PROVIDER NEWS
A newsletter for the Highmark Blue Cross Blue Shield providers in western Pennsylvania

HIGHMARK.
Issue 1, 2021

Making PROVIDER ACCESS and AVAILABILITY a Priority in 2021

Provider access and availability for its members is a priority for Highmark. Every year Highmark conducts annual member surveys to evaluate their overall experiences with network providers and to identify areas for improvement. We ask your patients how well you communicate with them, and if they find the information that you give them easy to understand.

The scores on these surveys is part of how we evaluate our Consumer Assessment of Healthcare Providers and Systems (CAPHS) scores for the year. Below are some tips on how you can improve your access and availability for the 2021 year.

Make Your Practice More Digital

While some of the elderly population may still prefer phone calls, an increasing amount of the population now wants a digital experience. This does not only mean telehealth visits (although that has become an increasingly valuable experience since the COVID-19 pandemic) but could also mean:

- **Digital Appointments:** Increasingly, your patients want to be able to make appointments online without having to call an office. By adopting a digital appointment approach, you will free up office staff to handle other priorities beyond setting up appointments while giving your patients the convenience of online appointment making.

- **Online Portal:** An online portal gives your patients the option of creating appointments, reviewing test results, and reviewing visit notes from their

computer or phone. It also provides you with another channel to communicate with your patients about essential health information.

- **Video and Phone Visits:** Offering the option of virtual visits for your patients is especially important now as many patients are nervous to leave their house for a doctor's appointment during the pandemic. This can also help patients who:
    - Do not have access to transportation to get to the office
    - Have a disability that makes it difficult to move around
    - Have anxiety about doctor offices
- **Digital Check-Ins:** This allows patients to socially distance themselves in their car while they wait for their appointment to begin.

Non-Digital Ways to Improve Member Experience

While going digital can have a positive impact on member experience, there are other ways to improve their office experience as well.

- **Extend Office Hours:** If your office hours are primarily between 8 a.m. – 5 p.m., many patients will be at work or school during these hours. This can lead patients to skip or postpone appointments.
- **Decrease Wait Time:** The longer the patient has to stay in the waiting room to be seen, the less satisfied they will be with your office and the less likely they are to come back. If possible, limit wait times to under 10 minutes to increase patient satisfaction.

Why This Matters

Many patients who are not receiving the care they need in a timely manner (whether it be long wait times on the phone to make an appointment, no open afternoon/evening appointments, or longer wait times in the office) tend to stop seeing their provider as often as they should.

Missing appointments can lead to the member not addressing new health problems, stopping treatment for chronic health issues, or going to the emergency room or an out-of-network provider to get quicker access. All of this is costly to the patient's finances and health leading to further patient dissatisfaction.

By decreasing wait times, offering digital alternatives, and helping patients have quicker easier access to you will improve their satisfaction and bring them back to your office again and again.

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Childhood and Adolescent Immunizations added to CHIP Requirements for 2021

The Pennsylvania Children's Health Insurance Program (CHIP) requires well child visits, lead blood tests, and developmental screenings for CHIP patients of certain ages. To help provider offices identify Highmark CHIP members and outstanding services, Highmark produces a monthly "Highmark CHIP Gap Report." This practice-level report is intended for practices who, according to Highmark claims records, are attributed to a Highmark CHIP member.

To help provider offices identify Highmark CHIP members and outstanding services, Highmark produces a monthly "Highmark CHIP Gap Report."

The report will assist in addressing potential gaps in care for your Highmark CHIP patients and can be found under the Quality Blue section in NaviNet®. These reports run monthly starting in March of each year and will provide you with service statuses of lead, well child visits (w15), developmental screenings, and (beginning March 2021) childhood and adolescent immunizations.

In the report, providers can find service statuses of lead, well child visits (w15), childhood and adolescent immunizations, and developmental screenings for their Highmark CHIP patients based on Highmark claims.

More information on CHIP requirements can be found on the **Provider Resource Center.**

- Go to **Provider Training**
- Select **CHIP Training and Documentation**

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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.

