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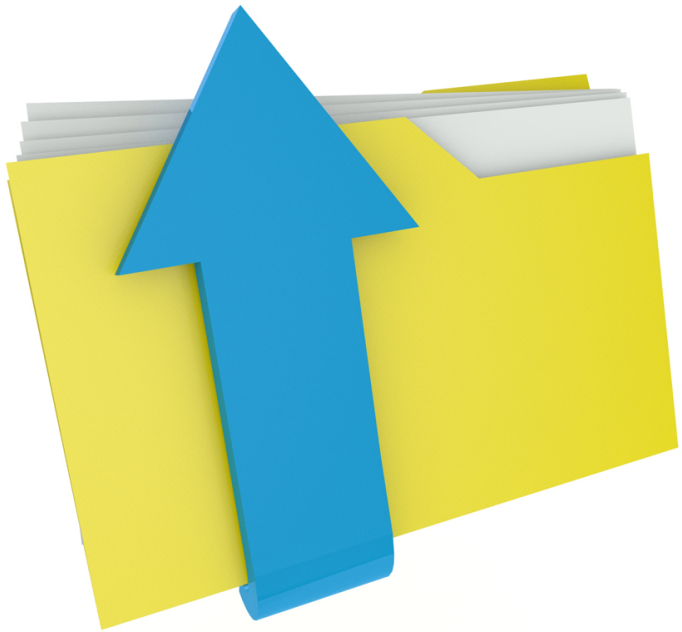
Document Attachment Feature in NaviNet® Available: Have You Used It?

You can attach supporting documentation at the same time you are submitting your authorization requests via NaviNet, as well as responding to inquiries and requests for additional information.



This new feature will eliminate the need for you to fax supporting documents separately or wait for assistance by phone.

Review the Step-by-Step Guide

A step-by-step guide is available on the Provider Resource Center and NaviNet Plan Central. We encourage you to review this guide for tips and instructions.

Are You Signed Up for NaviNet?

This feature is available to providers who use NaviNet. If you have not yet signed up for NaviNet, visit www.NaviNet.net and click the **Providers: Sign Up for NaviNet** tab.

Tell Us What You Think!

Take our survey for you to share your experience with using this feature so that we can make this feature and others more helpful and easier to use. Click the rotating banner ad on the homepage of the Provider Resource Center to access this survey.

We'll also be emailing you this survey if you've submitted your email address to us.

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Changes to Unplanned Inpatient Hospitalization Requests Submitted Through NaviNet Effective December 1, 2019

At Highmark, we put the patient at the center of everything we do and we continue to support you so you can provide the most appropriate care possible.

Working with health care providers, we're helping to implement nationally accepted, evidence-based guidelines. Often, these models only suggest some changes to current practices. Importantly, these changes are proven to add up to better patient outcomes and more affordable care.

To that end, effective **12/1/2019**, Highmark will make changes to the urgent / unplanned inpatient hospitalization process for authorizations submitted via NaviNet.

- Consistent with the review process already in place today for all urgent and unplanned inpatient hospital admission requests that come in through other channels (i.e., phone, fax), Highmark will complete an enhanced inpatient review for all authorizations submitted via NaviNet.
- Additionally, the goal length of stay will be based on clinical diagnosis vs. InterQual criteria.

Details: Changes to Urgent / Unplanned Inpatient Requests

Consistent with our processes outside of NaviNet submissions, Highmark will implement enhanced medical necessity review for all urgent unplanned inpatient admission requests, which will pend for additional review regardless of the diagnosis

when the green “Criteria Met” indicator is received and displayed in InterQual as it appears below. Urgent unplanned requests will no longer auto-approve, in order to ensure our members, your patients, are receiving medically necessary care in the most appropriate setting.

The InterQual criteria are used as a guide to determine inpatient appropriateness, also taking into consideration the CMS 2-Midnight Rule, Ambulatory Care Sensitive Conditions, and the medical complexities of the member. Members may always be converted from an observation to inpatient level of care if symptoms do not improve or the condition worsens during the observation period.

Changes to Goal Length of Stay Based On Clinical Diagnosis

In addition, Highmark will apply condition-specific guidelines to determine when the next clinical update is due based on the goal length of stay for the diagnoses.

This will result in the last covered day moving away from an initial 5-day approval to a more clinically appropriate initial approval.

