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"So many people across the country, and particularly in the regions that we serve, have been affected in some way by the opioid crisis," said Deborah Rice-Johnson, president, Highmark Inc., at a press briefing on April 16, 2019. "In response, we launched a 'war on opioids' in 2018 to address this urgent problem through new programs, policy changes and partnerships that span across the Highmark enterprise and extend into the community. We are pleased with the initiative's early progress. But we recognize that this war will not be won easily, and that doing so will require a spirit of collaboration. We are committed to serving our members and the community throughout this evolving public health crisis — including through expanded education and outreach initiatives that combat stigma and re-frame opioid dependence as a chronic disease, rather than a moral failing."

Highmark's core health insurance markets have been hit especially hard by the opioid epidemic. Delaware has the nation's third-highest rate of diagnosed opioid use disorder among patients who are insured by members of the Blue Cross Blue Shield Association (BCBSA), while West Virginia ranks fourth and Pennsylvania ranks 15th. The prevalence of opioid use disorder among Highmark's commercially insured members as of January 2019 is about seven per 1,000 people.

Key interventions in place

Our three-pronged approach:

1. Effective pain management

Manage pain without opioids and leverage alternative treatments (acupuncture, massage, etc.).

2. Safe prescribing

If opioids are necessary, prescribe safely and identify addiction early.

3. Effective treatment and therapy

Mitigate personal and societal risk of opioid addiction and ensure access to effective addiction treatment.

Highmark has implemented a three-pronged, progressively intensive strategy to address the opioid crisis. The first component focuses on prevention by offering effective, non-pharmaceutical pain management therapies at the site of care. This ensures that members who can manage their pain without opioids never receive them in the first place. Physical therapy, occupational therapy and chiropractic services are covered for Highmark's fully-insured members, and more than 40,000 practitioners offer discounts to members on alternative treatments such as massages, yoga, acupuncture and homeopathy. Highmark also provides cognitive behavioral therapy through psychologists as adjunctive therapy for pain.

The second component of Highmark's strategy emphasizes safe opioid utilization through new evidence-based medication policies, as well as ongoing monitoring and educational efforts for both members and prescribers.

Preventive measures:

7-day supply

Quantity level limits ensure members are using the drugs within medically accepted dosing limits.

Rx Lock In

Prevents doctor shopping.

Overutilization Monitoring

Watching out for seniors.

Prior authorizations required when:

3 drugs are prescribed and at least 1 drug is an opioid.

Opioid products with possible negative reactions to current medications are prescribed.

Transmucosal immediate-release fentanyl (TIRF) is prescribed.

In March of 2018, Highmark implemented a new policy for its commercial members who are prescribed opioid-based medications for the first time. The policy, which is designed to enhance safety, limits members in Highmark's core health insurance markets to a seven-day supply of medication. The policy follows the CDC's safe prescribing guidelines, which recognize the increased risk of dependence for individuals who use opioid-based medications for an extended period of time.

In addition to the new prescription policy, Highmark uses a data-driven approach to monitor members' prescription patterns and identify potentially unsafe use of opioids and other controlled substances.

"Our focus on primary prevention and safe opioid prescribing empowers patients and providers to have meaningful conversations about pain management," said Dr. Charles DeShazer, SVP, Chief Medical Officer, Highmark Inc. "Our goal is for members to partner with providers to identify the most effective, lowest-risk treatment methods that fit their particular pain management needs."

The third component of Highmark's strategy focuses on linking our members, your patients who have opioid use disorder with high-quality, accessible treatment programs that mitigate short-term risk and promote long-term recovery.

Watch for more information, coming soon.

Sources: Blue Cross Blue Shield Association July 2018 Health of America report; Highmark Opioids Steering Committee Report

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Stay Posted for PROVIDER EDUCATION WEBINARS

Throughout 2019, Highmark will be hosting live Provider Education Webinars.

Webinars will be live with an opportunity to ask questions during each session. At the end of each webinar, you'll have the opportunity to complete a survey and give us suggestions for future topics.

At Highmark, we know how important it is that you have the most up-to-date knowledge when it comes to taking care of our members and keeping your practices running smoothly. Watch the Provider Resource Center for news about upcoming webinars and other helpful educational resources.

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eAWV Program To Continue in 2019

Highmark will continue to give providers the option to participate in the eAWV (Annual Wellness Visit) Program in 2019. The eAWV Program is offered through a Highmark collaboration with Vatica to providers serving our Medicare Advantage members.

Enrolled practices work with Vatica to ensure accurate and complete condition capture occurs during Annual Wellness Visits in Vatica's eAWV solution.

NOTE: Practices enrolled in Highmark's Unconfirmed Diagnosis Code (UDC) or Risk Score Accuracy (RSA) Programs are not eligible for simultaneous enrollment in the eAWV Program.

