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

HIGHMARK. West Virginia

Issue 1, 2019

PCPs: Learn More About Virtual Visits

As a primary care physician (PCP), you are the traditional first point of contact for patients when they are sick.

But primary care also involves disease prevention, patient education, health maintenance, and coordination of patients' care across the broader health care system. So it's important that our members stay in close contact with you.

That is why, in addition to coverage for in-person office visits, Highmark gives you another option to connect with our members — Virtual PCP Visits and Virtual Retail Clinic Visits.

These visits give you the option of remotely delivering primary care services to our members via real-time interactive audio and video telecommunications, or "telemedicine," when appropriate. A patient can participate in a virtual visit from their home, office, or other private setting.

What are the advantages of virtual visits?

Virtual visits let you extend your reach and improve efficiency and effectiveness while still maintaining high-quality care and attention to patient safety.

Other benefits may include:

- Increased primary care access for all members, including underserved populations in rural and remote areas.
- Lower administrative costs for providers.
- Reduced travel costs for members.

- Ability to triage cases and help reduce emergency room visits and hospitalizations.

Who can offer virtual visits?

As a Highmark-participating primary care provider, you can offer virtual visits if you have the required telecommunications technology to properly conduct and support them. Services performed must fall under the scope of your license, and the sessions must be conducted following Highmark's service and security guidelines.

Providing virtual visits for Highmark members is optional and not a requirement of our network providers.

For more information

To learn more about virtual visits, see Chapter 2, Unit 5, Pages 9–15 of the *Highmark Provider Manual*. The manual is located under **Education/Manuals** on our online Provider Resource Center.

Get help promoting virtual visits

If you already offer Virtual PCP or Virtual Retail Clinic Visits and want to promote those services to eligible Highmark members, see Chapter 2, Unit 5, Page 12 of the *Highmark Provider Manual*. There, you'll find links to informational fliers that you can download, customize for your practice, and give to Highmark members.

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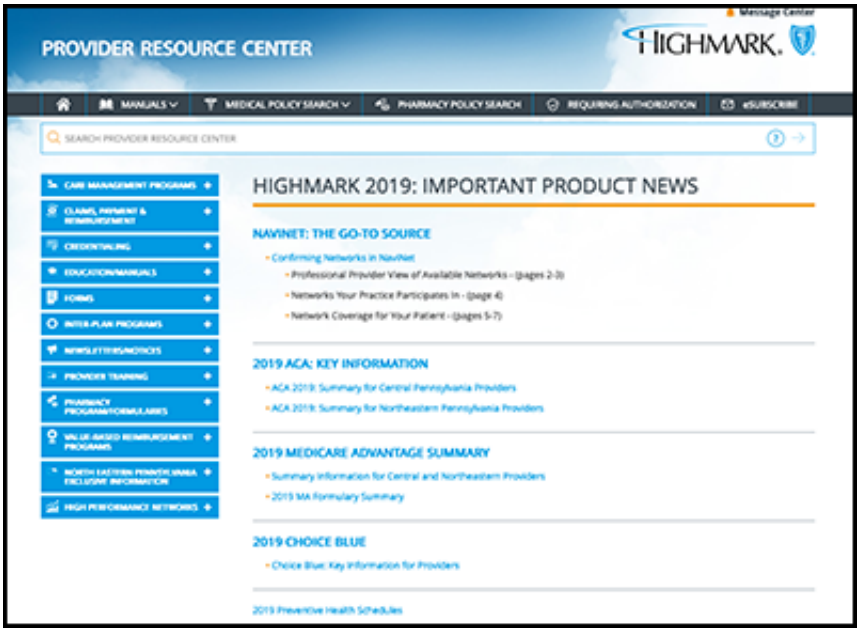
Get Highmark 2019 Product Information Fast



A new benefit year has begun. And if you haven't seen what is changing with Highmark products for 2019, now is a perfect time to check out the overview of product changes on our online Provider Resource Center (PRC).

This helpful resource offers key updates on what's new with Highmark's commercial and Medicare Advantage products for 2019. Please share this important information with your staff so they stay informed.

Also, since members' drug formularies often change with the new benefit year, please see the related story that was published in Issue 6, 2018, of *Provider News*. And check out the story in this issue of *Provider News* about the importance of updating your provider information that is on file with Highmark.

We thank you for providing quality care and service to our members in 2019 and beyond.

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Keeping Your Directory Information Current Is More Important than Ever

With the turn of the calendar to 2019, both new and returning Highmark members may be switching PCPs or looking for specialists. And they will be relying on Highmark's online provider directory for accurate and current information about our network providers.

That is why it's more important than ever to ensure that your practice information on file with Highmark remains up to date. We use this information to populate our provider directory and to help ensure correct claims processing.