This change will:

- Allow for proactive discharge planning,
- Help ensure members are connected to case management earlier,
- Identify care needs sooner in the hospital, and
- Avoid delays in transitioning the member to the most appropriate care setting at the most appropriate time.

Highmark’s appeals process for both Medical Advantage and Commercial members will remain the same with the implementation of this change. As a reminder, our current processes are as follows:

Medicare Advantage Appeals
To remain in compliance with CMS requirements, providers may request either an expedited or standard appeal, which is also known as a standard org determination, for authorization denials for Highmark's Medicare Advantage members. An expedited appeal is suggested when the patient remains hospitalized, while a standard appeal is typical if the patient has already been discharged. CMS does not recognize a peer-to-peer appeal type, nor does Highmark for its Medicare Advantage members.

For any appeal requested, please be able to provide the patient’s name, identification number, date of birth, type of service denied, and REQ or Case number referenced in

the denial notice.

Commercial Appeals
Peer-to-peer reconsiderations are available for Highmark Commercial members to offer providers the opportunity to discuss an adverse determination of an authorization request with a Highmark Medical Director. Providers may also request an expedited or standard appeal after, or in lieu of, a peer-to-peer reconsideration for Commercial authorization denials.

For more information about the appeals process, please refer to the *Highmark Provider Manual*'s Chapter 5.5, Denials, Grievances, and Appeals. The *Highmark Provider Manual* is available under **EDUCATION/MANUALS** on the Provider Resource Center. It can also be accessed quickly by selecting **MANUALS** on the **Quicklinks Bar**.

Take the Virtual Training

Virtual training on these changes is available on the Provider Resource Center. We encourage you to take this training and share it with your staff.

Click the "**Authorization Process Changes for Urgent/Unplanned Inpatient Requests: View Virtual Training"** rotating image on the homepage of the Provider Resource Center.

You can also go to **PROVIDER TRAINING > Provider Training> NaviNet Self Service** and click the "Virtual Training: Authorization Process Changes for Urgent/Unplanned Inpatient Requests" link.

Thank you for your support and the high-quality, cost-effective care you provide to our members. We look forward to your continued collaboration to ensure that Highmark members receive medically necessary services in a high-quality, clinically appropriate fashion.

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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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Introducing a New Unit in the Highmark Provider Manual

Highmark strives to improve the resources we make available to you. The *Highmark Provider Manual*, your primary reference source, is meant to simplify your experience by providing one all-inclusive provider manual for all provider types in all of our services areas. And we continually review and update the manual to better meet your needs.

Chapter 4.7: Medical Records Documentation Requirements is the latest edition to the *Highmark Provider Manual.* This unit was developed to provide guidelines for documenting members' medical records that will help you to have the appropriate documentation readily available for medical necessity reviews. This will help us to ensure accuracy of billed claims data and, therefore, prevent delays in reviews and payment.

The Importance of Accurate Medical Record Documentation

Medical record documentation is necessary to record applicable observations and findings regarding the member's history, examinations, diagnostic tests and procedures, diagnoses, treatments and treatment plan, necessary follow-up care, and outcomes or responses to care per date of service or encounter.

Additionally, the medical record serves as a formal document and a communication tool between providers, vendors, and Highmark. All medical documentation must be maintained in the member's medical record and, if requested, made available to Highmark or its contracted vendor by the requested date.

Furthermore, providers are responsible for adhering to professional standards, as well as applicable laws, regulations, and directives, with respect to medical recordkeeping and documentation.

Highlights of Chapter 4.7

This new unit contains information about:

- Documentation requirements for all providers
- Electronic health record requirements
- Requirements for hospital/facility services
- Requirements for ancillary services, behavioral health, substance abuse, and Durable Medical Equipment
- …And more.

Review Chapter 4.7

Select **MANUALS** from the Quicklinks bar that spans across the top of the Provider Resource Center (PRC). Scroll down to **Chapter 4**, and then click on **VIEW MORE +** to access all units within Chapter 4, including the new Unit 7.

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Highmark Product News: Important Updates Coming for 2020

When Highmark members visit your office or facility in 2020, they will be presenting new identification cards. They may be new Highmark members. Or, they might be existing members with only a few benefit changes or may be enrolled in a completely different Highmark plan.

