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

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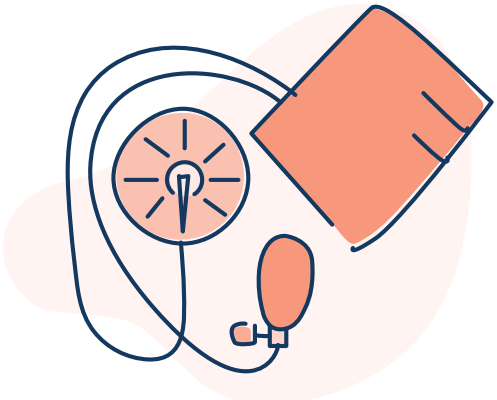
ANNUAL HEDIS® MEDICAL RECORD REVIEW

The annual Healthcare Effectiveness Data and Information Set (HEDIS) Medical Record Review is being conducted now through May 2022.

This review assesses Highmark's provider compliance with a set of standardized performance measurements that Highmark is required to report to the National Committee for Quality Assurance (NCQA). HEDIS data is collected and reported on an annual basis as part of Highmark's accrediting and governmental requirements.

The measurements this year are:



- Controlling High Blood Pressure
- Colorectal Cancer Screening
- Comprehensive Diabetes Care
- Transitions of Care
- Cervical Cancer Screening
- Childhood Immunization Status
- Immunizations for Adolescents
- Lead Screening in Children
- Prenatal and Postpartum Care
- Weight Assessment and Counseling for Nutrition and Counseling for Physical Activity for Children and Adolescents

For information on who will be conducting this year's review, who to contact with your questions, or what the COVID-19 procedures are, please review the **HIGHMARK TO**

PERFORM ANNUAL HEDIS® MEDICAL RECORD REVIEWS BEGINNING FEBRUARY 2022

Plan Central message on NaviNet or in the Plan Central Library on the Provider Resource Center.

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Administration of the Flu and COVID-19 Vaccinations

According to the Centers for Disease Control and Prevention (CDC) and the National Center for Immunization and Respiratory Diseases (NCIRD), in the United States, flu season occurs in the fall and winter. While influenza viruses spread year-round, most of the time, flu activity peaks between December and February, but activity can last as late as May.

> When providing members with the flu vaccine, **you should ensure** they do not have a suspected or confirmed case of COVID-19.

When providing members with the flu vaccine, you should ensure they do not have a suspected or confirmed case of COVID-19. Flu vaccination should be deferred for people with suspected or confirmed COVID-19, even if they don't have symptoms, until they meet criteria for leaving quarantine (based on CDC guidance). While mild illness is not a contraindication to flu vaccination, vaccination visits for these members should be postponed in order to avoid exposing healthcare personnel and other patients to the virus that causes COVID-19. When scheduling or confirming appointments for flu vaccination, members should be instructed to notify your office or clinic in advance if they currently have or if they develop any symptoms of COVID-19.

If the member has a confirmed case of COVID-19, flu vaccination should be deferred until the member is no longer acutely ill from COVID-19. This may be different for members who are already being cared for in a medical setting than it is for members who are

quarantining at home. In a medical setting, the timing for vaccination is a matter of clinical discretion.

If a member is eligible, both the influenza and COVID-19 vaccines can be administered at the same visit, without regard to timing, as recommended by CDC and its Advisory Committee on Immunization Practices (ACIP). Best practices for administering more than one vaccine, including COVID-19 vaccines and influenza vaccines, include:

- Labeling each with the name and dosage (amount) of vaccine, lot number, the initials of the preparer, and the exact beyond-use time, if applicable.
- Always injecting vaccines into different injection sites with sites at least 1 inch apart, if possible, so that any local reactions can be differentiated.
- If administered at the same time, COVID-19 vaccines and vaccines that might be more likely to cause a local injection site reaction (for example, high-dose and adjuvanted inactivated influenza vaccines) should be administered in different limbs, if possible.
- Injecting the vaccines rapidly without aspiration since aspiration is not recommended before administering a vaccine.

The CDC has developed clinical algorithms that can help guide decisions for influenza testing and treatment when SARS-CoV-2 and influenza viruses are co-circulating.

