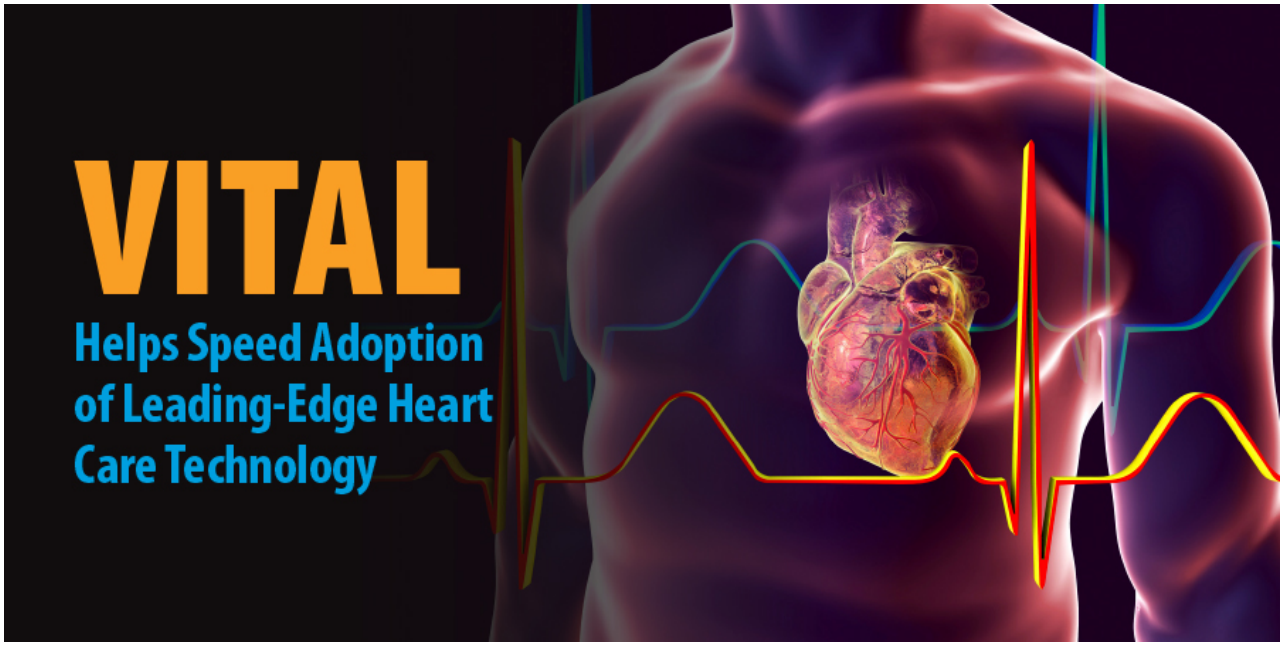
PROVIDER NEWS
A Newsletter for Highmark Blue Cross Blue Shield West Virginia Providers

HIGHMARK. West Virginia

Issue 1, 2018



Moneal Shah, MD

Three years ago, cardiologist Moneal Shah, MD, of Allegheny Health Network (AHN) had heard about a groundbreaking new non-invasive, diagnostic technology called HeartFlow®.

Approved by the U.S. Food and Drug Administration (FDA), HeartFlow uses 3-D computer modeling and highly advanced software to diagnose a patient's coronary arterial blockage and how it affects blood flow.

"In the beginning, when I heard about HeartFlow, I wanted to talk to my division chief, Dr. Srinivas Murali, about exploring it," said Dr. Shah, AHN's co-director of Cardiovascular MRI. "But then I heard that Highmark Health and VITAL were already talking to HeartFlow, which is a company from California."

Dr. Shah got involved in the conversations. "They needed a physician champion to put HeartFlow to the test, and I expressed interest," he said.

Soon, Dr. Shah and his colleagues were putting HeartFlow through its paces at AHN facilities — learning firsthand how the new technology could make heart care safer, smarter, and less expensive for patients.

A Bridge to Health Care Advancement

VITAL is a program of Highmark Health that provides the missing link between FDA approval of a new medical technology and its reimbursement by Highmark and, potentially, as part of a planned expansion, other commercial insurers. VITAL's overall goal is to make leading-edge technologies and treatments available sooner for patients.

When doctors or other industry partners identify a potential new treatment, technology, or procedure, VITAL offers support that helps them gain insights and collect the needed data to demonstrate the effectiveness of the innovation. VITAL collects evidence of clinical quality, financial feasibility, and patient experience to make a case for adopting the new solution within the care delivery system. That information helps to explore opportunities for care management programs and changes to coverage and reimbursement policies. And that can give patients faster access to new, promising treatments.*

Collaboration with VITAL Leads to Pilot

Support from VITAL enabled Dr. Shah and his colleagues at AHN to launch a HeartFlow pilot project Jan. 1, 2016. And from the very start, they saw the revolutionary impact the technology would have on diagnosing and treating heart blockages.