Program Compensation

Compensation in the 2019 eAWV Program will be awarded at $125 per completed and signed eAWV encounter for eligible assessments completed with 2019 dates. This base program compensation is in addition to the contracted fee schedule payment providers receive for performing the annual wellness visit, and is an added benefit to the providers to compensate for the additional work effort required by the eAWV Program.

Bonus compensation will be available to high-performing providers at the following thresholds:

1. Providers that perform eAWVs for 60% of their attributed Medicare Advantage membership will receive an additional $25 (total of $150) per every completion.
2. Providers that perform eAWVs for 75% of their attributed Medicare Advantage membership will receive an additional $40 (total of $165) per every completion.

Any bonuses earned in 2019 will be calculated in conjunction with the fourth quarter payments and paid as a lump sum in the following year. Base program payment will continue on a quarterly basis as a separate amount for eAWV services rendered, finalized, and billed each quarter.

Program Materials & Support

The program manual that supports the eAWV Program is posted on the Provider Resource Center available via NaviNet for practices to access. The eAWV Program Manual will be updated for the 2019 eAWV Program.

To access the eAWV Program Manual via NaviNet, click on **Resource Center** from the left workflow pane, then click on **Education/Manuals** from the left panel, and then click on **Risk Adjustment Programs.**

Please review the eAWV Program Manual for requirements and direct any questions or concerns you have to your Provider Account Liaison or the Provider Service Center at 1-800-547-3627.

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Change in Bilateral Procedure Reporting Rules

Effective for claims processed on or after July 1, 2019, Highmark will be updating the reporting guidelines for bilateral services. This change is to more closely follow CMS bilateral rules and simplify billing practices for professional providers.

Keep in mind that there are several ways to report bilateral procedures. When reporting procedures that were performed bilaterally, you must report the correct number of services to correspond with the modifier(s) you report.

Special eBulletin dated March 29, 2019 has more information about these changes.

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Review New FAQs for Billing IPPEs and AWVs

As part of their benefits, patients with Medicare Advantage coverage are eligible to receive an initial preventive physical examination (IPPE), or "Welcome to Medicare" visit, and Annual Wellness Visits (AWVs).

Correct billing for these and all services ensures that providers are accurately reimbursed for the care they deliver, and that patients are accurately billed for the care they receive. It's important to follow the Centers for Medicare and Medicaid Services (CMS) rules for billing for these visits so that your patients don't receive unexpected bills.

We've recently created some Frequently Asked Questions (FAQs) about billing for IPPEs and AWVs and made them available under the Provider Training section of the Provider Resource Center. We encourage you to review them.

To review these FAQs, click the **PROVIDER TRAINING** tab at the left on the homepage, click the **Provider Training** link, and click **the Billing the Initial Preventive Physical Examination (IPPE) & Annual Wellness Visits (AWVs) for Medicare Advantage Patients FAQs** link under **MEDICARE ADVANTAGE TRAINING AND DOCUMENTATION.**

We also recommend that you review the CMS guidance around IPPEs and AWVs that's also available at the following online resources:

- IPPEs: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MPS_QRI_IPPE001a.pdf
- AWVs: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AWV_Chart_ICN905706.pdf

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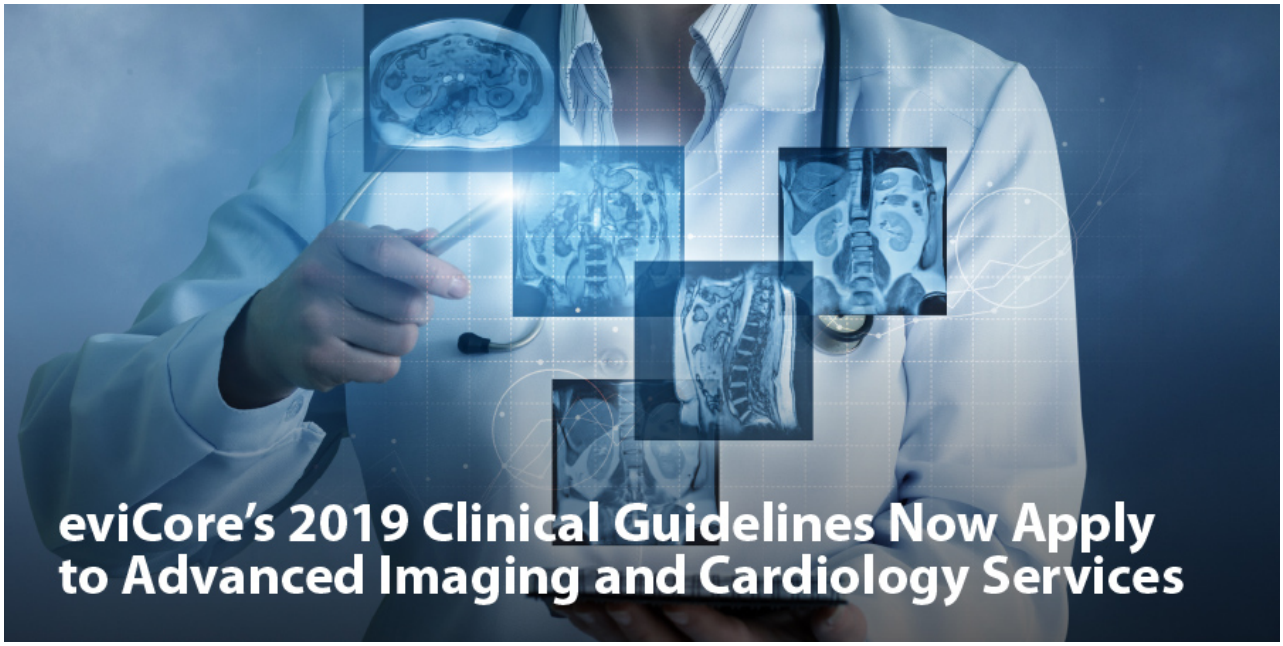

