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

HIGHMARK.
Issue 5, 2021

The Population Health University page (available on the Provider Resource Center) has been updated with new toolkits, toolkit overviews and the Transitions of Care Module (including videos and an article on Transitions of Care).

These updates are in support of Highmark's journey to transform health and be a leader in the industry by focusing on the individual needs of each member and provider (Highmark refers to this as Living Health). We want to create new relationships with you by leveraging the use of new technologies and best practices to build a better model.

We want to create new relationships with you by leveraging the use of new technologies and best practices to build a better model.

This new approach provides us with the dedicated time, resources and capacity to rapidly address the identified needs of the market and continuously improve your experience with us. This allows us to:

- Tailor strategies and support based on your capabilities and market-specific needs
- Utilize analytical capabilities and expertise to provide actionable insights to assist you in achieving success in our value-based reimbursement programs

This dynamic approach - and partnership with the American Journal of Managed Care - allows Highmark to build a place to share our tools, discuss best practices, and provide a space for open dialogue between you and Highmark. These tools and best practices are available for view on the Population Health University page on the Provider Resource Center.

To access this page, click here: https://hbcbs.highmarkprc.com/Education-Manuals/Population-Health-University

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New Claims Status Inquiry **Attachment Feature** in NaviNet® **IS NOW LIVE**

The new claim status inquiry attachment feature in NaviNet is live as of November 1. Providers who are responding to a Highmark request for additional information regarding a claim will be able to upload and attach supporting documents directly through NaviNet. This functionality will help to streamline the claim status inquiry process and ensure Highmark receives the correct supporting documentation. You will be able to attach four types of documents to a claim status inquiry:

1. **PWK** (Additional Documentation to Support an Electronic Claim)
2. **Out of Area Medical Records** (Including Barcoded Request Letter)
3. **Medical Record Request**
4. **General Provider/Facility Inquiry**

A Special Bulletin with additional information and step-by-step instructions is available on the Provider Resource Center sites. To access it:

1. **Click Newsletters/Notices**
2. **Select Special Bulletins & Mailings**

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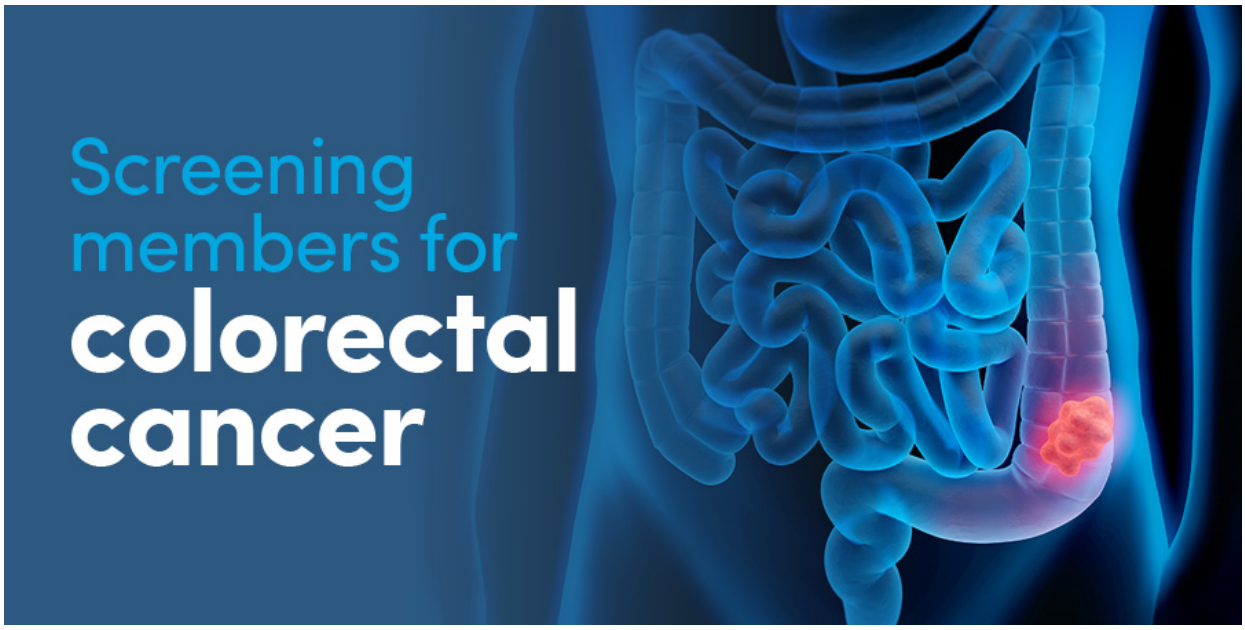

Colorectal cancer is one of most dangerous digestive cancers, often leading to morbidity or mortality. According to The American Cancer Society, the overall lifetime risk of developing colorectal cancer is about 1 in 23 for men and 1 in 25 for women. Due to the prevalence of colorectal cancer, Highmark recommends providers perform the following colorectal cancer screenings for patients aged 50 and up:

- **Preferred colorectal cancer screenings:**
  - Colonoscopy every 10 years
  - When a member declines a colonoscopy, perform an annual Fecal Immunochemical Test (FIT) for blood

- **Alternative colorectal cancer screenings:**
  - Flexible sigmoidoscopy every 5 years
  - Computed Tomography (CT) colonography every 5 years

- **Additional colorectal cancer screenings:**
  - Annual Hemoccult Sensa Test
  - Fecal DNA testing every 3 years

Effective January 1, 2022, there will be an age change from 50 to 45 years old based on the recommendations of the United States Preventive Task Force.