HeartFlow uses images from standard coronary CT angiograms (cCTAs) to create personalized digital 3-D models of each patient's coronary arteries. Using advanced computer algorithms to solve millions of complex equations, the technology determines a "fractional flow reserve" for all the arteries, which assesses the impact of blockages on blood flow.

HeartFlow uses images from standard coronary CT angiograms (cCTAs) to create personalized digital 3-D models of each patient's coronary arteries.

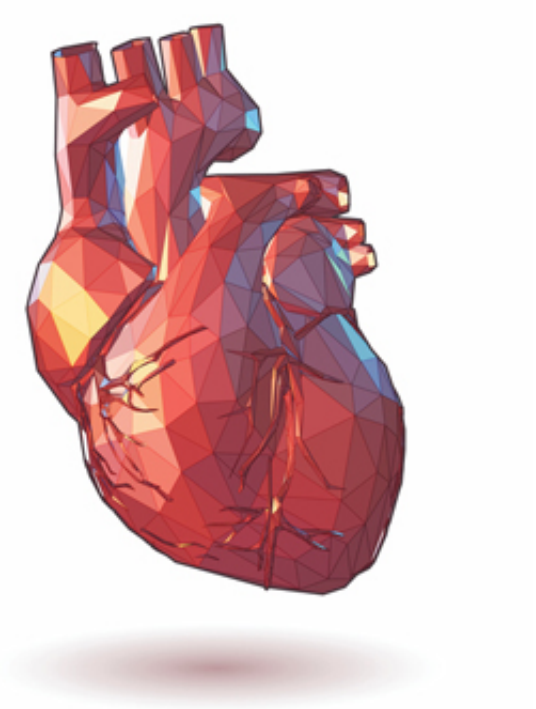
This information helps physicians decide the best treatment for each patient.

"Prior to HeartFlow, no single non-invasive cardiovascular test offered both anatomic and functional heart information simultaneously," said Dr. Shah, who serves as lead investigator on the project. "CT alone can show a blockage but not how significant it is or if it impairs blood flow. A stress test alone gives us functional information but not anatomical insights."

Conversely, HeartFlow offers the full anatomical and functional picture of the heart and can eliminate the need for multiple tests.

"It's totally new and unprecedented," Dr. Shah added. "It gives us a clear map of the coronary tree. It's a huge leap from the kind of information we used to get from a non-invasive test. And HeartFlow can let us know whether the patient needs additional tests or procedures."

Evidence Shows Positive Impact



To date, roughly 100 AHN patients have been assessed and diagnosed using HeartFlow. Although data are still being gathered, the pilot project offers evidence of the new technology's positive impact on patient care — a primary driver of VITAL's mission.

For example, HeartFlow reduced unnecessary angiograms by over 83%. And, on average, overall care costs were reduced by 48%, which also lowered patients' out-of-pocket expenses.

"Any time we can prevent unnecessary procedures, especially invasive procedures like heart caths, that reduces risks for the patient," Dr. Shah said. "The associated health care savings also are a plus."

He recalls a 63-year-old female patient who exemplifies HeartFlow's positive impact.

"She had an abnormal stress test and was going to be having a heart cath," Dr. Shah said. "She was very anxious, not only for the test itself, but also because she had to take care of her elderly mother and didn't want an overnight hospital stay."

So HeartFlow was used, and it showed no need for the heart catheterization. "It was a huge weight off of her mind," Dr. Shah said.

Conversely, HeartFlow has surprised physicians by showing the need for invasive intervention. "We saw one patient who had a normal stress test but was still having symptoms," he said. "HeartFlow revealed the patient had a significant blockage. So it's allowed us to be more thorough and more precise."

Upcoming HeartFlow advancements are expected to make the technology even more useful.

"Just like with other technology, HeartFlow is advancing and adding more capabilities," Dr. Shah said. "They are developing simulation technology that will let us virtually place a stent and see how much better blood flow gets to determine if stenting will be helpful. It's called virtual stenting."

On a Faster Path with VITAL

Getting HeartFlow into the patient care environment at AHN likely would have taken longer — potentially two to three years longer — without support from VITAL, Dr. Shah noted.

"VITAL was instrumental because, originally, I thought I'd have to convince my administration to adopt HeartFlow," he said. "For me, as one person, it might have been very challenging to make the case for it.

"But to have the backing of VITAL and their support in the pilot made it much easier," Dr. Shah said. "VITAL gave us the perfect avenue to put this technology into practice."

And, based on the results of the pilot, health insurers will realize how HeartFlow can benefit patients and the health care system.

