PROVIDER NEWS
A Newsletter for Highmark Blue Cross Blue Shield Delaware Providers
HIGHMARK Delaware
Issue 1, 2017

Contains helpful information for Highmark Health Options providers, too!

True Performance Program Values Outcomes, Not Volume

Healthier Members, Less Costly Care the Goals for PCP Incentive Program

Highmark launched the True Performance program for eligible PCPs on Jan. 1, 2017. The new value-based program replaced all of Highmark's primary care pay-for-value programs.

True Performance is designed to improve the quality of health care delivered to our members while working to reduce the overall cost of their health care. True Performance rewards participating PCPs for providing better outcomes to our members instead of the quantity of care.

True Performance Rewards Outcomes

True Performance shifts providers from volume-based payment methods to reimbursement related to quality and total cost-of-care outcomes. True Performance ties compensation to results by focusing on positive outcomes.

PCPs need to meet certain quality and cost measures to earn a reimbursement incentive. Patients should receive certain preventive and treatment services, such as childhood immunizations, appropriate drug therapy for chronic diseases, cancer screenings, and annual wellness exams — all key to keeping patients healthier. This

helps our members avoid more costly care later.

Amy Fahrenkopf, MD, MPH, medical director and vice president of Market Transformation, noted that the program “aligns the incentives of both Highmark and the physician” to deliver the right care at the proper price.

Another positive aspect of this program for both members and PCPs is a monthly care coordination payment per patient that PCPs receive. PCPs invest this money to improve patient convenience, such as offering appointments outside of traditional office hours, hiring staff members to call and check on patients, and other patient-focused approaches.

As the health care industry becomes more complex, Highmark is taking steps toward more simplicity for PCPs and our members through True Performance.

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NaviNet: Your Most Powerful Self-Service Tool

System Puts Information on Members' HRAs, NIA Retro Auths at Your Fingertips

NaviNet® is always your first stop for eligibility and benefit information, to check your allowances for the services you're providing, to request needed authorizations, to submit and check the status of claims, and much more.

But can you name the additional capabilities that NaviNet offers? In this issue of *Provider News*, as well as upcoming issues, we're going to respond to your questions by focusing on some of the underutilized tools that are embedded in NaviNet. In this issue, we'll show you how you can access a Highmark member's health reimbursement account (HRA) information. We've also included a reminder of the retrospective (retro) review process for imaging services.

Checking a Member's HRA

Many Highmark members now have plans with high deductibles that are tied to corresponding HRAs. You can easily tell if a member has an available HRA and access

that information using NaviNet. To retrieve a member's HRA information, select **HRA Coverage Details** (highlighted in yellow in the screen capture below) from the **Eligibility and Benefits Details** page.

Eligibility and Benefits Details

Print

Patient Information

Member ID Number:		**Patient Name:**	
Member Address:		**Patient Date of Birth:**	
		Relationship to Subscriber:	
Date of Service From:	02/06/2017	**Date of Service To:**	02/06/2017

Other Insurance Applies:	NO	**Other Insurance Effective Date:**	04/02/2008
Reverification Date:	05/12/2015	**COB Review Status:**	FINALIZED
COB Investigation Method:	Pursue and Pay		

Group Information

Effective Date:	01/01/2012	**Term Date:**	00/00/0000
Group Number:		**Group Name:**	
Product:	PPO	**Advanced Imaging UM by NIA:**	YES
Plan Area:	378	**Radiation Therapy Management:**	NO
Group Renewal:	01/01/2018	**Physical Medicine Management:**	NO
Alpha Prefix:	ZAR		

View Current Member ID Card

PPO BLUE Provisions	Inpatient Facility Services	Outpatient Facility Services	Behavioral Health/Substance Abuse
Professional Services	Professional Therapy and Rehabilitation Services	Routine/Preventive Care	Ancillary Services/Supplies
Other Reproductive Services (non Maternity)	Oral Surgery/Dental Accident	Educational & Medical Programs	Conditions
Other Services	HRA Coverage Details		

The HRA Coverage Details page shows the amounts for both the Individual and Family Annual Election. If the HRA is partially funded by the member's employer, this page will show any amount that the member (employee) is required to pay. Please note that you will have to contact Highmark to determine if the member has met any of the HRA amounts listed.

HRA Coverage Details

Patient Information

Patient Name:
Member ID Number:

Benefit Effective Date:	01/01/2017
Benefit Term Date:	00/00/0000

Contributions

Individual Annual Election:	$ 1250
Employee & Child Annual Election:	$
Employee & Children Annual Election:	$
Employee & Spouse Annual Election:	$
Family Annual Election:	$ 2500

Participant Deductibles

Special Plan Design:	Employee Pays First
Individual Deductible Amount:	$ 250
Employee & Child Deductible Amount:	$
Employee & Children Deductible Amount:	$
Employee & Spouse Deductible Amount:	$
Family Deductible Amount:	$ 500
Embedded Deductible:	Yes
Embedded Deductible Amount:	$ 250

Expense Types

Coinsurance:	No
Copay:	No
Deductible:	Yes

If a member's HRA has been set up as "Direct Pay to Provider," payment will be made directly from the HRA to the provider.

