopted, provider reimbursement was redefined, and patient care was redesigned to be more engaging and efficient. And the model called for the establishment of the Multi-Disciplinary Cancer Conference (MDCC) review board to examine colorectal cancers and provide a comprehensive evaluation of each patient case to develop the best course of treatment.

Today, comparing patient data against the clinical pathways, participating physicians are able to:

- Identify the most promising treatment for a given cancer type
- Eliminate inappropriate treatments and surgeries
- Help improve patient safety by eliminating unnecessary chemotherapy or radiation sessions
- Eliminate duplicative or unnecessary testing to save costs for patients
- Make faster, more informed care decisions

To date, participating Collaborative physicians made 259 patient decisions with 80% adherence to the new colorectal cancer pathways.

Additional benefits of the new colorectal cancer care model's workflow include:

- Streamlined patient intake through use of nurse navigators who coordinate patients' appointments with multiple doctors to maximize progress, minimize visits, and save time
- Elimination of redundant forms/paperwork
- Enhanced patient learning and education
- Improved linking of patients with supportive services at the appropriate time, including diet and nutrition guidance, behavioral/emotional health counseling, spiritual or social support, and financial guidance
- Faster connection of patients to the latest national colorectal cancer clinical trials

Taking a wider approach

The number of participating Collaborative physicians and hospitals continues to grow throughout Pennsylvania. But Highmark saw how application of the new colorectal cancer model would benefit all Highmark members, not just those treated through Collaborative partner doctors and hospitals.

"As a Cancer Collaborative partner, Highmark helped to develop the new colorectal cancer care model alongside the medical, clinical, and research experts at Allegheny Health Network for replication with other provider partners," says Nancy Myers, vice president of Clinical Transformation for Highmark.

"It exemplifies what we're all working to achieve on an even larger scale — transform care, create a better experience for all patients, and give them a greater value."

In time, data and details will be shared on how the new care model is working to improve screening, diagnosis, and treatment for colorectal cancer patients. Watch *Provider News* for updates, including news about other Highmark Cancer Collaborative success stories.

*Providers participating in the Cancer Collaborative retain their independent judgment regarding the treatment of their patients.

Savings on aggregated breast, colon, and lung cancer spending as high as 15% can be achieved in the first year of a pathways program with as much as a 7% reduction in hospital admissions (Third-Party Validation of Observed Savings from an Oncology Pathways Program. 2013 **AJMC.com Journals). Additionally, a national study published in the *Journal of Oncology Practice*, 2010, found that patients following evidence-based clinical pathways for oncology treatments saw 35% lower costs vs. off-pathway patients.

+Highmark data

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Be a Voice in Health Care Evolution

PROFESSIONAL PROVIDERS

Did you know that Highmark Health's VITAL program provides support for studies designed to accelerate the adoption of novel medical technologies into the standard of care?

Launched in 2015, the VITAL program was designed to provide the missing link between FDA approval of a new technology and its full reimbursement by commercial insurers. It has already accelerated significant care enhancements, including:

• The LINX® Reflux Management System for treating patients with gastro-esophageal reflux disease (GERD) -- featured in current Living Proof campaign.
• The HeartFlow® non-invasive diagnostic technology that offers physicians insight into both the extent of a patient's coronary arterial blockage and the impact the blockage has on blood flow.

VITAL's overall goal is to make new technologies and services available through commercial insurers to the public sooner. Through VITAL:

• Participants get access to innovative, safe technologies that can help them, before these procedures are approved for coverage, without a high out-of-pocket cost
• Highmark Health can more quickly understand the full impact of new technologies, procedures and protocols on patient outcomes and overall costs of care. This will accelerate the adoption of formal changes to insurers' medical policies.
• Technology vendors and specialist providers can prove the benefits of their new innovations to patients and health plans.

As one of the largest integrated delivery and financing systems, Highmark Health is poised to drive innovation and discover new interventions that will improve the experience, access, outcomes, and affordability of health care. Effective deployment of new solutions could drive better care at lower cost.

Without support from commercial payers, it is difficult for innovations to influence the practice of medicine. VITAL provides a test bed designed to facilitate early use of interventions that have demonstrated safety and efficacy and have received regulatory approval, but are not yet covered by most commercial insurers. VITAL is designed to provide the missing link between regulatory approval of an innovative intervention and its full reimbursement.