"One of the reasons that Medicare approved HeartFlow for coverage was the evidence we generated from the VITAL pilot, which took about two years," Dr. Shah said. "And once Medicare approves something, a lot of other payers take notice."

As of Feb. 1, 2018, Highmark began covering HeartFlow.*

Dr. Shah highly encourages other clinicians to reach out to VITAL if they've identified a promising new medical technology or treatment that may make a difference for patients.

"VITAL is looking for good ideas and new technology to test in a real-world environment," he said. "Working with them has been a very rewarding experience."

For more information or to begin an application, visit **vitalinnovationprogram.org** or send an email to **VITAL@highmarkhealth.org**.

*The coverage of any medical service or treatment is subject to the terms of the member's benefit plan. Please be sure to use NaviNet® or the applicable HIPAA electronic transactions to check member benefits and eligibility prior to ordering or providing services.

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True Performance Program Achieves Successes in Inaugural Year

Highmark launched the True Performance value-based incentive program for eligible network PCPs on Jan. 1, 2017. The program strives to improve health care quality and the patient experience while reducing the overall cost of care for Highmark members.

During its first year, True Performance made significant strides in achieving those goals, which can result in better outcomes and more efficient care delivery.

Notable successes from 2017 include the reduction of emergency department use and inpatient admissions to address inappropriate or unnecessary utilization. Specifically, year-to-date improvement rates in those True Performance quality indicators for participating versus non-participating PCPs were:

- True Performance providers' emergency department utilization was 13.1 percent lower than those not in the program.
- True Performance providers recorded inpatient admission utilization at a 16.3 percent lower rate than those not in the program.

With an emergency department visit averaging $1,123 and an inpatient admission costing $12,782 on average across Highmark's networks, True Performance providers are demonstrating that they are improving care while helping to control escalating health care costs.

By averting emergency department visits and inpatient admissions when they truly are inappropriate or unnecessary, True Performance providers have helped to achieve year-to-date avoided costs of $26.3 million in emergency department use and $153.5 million for inpatient admissions.

True Performance Rewards Outcomes

With 7,400 participating physicians, True Performance is one of the largest value-based programs of its kind in the United States.

True Performance providers are reimbursed in part based on the health outcomes of their Highmark patients, rather than solely on the volume of services they provide. The program emphasizes delivering the right care at the right time and in the most appropriate setting — and helping patients get better or avoid illness.

Participating PCPs need to meet certain quality and cost measures to earn a reimbursement incentive. Patients should receive certain preventive and treatment services, such as childhood immunizations, appropriate drug therapy for chronic diseases, cancer screenings, and annual wellness exams — all key to keeping patients healthier. This helps our members avoid more costly care later.

True Performance also encourages PCP-specialist collaboration that can lead to more efficient care processes while maintaining high-quality health care for 1.8 million Highmark members. Among these process improvement goals is better communication with patients to help them make more informed decisions that will keep them healthier.

Watch *Provider News* for updates on how Highmark and participating physicians are improving care quality and outcomes through True Performance.

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Reminder: Check Out Important Highmark Product Changes for 2018

New and existing Highmark members had benefit plans take effect Jan. 1, 2018.

Keeping up with what's new is important for you and your staff so that you're prepared when Highmark members — including commercial, Medicare Advantage, and Patient Protection and Affordable Care Act of 2010 (ACA) plan members — visit your office or facility in 2018 and present their new identification cards.

Please note: Highmark's provider network for our ACA products is narrower this year.

Please take a minute to read the overview of product changes on the **Highmark 2018** web page, which you can access via the Provider Resource Center (PRC). The PRC is accessible through NaviNet® or through our website, under **Helpful Links**.

We look forward to a successful 2018, working with you to connect our members with the quality health care they need.

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Tips for Transitioning Children from Pediatric to Adult Care Providers

The transition from child to adult is one filled with many changes. And one of the most important changes is transitioning from a pediatric to adult health care practitioner.

Proper planning and ongoing discussions with both parents and children beginning in early adolescence can make the transition occur more smoothly. This process can be accomplished through provider, family, and adolescent readiness planning.

A 2011 American Academy of Pediatrics (AAP) report titled "Supporting the Health Care Transition from Adolescence to Adulthood in the Medical Home" offers physicians practical guidance to help plan and execute this transition for children and their families.

Create an Office Policy

It is recommended that care providers create an office policy regarding their transition process that is readily available to practitioners, parents/guardians, and adolescents. According to gottransition.org, this policy and process should be a part of planning for all adolescents, including those with special needs.

The policy should outline how this process is going to be documented, such as with a form in a paper chart or through prompts in an electronic health record (EHR), and at what age it should begin.

Educate Families, Empower Children

Family members need to be educated about their role in the transition process,

including the legal changes that occur once a child reaches age 18 and how pediatric and adult care are delivered differently. Providers should be prepared to address any family stress and questions regarding this transition.

