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

HIGHMARK
Issue 6, 2021

NEW Address Change Form

As part of the No Surprises Act and Highmark's Provider Directory requirements, you must verify your information with Highmark every 90 days to remain in our directory. Highmark members looking for a provider will not have access to providers who are no longer listed in our directory.

Beginning January 1, 2022, Highmark will have a new form for professional providers to fill out for name, address, phone, specialist, website, and terming practitioners from a group changes. Facility/Ancillary providers should continue to use the existing form. Once received, Highmark will update our directory with your information within two business days.

Additionally, we will be announcing a new NaviNet® function in early 2022 that will allow you to verify and edit your information online without having to submit a form or call us. Once this is live, you should use NaviNet to make changes whenever possible. Watch Plan Central and the Provider Resource Center for more information regarding this function in the coming weeks.

There will be a new form for professional providers to fill out for name, address, phone, specialist, website, and terming practitioners from a group changes.

For more information on this change and other changes Highmark is making in regards to the No Surprises Act, review the **No Surprises Act** section of the **Provider Resource Center**.

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Highmark is excited to announce that Pennsylvania's Telephonic Psychiatric Consultation Service (TiPS) for children insured by Pennsylvania's Medical Assistance (Medicaid) is being expanded to include the Children's Health Insurance Program (CHIP). TiPS is a Pennsylvania program designed to increase the availability of child psychiatry consultation teams regionally and telephonically to primary care providers (PCPs) and other prescribers of psychotropic medications.

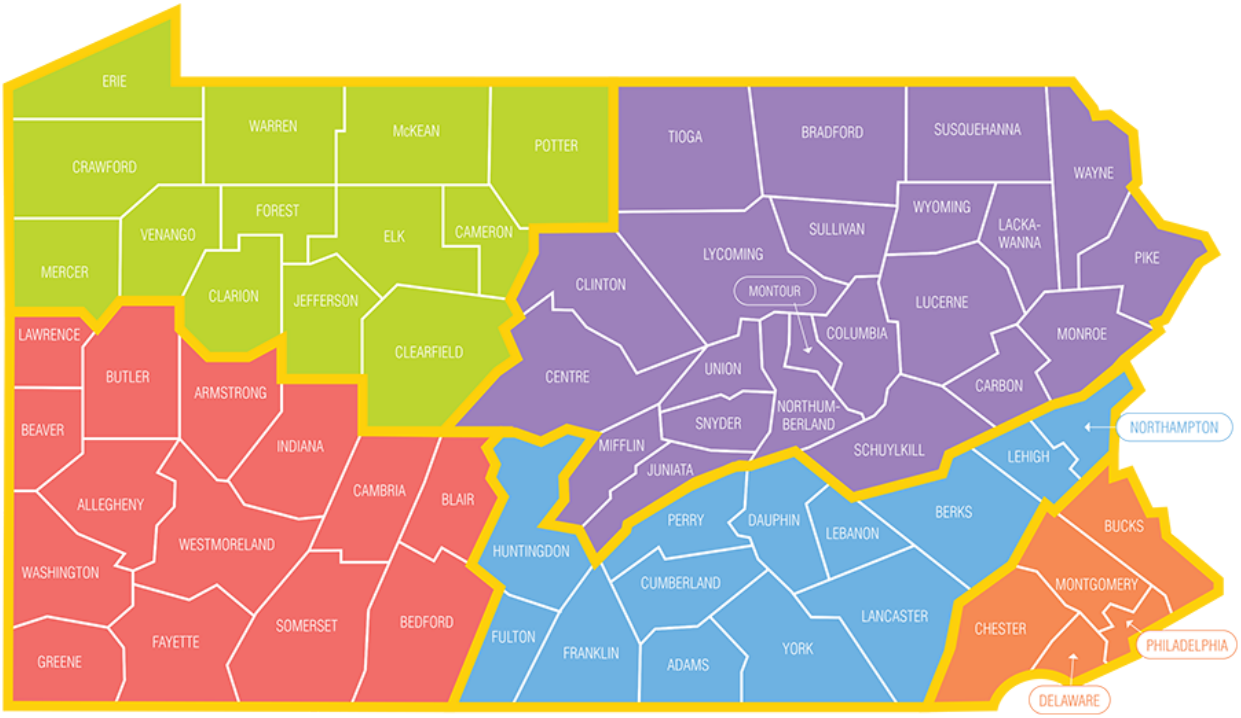
Starting in 2022, this program will be available to Highmark CHIP providers. TiPS provides one team per HealthChoices/CHIP zone (shown below) and ensures access to quality services in the appropriate setting based on need. Modeled after the Massachusetts Medical School program, TiPS teams (child psychiatrists, licensed therapists, care coordinators, and administrative support), pediatricians, and family physicians can effectively meet the needs of youth with common mental health conditions such as Attention Deficit Hyperactive Disorder (ADHD) and mild depression.

TiPS also provides real time peer-to-peer resources to PCPs who desire immediate consultative advice for children (up to age 21) with behavioral health concerns. If the child needs specialty psychiatric care or has medication needs that are not appropriately managed in the primary care setting, TiPS teams can help connect him or her to appropriate care.