That is why, as a new benefit year approaches, we want to give you advance notice of Highmark commercial and Medicare Advantage product changes, enhancements, and innovations coming in 2020.

To help you and your staff prepare, we will publish an overview of product changes later this year on our online Provider Resource Center (PRC), which is accessible through NaviNet® or through our website, under **Helpful Links**. Please watch the PRC and NaviNet for news about this web page and share it with your staff so they can keep up with what's new and what's changing with Highmark products in 2020.

We look forward to another successful year of working with you to connect our members to quality care.

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Is Your Practice Health Literacy Aware?

Highmark's Health Equity & Quality Services mission is to help providers improve health literacy, as well as provide culturally and linguistically appropriate services to our members.

As health care providers, you play a vital role as the connection to the health services your patients need. You also play a vital role as a trusted source of health information.

Your patients can only make the most of the resources and information you provide if they can read, understand, and act on health care information – which means having a high level of health literacy.

Here are some key facts about health literacy, why health literacy is important, things that clinicians and office staff can do to promote health literacy in their practices, and helpful resources and additional information on health literacy. We encourage you to share this information with both clinicians and office staff in your practices.

Did You Know...?

According to the National Assessment of Adult Literacy (NAAL):[1]

- Only 12 percent of U.S. adults had proficient health literacy.
- Over a third of U.S. adults would have difficulty with common health tasks, such as following directions on a prescription drug label or adhering to a childhood immunization schedule using a standard chart.
- Limited health literacy affects adults in all racial and ethnic groups.
- Even high school and college graduates can have limited health literacy.
- Compared to privately insured adults, both publicly insured and uninsured adults had lower health literacy skills.
- All adults, regardless of their health literacy skills, were more likely to get health information from radio/television, friends/family, and health professionals than from

print media.

Why Health Literacy Is Important

- Health literacy is critical for healthier people and communities: People with limited health literacy are more likely to have poorer health statuses than others.[2]
- Health literacy is also key to managing high health care costs: Low health literacy costs the U.S. healthcare system between approximately $106 billion and $238 billion.[3]
- Poor communication between patients and clinicians is a major factor leading to malpractice lawsuits.[4]
- Highmark conducts annual member surveys to evaluate their overall experiences with network providers and to identify areas for improvement. We ask members how well their providers communicate with them, and if they find the information that providers give them easy to understand.

What You Can Do

Many tools, techniques and resources are available to doctors, nurses, and office staff to ensure that communication between the health care provider and the patient is as effective as possible.

Tips for Clinicians

- Encourage your patients to ask questions about their treatment, and ask patients if they have any questions about their treatment, especially:
  - What the nature of their problem is
  - What patients need to do about the problem
  - Why it's important to do what they need to do[5]
- Use the "teach-back" technique: Ask patients to explain or demonstrate how they will undertake a recommended treatment or intervention[6]
- Recognize signs that patients may be having health literacy issues, such as lack of follow-through on instructions[7]
- Connect patients to reliable, credible resources of health information, such as the Centers for Disease Control (CDC)'s health information pages.

Tips for Office Staff

- Ask patients if they understand their providers' instructions before they leave the office, and understand their next steps.
- Make sure patients have access to educational resources in your office, such as in your waiting room and treatment rooms.
- For patients whose primary language is not English, provide access to translation services and patient materials in languages commonly spoken in your practice.
- If patients are, for example, cancelling or missing appointments, or failing to fill prescriptions, follow up to see if patients understand the providers' instructions.

Helpful Resources

Other helpful resources include:

- Agency for Healthcare Research and Quality (AHRQ), Health Literacy Universal Precautions Toolkit
- The Public Health Foundation, Effective Communication Tools for Healthcare Professionals
- The Medical Library Association, Prescription for Information: Addressing Health Information Literacy
- The Centers for Disease Control and Prevention, Health Literacy for Public Health Professionals

Review these resources and share them with others in your practice to learn more about how you can make your practice more health literacy-friendly.