The adolescent must be viewed as the driver behind this process, according to gottransition.org. Discussions should begin in early adolescence, ideally around 12 years of age, with the goal to complete the process between the ages of 18 and 21. To assess the patient's readiness for transition, physicians can download and administer the Boston Children's Hospital's ADAPT Survey.

Topics that should be discussed during this process include plans after graduation, such as attending college, joining the military, or entering the workforce, as these can impact the care transition process for young adults.

Key Transition Plan Components

In its report, the AAP recommends including four key components in a transition plan:

1. **Assess for transition readiness.** Begin talking to patients and families about the transition to adult care, including the child's awareness of his/her personal medical needs and age-appropriate preventive care. Measure transition progress at each visit using the same criteria/checklist.
2. **Plan a dynamic and forward-moving process for accomplishing realistic goals.** Establish formal goals for a seamless transition. Write down the goals and include specific actions to achieve them. Also include timelines for reaching those goals and note who will be responsible for completing them. This information should be part of the patient's medical record by age 14.
3. **Implement the plan by educating everyone involved and empowering children in areas of self-care.** Begin teaching children specific needed health care skills. Such skills may include learning personal medical history, talking one-on-one with a doctor, and understanding any required medications they are using. Pediatric providers should assist children and families in identifying potential adult practices one to two years before medical care is transferred.
4. **Document progress and movement of medical information to the adult care provider.** Whether using paper records or an EHR, ensure documentation is complete and ready for transition to the receiving care provider. Ensure the medical documentation includes the transition plan, readiness checklists, and a portable medical summary.

To Learn More

Developing a plan for your practice to support children in their transition to adult

care providers is essential to ensure patients receive quality, uninterrupted, and age-appropriate care.

For additional guidance on establishing transition plans for adolescent patients, see **the AAP's report**.

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Preventive Schedule Updates: Helping Highmark Members to Live Healthier in 2018 and Beyond

Highmark maintains a Preventive Schedule* for members that is intended to help them get the most out of their preventive care benefits — everything from regular physicals to specific screenings for members who are at risk for certain chronic or serious health conditions.

By publishing this information on the Provider Resource Center, we make it easy for you and your patient care staff to keep up with these recommendations as we work to keep our members healthy.

We revise and update our Preventive Schedule and Preventive Health Guidelines periodically to ensure that they reflect the latest evidence-based, nationally recommended clinical guidelines for care. Other changes simply clarify certain guidelines so they're clear and understandable for our members.

Please note the following important updates:

Cardiovascular

The United States Preventive Services Task Force (USPSTF) mandates **low to moderate dose select generic statin drugs for prevention of cardiovascular disease (CVD)** for certain at-risk adults.

The Highmark Preventive Schedule now recommends such statins for adults ages 40 to 75 years with one or more CVD risk factors (such as dyslipidemia, diabetes, hypertension, or smoking) and who have a calculated 10-year risk of 10% or greater

for a cardiovascular event.

Adult Diabetes Prevention Program (DPP)

For members who qualify for enrollment in certain select Centers for Disease Control and Prevention-recognized (CDC) lifestyle change DPPs for weight loss, the program now enhances prevention services to include onsite and virtual options for members meeting eligible enrollment criteria.

The eligibility criteria apply to adults 18 years and older and are:

- Without a diagnosis of diabetes (does not include a history of gestational diabetes) and
- Overweight or obese (determined by BMI) and
- Fasting blood glucose of 100-125 mg/dl or HGBA1c of 5.7 to 6.4 percent or impaired glucose tolerance test results of 140-199 mg/dl

More information about this program is available in Issue 6, 2017, of *Provider News*.

For the Current Guidelines

To access the guidelines, visit the Resource Center via NaviNet® or our main website under **Helpful Links**. On the Resource Center, choose ***Education/Manuals*** and ***Clinical Practice and Preventive Health Guidelines***.

We encourage you to consult our Preventive Health Guidelines when planning care for your patients with Highmark coverage, and we thank you for your commitment in addressing their health needs.

*Please note that most, but not all, of our customer groups follow the Highmark Preventive Schedule, meaning not all members may have coverage for services on the schedule. Therefore, when providing services for our members, please remember to check the member's benefits via NaviNet or by using the appropriate HIPAA electronic transactions to determine if services are covered and if any associated member cost sharing applies. (If you do not have access to NaviNet, please call Provider Service to obtain benefits and eligibility information.)

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Highmark Now Performing Annual HEDIS Medical Record Reviews

Staff from Highmark who are trained as registered nurses are conducting the annual Healthcare Effectiveness Data and Information Set (HEDIS®) medical record reviews from February through mid-May 2018. The reviews will be based on measurement year 2017 data.

