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

HIGHMARK. West Virginia

Issue 4, 2017

Visit Our Newly Redesigned Provider Resource Center

Easier Navigation, Device-Friendly Viewing Among Key Improvements

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

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

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

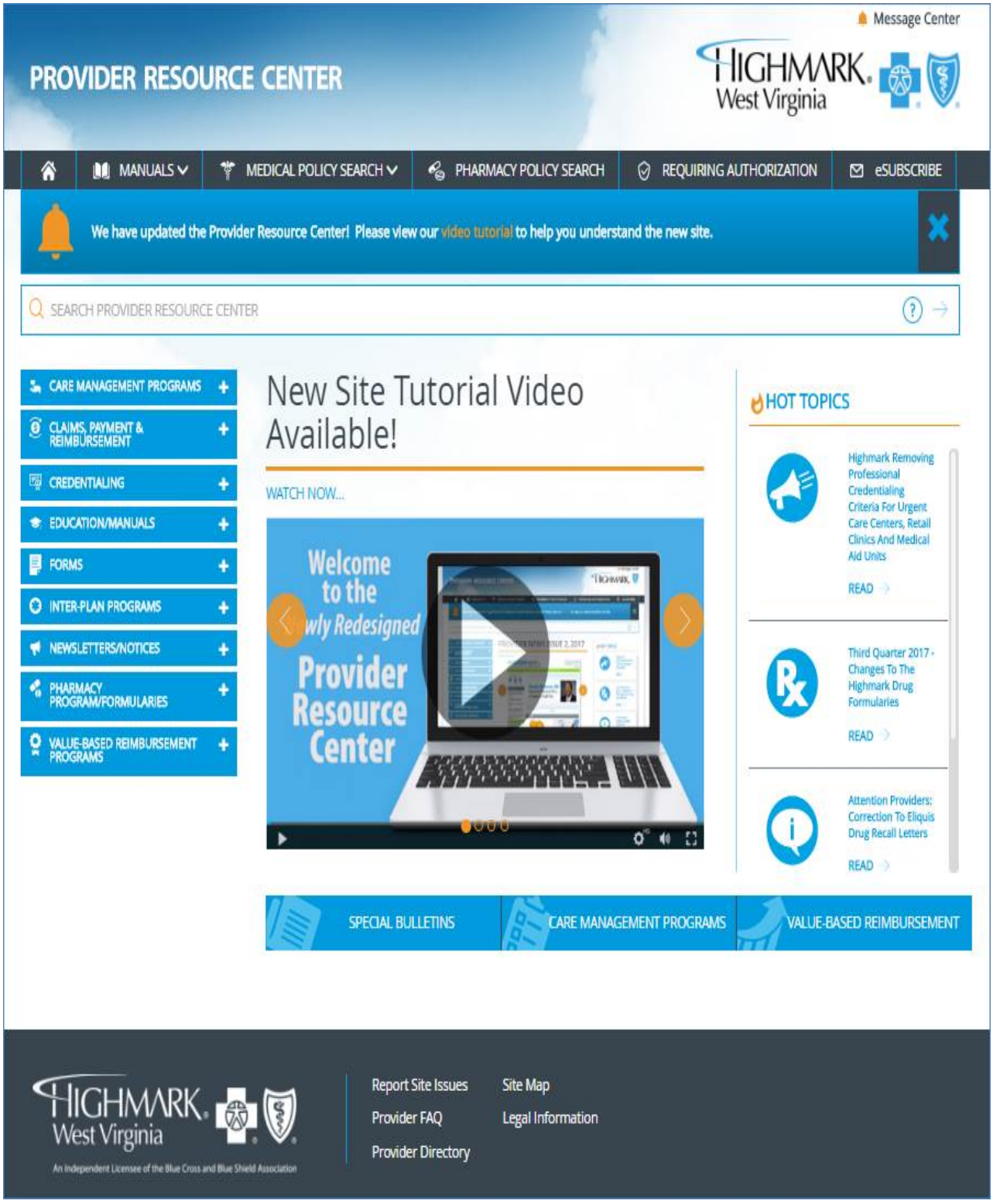
Less clutter

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

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

- **Care Management Programs** (including the Physical Medicine Management and Radiology Management programs)
- **Claims, Payment & Reimbursement** (including medical and reimbursement policies)
- **Credentialing**
- **Education/Manuals** (including the *Highmark Blue Shield Office Manual* and *Highmark Facility Manual*)
- **Forms**

- **Inter-Plan Programs** (including the BlueCard® Information Center)
- **Newsletters/Notices** (including *Provider News* and e-Subscribe)
- **Pharmacy Program/Formularies**
- **Value-Based Programs**



Easier to access Quicklinks

At the top of the home page, we've made several of the most popular Quicklinks

available in gray buttons oriented horizontally across the page. These include **Manuals**, **Medical Policy Search**, and **Pharmacy Policy Search**.