Sources

- Office of Disease Prevention and Health Promotion Health Communication Activities https://health.gov/communication/literacy/issuebrief/
- Health Literacy: A Prescription to End Confusion: https://www.ncbi.nlm.nih.gov/pubmed/25009856
- https://publichealth.gwu.edu/departments/healthpolicy/CHPR/downloads/LowHealthLiteracyReport10_4_07.pdf
- Low Health Literacy: Implications for National Health Policy American Speech-Language-Hearing Association: Health Literacyhttps://publichealth.gwu.edu/departments/healthpolicy/CHPR/downloads/LowHealthLiteracyReport10_4_07.pdf
- Physician-patient communication in managed care. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1303255/
- Institute for Healthcare Improvement. Ask Me 3: Good Questions for Your Good Health: http://www.ihi.org/resources/Pages/Tools/Ask-Me-3-Good-Questions-for-Your-Good-Health.aspx
- Health Literacy Universal Precautions Toolkit, 2nd Edition. https://www.ahrq.gov/health-literacy/quality-resources/tools/literacy-toolkit/healthlittoolkit2-tool5.html
- Center for Health Care Strategies, Inc. How is Low Health Literacy Identified? http://www.chcs.org/media/How_is_Low_Health_Literacy_Identified.pdf

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Attention Primary Care Providers: CDC 2019-2020 Flu Season Vaccine Recommendations Now Available

The Centers for Disease Control (CDC)'s Advisory Committee on Immunization Practices (ACIP) has released its latest guidance and recommendations for the 2019-2020 flu season.

This is an update from ACIP's 2018-2019 recommendations and guidance and recommends annual influenza vaccination for all persons aged six months or older who do not have contraindications.

Flu vaccination compliance is part of our quality care measures. Also, for providers participating in True Performance, childhood immunization status, including flu vaccination, is a performance metric that may affect reimbursement rates.

Key Actions

- Review the CDC's recommendations above.
- An updated Flu Flyer is available on the Provider Resource Center for you to share with your patients and staff.
- Confirm your patient's preventive and diagnostic benefits **before** administering the vaccine.
    - The flu vaccine is part of Highmark's preventive schedule and is available to members and their covered dependents of all ages at ***no*** in-network out-of-pocket cost, including Medicare Advantage members.
    - Members' preventive schedules may vary from the standard preventive schedule.

- View and confirm preventive benefits for your patients in real time by using the Eligibility and Benefits Inquiry function in NaviNet®.
- We also encourage you to review the Highmark Preventive Health Guidelines and immunization schedules on the Provider Resource Center.
    - Click **EDUCATION/MANUALS > Preventive Health Guidelines** to access the 2019 Preventive Health Guidelines, as well as immunization schedules for children and adults.

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Supporting Your Patients with Diabetes

People with diabetes and their health care providers need to work together to manage this condition properly. Poorly managed diabetes increases the risk of complications, which can mean more costly emergency room visits, hospitalizations, and readmissions – which can be prevented.

As a health care provider, you play an integral part in supporting our members with diabetes by educating them about their condition and giving them the knowledge and tools they need to make managing diabetes easier. We'd like to remind you about some key ways you can support your patients with diabetes, and the resources we have available to you and your patients.

Talk To Your Patients

Ask your patients about how they're:

- Managing their diabetes overall
- Experiencing any complications
- Handling daily life activities
- Coping with emotional issues, including future concerns

Keep Tabs on Preventive Care

People with diabetes need additional preventive care to reduce the risk of complications, as well as catch any diabetes-related problems, such as diabetic retinopathy, early. Make sure your patients understand what preventive care they need: Review and share the Highmark Preventive Schedules available on the Provider

Resource Center. Keep in mind that for most Highmark members, preventive services are covered with little or no out-of-pocket cost.

To access the Preventive Schedules:

- Click **Education/Manuals**
- Select **Educational Resources - Member and Provider**
- Click **Preventive & Bright Futures Health Guidelines**
- Click any of the **Preventive Schedules**

Share Helpful Educational Resources

The Highmark Provider Resource Center has resources to help you educate your patients on how to manage diabetes, including:

- Diabetic Eye Exam Screening Reminder Card
- Diabetes Management Brochure and Tracker
- Diabetic Retinopathy Eye Examination Report Template

To access these resources on the Provider Resource Center:

- Click **Education/Manuals**
- Select **Educational Resources - Member and Provider**
- Scroll down to **Track and Tools**
- Select **Diabetes Information**

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Behavioral Health Measures for Children and Adolescents: Important Things You Need to Know

Behavioral Health measures as required by HEDIS® are not just for the adult population, but for children and adolescents as well. In particular, there are 3 measures specifically for this population. These measures are outlined below, including a description of each measure and why each measure is important.