IMPORTANT NOTE:
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.

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.

Your thorough review of your directory information confirms:

- Each practitioner's name is correct and matches the name on his/her medical license.
- The practice name is correct and matches the name used when you answer the phone.
- All specialties are correctly listed and are, in fact, currently being practiced.
- Practitioners listed at a location actually see patients and schedule appointments at that office on a regular basis. All practitioners listed must be affiliated with the group. (Practitioners who cover on an occasional basis are not required to be listed.)
- The practitioner is accepting new patients — or not accepting new patients — at the location.
- The practitioner's address, suite number (if any), and phone number are

correct.

Change happens

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

- Current address
- Phone number
- Fax number

Remember to review your data at least once a quarter to ensure it is 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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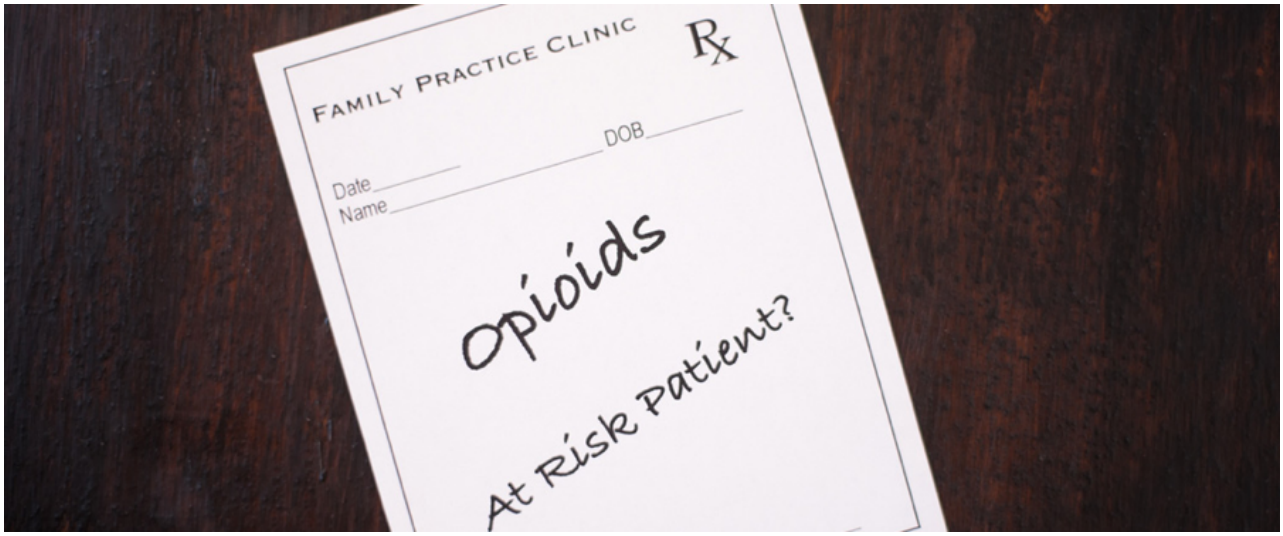
Highmark Begins Using CMS Opioid Safety Edits and CARA Provisions



One of Highmark's top priorities is promoting the safe, effective use of opioid drugs among our members while preventing the development of opioid use disorder.

That is why, effective Jan. 1, 2019, Highmark began using Centers for Medicare & Medicaid Services (CMS) opioid safety edits and provisions of the Comprehensive Addiction and Recovery Act (CARA).

In certain circumstances, pharmacies can resolve some safety edits. Therefore, the Highmark member's pharmacy may contact you for more information before they fill prescriptions for opioid medications. Questions may include potential drug interactions, duplication of medications, or potentially incorrect dosages.

CARA allows Medicare Part D plans to establish drug management programs that will work with you to decide on the safest dose for the patient. Medicare Part D plans may limit at-risk beneficiaries' access to coverage of controlled substances that are considered to be frequently abused drugs (FADs). Drugs in this category target opioids, along with benzodiazepines, benzodiazepines plus carisoprodol, and gabapentinoids.

For more information

To learn more, see the NaviNet® Plan Central message posted Dec. 21, 2018, for professional providers and titled "Highmark Implementing CMS Opioid Safety Edits

and CARA Provisions Effective Jan. 1, 2019."

You also can consult these resources:

- Provider Resource Center: Managed Rx Coverage Policy J-355, Combination Prescription Drug Safety Edits
- CMS Part D Opioid Overutilization Policies for 2019
- Issue 5, 2018, of *Provider News*

We thank you for your vigilance in ensuring our members' safety and well-being when considering the use of opioids.

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Talking to Your Patients About Their Medications

With the ever-increasing emphasis on patient-centered care, several industry organizations recommend that physicians have detailed conversations with patients about their medications.