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

Helpful new features

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

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

New search functions
You can still search the entire PRC by using the search window at the top of the home page. But now you can conduct an advanced search by clicking the question mark at the far right of the search window, helping you find what you need more quickly.

The medical and pharmacy policy searches are still available from those individual pages. But the new site also lets you search within our provider manuals and in our Special Bulletins & Mailings archive. Simply visit the ***Highmark Blue Shield Office Manual***, ***Highmark Facility Manual***, and **Special Bulletins & Mailings** pages, and use the search window provided on each page.

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

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ALL PROVIDER TYPES

The Highmark Cancer Collaborative recently announced that in its first year, participating medical oncologists and radiation oncologists achieved industry-leading results that positively impact Highmark members.

This success included 83-percent adherence with evidence-based, clinical pathways recommended by leading national cancer experts, centers, and specialty societies. And use of innovative "episode-of-care" payment models helped to incent value-based care over the volume of procedures performed. Published studies indicate 35-percent cost savings are associated with pathways adherence, along with higher care quality; safer, more effective treatment; and more cost-effective care.*

In addition, through collaboration with Johns Hopkins Kimmel Cancer Center, the Highmark Cancer Collaborative has facilitated expanded access to innovative clinical trials available to qualified patients in western Pennsylvania. For Highmark members in all coverage areas, the Collaborative also introduced second-opinion consults for rare and complex cancers with leading cancer researchers and increased the use of appropriate molecular testing to provide actionable data for use in enhancing treatment and providing a safer, more patient-friendly experience of care.

Success by the numbers

During the Highmark Cancer Collaborative's inaugural year, 29 physician practices participated in its pathways program. Together they made over 2,000 treatment decisions using advanced decision-support tools, demonstrating how quickly best practices can be adopted.

Based on this success, the Highmark Cancer Collaborative is expanding its clinical pathways program to include guidelines on five additional cancers — myelodysplastic syndromes and kidney, bladder, esophageal, and gastric cancers. These five cancers were selected because data indicate their inclusion would greatly impact additional Highmark members.

The Highmark Cancer Collaborative is expanding its clinical pathways program to include guidelines on five additional cancers:

- myelodysplastic syndromes
- kidney
- bladder
- esophageal
- gastric cancers

The Collaborative now offers clinical pathways for 23 different cancer types, covering over 96 percent of cancers impacting Highmark members.

Greater collaboration with Johns Hopkins Medicine

As part of the expanded relationship with Johns Hopkins Medicine, Highmark is establishing a Preferred Referral Partnership, which entails:

- Highmark members in all our markets will have access on an in-network basis to Johns Hopkins for rare and complex adult and pediatric cancers and for lung and pediatric bone-marrow transplants.
- Highmark will offer a “Concierge” program committed to enhancing members' access to Johns Hopkins when necessary.
- Both Highmark and John Hopkins Medicine will continue to collaborate on even greater value-based reimbursement plan designs for the benefit of employers and members alike. The organizations expect to have products in the market as early as 2019 and reward members for seeking care at Johns Hopkins and participating high-value providers in Highmark’s network.

The expanded partnership with Johns Hopkins will include greater sharing of knowledge and expertise by Allegheny Health Network (AHN) and Johns Hopkins physicians.

Patients referred to Johns Hopkins will gain the benefit of world-class expertise and innovation in their treatment plans that drive the best possible results. These include remote consultation and second opinions, peer-to-peer consultations, and access to

new technology, such as proton beam therapy, a cutting-edge radiation treatment available at only a handful of centers nationwide.

AHN patients will also have access to hundreds of active and new clinical trials that will be conducted at both Johns Hopkins Medicine in Baltimore and at AHN in western Pennsylvania.

For more information about the Highmark Cancer Collaborative's recent successes, read this press release. And watch *Provider News* for updates on the progress that the Collaborative is making to improve cancer care.

*A national study published in the *Journal of Oncology Practice* found that patients following evidence-based clinical pathways for oncology treatments saw 35 percent lower costs versus patients receiving traditional treatment approaches.

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Confronting the Opioid Crisis

Highmark Teaming with axialHealthcare to Address Issue in Our Communities

ALL PROVIDER TYPES

In the 1990s, patient groups, academic journals, and the federal government urged health care providers to do more to address patients' pain — not just to reduce it, but also to eliminate it. Medical guidelines urged physicians to get patients as close to the zero on the pain scale as possible.

Some big hospital systems, including the Veterans Health Administration, dubbed pain as the "fifth vital sign," just as important as blood pressure and temperature. And, opioid medication came to market with promises of effectiveness with few side effects and little to no dependence.