NIA Retro Authorizations

Providers can request that National Imaging Associates Inc. (NIA) perform a retro review of a member's imaging scan for one of two reasons:

1. The *ordering* provider did not contact NIA prior to the service being performed, but calls NIA after the services have been performed.

- If NIA determines that the procedure was medically necessary and an authorization is used, the provider can then submit the claim to Highmark for payment.
- If NIA determines that the procedure was **not** medically necessary, a denial letter will be sent to the ordering and performing providers.

2. The *performing* provider is requesting a retro review because a claim denied based on no authorization being on file.

- To request a retro review, providers should call NIA at 1-800-346-6262. Select Option 2, then Option 4.
- The performing provider **must** have the name of the ordering provider.
- If NIA determines that the procedure was medically necessary and an authorization is issued, the performing provider will need to open an investigation in NaviNet and include the authorization number so the claim can be adjusted. The indicator on NaviNet for the dropdown box is "NIA Retrospective Review."

Providers who are not yet NaviNet-enabled must call Highmark Customer Service at 1-800-346-6262, Option 6, after the approved authorization is provided by NIA and request that an adjustment be made.

Complete information about the Radiology Management Program and the retrospective review process can be found in the **Highmark Radiology Management Program** section of the Provider Resource Center.

Contacting Provider Services

For more complex issues, the Provider Service telephone lines offer expanded functionality to better serve you. Innovative self-service prompts allow you to get the detailed information that you need quickly and efficiently.

How to Sign Up for NaviNet

If you don't have NaviNet, we strongly encourage you to visit **navinet.net** and gain access to the system. Current NaviNet users who have questions about the system may call 1-888-482-8057 to speak with a NaviNet representative.

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What Your Patients Think Matters

The annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey begins in February and lasts through May. The survey asks patients to report on and evaluate the care they receive from their providers. It covers topics that are most important to your patients and focuses on various aspects of quality. This survey is required to be compliant with CMS regulations and is conducted to a sample of Highmark members in all product lines.

Both CMS and state regulatory bodies require that health plans conduct member satisfaction surveys such as CAHPS each year. Please remember that the way you and your staff interact with patients impacts their perception of the quality of care they receive. Be positive. Encourage member questions. Communicate and coordinate care with other physicians the patient is seeing. As a rule, patients tend to rate their physician as “high,” or they switch physicians.

Here are a few examples of questions your patients will find on the CAHPS survey.

Getting Care Quickly

- How often did you get an appointment for a check or needed care as soon you needed?

- How often did you see the person you came to see within 15 minutes of your appointment time?

Getting Needed Care

- How often was it easy to get the care, test, or treatment you needed?

Shared Decision-Making

- How often did you and your personal doctor talk about all the prescription medicines you were taking (never, sometimes, usually, or always)?

Coordination of Care

- How often did she/he have your medical records or information about your care?
- When your personal doctor ordered an x-ray, blood test, or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
- How often did you get those results as soon as you needed them?
- Did you get the help you needed from your personal doctor's office to manage your care among different providers and services?

How Well Your Doctors Communicate with You

- How often did your personal doctor explain things in a way that was easy to understand?
- How often did your personal doctor listen carefully to you?
- Did your personal doctor show respect for what you had to say?
- Did your doctor spend enough time with you?

Your Personal Doctor

- What number would you use to rate your personal doctor? (0-10)

Your Specialist

- How often did you get an appointment to see a specialist as soon as you needed?
- How often did your personal doctor seem informed and up to date about the care you got from a specialist?
- What number would you use to rate your specialist? (0-10)

Additional CAHPS survey questions address clinical care and services provided by network providers. These include tobacco use counseling and cessation, as well as flu

and pneumococcal vaccinations. Your discussions with patients about these topics can make a positive difference in your survey scores.

Highmark reviews the CAHPS survey results to learn more about the overall experiences of our members and to identify possible areas of improvement. We value the importance of the survey results and will continue to work with our providers to enhance our members' perception of the care and services they receive.

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Laboratory Management Program Clinical Guideline Changes Now Effective

Changes to our Laboratory Management Program clinical guidelines took effect Feb. 6, 2017. The current edition of the **Laboratory Management Clinical Guidelines** is available for your reference. Details about these changes that were made Feb. 6 are available in this **Executive Summary**.

To learn more about the Laboratory Management Program, please visit the Provider Resource Center.

To learn more about the Laboratory Management Program and how to submit prior authorization requests through eviCore, please visit the **Laboratory Management Program** page, located under **Clinical Reference Materials** on the Provider Resource Center.

We appreciate your cooperation in this program to help support appropriate care for our members.

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Highmark Health Options News:

Treating Chronic Pain and Depression

There is a high rate of depression in patients with chronic pain — a rate of more than 50 percent in those with terminal illness and pain.[1]

Of course, physicians and care providers know that depression and pain often co-exist, and that one sometimes masks the other. Also, sometimes one condition is treated while the other is missed or under-treated. Patients in severe pain may attribute their depression symptoms to the pain itself and, therefore, under-report it.