We are seeking novel interventions that have received regulatory approval (eg. FDA) that lack sufficient scientific data to convince commercial insurers to pay for them. **Click here** to learn more today!

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Medicare Advantage News:

Peer-To-Peer Review Process Discontinued

Highmark's peer-to-peer review process for prior authorization requests for Medicare Advantage members is no longer available as of Sept. 12, 2017.

The peer-to-peer conversation offered providers the opportunity to discuss a pending adverse determination of an authorization request for medications or medical services with another peer designee from Highmark before Highmark made a final decision. Elimination of the Medicare Advantage peer-to-peer review process benefits the member and the provider by resulting in a more timely and efficient processing of authorization requests.

With notification of a denial decision, providers and members continue to be informed of their appeal rights and procedures. The denial letter includes instructions on how a provider or member can request a Medicare Advantage appeal. The appeal will provide an opportunity for review of the initial determination and any additional documentation provided to support the request.

Elimination of the Medicare Advantage peer-to-peer review process benefits the member and the provider by resulting in a more timely and efficient processing of authorization requests.

To ensure a thorough initial review of your authorization requests for medications or medical services for your Medicare Advantage patients, please be sure to:

- Submit all relevant medical records and pertinent information to support the request with the initial authorization request to Highmark.
- Respond promptly to any requests for additional information so a comprehensive review and decision can be made efficiently.

Note: Highmark's NCQA-accredited vendors (Tivity Health [formerly Healthways], National Imaging Associates, Inc., eviCore healthcare, and naviHealth) will continue to offer the peer-to-peer review process for prior authorization requests for Medicare Advantage members. These vendors must offer the peer-to-peer review process to meet NCQA accreditation requirements. Additionally, the peer-to-peer review process for prior authorization requests continues to be available for Highmark's commercial product members.

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A Prescription for Savings: Integrating Medical and Pharmacy Benefits

ALL PROVIDER TYPES

Prescription drug spending is the fastest growing part of health care spending. It represents approximately 20% of all health care spending and continues to rise year after year. There are many factors behind the rising costs, including:

- Increasing use of prescription drugs
- Newer, higher-priced drugs replacing older, less-expensive drugs
- Manufacturer price increases for existing drugs
- Fewer manufacturers, which means less competition
- Unnecessary prescriptions

To manage costs, some employers outsource, or "carve-out," their pharmacy coverage to a standalone pharmacy benefits manager (PBM). Others integrate, or "carve-in," their pharmacy benefits and medical coverage with their health plan.

Integrating benefits saves money, helps members live healthier

Highmark conducted a three-year study to find out which option yielded the most savings. The study compared approximately 1 million carve-in members and 1 million carve-out members of relative age and risk.

Researchers summarized the medical cost of each episode of care, emergency room

visit, and hospitalization for the three-year period and then calculated the cost differences between the carve-in members and the carve-out members.

The study showed members with integrated medical and pharmacy benefits had an average savings of $172 per member per year (PMPY). This figure included $54.72 PMPY lower costs to treat chronic conditions.

Members with integrated benefits also had 5% fewer hospital admissions and 16% lower hospitalization costs. And, those members showed a 1–2% higher adherence rate to medications for chronic conditions.

Integrating benefits for a complete health picture

A key reason integrating benefits leads to cost savings and better health outcomes is that doing so allows for access to real-time data around both medical and pharmacy care and coverage for members.

With a more complete picture of members' health, health plans can more effectively manage members' total care and make smarter decisions. It offers opportunities to:

- Identify and resolve care gaps
- Manage members' chronic conditions and costly complications better
- Reduce unnecessary treatments, duplications, and inappropriate prescription use

All of those can lead to higher costs, complications, and errors.

Highmark's integrated approach leverages the advantages of real-time data and the strength of a multidisciplinary team, including trained pharmacists, to meet member needs, help improve overall health care outcomes, and efficiently manage both pharmacy and medical costs.*

*Health care plans and the benefits thereunder are subject to the terms of the applicable benefit agreement.