Sources:

Centers for Disease Control and Prevention

National Center for Immunization and Respiratory Diseases (NCIRD)

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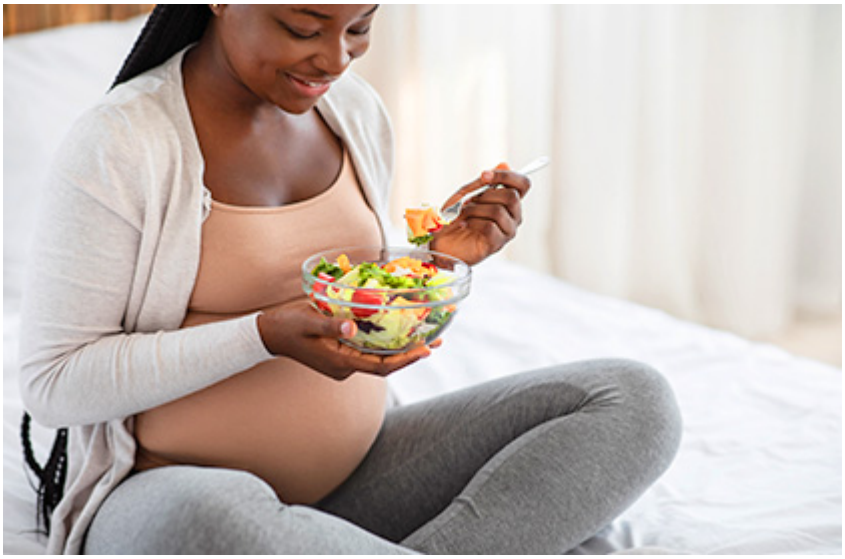
Changes to Highmark's 2022 Preventive Health Guidelines

Below is a list of all changes that were made to Highmark's Preventive Health Guidelines for the year 2022.



- **Expanded Benefit: Colon Cancer Screening – lowered eligible age from 50 to 45 for general population colon cancer screening as well as Certain Colonoscopy Preps:** On May 18, 2021, the United States Preventive Services Task Force (USPSTF) released a final statement for lowering the age of colorectal cancer screenings from 50 to 45 years of age. The USPSTF recommends screening for colorectal cancer in adults aged 45 to 49 years.

- **Expanded Benefit: Lung Cancer Screening – lowered eligible age from 55 to 50 and pack per year (PPY) from 30 to 20:** The USPSTF recommends annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 50 to 80 years who have a 20 PPY smoking history and are currently smoking or have quit smoking within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery. (B recommendation)

- **Expanded Benefit: PrEP Drugs:** Certain Related Services for PrEP drug use were added under Select Drugs Requiring Prescription. An FAQ was released with guidance for first dollar coverage of related services to PrEP drug usage. Additionally, cost sharing no longer applies as of effective date 9.17.2021 per federal law. The Provider Resource Center – Preventive Health Guidelines Section - contains the list of procedures/testing that is included in first dollar coverage.

- **New Benefit: Nutritional counseling for pregnant women to promote healthy weight during the pregnancy:** On May 25, 2021, the USPSTF released a recommendation that clinicians offer pregnant persons effective behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy. As such, nutritional counseling for pregnant women has been added to the preventive schedule. (B recommendation)

- **Depression Screening:** To align with Bright Futures and the USPSTF, depression screening to begin at age 12, not age 11. Preventive schedule language updated to read "once a year, age 12-18"

- **Hepatitis C Screening: Beginning age 18:** "High Risk" recommendation was removed from the preventive schedule and a single dot added to age 18 per Bright Futures update to align with USPSTF recommendations for screening beginning at this age.

Reviewing Highmark's Preventive Health Guidelines

To access the Preventive Health Guidelines on the Provider Resource Center, select **EDUCATION/MANUALS**, and then click on **Preventive Health Guidelines.**

We encourage you to consult our Preventive Health Guidelines and discuss them with members when planning care.

NOTE: Most, although not all, Highmark members have coverage for services on the preventive schedule. To verify that the member is covered for a preventive health screening, use the Eligibility and Benefits transaction in NaviNet® to perform an electronic HIPAA 270 Eligibility/Benefit Inquiry transaction, or call the Provider Service Center.

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Breast Cancer Screening and Adjunct Imaging in Single Visit Offers Increased Convenience and Compliance

A recent study conducted by the National Cancer Institute estimates an additional 2,500 breast cancer deaths between 2020 and 2030 due to reduced screenings, delayed diagnoses, and decreased chemotherapy treatments during the COVID-19 pandemic.