HEDIS Follow-up Care for Children Prescribed Attention Deficit Hyperactivity (ADHD) Medication

This measure looks at the percentage of children between the ages of 6 – 12 years of age with a newly prescribed ADHD medication who had at least **three (3)** follow-up visits within a 10 month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported:

- ***Initiation Phase*** – the percentage of these members with an ambulatory prescription dispensed for ADHD medication who had **one (1) follow-up visit** with a practitioner with prescribing authority within **30 days** of receiving the prescription.
- ***Continuation and Maintenance (C&M) Phase*** – The percentage of these members with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least **210 days**, and, had at least **two (2) additional follow-up visits** with a practitioner within **270 days (9 months)** after the 30 day Initiation Phase ended.

- *Note: **one (1)** of these visits may be a telephone visit*

Importance of the Measure
ADHD is one of the most common chronic conditions of childhood. According to the Centers for Disease Control and Prevention (CDC), the latest statistics (2016) show that approximately 9.4% of children 2 – 17 years of age (6.1 million) had been diagnosed with ADHD. Children with ADHD can experience significant functional problems that can affect academic performance and relationships with family and peers; they may develop behavioral problems as well. Medication is recommended for children 6 years of age and older by the American Academy of Pediatrics (AAP) to control the symptoms of ADHD. Once the child is stable, follow-up visits are essential to monitor any side effects and the efficacy of the medication.

HEDIS Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

This measure looks at the percentage of children and adolescents 1 – 17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as a first-line treatment. Two age stratifications (1 – 11 years and 12 – 17 years) and a total rate are reported.

Importance of the Measure
While antipsychotic medications may be appropriate for some psychiatric disorders in children, they are often prescribed for nonpsychotic conditions, such as ADHD and disruptive behaviors, conditions more amenable to psychosocial interventions which are considered first-line treatment. This measure ensures that these children on antipsychotics are evaluated for psychosocial interventions and to make sure that these medications are indeed appropriate. Bipolar disorder and schizophrenia and psychotic disorders are the only conditions for which antipsychotics are a first-line treatment for children and adolescents, and both have Food and Drug Administration (FDA) approval for this population.

HEDIS Metabolic Monitoring for Children and Adolescents on Antipsychotics

This measure looks at the percentage of children and adolescents 1 – 17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Two age stratifications (1 – 11 years and 12 – 17 years) and a total rate are reported on. Measured are the percentage of children and adolescents on antipsychotics who received:

- Blood glucose testing (blood glucose or HbA1c)
- Cholesterol testing (LDL-C or cholesterol)

- Blood glucose and cholesterol testing

Importance of the Measure
While antipsychotic medications are necessary for treatment for certain diagnosed psychotic disorders in children and adolescents, they can increase the risk of causing serious health concerns, including metabolic health complications, especially weight gain and Type 2 diabetes. Research studies suggest metabolic problems in childhood and adolescence are associated with poor cardio-metabolic outcomes in adulthood. Because of these potential side effects from antipsychotics, it is important to establish a baseline and continuously monitor for metabolic abnormalities, so that appropriate management can be initiated and evaluated while the medication continues. This HEDIS measure is supported by guidelines from the American Academy of Child and Adolescent Psychiatry.

Additional Information on these and other HEDIS measures can be accessed on the Highmark Provider Resource Center at:
https://content.highmarkprc.com/Files/EducationManuals/QualityMgmtToolkit/hedis-ref-guide.pdf

Sources:

- HEDIS 2019 volume 1: Narrative, National Committee for Quality Assurance
- American Academy of Child and Adolescent Psychiatry Practice Parameters for the Use of Atypical Antipsychotic Medications in Children and Adolescents 2011 accessed 9/23/2019 https://www.ahrq.gov/sites/default/files/wysiwyg/pqmp/measures/chronic/chipra-148-antipsychotics-psychosocial-care-report.pdf

NOTE:
The measures, guidance and guidelines described above (collectively, "Guidelines") are presented for your information, consideration and assessment only. They were selected from materials developed by various organizations and associations. Please assess whether the Guidelines are consistent with your treatment plans for a patient. The Guidelines are not intended to situate Highmark as a provider of medical services or dictate the diagnosis, care or treatment of patients. Your medical judgment remains independent with respect

to all medically necessary care of your patients. Please note that the coverage of services and drugs is subject to the terms of each member's benefit plan. Additionally, state laws and regulations governing health insurance, health plans and coverage may apply and will vary from state to state.

