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As of July 1, 2021, Highmark is ending our exclusive arrangement with LabCorp for our Delaware market. **We are inviting all laboratories (especially those already contracted in Pennsylvania or West Virginia) who meet our credentialing standards (as stated in the application) and sign an agreement before July 1, 2021 to apply for our Delaware market.**

As of July 1, 2021, Highmark is ending our exclusive arrangement with LabCorp for our Delaware market.

To apply for the Delaware market, please click here.

When our adequacy needs have been met, Highmark will close the network and begin working with the accepted laboratories.

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The importance and validity of virtual therapy has become particularly evident in the current reality of the COVID–19 pandemic. Utilization of virtual therapy for behavioral health (BH) diagnoses was quite modest prior to 2020.

To help avoid further spread the virus, Highmark is actively encouraging our members to utilize telehealth: virtual visits (provided by an in-network provider) and telemedicine (provided by a Highmark-contracted telemedicine vendor). The use of telehealth allows members easier access to care to address their emotional well-being. The treatment of behavioral health diagnoses and substance use disorders (SUDs) are challenges for all health plans today, including Highmark.

The use of telehealth allows members easier access to care to address their emotional well-being.

From January 2020 through December 2020, the following number of members[1] had one or more of the diagnoses below:

- **Depression** – 225,261 (8.88%)
- **SUD** – 157,966 (6.23%)
- **Anxiety** – 154,089 (6.08%)
- **Other BH Diagnoses** – 189,994 (7.49%)

The use of virtual therapy can help our members receive the care they need, especially as the COVID-19 pandemic continues.

Why is Telehealth Important?

In 2019, 61.2 million Americans (5.9% more than 2018) were diagnosed with a mental and/or SUD.[2] To complicate this, there has been an increasing shortage of BH Professionals across the United States. It is estimated that there may be a deficit upwards of 250,000 BH Practitioners (including Psychiatrists, BH Nurse Practitioners, BH Physician Assistants, Clinical Counselors/Psychologists, SUD Counselors/Social Workers, and Family Therapists) by the year 2025.[3]

While some of those with a diagnosed SUD and/or mental illness do not perceive a need for treatment, there are gaps in access to care for those who do need treatment. According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2019 report:[2]

- **20.4 million children and adults 12 years of age or older** have been diagnosed with a SUD with 89.7% not receiving treatment
- **51.5 million adults 18 years or older** are diagnosed with Any Mental Illness (AMI) with 55.2% not receiving treatment
- **13.1 million adults 18 years or older** have been diagnosed with Serious Mental Illness with 34.5% not receiving treatment
- **9.5 million adults 18 years or older** have been diagnosed with Co-Occurring AMI and SUD with 51.4% not receiving treatment
- **3.8 million adolescents between the ages of 12 and 17** have been diagnosed with Major Depressive Episode with 56.7% not receiving treatment

Telehealth visits can help provide care to patients who cannot travel to a provider's office and/or in areas where there are not as many behavioral health providers. The American Psychiatric Association (APA) issued the following position statement in 2015: "Telemedicine in psychiatry, using video conferencing, is a validated and effective practice of medicine that increases access to care. The American Psychiatric Association supports the use of telemedicine as a legitimate component of a mental health delivery system to the extent that its use is in the best interest of the patient and is in compliance with the APA policies on medical ethics and confidentiality."[4] Additionally, increasing evidence has demonstrated that telebehavioral health care is generally as effective as in-person care for a number of common behavioral health conditions.[5]

Footnotes:

[1]These percentages are out of the 2,535,727 members in PA, DE, and WV who were actively enrolled in Cotiviti chronic conditions for behavioral health for the 2020 year.

The number of members identified utilizing BH Virtual Therapy in 2019 in PA, DE, and WV through claims was 9,253 members for 30,015 visits. In 2020, that number rose to 177,904

members (↑1823%) for 1,503,724 visits (↑4909%).

[2]Substance Abuse and Mental Health Services Administration. (2020). Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health (HHS Publication No. PEP20-07-001, NSDUH Series H 55). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved 09/23/2020 @ https://www.samhsa.gov/data

[3]U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, National Center for Health Workforce Analysis: National Projections of Supply and demand for Selected Behavioral Health Practitioners: 2013 – 2025 , November 2016, retrieved 09/23/2020 @ https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/behavioral-health2013-2025.pdf

[4]American Psychiatric Association: What is Telepsychiatry? Retrieved 09/23/2020 @ https://www.psychiatry.org/patients-families/what-is-telepsychiatry

[5]Lazur,B., Sobolik, L.., King, V.: Telebehavioral Health: An Effective Alternative to In-Person Care; Issue Brief October 2020, retrieved 03/04/2021 @ https://www.milbank.org/wp-content/uploads/2020/10/TeleBH_B_6.pdf

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Working to Meet Members' Language Needs

Our quality improvement efforts are designed to ensure quality care and member satisfaction. To achieve these goals, we continually review the aspects of our plan that affect member care and satisfaction and look for ways to improve them. One way to do that is to share details with network practitioners about the languages members in their area may speak and to provide information on available interpreting services.