The HEDIS report includes the medical record review for the assessment of compliance with a set of standardized performance measurements that health plans report on to the National Committee for Quality Assurance. The HEDIS data are collected and reported on an annual basis as part of Highmark's accrediting and governmental requirements.

The measurements this year are:

- Adult body mass index (BMI) assessment
- Weight assessment and counseling for nutrition and physical activity for children and adolescents
- Childhood immunization status
- Immunizations for adolescents
- Lead screening in children
- Cervical cancer screening
- Colorectal cancer screening
- Controlling high blood pressure
- Comprehensive diabetes care
- Medication reconciliation post-discharge
- Transitions of care
- Prenatal and postpartum care
- Well-child visits for the first 15 months of life, 3-6 years, and adolescent well-care visits

A random sample of members will be identified, and a representative from Highmark will notify you either by telephone or fax to set up an onsite review or to have specific elements of the member's medical records faxed or mailed to Highmark for review.

For more information regarding HEDIS measures, please review the **HEDIS Measures Reference Guide**.

If you have any questions regarding the HEDIS report, please contact one of the following representatives from Highmark's Clinical Service area: Anne Strout at 412-544-4592 or Joan Zalewski at 412-544-2696.

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2017 HEDIS Audit Results

A Look at Commercial and Medicare Advantage Products

The Healthcare Effectiveness Data and Information Set (HEDIS®) is the most widely used set of performance measures in the managed care industry. HEDIS helps your patients compare how managed care plans perform in the areas they care about.

Developed by the National Committee for Quality Assurance (NCQA), HEDIS is one part of a larger system that establishes accountability in health care and complements the NCQA accreditation program.

Highmark annually gathers HEDIS data on Commercial PPO and Medicare Advantage PPO members for:

- Effectiveness of care
- Access/availability of care
- Experience of care
- Utilization and relative resource use
- Health plan descriptive information

Clinical Advisory Committees Generate Improvements

To help practitioners improve their “effectiveness of care” measures, Highmark continues to support clinical advisory committees. Network physicians from internal medicine, family practice, endocrinology, cardiology, geriatrics, women’s health, pulmonary, pediatrics, infection control, and behavioral health, among others, serve on these committees. These committees review the annual HEDIS results, along with other pertinent data, to determine clinical quality improvement opportunities.

HEDIS Audit Results for 2017

Here is a subset of the HEDIS measures. This will provide you with a comparison based on services received in the 2016 measurement year (MY 2016) for the HEDIS 2017 reporting year (RY) as compared to the 2017 national averages. We also have provided 2015 measurement year (MY 2015) results for additional comparison.

Important Note: The source of the National Average data contained in this publication is from either Quality Compass® 2017 or The State of Healthcare Quality 2017 and is used with the permission of the NCQA. Quality Compass 2017 includes certain CAHPS® data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. The Medicare Health Outcomes Survey results are released on CMS Health Plan Management System (HPMS).

HEDIS Results for Commercial PPO

COMMERCIAL PPO	*MY 2016*	*MY 2015*	*2017 PPO NATIONAL AVERAGE*
Prevention and Screening			
Adult BMI Assessment	86.90%	84.92%	62.90%
Weight Assessment, Nutritional Counseling & Physical Activity for Children/Adolescents			
BMI Percentile Total	71.29%	63.99%	51.99%
Counseling for Nutrition Total	63.26%	55.72%	49.99%
Counseling for Physical Activity Total	58.39%	49.88%	44.89%
Childhood Immunizations			

Combo 2 - DTaP, Polio, MMR, HepB, Hib + VZV	78.10%	75.43%	69.56%
Breast Cancer Screening	64.39%	65.07%	70.16%
Cervical Cancer Screening	66.45%	66.90%	72.96%
Colorectal Cancer Screening	61.56%	59.75%	58.31%
Chlamydia Screening			
Combined Rate	35.44%	34.43%	44.93%
Respiratory Conditions			
Appropriate Testing of Children with Pharyngitis	77.84%	77.55%	83.28%
Use of Spirometry Testing in Assessment and DX of COPD	33.06%	36.34%	40.46%
Pharmacotherapy Management of COPD Exacerbation			
Systemic Corticosteroid	77.17%	79.67%	69.09%
Bronchodilator	74.60%	77.24%	75.04%
Cardiovascular Conditions			
Controlling High Blood Pressure	66.83%	58.47%	54.51%