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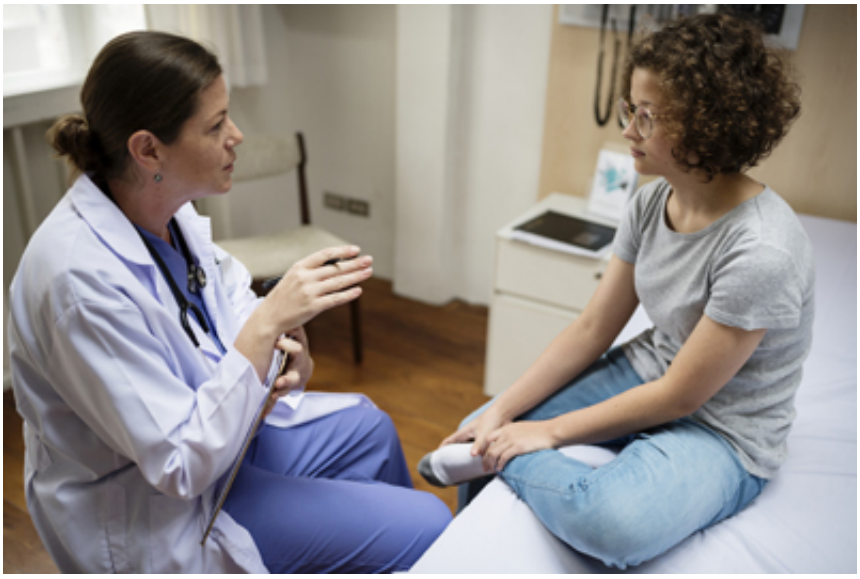
Transitioning Children from Pediatric to Adult Care Providers



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

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

Developing a plan for your practice to support children in their transition to adult care providers is essential to ensure patients receive quality, uninterrupted, and age-appropriate care.

Create an Office Policy

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

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

Educate Families, Empower Children

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

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

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

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

Key Transition Plan Components

In its report, the American Academy of Pediatrics (AAP) recommends including four key components in a transition plan:

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

Learn More

Review the 2011 American Academy of Pediatrics (AAP) report titled "Supporting

the Health Care Transition from Adolescence to Adulthood in the Medical Home" for practical guidance to help plan and execute this transition for children and their families, along with additional guidance on establishing transition plans for adolescent patients.

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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.

New and Updated Reimbursement Policies Issued

Highmark recently issued new reimbursement policies for inpatient readmissions and for gene and cellular therapy. In addition, the policies on anesthesia services and services not separately reimbursed have been revised.

Reimbursement Policy Bulletin RP-033 Anesthesia Services

A revised version of Highmark Reimbursement Policy Bulletin RP-033 was issued on October 1, 2019 to include additional information about dental and labor and delivery anesthesia services.

Reimbursement Policy Bulletin RP-041 Services Not Separately Reimbursed

A revised version of Highmark Reimbursement Policy Bulletin RP-041 was issued on September 30, 2019 to add procedure code S9430.

Reimbursement Policy Bulletin RP-050 Inpatient Readmissions

Effective December 2, 2019, Highmark Reimbursement Policy Bulletin RP-050 documents readmission guidelines for Commercial and Medicare Advantage acute care inpatient admissions and reimbursement policies for these readmissions to promote more effective and cost-efficient health care through appropriate and safe hospital discharge of patients.

Reimbursement Policy Bulletin RP-053 Gene & Cellular Therapy

Effective October 1, 2019, Highmark Reimbursement Policy Bulletin RP-053 documents Highmark's reimbursement guidelines for gene and cellular therapy drugs.

To access Highmark reimbursement policy bulletins, select **CLAIMS, PAYMENT & REIMBURSEMENT** from the Provider Resource Center main menu, and then click on **Reimbursement Policy**.

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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 Provider Resource Center (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***.

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Comments/Suggestions Welcome

Bryce Walat, 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 **Bryce.Walat@highmark.com**.

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.

PROVIDER NEWS
A Newsletter for Highmark Blue Cross Blue Shield West Virginia Providers
HIGHMARK. WEST VIRGINIA
Issue 4, 2019

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