Highmark annually assesses languages spoken by the population in our service area and compares them to the data that practitioners report on their network applications. Our 2021 analysis concluded that the following counties had greater than 1,000 residents speaking the following primary languages:

Language:	Counties in which language is spoken, *and* PCPs are available who speak the language:	Counties in which language is spoken, *and there are no* PCPs available who speak the language:

Arabic	Monongalia	–
Chinese (including Mandarin and Cantonese)	Monongalia	–
Other Indo-European	Monongalia	–
Spanish	Berkeley, Jefferson, Kanawha, Monongalia, Raleigh	–

- The above data is from the 2019 U.S. Census - American Community Survey Five-Year Estimates.
- This information is based on county population and not Highmark membership population.

In addition, our telephone translation vendor provided a breakdown of all calls Highmark customer service representatives received during the year that required interpreter services. In 2020, Member Services received 32,124 calls from members speaking 58 different languages. That was an 18.9 percent increase from 2019. The largest percentage of calls (90.3 percent) was from members speaking Spanish. The total number of calls serviced for Spanish was 29,015.

In 2020, Highmark received 32,124 requests for telephone translation. The following is a breakdown of the language requests:

- **Spanish** 29,015 (90.3%)
- **Mandarin** 538 (1.7%)
- **Vietnamese** 414 (1.3%)
- All other language requests were below 1.0% for the year.

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

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

These changes are announced in the form of Special eBulletins that are posted on Highmark's Provider Resource Centers (PRC).

To view the List of Procedures/DME Requiring Authorization, click **Requiring Authorization** in the gray bar near the top of the PRC homepage.

Please note that the Highmark member must be eligible on the date of service and the service must be a covered benefit for Highmark to pay the 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 are not signed up for NaviNet or do not have access to the HIPAA electronic transactions, please call Clinical Services to obtain an authorization for services:

- Highmark Delaware Contact Information for Providers
- Highmark Contact Information for Pennsylvania Providers
- Highmark West Virginia Contact Information for Providers

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Notifications for Providers

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

2020 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 is 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) 2019 for the HEDIS reporting year (RY) 2020 is compared to the 2020 national averages. For additional comparison, MY 2019 results are included.

You may review these results on the Provider Resource Center by:

- Going to **Education/Manuals**
- Clicking **HEDIS**
- Selecting **HEDIS Results**

Important Note: The source of the National Average data contained in this publication is from Quality Compass® 2020 and is used with the permission of NCQA®. Quality Compass 2020 includes certain CAHPS® data. Any data display, analysis, interpretation, or conclusion based on this data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion.

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 the **Provider Resource Center** 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, Health Plan Quality
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 primary care physician (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 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** for Medical/Surgical-related criteria/guidelines
- **1-800-258-9808** for Behavioral Health-related criteria/guidelines
- **1-800-600-2227** for Pharmacy-related criteria/guidelines

This information is also available online:

- Highmark's medical and pharmacy policies are available via the Provider Resource Center (PRC)
- The Federal Employee Program (FEP) Medical Policy Manual is available via the FEP's website at www.fepblue.org
- The FEP Pharmacy criteria/guidelines are available via the following link: FEP Pharmacy Criteria/Guidelines

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.

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.

Quality Program Information Available Online

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

Highmark works 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 Highmark.com. 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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Quarterly Formulary Updates Available Online

Highmark regularly updates 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 eBulletins that can be found on Highmark's Provider Resource Center.

Providers who do not have internet access or do not use 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 1) providing information for exception requests; 2) the process for generic substitutions; and 3) explanations of limits/quotas, therapeutic interchange, and step-therapy protocols, please refer to the **Pharmacy Program/Formularies** page, accessible from the main menu on the Provider Resource Center (PRC).

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Staying Up to Date with the Highmark Provider Manual

Ensure you are regularly reviewing the Highmark Provider Manual for our most recent guidance on:

- Participation Rules
- Credentialing/Recredentialing Criteria and Procedures
- Medical Record Criteria
- Requirements for 24/7 Coverage

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Help Our Members Find You

The sign in front of your office helps patients find their way to you — so does your contact information in the online Highmark provider directory.

You are required to supply Highmark with your practice name, clinical team, locations, and contact information for our provider directory. It is essential that Highmark has your up-to-date information to help our members make informed decisions on where to seek care. You are required to supply Highmark with your information on a quarterly basis.

Reviewing data is vital for you

The Centers for Medicare & Medicaid Services (CMS) requires Highmark to reach out to you every quarter and ask you to validate your provider information. We use this information to populate our provider directory and to help ensure correct claims processing.

Providers who don't confirm and attest that their data is accurate will be immediately removed from the directory, and their status within Highmark's networks may be impacted. Your thorough review of your directory information confirms:

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

- The practitioner is accepting new patients — or not accepting new patients — at the location.
- The practitioner's address, suite number (if any), and phone number are correct.

Change happens

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

- Current address
- Phone number
- Fax number

Remember to review data at least once a quarter to ensure it's accurate.

Detailed instructions are available in the Provider File Management NaviNet Guide, which is available on the Provider Resource Center under **Education/Manuals**.

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

Atlas is an independent company that performs outreach to physicians on behalf of Highmark.

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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

Arielle Reinert, Editor

We want *Provider News* to meet your needs for timely, effective communication. If you have any suggestions, comments or ideas for articles in future issues, please write to the editor at Arielle.Reinert@highmark.com.

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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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.

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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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