Persistence of Beta Blocker Treatment after Heart Attack	88.83%	77.50%	83.76%
Diabetes			
Hemoglobin A1c (HbA1c) Testing	89.67%	87.23%	89.30%
*HbA1c Poor Control >9.0%****	[2]28.33%	[2]35.58%	42.53%
HbA1c Poor Control <8.0%	59.17%	52.01%	46.62%
HbA1c Poor Control <7.0%	42.58%	31.87%	34.49%
Diabetic Retinal Eye Exam	50.33%	50.73%	47.55%
Nephropathy Screening	88.50%	88.32%	88.08%
Blood Pressure Control <140/90	62.83%	58.76%	50.47%
Behavioral Health			
Antidepressant Medication Management			
Acute Phase Treatment	66.76%	63.68%	67.87%
Continuation Phase Treatment	52.02%	46.23%	52.62%
Follow-Up Care For Children Prescribed ADHD Medication			
Initiation Phase	43.59%	45.94%	39.02%

Continuation/Maintenance Phase	50.85%	57.14%	45.84%
Follow-up After Hosp. for Mental Illness			
7 day	41.54%	40.61%	50.42%
Overuse/Appropriateness			
Appropriate Treatment of Children with URI *(Inverted rate)*	79.89%	79.25%	87.01%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis*	[2]23.65%	[2]20.91%	27.04%
Use of Imaging Studies for Low Back Pain	63.48%	69.35%	74.31%
Access/Availability of Care			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	88.50%	84.80%	76.37%
Checkups After Delivery	84.66%	75.34%	65.94%
CAHPS®			
Flu Shots for Adults *Ages 18-64*	49.64%	52.23%	47.06%

**[2]Lower rates are better for this measure.*

HEDIS Results for Medicare Advantage PPO

Medicare Advantage PPO	*MY 2016*	*MY 2015*	*2017 MEDICARE PPO NATIONAL AVERAGE*
Prevention and Screening			
Adult BMI Assessment	99.00%	99.00%	91.79%
Breast Cancer Screening	68.91%	70.69%	72.49%
Colorectal Cancer Screening	75.56%	68.08%	69.77%
Respiratory Conditions			
Use of Spirometry Testing in Assessment & Testing of COPD	30.30%	31.92%	35.03%
Pharmacotherapy Management of COPD Exacerbation			
Systemic Corticosteroid	68.98%	79.25%	68.62%
Bronchodilator	54.01%	65.09%	74.06%
Cardiovascular Conditions			
Controlling High Blood Pressure	74.77%	74.76%	69.66%
Persistence of Beta Blocker After	95.92%	88.10%	89.86%

Heart Attack			
Diabetes			
Comprehensive Diabetes Care			
Hemoglobin A1c (HbA1c) testing	91.21%	93.16%	93.62%
*HbA1c Poor Control >9.0%****	[2]22.36%	[2]25.26%	23.34%
HbA1c Control <8.0%	66.33%	59.47%	66.28%
Diabetic Retinal Eye Exam	65.08%	68.68%	69.60%
Nephropathy Screening	96.23%	96.32%	95.33%
Blood Pressure Control <140/90	67.59%	68.95%	60.56%
Musculoskeletal Conditions			
Osteoporosis Management in Women Who Had a Fracture	26.19%	25.88%	34.16%
Behavioral Health			
Antidepressant Medication Management			
Acute Phase Treatment	69.07%	64.21%	73.24%
Continuation Phase Treatment	56.19%	54.74%	59.45%

Follow-up After Hospitalization for Mental Illness			
7 day	31.43%	NA	35.40%
Medication Management			
Annual Monitoring for Patients on Persistent Medications			
Total	91.32%	90.93%	91.90%
Use of High Risk Medications in the Elderly			
*One Prescription**[2]	[2]20.36%	[2]17.76%	12.55%
*At Least Two Prescriptions**[2]	[2]13.49%	[2]2.70%	8.56%
CAHPS®			
Flu Shots for Older Adults	76%	74%	73%
Pneumonia Vaccination for Older Adults	77%	77%	73%

**[2]Lower rates are better for this measure.*

NA — Not applicable;-denominator fewer than 30

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Protect Your Network Status: Ensure Your Directory Information Stays Current

When Highmark members are looking for a PCP or specialist, they expect that our online provider directory presents information that is accurate and current.

That's why it is essential to ensure that your practice information on file with Highmark remains up to date.

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

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 contract(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, Atlas, are currently making outreach calls to providers to verify the accuracy of provider data. If you receive a call, please provide our agent with the requested information.

Note About Lactation Services

Does your practice offer lactation counseling services? If so, you need to update your provider directory information in NaviNet to let our members and your potential new patients know about the services you deliver. To confirm or update your information:

- Select **Provider File Management**.
- Select **Practice Location** to edit.
- Expand **Office Accessibility and Services**.
- Click **Edit** on **Services Offered at this Location**.
- Select the box that reads **Lactation Counseling**, and then click **Submit**.

