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According to the American Medical Association, low back pain is one of the leading causes of primary and emergency room visits and job related disability in the United States.[1] The goal in the primary treatment of low back pain is symptomatic relief and acute reduction of pain with the attention to the following:

- The exclusion of serious disease
- The detection of clues that might suggest a specific diagnosis
- The early detection of psychosocial factors that promote chronification

The *Journal of Family and Community Medicine* states that careful history taking and physical examination are crucial to diagnosing the etiology of back pain with attention to strength, reflexes, spine percussion, and segmental mobility, as well as assessing pain and function. Depression screening is also recommended since concurrent coincident depression worsens prognosis.[2]

According to an article in *American Family Physicians*, most patients do not need imaging in the initial evaluation of acute low back pain if there are no features in the history or physical examination that suggest a specific cause. Physical examination is directed toward ruling out suspected “red flags” of lower back pain:

- Fever
- Unexpected anal sphincter laxity
- Perianal/perineal sensor loss

- Major motor weakness
- Point tenderness to percussion
- Positive straight leg raise test result

Most patients with acute back pain have substantial improvements in pain and function in the first six weeks and imaging is unlikely to improve on this or effect treatment plans.[3]

The American Academy of Family Physicians' "Choosing Wisely" guidelines indicate that physicians should not "do imaging for low back pain within the first six weeks, unless red flags are present." Imaging on initial presentation should be reserved for when there is suspicion for cauda equina syndrome, malignancy, fracture, or infection.[4]

In addition, a report by the NCQA has found evidence that routine imaging for low back pain by using radiography or advanced imaging methods is not associated with clinically meaningful effect on patient outcomes. Unnecessary imaging exposes patients to preventable harms, may lead to additional unnecessary interventions, and results in unnecessary costs.[5]

According to an article in *BioMed Central Family Practice*, patients' expectations about treatment for back pain are generally as follows:

- Patients' expectations regarding back imaging are frequently at odds with the evidence showing imaging is not necessary with patients' symptoms or presentation.
- Patients' expectations about diagnostic investigations are influenced by their previous experience of low back care, family, colleagues and/or other health professionals.
- Patients may feel that their back pain needs to receive active treatment and have little understanding of its natural prognosis. A guideline recommendation is that patients should receive education and reassurance, yet patients may not perceive this as sufficient, wanting "something done."

Physicians are encouraged to specifically enquire about patients' expectations to correct common misperceptions and open patient communication on:

- The prognosis of acute low back pain
- The role of imaging with associated downsides about diagnostic limitations
- Management recommendations with their rationale.[6]

Based on some findings by Practical Pain Management, physicians may not need to provide intensive patient education. More information is not necessarily more

effective. Once the patients' intense symptomatic period is over brief educational interventions limited to 5 min to 20 min. explaining the diagnosis, treatment, and expected management plan could help bring expectations more in line with the evidence. This finding will require further research.[7]

Supplementing face-to-face simple, clear, understandable information with patient handouts, self-care education books, online materials, mass media educational campaigns, or other methods could be an efficient strategy for reinforcing or expanding on key points.

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Highmark does not recommend particular treatments or healthcare services. This informational article is not intended to be a substitute for professional medical advice, diagnosis, or treatment. The member's provider should determine the appropriate treatment and follow-up with his or her patient. This informational article is based upon a search of literature: there may be other recommendations or suggested practices that may be suitable in the care of patients. Coverage of services 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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Coming Soon! Document Attachment Feature in NaviNet®

Soon you will have the ability to 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 feature will reduce the need for you to fax supporting documents separately or wait for assistance by phone. It will be available to you in August 2019. The ability to attach these documents in NaviNet at the same time as the request or inquiry will:

- Ensure that our providers receive the right supporting documentation to make more informed and timely medical necessity decisions
- Simplify and expedite the overall process
- Reduce administrative burden

Stay Posted for More Details

We'll be sharing more about this feature in the weeks to come. Stay posted to the Provider Resource Center and NaviNet Plan Central, and also check your email for additional information and resources, including:

- Additional messaging on details of the document attachment feature
- Helpful job aids to give you step-by-step instructions
- Webinars to walk you through the process in real time

We appreciate the work you do in caring for our members. We're working to empower you with helpful tools and resources to help you deliver the right care more

efficiently.