TiPS care coordinators identify and maintain up-to-date behavioral health resources in the community. They work with families to identify appropriate options, provide information on the expected wait times, follow up to ensure connections are made, and

keep you informed of the referrals and the outcome of the follow-up efforts so you can ensure your patients are receiving the care they need.

IMPORTANT: TiPS psychiatrists do not prescribe medications.



TiPS Team	Chikdren's Hospital of Philadelphia	Penn State Children's Hospital	Children's Community Pediatrics (CCP)
Zone(s):	●	● ●	● ●
Phone:	**267-426-1776**	**800-233-4082**	**844-WPA-TiPS**

For more information Review:

- Pennsylvania's Telephonic Psychiatric Consultation Service Program for CHIP Members eBulletin
- Telephonic Psychiatric Consultation Service Program (TiPS) (pa.gov)
- Telephonic Psychiatric Services | Penn State Health

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Transitions of Care (TOC) is an important topic for the transformation of health care. It is the movement of a patient from one care setting to another involving a set of proactive actions. Many patients leave the hospital, rehabilitation facility or long-term care setting often in a vulnerable state with little understanding of what comes next.

Highmark and our Population Health University team are happy to announce that you can now **earn Continuing Medical Education (CME)** credits for completing the Transitions of Care module either in part or in whole.

As part of Highmark's Population Health University, we held a panel discussion to highlight why effective transitions in care are important and discuss collaborative efforts to support care coordination. We also discussed how improvements to patient care have a positive effect on the patient, physician experience and readmission rates.

Highmark and our Population Health University team are happy to announce that you can now earn Continuing Medical Education (CME) credits for completing the Transitions of Care module either in part or in whole.

All CME credits are obtained through the Allegheny Health Network (AHN) CME platform. To earn CME credits, you must register for an account here. Once an account is created you will not need to re-register in the future for Highmark/AHN CME offerings.

You will be eligible to receive partial CME credit for the individual components of the module that you complete, or full credit for completing the entire module. You are only able to apply for CMEs for the Transitions of Care Module one time, so ensure you complete all components you want credit for prior to submitting CME credit.

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ECCM to Replace Aspire Health

As Aspire Health is being decommissioned, ensure you are setting your patients up with the Enhanced Community Care Management (ECCM) team for specialized care coordination, palliative, and supportive care. The ECCM team helps members living with serious illness live their best life possible while maintaining their independence in the community regardless of homebound status or specific skilled need.

ECCM's interdisciplinary care team, including physicians, advanced practice providers (NP or PA), nurses and social workers, are all trained in motivational interviewing, health literacy, and how to help those struggling with social determinants of health (SDoH). Clinicians provide team-driven care directed by whole-person centered outcomes. Care is focused on activating members in engaging in the self-management of their chronic conditions, quality of life, symptom burden, emotional well-being, advanced care planning, communication, continuity of care and caregiver burden.

ECCM is a free, flexible program that reduces disruption for the member, family, and caregiver by streamlining communication across health care settings to ensure the member's needs are matched with the appropriate resources. The team also provides closer oversight of the member and their illness (through virtual and in home care – including nursing facilities) while working with the member's doctor and healthcare providers.

For more information on this program and how to refer members to the ECCM team, review the **ECCM** page on the **Provider Resource Center** under **Care Management Programs**.

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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.

The following reimbursement policies have been updated within the last 60 days and should be reviewed:

- RP-010: Incident To Billing Services and Advanced Practice Provider Reductions
- RP-053: Gene and Cellular Therapy
- RP-064: Government Supplied Vaccinations and Antibody Treatments
- MRP-001: Microsurgery (Medicare Advantage)
- MRP-002: Reporting Clinical Pathology Services (Medicare Advantage)
- MRP-004: Prolonged Services (Medicare Advantage)

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

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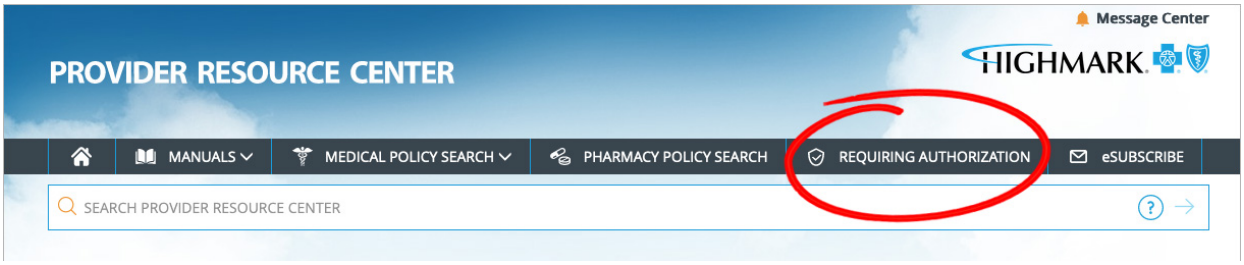
Watch for Updates to Highmark's List of Procedures Requiring Authorization

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

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.

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

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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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