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 provider (PCP) or specialist requests a service that a clinician in Utilization Management is unable to approve based on criteria/guidelines, the clinician will refer the request to a Highmark Physician Reviewer. A Highmark Physician Reviewer may contact the PCP or specialist to discuss the request or to obtain additional clinical information.

A decision is made after all of the clinical information has been reviewed.

At any time, the PCP or specialist may request a copy of the criteria/guidelines used in making medical/surgical decisions by calling Highmark at:

- 1-800-421-4744 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)
    - Delaware: https://hdebcbs.highmarkprc.com
    - Central Pennsylvania and North Eastern Pennsylvania: https://hbs.highmarkprc.com
    - Western Pennsylvania: https://hbcbs.highmarkprc.com
    - West Virginia: https://hwvbcbs.highmarkprc.com
- 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.

Case Management Referral

You can now submit automated referrals for Clinical Care and Wellness (CC&W) case management programs via NaviNet. This feature will help to: Ensure that patients with chronic conditions and complex medical needs are connected with the

right clinical support for their needs.

To access this feature:

- Log into NaviNet and access **Plan Central**.
- Click the **Case Management Referral** and Inquiry link under **Workflows for this Plan** to go to the **Clinical Care & Wellness** page.
- Click the **Create New Referral** button under **Submit New Referral to CC&W**
- Follow the steps to create and submit the referral.

We also want to remind you that the Highmark Member Clinical Programs and Services catalog (complete with useful information and helpful resources) is available to further your understanding of the full range of programs and services available to Highmark members in all service areas for all lines of business.

We encourage you to review this catalog to help you identify members who can benefit from the programs and services we offer.

To access the Highmark Member Clinical Programs and Services catalog on the Provider Resource Center:

- Click **EDUCATION/MANUALS**
- Click **Clinical Programs and Services for Highmark Members**
- Click the link to the **Catalog Reference Guide**

Peer-to-Peer Conversations: Availability of Physicians, Behavioral Health Practitioners, and Pharmacist Reviewers*

Highmark provides you with an opportunity to discuss utilization review denial decisions with a clinical peer reviewer following notification of a denial determination. Clinical peer reviewers are licensed and board-certified physicians, licensed behavioral health care practitioners, and licensed pharmacists, and they are available to discuss review determinations during normal business hours.

Your call will be connected directly to the peer reviewer involved in the initial review determination, if he or she is available. If the original peer reviewer is not available when you call, another clinical peer will be made available to discuss the denial determination within one business day of your request. To request a peer-to-peer conversation, you may call the appropriate number listed in the chart below.

***IMPORTANT NOTE: The peer-to-peer review process is no longer available for**

Medicare Advantage members. See Chapter 5, Units 3 and 5, of the *Highmark Provider Manual* for details.

Practitioner/ ordering provider	Um issue	Telephone number
Practitioners	Med/Surg UM decisions	1-866-634-6468
Behavioral health providers	Behavioral health	1-866-634-6468
Pharmacists	Pharmacy services	Telephone number identified on determination letter
Practitioners	Advanced radiology imaging	Telephone number identified on determination letter
Practitioners	Radiation Therapy	Telephone number identified on determination letter
Practitioners	Physical Medicine	Telephone number identified on determination letter

Provider Accessibility Expectations

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

The standards set forth specific time frames in which network providers should respond

to member needs based on symptoms.

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

PCP and Medical Specialist Accessibility Expectations

Patient's Need:	Performance Standard:
Emergency/life-threatening care • Sudden, life-threatening symptom(s) or condition requiring immediate medical treatment (e.g., chest pain, shortness of breath)	Immediate response
Urgent-care appointments • An urgently needed service is a medical condition that requires rapid clinical intervention as a result of an unforeseen illness, injury, or condition (e.g., high fever, persistent vomiting/diarrhea)	Office visit within 1 day (24 hours)
Regular and routine care appointments • Non-urgent but in need of attention appointment (e.g., headache, cold, cough, rash, joint/muscle pain) • Routine wellness appointments (e.g., asymptomatic/preventive care, well child/patient exams, physical exams)	**Pennsylvania and West Virginia:** • Within 2-7 days (Non-urgent) • Within 30 days (Routine wellness) **Delaware:** Office visit within 3 weeks of member request