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Provider Enrollment Required for Services Delivered to CHIP Members

Enroll by Dec. 31, 2017, or Your CHIP Claims Won't be Paid

Effective Jan. 1, 2018, the Pennsylvania Department of Human Services will implement a Patient Protection and Affordable Care Act of 2010 provision that requires Children's Health Insurance Program (CHIP) care providers to be enrolled formally with the department. The provision applies to all providers who order, refer, or prescribe items or services to CHIP members, including Highmark members covered under a CHIP plan.

Additionally, the provision requires that CHIP claims for payment include the provider's National Provider Identifier.

As announced on Highmark's NaviNet Plan Central page in August, providers who offer services to CHIP members must complete an enrollment application for their specific practitioner type for each service location/address and submit all required documents to the department.

To allow for timely processing of your application, all documents must be submitted to the department at least 60 days in advance of Dec. 31, 2017.

Please note that providers who:

- Have already enrolled in the Pennsylvania Medical Assistance (MA) Program don't need to enroll as a CHIP provider
- Are part of another state's Medicaid or CHIP Program, or who are enrolled in Medicare, must still enroll with the department as a CHIP provider
- See CHIP patients at multiple locations must list each service location on their CHIP applications
- Do not enroll by the December 31, 2017, deadline cannot render services to CHIP members, and Highmark cannot process the providers' claims for those members.

More information, including details about the departments' provider enrollment and screening process, can be found at **http://dhs.pa.gov/provider/promise/enrollmentinformation/CHIPProEnrollInfo/index.htm**.

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Urgent Reminder: Make Sure Your Provider Directory Information Is Accurate and Up-to-Date

PROFESSIONAL PROVIDERS

Imagine you're a new Highmark member who wants to find a network PCP. You look in the Provider Directory for a doctor who has been recommended by a friend. But the practice name can't be found. Why? The practice name changed a few months ago, but it wasn't updated in the Provider Directory.

Lost opportunities like this one are just one reason why it's vital that you update your information in Highmark's Provider Directory. Our members use the Provider Directory to make informed decisions when selecting a provider. So, it's to your advantage to make sure your directory information is correct and current.

Highmark is committed to ensuring the information in the Provider Directory meets our standards for quality. **Therefore, please be aware that providers who do not validate their data will be immediately removed from the directory and their status within Highmark's networks may be impacted.**

The Centers for Medicare & Medicaid Services requires Highmark to conduct a quarterly outreach to validate provider information. We use this information to populate our Provider Directory and to ensure correct claims processing. Each review confirms:

- **The practitioner name is correct.** For example, we must ensure the practitioner's name in the directory matches the name on his/her medical license.
- **The practice name is correct.** For example, is there a difference between the practice name that is being used when phones are answered versus the

practice name listed in the directory?

- **The practitioner's specialties are correctly listed.** Is there more than one specialty listed in the directory? Are both specialties being practiced?
- **Practitioners are not listed at practice locations where they don't actually practice.** Practitioners listed must be affiliated with the group. Practitioners who cover on an occasional basis are not required to be listed. Practitioners who do not see patients on a regular basis at a location should not be listed at that location.
- **The practitioner is accepting new patients — or not accepting new patients — at the location.**
- **The practitioner's address, suite number (if any), and phone number are correct.**

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

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

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

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Quarterly Formulary Updates Available Online

We regularly update our prescription drug formularies and related pharmaceutical management procedures. To keep our in-network physicians apprised of these changes, we provide quarterly formulary updates in the form of Special *e*Bulletins. These Special *e*Bulletins are available online. Additionally, notices are placed on the Provider Resource Center's **Today's Messages** page to alert physicians when new quarterly formulary update Special *e*Bulletins are available.

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

Pharmaceutical Management Procedures

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

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About This Newsletter

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

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

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

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

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

Comments/Suggestions Welcome

Laura Pieczynski, Manager, Copywriting
Joe Deemer, Copy Editor
Adam Burau, Editor

We want *Provider News* to meet your needs for timely, effective communication. If you

have any suggestions, comments or ideas for articles in future issues, please write to the editor at **adam.burau@highmarkhealth.org**.

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Contact Us

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

HIGHMARK
1-866-731-8080

Convenient self-service prompts available.

1-866-588-6967 — Freedom Blue℠ PPO Provider Service Center

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

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

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

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

Legal Information

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