In 2016, deaths due to drug overdose from opioids likely exceeded 59,000, the largest annual jump ever recorded in the U.S., according to preliminary data compiled by *The New York Times*. The number of deaths in 2015 was 33,091.

Drug overdoses now exceed car crashes as the leading cause of unintentional death.

While the rate of opioid prescriptions has started to decline, it remains 56 percent higher than it was 20 years ago.

Helping to Prevent Abuse

A key to preventing abuse is for patients to have an understanding of the risk factors associated with their medications. You can help promote this understanding by frankly discussing the risks, the realistic benefits of the medication, and expected

length of treatment.

Most doctors voice their concerns:

- 86 percent say they talk about the risk of addiction and abuse
- 91 percent discuss how and when to take the medications
- 93 percent cover side effects
- 45 percent do not discuss how to safely store or properly dispose of these medications

The National Institute on Drug Abuse offers some guidelines for opioid prescriptions:

- Start low and go slow – taking the lowest possible dose for the least amount of time
- Use immediate-release rather than extended-release or long-acting opioids
- Avoid taking more than one opioid at the same time, if possible

Treating acute pain with non-opioid medications may be an effective starting place. Research shows opioids are no more effective than non-opioid alternatives, like Tylenol or Advil, or the generic versions, at reducing acute pain.

"Opioid use has become an issue of national concern. While they can be effective in treating acute pain, there is mounting evidence that opioids are less than effective when used for chronic pain — and can actually do more harm than good," said Norman Montalto, MD, a medical director with Highmark in West Virginia.

"Opioid use has become an issue of national concern. While they can be effective in treating acute pain, there is mounting evidence that opioids are less than effective when used for chronic pain — and can actually do more harm than good"

— Norman Montalto, MD
Highmark in West Virginia

Treating Addiction

Some health systems now are providing behavioral and physical health treatments to minimize patients' anxiety and reduce any delay in getting the treatment and other services they need. Without professional care coordination, many people drop out of treatment before attending follow-up appointments.

Alternative Pain Treatments

Many physicians now accept alternative, or holistic, medicine as a valid treatment

option for pain. In fact, many alternative methods are standard practice at pain treatment centers.

Some of the most common alternative pain treatments are acupuncture, chiropractic manipulations, exercise, behavioral health therapy, relaxation therapy, hypnosis, biofeedback, massage, meditation, or yoga.

Prescription Benefits Manager

In addition to processing and paying pharmacy claims, prescription benefits managers (PBMs) may "flag" individuals who are suspected of abusing or misusing prescription medications. Some of the "flags" are:

- Repeated attempts to fill scripts early
- Scripts for the same drug from several doctors
- Dosage –high daily dosages that create a greater risk of a fatal overdose
- Combinations with other drugs, especially sedatives
- Whether dispensing pharmacists are checking the databases and how often

PBMs may also track data on doctors who prescribe opioids, monitoring frequency, dosage, and length of therapy.

Many states also are using similar databases to track this information. In Pennsylvania, where the opioid death rate is above the national average, doctors now face sanctions if they don't check the state database to verify if the individual has opioid prescriptions from multiple doctors. Please see your state law for any requirements applicable to prescribing.

Working with Others

In 2016, Highmark joined forces with axialHealthcare, a national leader in the appropriate use of opioids for pain management. Initiated in West Virginia, this partnership helps physicians better understand their patients' total prescription and medication use and gain insight into their own prescribing patterns.

The bulk of pain treatment in West Virginia falls to PCPs due to a shortage of pain specialists.

Patients seeking pain treatment often have two choices: Drive several hours to a pain center or rely on a PCP in their area. For those without the resources to drive several hours multiple times a month for treatment, the decision is obvious.

PCPs and specialists outside of the pain-management field sometimes prescribe opioids and may not have information about other treatment options, such as steroidal injections, interventional treatment, nerve blocks, or physical therapy.

axialHealthcare is helping to resolve that problem through the Pain Management Program Portal. The portal gives physicians insights into individual patients along with resources to support decisions about treatment options for patients using opioids. It also includes patient alerts, care pathways, clinical guidelines, and a link to the West Virginia Controlled Substance Monitoring Program.

For doctors to access the portal:

- Use **Auth Inquiry and Reports** in Highmark NaviNet®
- Select the appropriate **Billing Provider and Service Provider** and click **Submit**.
- Select the **RIM Score View Full Report** radial button.

The RIM Score is comprised of 15 evidence-based quality metrics proven to impact patient safety and quality of care around opioid prescribing. Your score is an assessment of your opioid prescribing patterns compared to your specialty peer group, and the RIM Score shown in NaviNet is for the most recent 1-month period*.