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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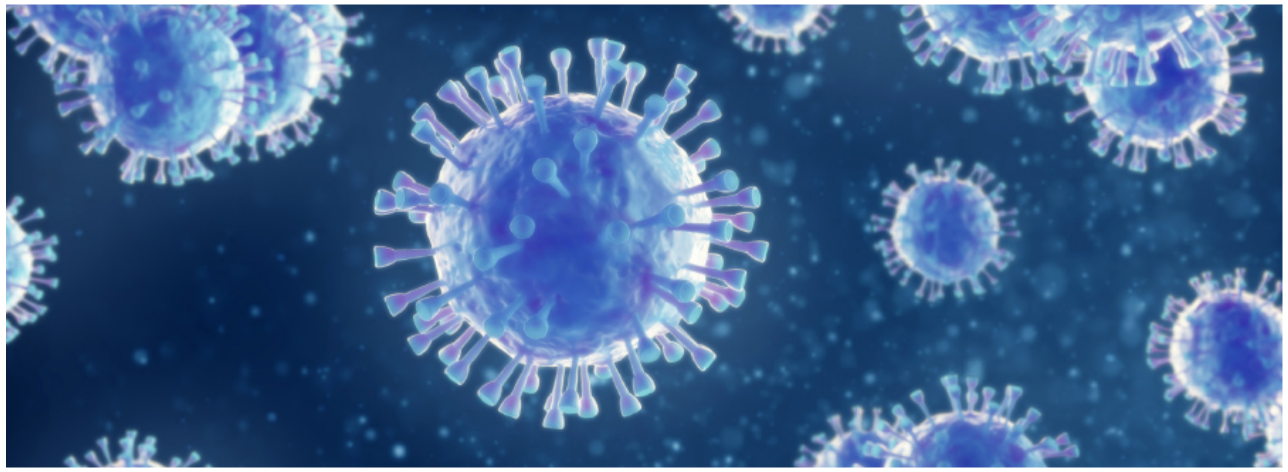

Attention Primary Care Providers: Important Information About Measles Vaccinations & Titers

Measles outbreaks are making headlines nationwide every day, including in the regions Highmark serves. As a result, patients may be reaching out to providers like you with questions and concerns about their need for measles vaccination and/or titers to test for immunity to measles, as well as whether these are covered under their insurance.

Special eBulletin dated May 13, 2019 has more information, including Centers for Disease Control (CDC) recommendations, coverage for vaccination and titers, and additional helpful resources.

We thank you for your role in safeguarding the health of the communities we serve.

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Starting the Conversation: Talking to Your Patients About Their Preventive Care

Preventive care is critical to your patients' health. By receiving their preventive exams on a regular basis, you can locate any health problems early on so that you and your patient can take steps to prevent it from becoming a chronic illness. It may even save your patient's life!

What the Patient Needs to Know

When discussing preventive care with your patients, it's important that they are aware of the following:

- Why it is important to schedule preventive care visits
- How to locate their preventive care schedule
  - For Highmark members, the schedule is located on Highmark's Member website.
  - Once accessing the site they need to select the **Coverage Tab**, click **Medical Benefits**, and scroll down to the **Preventive Care** section.
- To bring their preventive schedule with them to their office appointments

Starting the Conversation

It can be hard to start a conversation about preventive health with a patient, especially if you are not their Primary Care Physician (PCP) or don't know what information they already know. Here are some questions you can ask to help start and guide the conversation.