Members trust you and look to you for education on what to do during this time. You can help reduce breast cancer deaths by:

- Providing the right education to our members on the risk factors of breast cancer and effectiveness of screenings
- Assessing, identifying, and evaluating potential Social Determinants of Health (SDOH) needs such as transportation needs/concerns when coordinating member care from Pre-screening, Scheduling, Screening, and Post-screening

Highmark provides the resources below to share the importance of prevention our members and your staff. You can order printed copies to make available to Highmark members you see during office visits or for mailing to their homes.

- Breast Cancer Brochure
- Breast Cancer Screening Flyer (available in Spanish)
- Breast Cancer Screening Reminder Card
- Health Screening and Vaccination Tracker (available in Spanish)

You can order the resource here.

Why Scheduling In-Office Screenings Helps

Scheduling completed in your office not only ensures that the screening is scheduled, but also decreases the burden for the member in scheduling their screening. By completing the mammogram and tomosynthesis in your office, you offer the right set of circumstances to order necessary (adjunct) testing at their screening appointment. For instance, the diagnosis of dense breast tissue is common and has been often associated with an increased risk of breast cancer, members with dense breasts may require additional imaging exams such as complete (asymptomatic) breast ultrasound[2]. Member screening/testing compliance is elevated when convenience is at the core.

Common breast imaging codes are as follows:

77067 Screening digital mammography, 2-view study of each breast, bilateral
77063 Screening digital breast tomosynthesis (3D mammography), bilateral
77066 Diagnostic digital mammography, bilateral
77062 Diagnostic digital breast tomosynthesis, bilateral
77065 Diagnostic digital mammography,
77061 Diagnostic digital breast tomosynthesis, unilateral
76641 Ultrasound, breast, complete, 4 quadrants, unilateral
76642 Ultrasound, breast, limited, targeted area, unilateral

NOTE: Additional breast imaging exams may be considered diagnostic and therefore subject to individual policy benefits including deductibles, co-insurance, and/or co-pays. The clinical information provided is not intended to interfere with clinical or coding judgment.

Highmark Preventive Health Guidelines

We encourage you to consult our Preventive Health Guidelines when planning care for Highmark members. We thank you for your partnership in addressing their health care needs. To access the Preventive Health Guidelines, click here.

Please note that most, although not all, of our customer groups follow the Highmark Preventive Schedule. Therefore, not all Highmark members may have coverage for services on the preventive schedule. Additional breast imaging exams may be considered diagnostic and therefore subject to individual policy benefits including deductibles, co-insurance, and/or co-pays.

As always, we recommend verifying a member's eligibility and benefits prior to providing services. You can verify a Highmark member's coverage by using the Eligibility and Benefits transaction in NaviNet®, performing an electronic HIPAA 270 Eligibility/Benefit Inquiry transaction, or by calling the Provider Service Center.

References

1. Alagoz, O, Lowry KP, Kurian AW, et al. Impact of the COVID-19 Pandemic on breast cancer mortality in the US: estimates from collaborative simulation modeling. JNCI: Journal of the National Cancer Institute, 2021; 113(11): 1484-1494. https://doi.org/10.1093/jnci/djab097

2. Thigpen D, Kappler A, Brem R. The role of ultrasound in screening dense breasts—a review of the literature and practical solutions for implementation. Diagnostics. 2018; 8(1):20. https://doi.org/10.3390/diagnostics8010020

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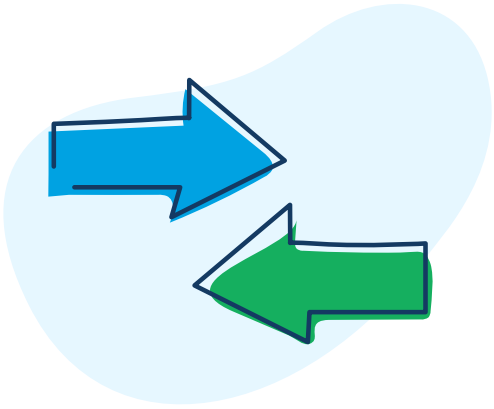
New and Updated Reimbursement Policies



Highmark regularly issues new or updated reimbursement policies. Keep an eye on the Provider Resource Center homepage for eBulletins announcing new policies and the Reimbursement Policy page for policy updates.