Patients don't expect to become addicted to a medication prescribed by a physician. PCPs, states, and insurers like Highmark are working together to make sure that outcome is minimized as much as possible. In making sure doctors have the tools and resources they need to make better decisions about opioids, the goal is to improve pain management for existing patients and prevent addiction for future patients.

*The metrics that make up the RIM Score all have different look-back periods, but the score itself is calculated monthly.

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

PROFESSIONAL PROVIDERS

Put yourself in this member's shoes. You're new to Highmark coverage and want to find a network PCP. You look in the Provider Directory for a doctor who has been recommended by a friend. But the doctor isn't listed. Why? She married a few months ago and changed her last name but failed to update her name in the Provider Directory.

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

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

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

- **The provider name is correct.** For example, we must ensure the provider'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 provider's specialties are correctly listed.** Is there more than one specialty listed in the directory? Are both specialties being practiced?
- **There aren't providers listed at practice locations where they don't actually practice.** Providers listed must be affiliated with the group. Providers who cover on an occasional basis are not required to be listed. Providers who do not see patients on a regular basis at a location should not be listed at that location.
- **The provider is accepting new patients — or not accepting new patients — at the location.**
- **The provider's address 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 are currently making outreach calls to providers to verify the accuracy of provider data. If you receive a call, please provide our agent with the requested information.

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Resources to Address Medication Non-Adherence

PROFESSIONAL PROVIDERS

Medication non-adherence is a growing concern to clinicians, healthcare systems, and insurers because it is associated with adverse outcomes and increased care costs. Published literature indicates the following:

- 50 percent of patients take their medications as prescribed by their doctors[1]
- 31 percent of prescriptions never get filled at the pharmacy[2]
- 33 to 69 percent of medical-related hospital admissions are related to poor medication adherence[3]

Medication adherence plays an important role in the prevention of long-term complications related to diabetes, hypertension, and hyperlipidemia. Promoting health awareness, simplifying a medication regimen by avoiding pill splitting or multiple daily doses, and prescribing low-cost but safe and effective alternatives are ways that you can help patients achieve the most from their prescription drugs.

There are many free tools and services available within the community that will help your patients stay on track with their medications. Please review the table below to determine the most convenient resources for your patients, our members.

Resource	Description	Call to Action
Automatic refill programs	• Service is offered by most retail pharmacy chains	Notify your patients of this program or personally connect them to their pharmacy via telephone to

	• Tool facilitates automatic refills for prescriptions and notifies patients that their medications are ready	enroll in this service.
Medication synchronization	Tool that coordinates fill dates so that all medications for a 30-day supply can be obtained on the same day each month	Notify your patients of this program or personally connect them to their pharmacy via telephone to enroll in this service.
Mail order	Service that offers home delivery of 90-day supplies for maintenance medications	Contact Express Scripts at 1-800-903-6228 to set your patients up for mail order services.
Automated reminders	Service offered by pharmacies that will send automated refill reminders in the form of text messages or interactive voice-response calls to notify patients that it's time to pick up their medications	Notify your patients of this program or personally connect them to their pharmacy via telephone to enroll in this service.
Highmark mobile app	Highmark's app supports patients via automated refill reminders and daily reminders to take each dose of medication.	Refer patients to Highmark Member Service for help in downloading the application. (The Member Service telephone number is on the back of members' ID cards)

We realize your patients may be obtaining their medications through discount programs offered throughout the community. Please note that insurance claims aren't generated in these instances. That means your patients appear to be non-

adherent, per our records. Please encourage your patients to always use their Highmark member ID cards to obtain their medications. Doing so allows Highmark to identify care coordination opportunities that will help to improve the overall quality of care that is delivered to our members.

1. Sabate E., et al. Adherence to Long Term Therapies: Evidence for Action. Geneva, Switzerland, World Health Organization; 2003
2. One in Three Patients Not Filling Prescriptions, study finds: http://www.aafp.org/news/health-of-the-public/20140428nonadherencestudy.html. Accessed March 22, 2017
3. Osterberg L., et al. Adherence to Medication. *New England Journal of Medicine*, 2005; 353(5) 487-497

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Campaign Shows 'There's Value in That'

ALL PROVIDER TYPES

Employers of all sizes are concerned with rising medical costs. Highmark strives to offer employers more value for their healthcare dollar through innovative health plans, programs, and collaborations.

That's why Highmark has launched a new advertising campaign to let employers throughout our region know about the unique ways we're delivering on that promise. Developed around the slogan "There's value in that," the campaign uses radio spots, print ads in local business publications, and digital ads on targeted websites for benefits decision-makers to spread the word. Highmark also produced a YouTube video as part of this outreach.

A focus on creating value

The ads focus on topics ranging from pharmacy, to cancer care, to high-performing provider networks. And you may have already heard about or seen the ads in your area.