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

Maternity Care Accessibility Expectations (Obstetrics)

Patient's Need:	**Performance Standard:**
Maternity Emergency	Immediate response
Maternity 1st Trimester	Within 3 weeks of first request
Maternity 2nd Trimester	Within 7 calendar days of first request
Maternity 3rd Trimester	Within 3 calendar days of first request

Maternity High Risk	Within 3 days of identification of high risk

Behavioral Health Provider Accessibility Expectations

Patient's Need:	**Performance Standard:**
Care for a life-threatening emergency • Immediate intervention is required to prevent death or serious harm to patient or others	Immediate response
Care for a non-life-threatening emergency • Rapid intervention is required to prevent acute deterioration of the patient's clinical state that compromises patient safety	Care within 6 hours
Urgent care • Timely evaluation is needed to prevent deterioration of patient condition	Office visit within 48 hours

Routine office visit • Patient's condition is considered to be stable	**Pennsylvania and West Virginia:** Office visit within 10 business days **Delaware:** Office visit within 7 calendar days
After-hours care • Access to providers after the practice's regular business hours	Acceptable process in place to respond 24 hours per day, 7 days a week to member issues (answering service that pages the provider or answering machine message telling caller how to reach the provider after hours)
In-office waiting times • Providers are encouraged to see patients with scheduled appointments within 15 minutes of their scheduled appointment time. A reasonable attempt should be made to notify patients of delays.	Within 15 minutes

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Quarterly Formulary Updates Available Online

Highmark regularly updates its prescription drug formularies and related pharmaceutical management procedures. To keep our network physicians apprised of these changes, quarterly formulary updates are provided in the form of Special eBulletins.

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

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

Federal Employee Program (FEP) Drug Formularies and Pharmaceutical Management Procedures

The FEP specific drug formularies are available online using the following links:

- FEP Basic Option Formulary

- **FEP Standard Option Formulary**
- **FEP Blue Focus Formulary**

Providers who do not have internet access may obtain FEP Pharmacy information via phone by using the following toll free numbers and following the prompts for Pharmacy:

- **Delaware:** 1-800-721-8005
- **Pennsylvania:** 1-866-763-3608
- **West Virginia:** 1-800-535-5266

To learn more about the FEP exception request processes for Non-formulary drugs, use the following link: www.fepblue.org/claim-forms.

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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.

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.

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**.

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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About This Newsletter

Provider News is a newsletter for health care providers who participate in our networks. It contains valuable news, information, tips and reminders about our products and services.

- *Classic Blue*
- *Direct Blue*
- *EPO Blue*
- Freedom Blue PPO
- *Keystone Blue*
- Security Blue HMO
- *PPO Blue*
- *Advance Blue*
- *Simply Blue*
- *Choice Blue*
- *Community Blue*
- *Connect Blue EPO*

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 (or changes thereto) which are binding upon Highmark and its contracted providers. Pursuant to their contract, Highmark 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**.

Contact Us

Providers with internet access will find helpful information online at highmarkbcbs.com. NaviNet® users should use NaviNet for all routine inquiries. But if you need to contact us, below are the telephone numbers exclusively for providers.

HIGHMARK
1-800-547-3627

Convenient self-service prompts available.

1-866-588-6967 — Freedom Blue℠ PPO Provider Service Center

1-866-675-8635 — Freedom Blue PFFS Provider Service Center

1-888-234-5374 — Community Blue Medicare HMO Provider Service Center

1-866-634-6468 — Requests for Medical Management and Policy peer-to-peer conversations

1-800-992-0246 — EDI Operations (electronic billing)

1-800-600-2227 — Option 2 — Pharmacy (prescription authorizations)

Legal Information

Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association. Highmark Blue Cross Blue Shield serves the 29 counties of western Pennsylvania. BlueCard, Blue Distinction, Blue Distinction Center, and the Federal Employee Program are registered marks and Blues On Call is a service mark of the Blue Cross and Blue Shield Association.

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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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