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Notifications for Providers

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

Preventive Health Guidelines and Clinical Practice Guidelines Available Online

Highmark and participating network physicians annually review and update the Preventive Health Guidelines and Clinical Practice Guidelines, which are distributed to the practitioner community as a reference tool to encourage and assist you in planning your patients' care.

To help make the information more accessible and convenient for you, we post the complete set of guidelines online. Just visit **highmarkbcbswv.com** and click **Provider Resource Center** under **Helpful Links**. (NaviNet® users, simply click on **Resource Center** from the Plan Central page.) Next, go to **Education/Manuals**, and then select **Clinical Practice and Preventive Health Guidelines**.

The Preventive Health Guidelines include:

- Adult (under and over 65)
- Pediatrics
- Prenatal/perinatal

There are Clinical Practice Guidelines for the following conditions/patient needs:

- ADHD
- COPD
- Depression
- Smoking cessation
- Asthma
- Cholesterol management
- Diabetes
- Substance abuse
- Stable ischemic heart disease
- Heart failure
- Hypertension
- Osteoporosis
- Opioid use

Please ask your clinical support staff to bookmark this web page as a handy reference

tool to help plan your patients' care. To obtain a paper copy of the guidelines, write to:

Highmark
Barb Cole, Director, Accreditation and Compliance
Fifth Avenue Place
120 Fifth Avenue, Suite P4425
Pittsburgh, PA 15222

Appropriate Utilization Decision-Making

Highmark makes utilization review decisions based only on the necessity and appropriateness of care and service and the existence of coverage. In addition, Highmark does not reward practitioners, providers, Highmark employees, or other individuals conducting utilization review for issuing denials of coverage or service, nor does it provide any financial incentives to utilization management decision-makers to encourage denials of coverage.

Request for Criteria

Highmark uses resources such as nationally recognized clinical review criteria, medical policy, and Medicare guidelines in determining whether a requested procedure, therapy, medication, or piece of equipment meets the requirements of medical necessity and appropriateness. This is done to ensure the delivery of consistent and medically appropriate health care for our members.

If a PCP or specialist requests a service that a clinician in Utilization Management is unable to approve based on criteria/guidelines, the clinician will refer the request to a Highmark Physician Reviewer. A Highmark Physician Reviewer may contact the PCP or specialist to discuss the request or to obtain additional clinical information.

A decision is made after all of the clinical information has been reviewed.

At any time, the PCP or specialist may request a copy of the criteria/guidelines used in making medical/surgical decisions by calling Highmark at 1-800-421-4744. To request a copy of the criteria/guidelines used in making behavioral health decisions, call 1-800-258-9808.

Patient Notification of Approvals, Denials

All network providers are expected to notify their Highmark patients of both approval and denial-of-coverage decisions as soon as possible upon their office receiving notification of the decision from Highmark or a delegated entity of Highmark.

Help Your Patients Manage Chronic Conditions

You know that many of your patients struggle with one or more health conditions that may slow them down, cause pain, and interfere with quality of life. Those conditions can take a toll on work, family, and social life.

You also know the good news: that even serious health conditions can be managed and that the need for emergency care and unnecessary hospitalization can be reduced.

Condition management programs are available to Highmark members who need help managing chronic health conditions, including:

- Asthma
- Diabetes
- Heart failure
- COPD
- Depression
- Hypertension
- High cholesterol
- High-risk pregnancy
- Inflammatory bowel disease
- Metabolic syndrome
- Migraine
- Musculoskeletal pain
- Osteoporosis
- Upper GI

A Highmark Clinician — a member of Highmark's staff who is trained as a registered

nurse or health care specialist who teams up with you, the doctor — can help your patients develop the skills they need to manage their conditions and improve their health and quality of life. Our condition management programs cover all aspects of dealing with a chronic condition, such as understanding a new diagnosis, taking the right medicine at the right time, managing symptoms, and changing habits and behaviors that affect overall health.

Our Clinicians provide patients with materials and resources designed to be supportive of your plan of care. There is no cost to the member for these programs.

So, if you have a patient with one or more of the conditions noted above (or any other health concerns), you can refer the patient to Blues On Call by asking him or her to call 1-888-BLUE-428 (1-888-258-3428).

Member Rights and Responsibilities

Our members have certain rights and responsibilities that are a vital part of membership with a managed care or PPO plan. These rights and responsibilities are included in the member handbooks and are reviewed annually in the member newsletter.

We also make them available online for our network providers to help you maintain awareness and support your relationship with your Highmark patients. (On the Provider Resource Center, click on **Education/Manuals**. You'll find the Member Rights and Responsibilities in Chapter 3, Unit 2, of the ***Highmark Blue Shield Office Manual*** and in Chapter 3, Unit 3, of the ***Highmark Facility Manual***.) A paper copy of the Member Rights and Responsibilities is available upon request.