For example, Highmark recognizes that patients' prescription drug and medical needs are too intertwined to view pharmacy and medical benefits separately, so we integrate them. That gives members more coordinated care and their employers an opportunity to save up to $172 per year per employee, according to our estimates.

That's great news, since prescription drug expenses are among the fastest-growing

healthcare costs for everyone.

Also to control rising costs, Blues plans have four times the number of network care providers participating in value-based programs than do other insurers. As a result, Blues plans like Highmark experience a 10-percent lower total cost of care while ensuring quality goals are met, which benefits our customers.

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Professional Providers: Important Change Coming 1/1/18 for Correcting Claims

PROFESSIONAL PROVIDERS

Effective January 1, 2018, Highmark will no longer accept requests for claim corrections via telephone or NaviNet® investigation. Providers instead must submit corrected (replacement) claims electronically.

Because electronic replacement claims normally process in the same time frame as an original claim, your adjustments will likely process faster than those changes requested via phone or NaviNet investigation.

Highmark's systems recognize claim submission types based on the claim frequency code submitted on professional (837P) electronic claims.

There are three valid Frequency Type claims:

- Frequency Type 1 is the original claim.
- Frequency Type 7 is a replacement claim. It corrects data that was incorrect on the original claim.
- Frequency Type 8 is a void or cancellation of a prior claim that was submitted in error.

The original claim number assigned by Highmark is required for all Frequency Type adjustment claims. Providers must work with their practice management system vendor to ensure the Highmark-assigned claim number is reported in the 837P, Loop 2300, REF – Payer Claim Control Number Segment.

This requirement also applies to claims already adjusted that now require a second

(or subsequent) adjustment.

Please note: Electronic corrected claims will replace the previously processed claims. When submitting a correction, send the claim with all changes exactly as the claim should be processed.

When to Submit a Replacement Claim (Frequency Type 7)

When to use	Highmark action	Examples of corrected claims that can be submitted
Use Frequency Type 7 when Highmark has processed a specific claim for payment and you have identified an error on the original claim. Information present on the corrected claim represents a complete or partial replacement of the previously submitted claim.	The initial claim is identified based on the original claim number reported. The replacement claim data is used to review, reprocess, and adjust the original claim as appropriate. The result could be an additional payment, no change in payment, or taking back an overpayment. The Frequency Type 7 or replacement claim will be reflected as a denied claim on the EOB and/or electronic remittance. Denials on the EOB will report Highmark proprietary code — E0775: The adjustment request received from the provider has been processed. The original claim has been adjusted based on the	When a change is made to a service, such as: • incorrect procedure or diagnosis code • incorrect place of service • incorrect total charge • incorrect units

	information received. The 835 will report Claim Adjustment Group and Reason Code — CO129: Prior processing information appears incorrect. Remark Code N770 will also be reported. (N770 – The adjustment request received from the provider has been processed. Your original claim has been adjusted based on the information received.)	

Additional information about how to submit electronic corrected claims begins on Page 21, Chapter 5, Unit 2, of the ***Highmark Blue Shield Office Manual***, which is available on our Provider Resource Center.

Paper claims

All providers are encouraged to file electronic claims.

However, effective January 1, 2018, you must submit a paper replacement claim if your original claim was submitted on paper.

In Box 22, enter the Frequency code under ***Resubmission code*** and Original Claim Number under ***Original Ref. No.*** to indicate you're submitting a replacement claim.