- Do you know the importance of preventive exams and visits?
- Do you know what exams someone your age and gender should be receiving?
- Do you know how often these exams should be received?
- Do you know how to locate your preventive schedule?
- When was your last exam?
- Did you know it is free to receive this exam with your insurance?
- Would you like to schedule a preventive exam with me today?

If you are an urgent care doctor or work in a hospital and need to start this conversation with your patient, here are some additional questions you can ask:

- Do you have a current PCP?
- Would you like a referral to a PCP in your area that accepts your insurance?

Staying Up to Date

Remember to regularly check for updates on the Provider Resource Center for updates to the Preventive Health Guidelines. You need to be aware of these changes to better assist your patients in making better health decisions.

To access these changes:

- Access your Provider Resource Center
- Click **Education/Manuals**
- Select any of the **Preventive Health Guidelines**

Children and adults alike also need to be up-to-date on their immunizations. To access the latest immunization schedules:

- Access your Provider Resource Center
- Click **Education/Manuals**
- Select any of the **Immunization Schedules**

Thank you for your continued care for your patients, our members.

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Virtual Visits – How They Relate to Behavioral Healthcare Providers

According to a recent report by the Institute of Medicine, the demand for behavioral health care services is increasing, but the access to qualified specialists is limited. Due to this, patients often have long wait times and may even give up on receiving help. Additionally, even when care is available, patients may be afraid to seek help due to social stigma.

To help combat these concerns and to better help your patients, Highmark offers Virtual Behavioral Health visits to our members. This allows patients to get the care they need, even when they're too afraid to seek help due to social stigma.

IMPORTANT: Virtual visits are not meant to replace in-person visits and support. You must determine what channel or channels of care is best for your patient and that the patient's plan provides the appropriate benefits for the anticipated service.

Benefits of Virtual Visits

Virtual visits provide many benefits, including:

- More access to mental health care, especially for patients with multiple chronic health conditions, severe illness and disability, or underserved populations in rural and remote areas.
- Some patients may be less fearful when they are not meeting you face-to-face in your clinic or office.
- Counseling and intervention services can be delivered via teleconferencing sessions instead of through an on-site appointment which may take longer to

arrange.
- Virtual visits are cost-effective and allow you to deliver care anywhere* anytime without the administrative costs for you and the travel costs for your patients.
- You can conduct consultations to triage cases and help reduce emergency room visits and hospitalizations by providing less costly forms of care for your patients.

*All services are subject to state law requirements and restrictions.

Eligibility Requirements

You are eligible to provide your patient with this care option if:

- You have the necessary telecommunications technology to support a virtual outpatient mental health visit
- The services performed fall under the scope of your license
- The sessions are conducted following Highmark's recommended service and security guidelines
- The services are covered benefits under the member's health benefit plan.

Service and Security Guidelines

You must follow the following guidelines when conducting virtual behavioral health visits:

- Virtual visits must be conducted through real-time interactive **audio and video** telecommunications hardware and software that are Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH) compliant.
  - **IMPORTANT:** Highmark is not responsible for the security of virtual visits and does not validate the safeguards of any of the equipment and software used on either side of the virtual transmittal.
- All services provided must be medically appropriate and necessary.
- Services performed must fall under the scope of your license.
- You must comply with local, state, and federal laws, and other regulatory agency requirements.
- Treatment and consultations, including the authorization and dispensing of prescription medication(s), must be held to the same professional standards as those in a traditional in-office face-to-face encounter.
- You must take the appropriate steps to establish a doctor-patient relationship and conduct all evaluations and history consistent with traditional standards.
- You must have all relevant medical information to deliver a competent medical diagnosis, treatment, and counseling plan.

- Documentation of the real-time interactive audio and video telecommunication relevant to the ongoing medical care of your patient should be maintained as part of your patient's medical record.

More Information

For more information on how virtual visits may relate to you, please review Chapter 2.5 of the Provider Manual (located on the **Provider Resource Center** under **Education/Manuals**).