Providers should remind members that alternative screening tests that come out positive may require a follow-up diagnostic colonoscopy. This could mean new bowel preparation, work disruption and additional cost.

Members should also be aware that costs for a diagnostic colonoscopy following a positive alternative colorectal screening will be billed under medical benefits with potential member cost sharing.

Effective January 1, 2022, there will be an age change from 50 to 45 years old based on the recommendations of the United States Preventive Task Force.

Why Colonoscopies and FIT Tests Are the Preferred Tests

The U.S. Multi-Society Task Force on Colorectal Cancer classified colorectal cancer screenings into tiers based on performance and effectiveness, ranking both colonoscopy (every 10 years) and an annual FIT for first-tier screening as preferred methods for detecting colorectal cancer. These two tests are used to detect and prevent colorectal cancer before symptoms develop and aid in taking biopsies and removing polyps or other areas of abnormal tissue.

The U.S Multi-Society Task Force on Colorectal Cancer set these guidelines to maximize the risk-benefit ration based on the member's risk factors. A screening colonoscopy is the gold standard and is recommended for individuals aged 50-85 even if they feel perfectly fine.

Dr. Katie Farah, chief medical officer at Allegheny Health Network's (AHN) Wexford Hospital, said in her interview for the Ask a Doc series, "The tier-based classification represents the most up-to-date, evidence-based recommendations from the American College of Gastroenterology, the American Gastroenterological Association and the American Society for Gastrointestinal Endoscopy. We want patients as well as primary care providers (PCPs) and other referring physicians to use the tier 1 screening tests - that's colonoscopy as the first test of choice and, if refused by the patient an annual standard FIT...a stool-based screening with a high sensitivity for detecting colon cancer and colon polyps which has been noted to have fewer false positives reported in comparison to other screenings...as the second tier 1 option.

"While other tests are marketed for screening of colorectal cancer, they are currently considered tier 2 and may not be medically appropriate for your patient. For example, the FIT-DNA (Cologuard) stool-based screening is not approved for individuals at high risk of colorectal cancer and has shown a high rate of false positives leading to an additional procedure deemed diagnostic."

Highmark wants to work with you to encourage our eligible members to complete their colorectal cancer screenings. They can save lives.

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Highmark Product News:
Important Updates Coming for 2022

When Highmark members visit your office or facility in 2022, they will be presenting new identification cards. The members may be new to Highmark or they may be existing members with only a few benefit changes or 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 2022.

To help you and your staff prepare, we will publish an overview of product changes later this year on Highmark's Provider Resource Center (PRC) in the left-hand navigation under "**Product Information**". Please watch the PRC for news about our new products and share it with your staff. We look forward to another successful year of working with you to connect our members to quality care.

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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 home page for eBulletins announcing new policies and the Reimbursement Policy page for policy updates. Some recent changes include:

- Updates to Medicare Advantage Reimbursement Policies
- Updates to Reimbursement Policy 010

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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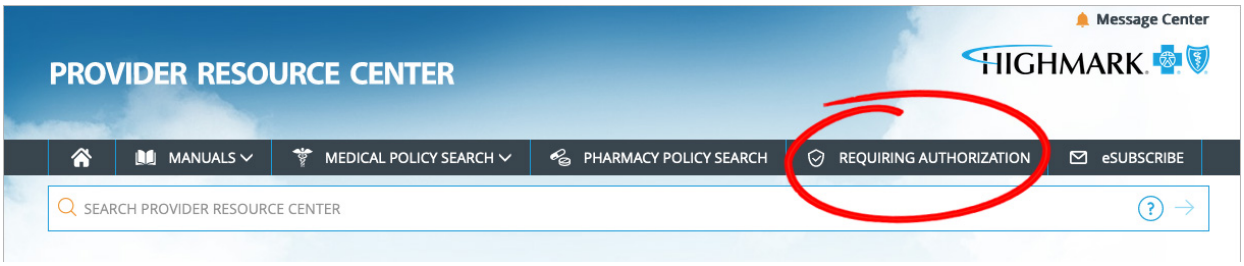
Watch for Updates to Highmark's List of Procedures Requiring Authorization

During the year, Highmark adjusts the List of Procedures 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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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 main menu on the Provider Resource Center.

This page 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:** 1-800-234-6008

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

The entirety of the Highmark Provider Manual has been updated to include Highmark Blue Cross Blue Shield of Western New York and Highmark of Northeastern New York information. Ensure you are regularly reviewing the Highmark Provider Manual for our most recent guidance on:

- 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.

Legal Information

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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.

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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.

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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