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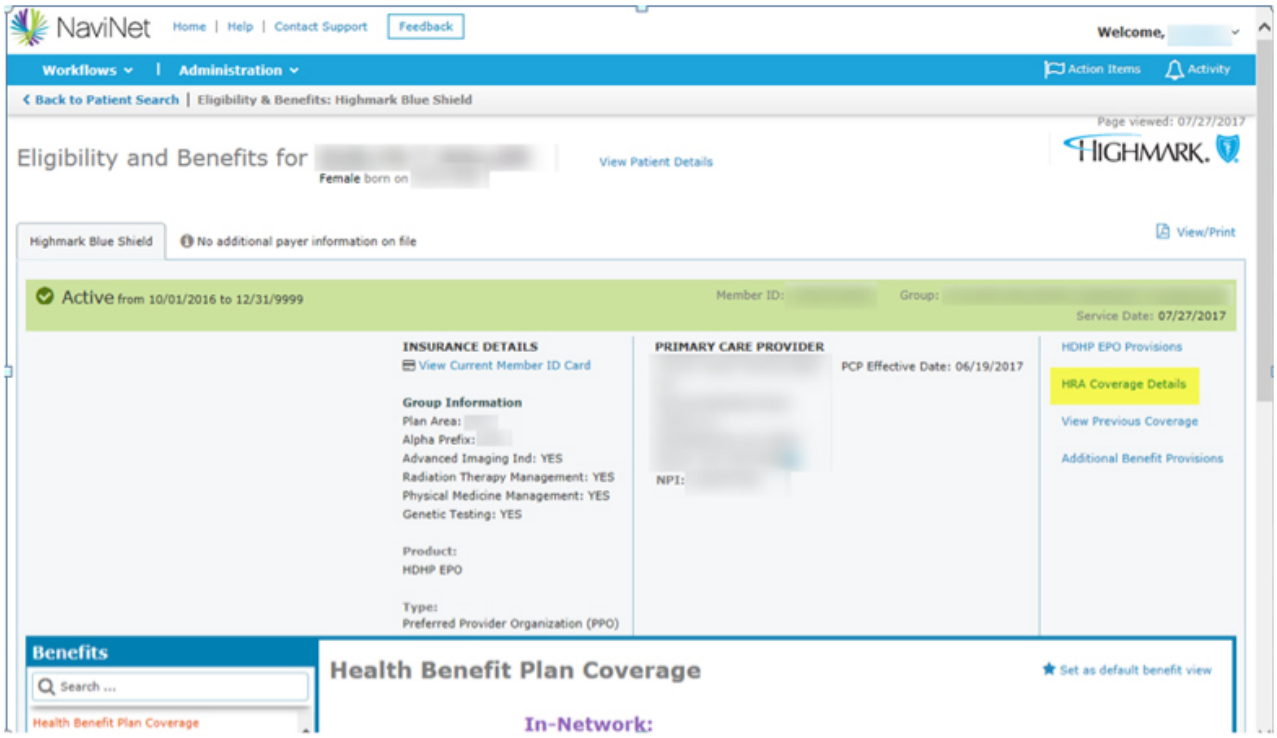
NaviNet Puts Information on Members' HRAs at Your Fingertips