For reimbursement guidelines, locate Reimbursement Policy 046 Telemedicine and Telehealth Services (on the **Provider Resource Center**, under **CLAIMS, PAYMENT & REIMBURSEMENT**, on the **Reimbursement Policy** page).

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CHIP News

Is Your PROMIS*e* ID Up To Date?

Providers who render, order, refer, or prescribe items or services to Children's Health Insurance Program (CHIP) members must have an active Provider Reimbursement and Operations Management Information System Identification (PROMIS*e*™ ID) on file with the Commonwealth of Pennsylvania Department of Human Services (DHS) and Highmark for their provider type and for each service location where they see CHIP enrollees.

You must ensure that your information is always up to date and you are enrolled for all locations where you provide services.

Effective July 1, 2019, Highmark is required to deny claims if we are unable to match the provider's NPI reported on the claim to a PROMIS*e* enrollment record for the service location where the services were performed.

In addition, you are required to select a PROMIS*e* ID-enrolled provider when submitting any authorization requests for referrals in NaviNet®.

Special eBulletin dated June 10, 2019 has more information, including PROMIS*e* ID

enrollment information and applications, FAQs, and links to information about CHIP in the *Highmark Provider Manual*.

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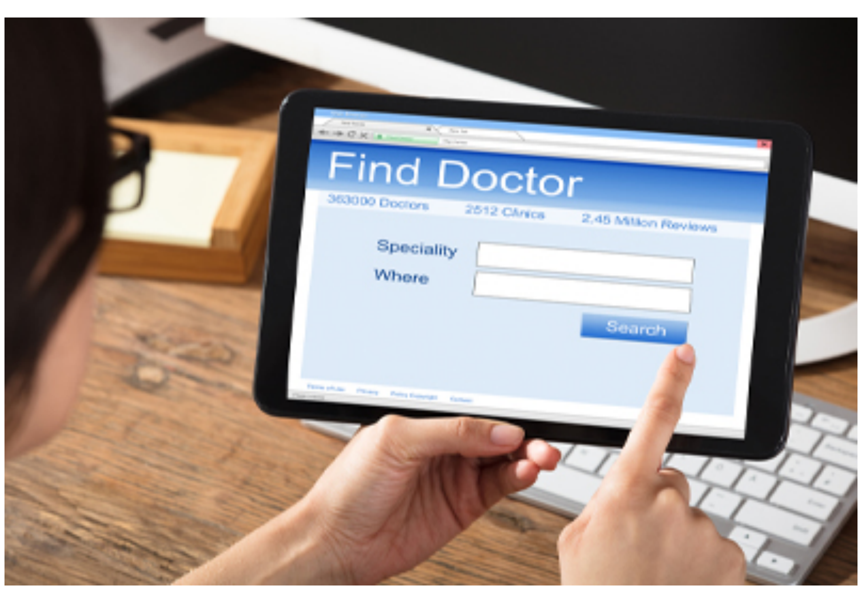
Make Sure Patients Can Find You



The sign in front of your office helps patients find their way to you. So does your contact information in the online Highmark provider directory — if you keep it up to date and accurate.

If you want Highmark members to be able to find you, make sure your practice name, physician team, locations, and contact information are correct in the Highmark provider directory. These are the facts members use to make informed decisions on where to seek care. That's why it's essential that the practice information you have on file with Highmark is up to date and is attested to on a quarterly basis.

Reviewing data is vital for you

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

Providers who don't confirm and attest that their data is accurate will be immediately removed from the directory, and their status within Highmark's networks may be impacted.

Your thorough review of your directory information confirms:

- Each practitioner's name is correct and matches the name on his/her medical license.
- The practice name is correct and matches the name used when you answer the phone.

- All specialties are correctly listed and are, in fact, currently being practiced.
- Practitioners listed at a location actually see patients and schedule appointments at that office on a regular basis. All practitioners listed must be affiliated with the group. (Practitioners who cover on an occasional basis are not required to be listed.)
- The practitioner is accepting new patients — or not accepting new patients — at the location.
- The practitioner's address, suite number (if any), and phone number are correct.