Peer-to-Peer Conversations: Availability of Physicians, Behavioral Health Practitioners, and Pharmacist Reviewers*

Highmark provides you with an opportunity to discuss Utilization Management (UM) denial decisions with a clinical peer reviewer following notification of a denial determination. Clinical peer reviewers are licensed and board-certified physicians, licensed behavioral health care practitioners, and licensed pharmacists, and they are available to discuss review determinations during normal business hours.

Your call will be connected directly to the peer reviewer involved in the initial review determination, if he or she is available. If the original peer reviewer isn't available when you call, another clinical peer will be made available to discuss the denial determination within one business day of your request. To request a peer-to-peer conversation, you may call the appropriate number listed in the chart below.

***IMPORTANT NOTE: The peer-to-peer review process is no longer available for Medicare Advantage members. See Chapter 3, Unit 6, of the *Highmark Blue Shield Office Manual* and Chapter 6, Unit 1, of the *Highmark Facility Manual* for details.**

PRACTITIONER/ ORDERING PROVIDER	UM ISSUE	TELEPHONE NUMBER
Practitioners	Med/Surg UM decisions	1-866-634-6468
Behavioral health providers	Behavioral health	1-866-634-6468
Pharmacists	Pharmacy services	Telephone number identified on determination letter
Practitioners	Advanced radiology imaging	Telephone number identified on determination letter
Practitioners	Radiation Therapy	Telephone number identified on determination letter

Practitioners	Physical Medicine	Telephone number identified on determination letter

PROVIDER NEWS
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HIGHMARK. West Virginia

Issue 1, 2018

Quarterly Formulary Updates Available Online

We regularly update our prescription drug formularies and related pharmaceutical management procedures. To keep our in-network physicians apprised of these changes, we provide quarterly formulary updates in the form of Special *e*Bulletins.

These Special *e*Bulletins are available **online** . Additionally, notices are placed on the Provider Resource Center's **Hot Topics** page to alert physicians when new quarterly formulary update Special *e*Bulletins are available.

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

Pharmaceutical Management Procedures

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

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HIGHMARK. West Virginia
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About This Newsletter

Provider News is a newsletter for health care professionals (and office staff) and facilities that participate in Highmark West Virginia's networks and submit claims to Highmark West Virginia and Highmark Senior Solutions Company using the 837P or 837I HIPAA transaction or the CMS 1500 or UB-04 form. It is designed to serve providers by offering information that will make submitting claims and treating our subscribers easier and contains valuable news, information, tips and reminders about the products and services of Highmark West Virginia and Highmark Senior Solutions Company.

- Simply Blue
- Super Blue Plus PPO
- Super Blue Plus QHDHP
- Freedom Blue PPO
- Federal Employee Program

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 West Virginia and Highmark Senior Solutions Company (or changes thereto) which are binding upon Highmark West Virginia and Highmark Senior Solutions Company and its contracted providers. Pursuant to their contract, Highmark West Virginia and Highmark Senior Solutions Company 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, write to the

editor at **adam.burau@highmarkhealth.org**.

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HIGHMARK. West Virginia

Issue 1, 2018

Contact Us

NaviNet® users and those with internet access will find helpful information online. Please use NaviNet for all routine inquiries. But if you need to contact us, here are the phone numbers exclusively for providers:

PROVIDER SERVICE CENTER
1-800-543-7822

Convenient self-service prompts are available.

FREEDOM BLUE PPO INFORMATION
1-866-588-6967: Freedom Blue PPO Provider Service Center

PRESCRIPTION/PHARMACY INQUIRIES
1-800-600-2227

CASE MANAGEMENT
1-800-344-5245 for Highmark West Virginia products
1-800-269-6389 for Highmark Senior Solutions Company Freedom Blue PPO

CASE MANAGEMENT REFERRAL FAX LINE
1-888-383-7081

ELECTRONIC BILLING
To inquire about electronic billing, call EDI Operations at 1-800-992-0246. Or visit our website at highmarkbcbswv.com — under **Helpful Links** at the bottom of the page, click **Provider Resource Center**; you'll find information under **Claims, Payment & Reimbursement** and then **Electronic Data Interchange (EDI) Services**. Also available via NaviNet.

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Highmark West Virginia
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Legal Information

It is the policy of Highmark Blue Cross Blue Shield West Virginia and Highmark Senior Solutions Company to not discriminate against any employee or applicant for employment on the basis of the person's gender, race, color, age, religion, creed, ethnicity, national origin, disability, veteran status, marital status, sexual orientation or any other category protected by applicable federal, state or local law. This policy applies to all terms, conditions and privileges of employment, including recruitment, hiring, training, orientation, placement and employee development, promotion, transfer, compensation, benefits, educational assistance, layoff and recall, social and recreational programs, employee facilities, and termination.

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are subsequently modified in whole or in part.