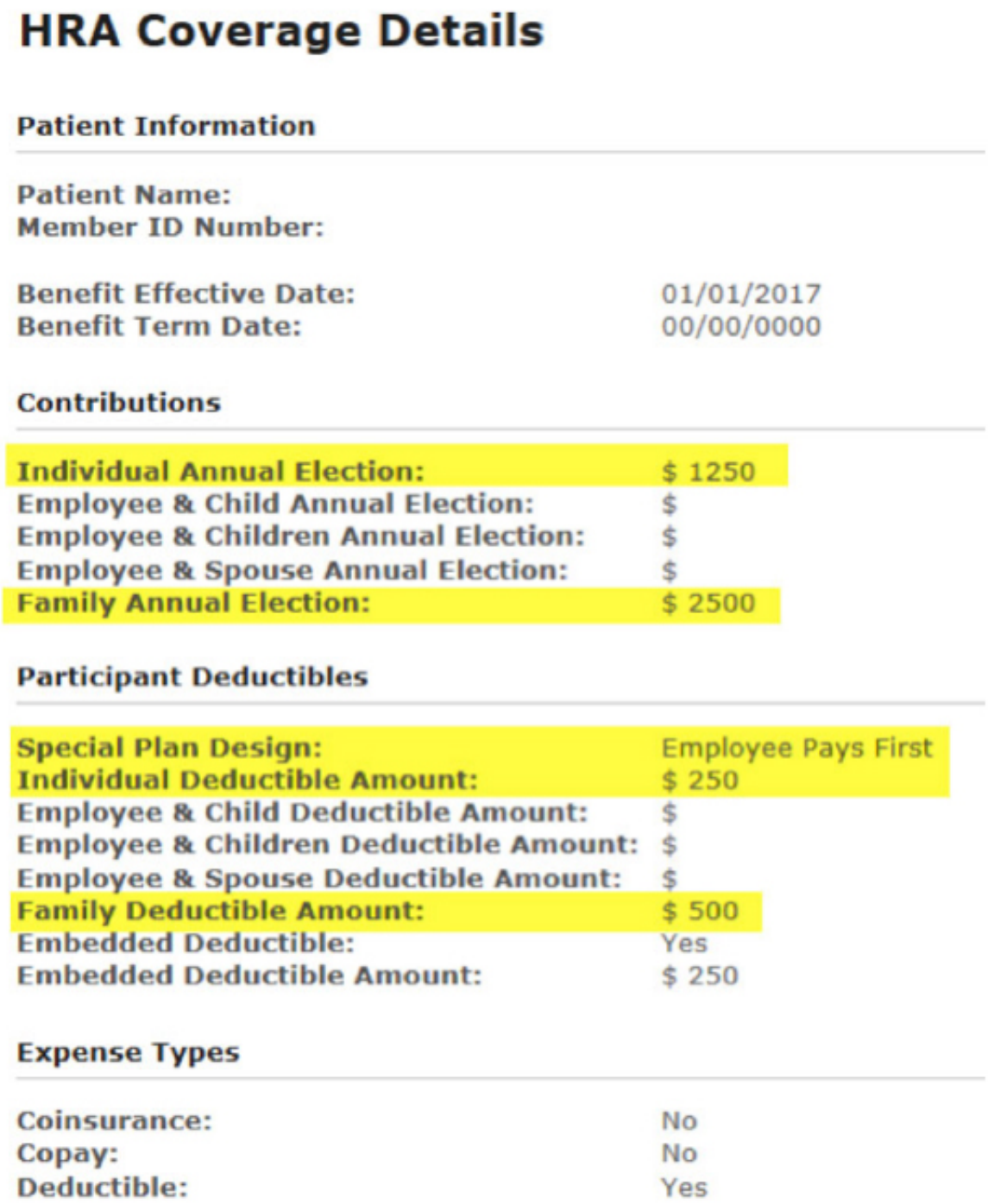
ALL PROVIDER TYPES

Many Highmark members now have health plans with high deductibles that are tied to corresponding health reimbursement arrangements (HRAs). You can easily tell if a member has an available HRA and access that information using NaviNet®.

To retrieve a member's HRA information, select **HRA Coverage Details** (highlighted in yellow in the screen capture below) from the **Eligibility and Benefits Details** page.



The HRA Coverage Details page shows the amounts for both the Individual and Family Annual Election. If the HRA is partially funded by the member's employer, this page will show any amount that the member (employee) is required to pay. Please note that you will have to contact Highmark to determine if the member has met any of the HRA amounts listed.



HRA Coverage Details

Patient Information

Patient Name:	
Member ID Number:	
Benefit Effective Date:	01/01/2017
Benefit Term Date:	00/00/0000

Contributions

Individual Annual Election:	$ 1250
Employee & Child Annual Election:	$
Employee & Children Annual Election:	$
Employee & Spouse Annual Election:	$
Family Annual Election:	$ 2500

Participant Deductibles

Special Plan Design:	Employee Pays First
Individual Deductible Amount:	$ 250
Employee & Child Deductible Amount:	$
Employee & Children Deductible Amount:	$
Employee & Spouse Deductible Amount:	$
Family Deductible Amount:	$ 500
Embedded Deductible:	Yes
Embedded Deductible Amount:	$ 250

Expense Types

Coinsurance:	No
Copay:	No
Deductible:	Yes

If a member's HRA has been set up as "Direct Pay to Provider," payment will be made directly from the HRA to the provider, if the HRA has an account balance.

How to sign up for NaviNet

If you don't have NaviNet, we strongly encourage you to visit navinet.net and gain access to the system. Current NaviNet users who have questions about the system may call 1-888-482-8057 to speak with a NaviNet representative.

In addition to using NaviNet to look up members' HRA information, you can use the

system to quickly locate eligibility and benefit information, to check your allowances for the services you're providing, to request needed authorizations, to submit and check the status of claims, and much more.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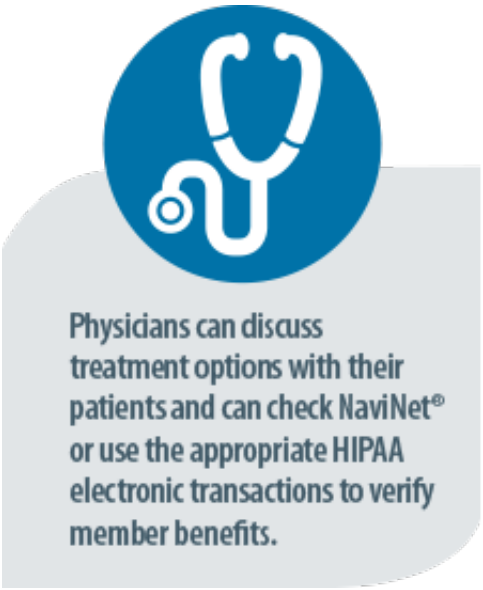
Check Out Important Preventive Schedule Updates

PROFESSIONAL PROVIDERS

Effective July 1, 2017, Highmark made the following key updates to our Preventive Schedule*:

- Addition of screening for latent tuberculosis infection (LTBI) in high-risk patients ages 18 years and older as recommended by the United States Preventive Services Task Force
- Change in dosing for children ages 9 through 14 years receiving the human papillomavirus (HPV) vaccine as recommended by the Centers for Disease Control and Prevention

Physicians can discuss treatment options with their patients and can check NaviNet® or use the appropriate HIPAA electronic transactions to verify member benefits. Members can get answers to their coverage questions by calling the Member Service number on the back of their member ID cards.