Change happens

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

- Current address
- Phone number
- Fax number

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

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

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

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

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Working to Meet Patients' Language Needs

Our quality improvement efforts are designed to help ensure quality care and member satisfaction. To achieve these goals, we continually review the aspects of our plan that affect member care and satisfaction and look for ways to improve them. One way to do that is to share details with network practitioners about the languages 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 that practitioners report on their network applications. Our 2019 analysis concluded that the following counties had greater than 1,000 residents speaking the following primary languages:

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

Chinese (including Mandarin and Cantonese)	Allegheny, Centre, Westmoreland	—
French, Haitian, and Cajun	Allegheny	—
German or Other West Germanic	Allegheny, Centre, Crawford, Erie, Mercer, Westmoreland	Indiana, Somerset,
Korean	Allegheny	Centre
Other Asian Languages	Allegheny, Centre	—
Other Indo-European	Allegheny, Centre, Erie, Washington, Westmoreland	Beaver
Russian, Polish, or Slavic	Allegheny, Centre, Erie	—
Spanish	Allegheny, Beaver, Butler, Cambria, Centre, Clearfield, Erie, Fayette, Washington, Westmoreland	—
Tagalog	Allegheny	—
Vietnamese	Allegheny	—

- The above data is from the 2013-2017 U.S. Census -American Community Survey Five-Year Estimates.
- This information is based on county population and not Highmark membership population.

In addition, our telephone translation vendor provided a breakdown of all calls Highmark Member Service (customer service) representatives received during the year that required interpreter services. In 2018, Member Service received 24,584 calls in all service areas (a 38.2 percent decrease from 2017) from members speaking 58 different languages. The largest percentage of calls (90.3 percent) was from members speaking Spanish. The total number of calls serviced for Spanish was 22,205.

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Medicare Advantage News

Key FAQs About Medicare Compliance and Fraud, Waste, and Abuse (FWA) Training

If your practice or facility cares for Medicare-eligible patients, please read this important notice and share it with your colleagues.

Q	**What kind of training is required by the Centers for Medicare & Medicaid Services (CMS)?**
A	CMS requires Highmark's Medicare First-tier, Downstream, and Related (FDR) Entities to complete two trainings: • Medicare Parts C&D General Compliance Training • Combatting Medicare Parts C&D Fraud, Waste, and Abuse (FWA) Training
Q	**Who must complete these trainings?**
A	Individuals associated with your practice or facility who work with Highmark's Medicare Advantage and/or Medicare Part D Prescription Drug Plan (PDP) members and who fall into one of these categories: • Employee • Governing-body member • Temporary worker • Contractor • Subcontractor • Volunteer
Q	**Why does CMS require these individuals to complete these trainings?**

A	CMS expects Highmark and its other Medicare-plan sponsors to ensure that all practices and facilities receiving Medicare dollars understand how to comply with the laws, regulations, guidelines, and policies for the Medicare program and how to prevent, detect, and correct Medicare fraud, waste, and abuse.
Q	**When does CMS require these individuals to complete these trainings?**
A	Both trainings must be completed: • Within 90 days of hire, contracting, or appointment • Annually thereafter (between Jan. 1 and Dec. 31 of any given contract year)
Q	**Where can individuals go to access these trainings?**
A	Individuals have three options for completing these training requirements. They can: • Complete both trainings online via the CMS Medicare Learning Network. • Complete Highmark's General Compliance Training and Fraud, Waste, and Abuse Training, which includes the CMS Medicare Learning Network Training. The course is located on the Highmark **Provider Resource Center**. To access the training, search using the keyword "Fraud." • Complete the General Compliance Training and Fraud, Waste, and Abuse Training offered by your practice or facility as long as it includes all of the content included in CMS's trainings, without any modifications.
Q	**What proof must be provided that the trainings were completed?**
A	Individuals must review the training programs in their entirety, and there must be some form of evidence that each individual completed the training. Acceptable forms of evidence include: • Sign-in sheets • Individual employee attestations • Electronic certifications The records must include: • Time