Highmark has adopted eviCore healthcare's (eviCore) 2019 cardiology and advanced imaging evidence-based clinical guidelines. Highmark began appling these guidelines to the Advanced Imaging and Cardiology Services Program on April 1, 2019. These guidelines replaced the 2018 guidelines, used for the eviCore Advanced Imaging and Cardiology Services program prior to April 1, 2019.

You may review the Advanced Imaging and Cardiology guidelines at eviCore's Highmark implementation site at: www.evicore.com/healthplan/highmark.

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Venipuncture Not Reimbursed When Billed With Lab Services

Effective May 6, 2019, Highmark will not reimburse venipuncture (blood draws) when billed with another blood or serum lab service on the same date of service, by the same provider, for the same patient. The venipuncture is considered incidental to the lab test and is not eligible for separate reimbursement.

We recommend that you review Highmark's Reimbursement Policy RP-047, Venipuncture and Lab Services, available on the Provider Resource Center.

Reimbursement policies are located on the Provider Resource Center as an option under **CLAIMS, PAYMENT & REIMBURSEMENT**. Select **Reimbursement Policy** to review Highmark's reimbursement policies. As new reimbursement policies are developed, they will be added to the **Reimbursement Policy** page. Check back regularly for the latest updates.

Special eBulletin dated March 1, 2019 has more information about this change.

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Are You Referring To Providers In Your Patients' Networks?

If you need to refer patients to other providers, such as specialist physicians, or for physical therapy, imaging services, or laboratory tests, keep in mind that referring them to providers who participate in their health plans' networks means a lower likelihood of denied claims and higher out-of-pocket expenses for your patients.

We'd also like to remind you that Highmark's Network Use Policy requires you to utilize in-network providers to perform any services on behalf of members whenever in-network providers are available.

If you have previously sent members to out-of-network providers when in-network providers are available, **immediately stop sending members to those providers.**

Confirm Patients' Networks Before Making Referrals

Before you refer your patients for care, confirm your members' networks and benefits in NaviNet®. A self-service guide with instructions for confirming networks in NaviNet is available on the Provider Resource Center under **PROVIDER TRAINING > Provider Training > NAVINET SELF SERVICE GUIDES.**

Remind Your Patients about Finding Network Providers

If your patients need help finding network providers, remind them that they can do so in one of the following ways:

- Using **Find a Doctor or Rx** on their member websites. Your patients can use Find a Doctor or Rx without logging in, but if they log in, their results will be more specific to their health plans' networks.
- Calling the toll-free number on the back of their member ID cards

Review the Network Use Policy

You can review the Network Use Policy in the Highmark Provider Manual's Chapter 3, Unit 1, section "Directing Care to Network Providers." Visit the Provider Resource Center and click **MANUALS** in the top navigation bar, and click the **Highmark Provider Manual** link.

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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 Highmark's 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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Notifications for Providers

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

Quality Program Information Available Online

The Quality Program has been designed to improve the quality, safety, and equity of the clinical care and services provided by providers to our members. To do this, we continually review the aspects that affect the quality of the member care experience and satisfaction and look for ways to improve them.

We work closely with the physician community in our efforts to address both the quality of the clinical care and service our members receive, as well as plan management to address the services provided by Highmark (i.e., authorizations, claims handling, appeals, etc.). We also use member satisfaction surveys and other tools to get feedback on how we're doing. These results are used to guide our future quality improvement activities and programs supporting such focuses as the clinical care and service received by our members, the provider network, member safety and health equity.

For more information about the Quality Program, including information about program goals and a report on progress toward meeting those goals, please visit our online Provider Resource Center via NaviNet® or through our main website. Once on the Provider Resource Center, from the black navigation bar at the top, select **Highmark Provider Manual**. See "Chapter 5: Care & Quality Management, Unit 6: Quality Management."

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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.

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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