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

The schedule makes it easier for you and your staff to review recommended preventive care guidelines as we partner to keep our members healthy.

Highmark updates the Preventive Schedule periodically to ensure it reflects the latest evidence-based, nationally recommended, clinical guidelines for care. Some changes are only to clarify information so it is clear and easier to understand.

*Please note that most, but not all, of our customer groups follow the Highmark Preventive Schedule. Some plans may not cover some services on the schedule. Always 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 use the Provider Service self-service touchtone telephone options to obtain benefits and eligibility information.)

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Working to Meet Patients' 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 this is to share with network practitioners the types of languages patients 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 practitioners report on their network applications. Our 2017 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:
Spanish or Spanish Creole	Berkeley, Jefferson, Kanawha, Monongalia, Raleigh	—

- The above data is from the 2010-2014 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 provides a breakdown of all calls Highmark Member Service representatives received during the year that required interpreter services. In 2016, Member Service received 47,775 calls (a 16.6 percent decrease from 2015) from members speaking 73 different languages. The largest percentage of calls (86.8 percent) was from members speaking Spanish. The total number of calls serviced for Spanish was 40,784.

If you currently see non-English-speaking members and need access to interpretation services, various vendors are available to provide 24/7 interpretation services on a fee-for-service basis. Your office would be responsible for making and paying for all necessary arrangements. More information is available in the article "Language Interpretation for Limited English Proficient Patients" that appeared in Issue 6, 2014, of *Provider News*.

Video remote interpretation services are available to you and your patients. For details, see the *Provider News* article titled Video Remote Interpreting: Another Way to Meet Your Patients' Language Access Needs.

Additionally, please review applicable laws governing language interpretation requirements.

Additional resources for providers, patients

You may wish to use the following resources to enhance interactions with patients of limited English proficiency (LEP):

- Signs that translate the expression "I need an interpreter" into various languages that providers can display in their offices. The signs are available on Highmark's online Provider Resource Center. Click on **Forms**, then **Miscellaneous Forms,** and lastly on **Interpreter Needed-Language Translation Sign for Provider Offices**.
- Pocket reference guides that translate common medical phrases and terminology into Spanish, French, or Russian are sold through websites, such as **booksmythe.com**.
- There are many professional vendors that offer telephonic-based, video-remote, or in-person interpretation services. Plan ahead by identifying which languages you will likely need to be translated for your patients. It is not enough to say "Chinese" — you will need to know if your Chinese patients speak Mandarin or Cantonese, for example. Identify multiple vendors and determine which company can best meet the needs of your practice. When competent interpretation services are provided, the interpreter clearly understands and speaks with enough fluency in both the source and target languages. He/she is also able to convey the intended meaning and help the healthcare professional

and patient achieve successful communication.

In an effort to better serve all members, we are expanding the information in our provider directory regarding the language services options that may be available at network physician practices. If you offer language services such as bilingual staff, telephone or in-person interpreters, Braille or American Sign Language, please update your practice and physician information via the NaviNet® **Provider File Management** function to reflect these services.

Patients and providers benefit by providing accessible language services

Patients and health care providers alike must have ready access to competent language services (including interpreting of oral communications and translating written materials), because language barriers increase avoidable risks to patient safety. A provider's focus should be to ensure that the patient and provider can communicate effectively in the same language.

The risk of poor medical care being delivered to LEP patients, as well as the risk of legal exposure for health care providers, is high. This risk can be significantly reduced when competent language services are provided[1]. To ensure necessary language services are available when needed, providers should collect and record accurate language data for patients; recognize a patient's language needs at each key patient encounter; and document the language services provided throughout the series of patient-provider encounters.

With a little planning, providers can identify needed language services and have the appropriate plans in place to ensure the timely provision of language services throughout the care continuum. This could include arranging for a competent interpreter before the patient's appointment. Such actions help to improve quality and eliminate health care disparities.

1. Kelvin Quan, JD MPH. The High Costs of Language Barriers in Medical Malpractice. The National Health Law Program, 2010.

PROVIDER NEWS
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Highmark West Virginia

Issue 4, 2017

Quarterly Formulary Updates Available Online

PROFESSIONAL PROVIDERS

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 in the Provider Resource Center's **Hot Topics** section to alert physicians when new quarterly formulary update Special *e*Bulletins are available.

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

Pharmaceutical Management Procedures

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

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About This Newsletter

Provider News is a newsletter for health care 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

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

We want *Provider News* to meet your needs for timely, effective communication. If you have any suggestions, comments or ideas for articles in future issues, 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

PROVIDER DATA SERVICES/CREDENTIALING INFORMATION
1-866-763-3224, Option 4

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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