Some recent changes include:

Reimbursement Policy Name	Description of Change	Date of Publication
RP-006: Multiple Endoscopy	Procedure code 42975 was added to the endoscopy family group 10 with base code 31575.	January 3, 2022
RP-007: Multiple Payment Reduction Certain Diagnostic Services	Added the following Procedure Codes to Appendix A and C: • Appendix A: Procedure codes 0689T and 0697T • Appendix C: 0683T, 0684T, and 0685T	January 3, 2022
RP-009: Modifiers 25, 59, XE, XP, XS, XU, FT	Added the following guidance for modifier FT: • Modifier FT can be used in the same instances as modifier 25 • Exceptions are outlined in each policy.	January 3, 2022
RP-020: Preventive Medicine and Office/Outpatient E&M Services		January 10, 2022
RP-021: Annual Gynecological and Rectal Exams		January 3, 2022
RP-027: Hemodialysis and		January 3, 2022

Peritoneal Dialysis		
RP-028: Insertion and Removal of Tympanic Ventilation Tubes		January 3, 2022
RP-032: Pain Management		January 3, 2022
RP-058: Acupuncture billed with an Evaluation Management		January 3, 2022
RP-010: Incident To Billing	Added the following guidance for modifier FR: • Modifier FR can be used when the Supervising Practitioner was present through the use of a two-way, audio/video communication technology.	January 3, 2022
RP-011: Procedure Codes N/A to Commercial Products	Added the following procedure codes to this policy: • G0028 • G0029 • G0048 • G0049 • G0051-G0067 • G1024-G1028 • G4001-G4038 • G9988-G9999 • M1072-M1089 • M1094-M1105	January 3, 2022
RP-022: Repeat Surgical Procedures	Procedure code 33470 was removed.	January 3, 2022
RP-025: Implantation of Subcutaneous Intravascular Catheter		January 3, 2022

RP-034: Prolonged Detention or Critical Care	Direction for modifiers FT and FS were added (see specifics above) and the following procedure codes were removed: • 93561 • 93562	January 3, 2022
RP-042: Global Surgery and Subsequent Services	Direction for modifier FT was added (see specifics above). Added the following procedure codes to the YYY 10-day post-op listing and YYY 90-day post-op listing: • 10-day post-op listing: 0673T and 0699T • 90-day post-op listing: 0671T, 0672T, 0674T, 0675T, 0677T, 0679T, 0680T, 0681T, 0682T, and 0686T	January 3, 2022
RP-043: Care Management		January 3, 2022
RP-046: Telemedicine and Telehealth Services	Added direction for modifiers FQ, FR, and 93 as well as for place of service 10. For information on the exact changes, review the policy.	January 3, 2022
RP-053: Gene and Cellular Therapy	Procedure code C9081 was removed and procedure code Q2055 was added to the policy.	January 3, 2022
RP-065: Modifier Reduction Glossary	Added the following modifiers to the policy: • CO • CQ • FQ • FR • FS • FT • 93	January 3, 2022

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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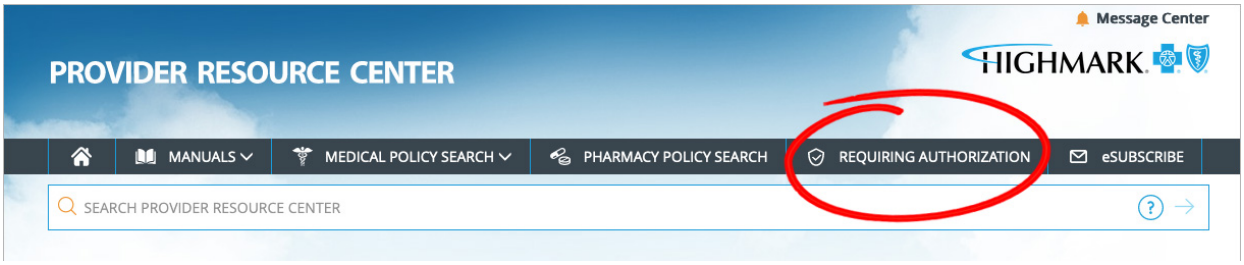
Updates to Highmark's List of Procedures Requiring Authorization

During the year, Highmark adjusts the List of Procedures and Durable Medical Equipment (DME) **Requiring Authorization**. For information regarding authorizations required for a member's specific benefit plan, providers may:

1. Call the number on the back of the member's card,
2. Check the member's eligibility and benefits via NaviNet®, or
3. Search BlueExchange through the provider's local provider portal.