The *Journal of General Internal Medicine* offers a simple, easy-to-remember, three-step process to begin these conversations:

- **Choice:** Begin the conversation by explaining what choices are available.
- **Option:** Provide detailed information about each option, making sure to cover both the benefits and limitations.
- **Discussion:** Explore preferences and answer questions.

The two most important things you can do:

- Use plain language and avoid medical jargon.
- Ask the patient to repeat what you've said in his or her own words.

Sometimes, patients may need extra time to consider the options before deciding. They may want to talk with a trusted friend or family member. Or they may want to do additional research on their own.

Shared decision making has benefits for you and your patients. Treatments are better understood, patients have more accurate expectations of both good and bad consequences, and there is better adherence to treatment.

While having these conversations may be challenging due to patients' low health literacy, time constraints, and cultural or language barriers, they build positive

relationships and strengthen trust, experts say. Initiating this conversation shows that physicians value the patient's concerns and preferences.

And doing so demonstrates that physicians respect the patient's ability to make informed decisions.

Sources:

- ncbi.nlm.nih.gov/pmc/articles/PMC3445676/
- ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/tools/index.html

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Check Out Important Preventive Schedule Updates for 2019

Whether our members need a regular physical or an important health screening, Highmark wants to help them get the most out of their preventive care benefits.

That's why we maintain a Preventive Schedule* of services to help members stay as healthy as possible.

By publishing the schedule on the Provider Resource Center (PRC), 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. Some of these changes simply clarify certain guidelines, so they are clear and understandable.

Please note the following important updates, which took effect Jan. 1, 2019:

Women's health services

- Coverage was added for postpartum diabetes screening for women who have experienced gestational diabetes.
- Urinary incontinence screening remains integral to the office-visit exam.

Adolescent health services

The age-range limit for adolescent hearing screenings was increased from age 18 to age 21.

Services for members age 65 and older

Coverage was removed for vitamin D supplements to prevent falls for members age 65 and older. The United States Preventive Services Task Force recommends against such supplementation for adults 65 and older who aren't known to have osteoporosis or vitamin D deficiency.

For the current guidelines

To access the guidelines, visit the PRC via NaviNet® or under **Helpful Links** on our main website. On the PRC, choose **Education/Manuals** and then **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 to 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 members' 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.)*

NOTE: These guidelines are for information only. The physician or other health professional will advise the member of the applicable guidelines and any related advice, testing, diagnosis, or treatment. Health plan coverage is subject to the terms of the member's health plan benefit agreement.

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2018 HEDIS Audit Results

The Healthcare Effectiveness Data and Information Set (HEDIS®) is the most widely used set of performance measures in the managed care industry. Developed by the National Committee for Quality Assurance (NCQA®), HEDIS is part of a larger system that complements the NCQA accreditation program and establishes accountability in health care.

In areas of most concern to your patients, HEDIS helps compare how managed care plans perform.

HEDIS data are collected annually for members of Highmark's various products. The HEDIS measures span many areas of care delivery and service:

- Effectiveness of care
- Access/availability of care
- Experience of care
- Utilization and risk-adjusted utilization
- Health plan descriptive information

Using this subset of HEDIS measures, the performance of services that Highmark members received in measurement year (MY) 2017 for the HEDIS reporting year (RY) 2018 is compared to the 2018 national averages. And for additional comparison, MY 2016 results are included.

Those results are now available for your review.

Important Note: The source of the National Average data contained in this publication is from Quality Compass® 2018 and is used with the permission of NCQA®. Quality Compass 2018 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.

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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 Available Online

Highmark and participating network physicians annually review and update the Preventive Health 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 **Preventive Health Guidelines**.

The Preventive Health Guidelines include:

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

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
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 review 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 patients who are Highmark members 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
- High-risk pregnancy
- Metabolic syndrome
- Musculoskeletal pain

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 (our members) 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 members 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 who is a Highmark member 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 patients who are Highmark members. (On the Provider Resource Center, click on **Education/Manuals**. You'll find the Member Rights and Responsibilities in Chapter 1, Unit 5, of the ***Highmark Provider 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 review 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 5, Units 3 and 5, of the *Highmark Provider 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 Accessibility Expectations

To stay healthy, our members must be able to see their physicians when needed. To support this goal, Highmark's expectations for accessibility of primary care physicians (PCPs), medical specialists, obstetricians, and behavioral health providers are outlined below.

The standards set forth specific time frames in which network providers should respond to member needs based on symptoms.

Physicians are encouraged to see patients with scheduled appointments within 15 minutes of their scheduled appointment time. A reasonable attempt should be made to notify patients of delays.