	- Attendance - Topic - Certificates of completion (if applicable) - Test scores (if applicable) Proof of training completion must be provided to Highmark upon request. Training records must be maintained for the period of the provider's contract with Highmark, plus an additional 10 years.
Q	**Are there any exceptions to these guidelines?**
A	Yes. FDRs who have met the FWA training and education certification requirements through enrollment into Parts A or B of the Medicare program or through accreditation as a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) are deemed to have met the training and educational requirements for fraud, waste, and abuse. However, these individuals are **not** exempt from the general compliance training requirement (the training is still required).

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Medicare Advantage News

Attention Medicare Advantage PPO Contracted Providers:

Medicare Advantage PPO Network Sharing Provides In-Network Access to Out-Of-Area Blue Plan Medicare Advantage PPO Members

All Blue Cross and/or Blue Shield Medicare Advantage PPO Plans participate in reciprocal network sharing. This network sharing allows all Blue Plan Medicare Advantage PPO members to obtain in-network benefits when traveling or living in the service area of any other Blue Medicare Advantage PPO Plan, as long as the member sees a contracted Blue Medicare Advantage PPO provider.

If you have a Medicare Advantage PPO contract with Highmark, you should provide the same access to care for members of other Blue Medicare Advantage PPO Plans as you do for Highmark's Medicare Advantage PPO members. Below are answers to questions you may have about Medicare Advantage PPO Network Sharing.

How does Medicare Advantage PPO Network Sharing work?

If you are a contracted Medicare Advantage PPO provider with Highmark and you

see Medicare Advantage PPO members from other Blue Plans, these members are to be given the same contractual access to care as Highmark members and you will be reimbursed in accordance with your negotiated rate under your Highmark contract. These members will receive in-network benefits in accordance with their benefit plan.

If you are not a contracted Medicare Advantage PPO provider with Highmark and you provide services for out-of-area Blue Medicare Advantage PPO members, you will receive the Medicare allowed amount for covered services based on where the services were rendered and according to the member's out-of-network benefit level. For emergency and urgent care, you will be reimbursed at the member's in-network benefit level.

How do I recognize an out-of-area member from one of the Plans participating in this program?

The "MA" in the suitcase on the member's Blue Plan Medicare Advantage PPO ID card indicates a member who is covered under the Medicare Advantage PPO Network Sharing Program. Members should be asked to show their Blue Cross and/or Blue Shield ID card when receiving services (and not their standard Medicare ID card).

Do I have to provide services to Medicare Advantage PPO members from other Blue Plans?

If you are a contracted Medicare Advantage PPO provider with Highmark, you should provide the same access to care as you do for Highmark Medicare Advantage PPO members.

If you are not a contracted Medicare Advantage PPO provider with Highmark, you may see other Blue Plan Medicare Advantage PPO members; however, you are not required to do so.

What if my practice is closed to new local Medicare Advantage PPO members?

If your practice is closed to accepting new Highmark Medicare Advantage PPO members, you are not required to provide care for out-of-area Blue Plan Medicare Advantage PPO members.

How do I verify eligibility and benefits?

You can verify eligibility and benefits for Medicare Advantage PPO members from other Blue Plans via Highmark's NaviNet® provider portal. Select **BlueExchange® (Out-of-Area)** under **Workflows for this Plan**, and then click on **BX Eligibility and Benefits Inquiry**.

You can also call the BlueCard® Eligibility line at **1-800-676-BLUE (2583)** and provide the member's 3-character prefix located on the member's ID card.

Where do I submit the claim?

Submit the claim to Highmark under your current billing practices. Once you submit the claim, Highmark will work with the out-of-area member's Blue Plan to determine benefits, and then Highmark will send you the payment.