These changes are announced in the form of Special eBulletins that are posted on Highmark's Provider Resource Center (PRC). To view the List of Procedures/DME Requiring Authorization, click **Requiring Authorization** in the gray bar near the top of the PRC homepage.



Please note that the Highmark member must be eligible on the date of service and the service must be a covered benefit for Highmark to pay the claim.

You may use NaviNet or the applicable HIPAA electronic transactions to:

- Check member benefits and eligibility
- Verify if an authorization is needed
- Obtain authorization for services

If you are not signed up for NaviNet or do not have access to the HIPAA electronic transactions, please call Clinical Services to obtain an authorization for services:

- Pennsylvania Contact Information for Providers

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Important Highmark Reminders

Appropriate Utilization Decision Making

Highmark makes utilization review decisions based only on the necessity and appropriateness of care and service and the existence of coverage. In addition, Highmark does not reward practitioners, providers, Highmark employees, or other individuals conducting utilization review for issuing denials of coverage or service, nor does it provide any financial incentives to utilization review decision-makers to encourage denials of coverage.

Request for Criteria

Highmark uses resources such as nationally recognized clinical review criteria, medical policy, and Medicare guidelines in determining whether a requested procedure, therapy, medication, or piece of equipment meets the requirements of medical necessity and appropriateness. This is done to ensure the delivery of consistent and medically appropriate health care for our members.

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

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

At any time, the PCP or specialist may request a copy of the criteria/guidelines used in making medical/surgical decisions by calling Highmark at **1-800-421-4744**. To request a copy of the criteria/guidelines used in making behavioral health decisions, call **1-800-258-9808**.

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.

To review members' rights and responsibilities, review Chapter 1, Unit 5 of the **Highmark Provider Manual**. A paper copy of the Member Rights and Responsibilities is available upon request.

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 who 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 isn't 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 Chapter 5, Unit 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. Highmark has set forth specific time frame standards in which network providers should respond to member needs based on symptoms.

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

More specific information on Highmark's time frame requirements is available in Chapter 1, Unit 4 of the **Highmark Provider Manual.**

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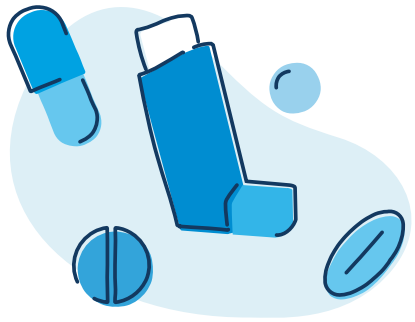
Quarterly Formulary Updates Available Online



Highmark regularly updates our prescription drug formularies and related pharmaceutical management procedures. To keep our network physicians apprised of these changes, we provide quarterly formulary updates on the **Formulary Updates** page under **Pharmacy Program/Formularies**.

Providers who do not have internet access or do not use NaviNet® may request paper copies of the formulary updates by contacting Highmark's Pharmacy department at **800-600-2227**.

Pharmaceutical Management Procedures

To learn more about how to use pharmaceutical management procedures refer to the **Pharmacy Program/Formularies** pages, accessible from the left-hand menu on the Provider Resource Center.

This section includes information on:

- Providing information for exception requests
- The process for generic substitutions
- 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. Providers who don't have internet access may obtain formulary information via phone by using the below toll-free numbers and following the prompts for *Pharmacy*:

- **Delaware:** 800-721-8005
- **Pennsylvania:** 866-763-3608
- **West Virginia:** 800-535-5266
- **New York:** 800-234-6008

To learn more about the FEP exception request processes for non-formulary drugs, click here.

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Staying Up to Date with the Highmark Provider Manual

Ensure you are regularly reviewing the Highmark Provider Manual for guidance on members who have moved onto Highmark's systems.

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

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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 ResourceCenter@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)

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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.

Highmark Senior Health Company and Highmark Coverage Advantage are service marks of Highmark Inc. Highmark Health is the parent company of Highmark Inc.

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.

Current Procedural Terminology (CPT) is a registered trademark of the American Medical Association. Healthcare Effectiveness Data and Information Set (HEDIS)® and Quality Compass® are registered trademarks of the National Committee for Quality Assurance (NCQA). Consumer Assessment of Healthcare Providers and Systems (CAHPS)® is a registered trademark of the Agency for Healthcare Research and Quality. CORE is a registered trademark of CAQH.

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