PCP and Medical Specialist Accessibility Expectations	
Patient's Need:	**Performance Standard:**
Emergency/life-threatening care • Sudden, life-threatening symptom(s) or condition requiring immediate medical treatment (e.g., chest pain, shortness of breath)	Immediate response
Urgent-care appointments • An urgently needed service is a medical condition that requires rapid clinical intervention as a result of an unforeseen illness, injury, or condition (e.g., high fever, persistent vomiting/diarrhea)	Office visit within 1 day (24 hours)
Regular and routine care appointments • Non-urgent but in need of	**Pennsylvania and West Virginia:** • Within 2-7 days (Non-urgent) • Within 30 days (Routine wellness)

attention appointment (e.g., headache, cold, cough, rash, joint/muscle pain) • Routine wellness appointments (e.g., asymptomatic/preventive care, well child/patient exams, physical exams)	**Delaware:** Office visit within 3 weeks of member request
After-hours care • Access to practitioners after the practice's regular business hours	Acceptable process in place to respond 24 hours per day, 7 days a week to member issues (answering service that pages the practitioner or answering machine message telling caller how to reach the practitioner after hours)
In-office waiting times • Practitioners are encouraged to see patients with scheduled appointments within 15 minutes of their scheduled appointment time. A reasonable attempt should be made to notify patients of delays.	Within 15 minutes

Maternity Care Accessibility Expectations (Obstetrics)	
Patient's Need:	**Performance Standard:**
Maternity Emergency	Immediate response
Maternity 1st Trimester	Within 3 weeks of first request
Maternity 2nd Trimester	Within 7 calendar days of first request

Maternity 3rd Trimester	Within 3 calendar days of first request
Maternity High Risk	Within 3 days of identification of high risk

Behavioral Health Provider Accessibility Expectations	
Patient's Need:	**Performance Standard:**
Care for a life-threatening emergency • Immediate intervention is required to prevent death or serious harm to patient or others	Immediate response
Care for a non-life-threatening emergency • Rapid intervention is required to prevent acute deterioration of the patient's clinical state that compromises patient safety	Care within 6 hours
Urgent care • Timely evaluation is needed to prevent deterioration of patient condition	Office visit within 48 hours
Routine office visit • Patient's condition is considered to be stable	**Pennsylvania and West Virginia:** Office visit within 10 business days **Delaware:** Office visit within 7 calendar days

After-hours care • Access to providers after the practice's regular business hours	Acceptable process in place to respond 24 hours per day, 7 days a week to member issues (answering service that pages the provider or answering machine message telling caller how to reach the provider after hours)
In-office waiting times • Providers are encouraged to see patients with scheduled appointments within 15 minutes of their scheduled appointment time. A reasonable attempt should be made to notify patients of delays.	Within 15 minutes


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

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

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

The list includes services such as:

- Potentially experimental, investigational, or cosmetic services
- Select injectable drugs
- Oxygen
- Not Otherwise Classified (NOC) procedure codes
- Certain outpatient procedures, services, and supplies

To view the List of Procedures/DME Requiring Authorization, click **Requiring Authorization** in the gray bar near the top of the PRC homepage. To search for a specific procedure code within the list, press the "Control" and "F" keys on your computer keyboard, enter the procedure code, and press "Enter." For up-to-date information on procedures that require authorization or to view the current list of procedure codes, visit the PRC, accessible via NaviNet® or under **Helpful Links** on our website.

Please note that the Highmark member must be eligible on the date of service, and

the service must be a covered benefit in order for Highmark to pay your claim.

You may use NaviNet or the applicable HIPAA electronic transactions to:

- Check member benefits and eligibility.
- Verify if an authorization is needed.
- Obtain authorization for services.

If you don't have NaviNet or access to the HIPAA electronic transactions, please call Clinical Services to obtain an authorization for services.

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Quarterly Formulary Updates Available Online

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

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

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

Pharmaceutical management procedures

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

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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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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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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.

Highmark Blue Cross Blue Shield West Virginia and Highmark Senior Solutions Company are independent licensees of the Blue Cross and Blue Shield Association. Blue Cross, Blue Shield, the Cross and Shield symbols, BlueCard, Blue Distinction, Blue Exchange, and SuperBlue are registered service marks and Blues On Call, Freedom Blue, Quality Blue, and Blue Rx are service marks of the Blue Cross and Blue Shield Association. Highmark is a registered mark of Highmark Inc. Highmark Health is the parent company of Highmark Inc.

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

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

NaviNet is a registered trademark of NaviNet, Inc., which is an independent company that provides a secure, web-based portal between providers and health care insurance companies.

Current Procedural Terminology (CPT) is a registered trademark of the American Medical Association. HEDIS and Quality Compass are registered trademarks of the National Committee for Quality Assurance. Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a registered trademark of the Agency for Healthcare Research and Quality. CORE is a registered trademark of CAQH.

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.

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