Please **do not** bill traditional Medicare for any services rendered to a Medicare Advantage member.

What is the member cost-sharing level and copayments?

When out-of-area Blue Plan Medicare Advantage PPO members see Medicare Advantage PPO contracted providers in Highmark's service areas, covered services and copayments will be at the member's in-network level of benefits. You may collect the copay amounts at the time of service.

May I balance bill the out-of-area member the difference between my charge and the allowance?

No, you may **not** balance bill the out-of-area member for this difference. Members may be billed for any applicable deductibles, coinsurance, and/or copays.

What if I disagree with the reimbursement amount I received?

If there is a question concerning the reimbursement you received, please contact Highmark Freedom Blue PPO Provider Services.

Who do I contact if I have a question about Medicare Advantage PPO Network Sharing?

If you have any questions about the Medicare Advantage PPO Network Sharing

Program, please contact Highmark Freedom Blue PPO Provider Services at **1-866-588-6967**.

Information on the Medicare Advantage PPO Network Sharing Program is available in the *Highmark Provider Manual*. Please see **Chapter 2.2: Medicare Advantage Products & Programs** and **Chapter 2.6: The BlueCard Program**.

BlueCard is a registered mark of the Blue Cross Blue Shield Association

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Improve Your Experience with the Physical Medicine Management Program

Highmark and WholeHealth Networks, Inc. (WHN), a subsidiary of Tivity Health Support, LLC., have been working together since 2012 to ensure Highmark members receive quality care that is aligned with evidence-based guidelines through Highmark's Physical Medicine Management Program. WHN applies guidelines developed using nationally accepted standards and with input from actively practicing practitioners in their authorization and medical necessity review processes for physical therapy, occupational therapy, and chiropractic services.

Highmark provides numerous resources on the Provider Resource Center to help you understand and navigate the requirements of the program. This includes the *Physical Medicine Management Program Administrative Guide* (the Administrative Guide"), which details the program's requirements and also provides step-by-step instructions for submitting registrations and authorization requests using NaviNet®.

To assist you in increasing your proficiency with the program, WHN offers you valuable tips for submitting your authorization requests and documenting your patients' care. These helpful tips were recently provided in a **Special eBulletin** dated July 1, 2019. You will also find these tips for improving your experience with the program in the program's Administrative Guide.

Accessing the Physical Medicine Management Program

Resources

To access the *Physical Medicine Management Program Administrative Guide* and much more, select **CARE MANAGEMENT PROGRAMS** from the main menu on the Provider Resource Center, and then click on **Physical Medicine Management Program**.

Whole Health Networks (WHN) is an independent company that provides physical medicine benefit management services for Highmark.

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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 independent diagnostic testing facilities and for telemedicine and telehealth services. In addition, the policy on drug wastage and convenience kits has been revised.

Reimbursement Policy Bulletin RP-048: Independent Diagnostic Testing Facility (IDTF)
An IDTF can be a mobile entity or a fixed location, and must operate its business following all Federal and State Licensure requirements. Highmark's new Reimbursement Policy Bulletin RP-048, effective July 15, 2019, includes Highmark's guidelines for billing and reimbursement.

Reimbursement Policy Bulletin RP-046: Telemedicine and Telehealth Services
Effective July 15, 2019, Highmark Reimbursement Policy Bulletin RP-046 provides guidance on the reimbursement of telemedicine, telehealth, virtual care, and e-Visit services for commercial and Medicare Advantage products.

Reimbursement Policy Bulletin RP-003: Drug Wastage and Convenience Kits
A revised version of Highmark Reimbursement Policy Bulletin RP-003 has been issued with added reimbursement rate information for claim lines reported with modifier JW (drug/biological amount discarded/not administered to any patient). This change implements a cost-based approach for drug wastage reimbursement for commercial professional claims effective August 5, 2019.

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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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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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 PRC.

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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

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, please write to

the editor at **Bryce.Walat@highmark.com**.

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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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