It is important to assume chronic pain patients are depressed and rule it out through direct questioning using a modified depression rating scale.[2] Many depressed patients with somatic complaints perceive their conditions as more problematic than their non-depressed peers with similar somatic illness. Treating depression effectively often results in less pain medication or other somatic interventions.

Chronic, unremitting pain correlates highly with suicidal thoughts and risk.

In particular, men with chronic, unremitting pain are at highest risk for suicide. For example, one study found men with carcinoma of the pancreas, known for its association with depression as well as chronic pain, to have an 11-fold increased risk for suicide over their non-afflicted peers.

Among terminally ill patients, the wish to die fluctuates over time and is often correlated with levels of depression, anxiety, and pain.[3] Furthermore, 8.5 percent of terminally ill patients, often those with unremitting pain, have sustained and pervasive wishes for an early death. Psychiatric palliative care measures diminish these requests substantially.

In addition, hidden substance abuse can be a complicating factor for chronic pain and depression and increases suicide risk.

Treating pain and depressive symptoms appropriately may significantly reduce the desire for death and abuse of alcohol or drugs. Health care providers often fail or are circumspect about asking patients or their family members about substance abuse concerns. Unidentified or unverified substance abuse undermines most treatment efforts for pain or depression.

Please remind the physicians and other caregivers in your practice or facility to:

- Be alert to depression or substance abuse in patients with chronic, unremitting pain.
- Treat depression aggressively with medication, with referral for specialized psychotherapy, or psychiatric consultation, if warranted.
- Ask both patients and family members about substance abuse.
- Try antidepressants that are FDA-approved for both pain control and depression for patients suffering from both conditions.

Sources:

1. Bailyn, R. and Rubin, J. "Psychiatric Treatment Challenges at the End of Life." Geriatric Psychiatry in Long-term Care. December 2003.
2. Marks, S. and Heinrick, T. "Assessing and Treating Depression in Palliative Care Patients." Current Psychiatry. August 2013.
3. Chochinov, HM et al. "Desire for Death in the Terminally Ill." Am. J. Psychiatry, 1995; 152: 1185-1191

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Highmark Health Options News:

Elder Abuse Serious and Under-Reported

Elder abuse is a major public health issue, and it is important that health care providers recognize the signs and symptoms.

The Centers for Disease Control and Prevention (CDC) defines elder abuse as "an intentional act, or failure to act, by a caregiver or another person in a relationship involving an expectation of trust that causes or creates a risk of harm to an older adult" (age 60 and older). Elder abuse includes physical abuse, sexual abuse, emotional/psychological abuse, financial abuse or exploitation, and neglect or self-neglect.

One out of every 10 older adults (5 million per year) residing at home experiences elder abuse. For every case that is reported, approximately 23 cases remain undiscovered.[1]

Elders who have been abused have a 300 percent higher risk of death[2] than those who have not been mistreated. According to the National Council on Aging, financial abuse and fraud are self-reported at a higher rate than emotional, physical, and sexual abuse or neglect, and it costs older Americans over $36.5 billion per year. In almost 90 percent of the cases, the abuser is a family member. Two thirds are adult children or spouses.

Risk factors include:

- Mental illness or drug and alcohol use
- Poor or inadequate training or preparation of caregiver
- Inadequate coping skills
- Becoming a caregiver at a young age
- Being abused as children

There is also a higher risk of abuse if the elder has a poor social support system or the individuals in the home are emotionally and financially dependent upon the elder.

Signs and symptoms of physical or psychological elder abuse are frequent unexplained injuries, multiple bruises, pressure sores, broken bones, and multiple somatic complaints, including pain. Other potential red flags are signs of poor nutrition and dehydration, increased susceptibility to new illness, exacerbation of chronic conditions, sleep disturbance, increased anxiety and fear (especially in the presence of the caregiver), and learned helplessness.

Increased care coordination, including strong relationships with people of varying social status, and increased community awareness may help protect an elder from abuse.

Residential institutions need to develop effective monitoring systems that include solid policies and procedures for patient care. Regular training on elder abuse and neglect for employees and caregivers — as well as education on durable power of attorney and advanced directives — is important to create awareness. Regular visits by family members, volunteers, and social workers should be encouraged and accommodated.

If an older adult is in immediate, life-threatening danger, call 911.

Anyone who suspects that an older adult is being mistreated should contact the local Adult Protective Services office, Long-Term Care Ombudsman, or police. Additional information on local resources is available on the **Eldercare Locator** online or by calling 1-800-677-1116.

Resources to call or contact:

- **National**
  - **Eldercare locator**
  - **Elder Abuse Prevention**
  - **National Center on Elder Abuse**
  - **National Institute on Aging**
  - **National Institute of Justice**
  - **cdc.gov**

- **Local**
  - **Delaware Division of Services for Aging & Adults with Physical Disabilities Adult Protective Services**
    - Contact Email: delawareadrc@state.de.us
    - Office Phone:1-800-223-9074
    - Information Phone: 1-800-223-9074
    - National Toll-Free Phone: 1-800-223-9074
  - **Long-Term Care Ombudsman Program Delaware Aging and Disability Resource Center (ADRC)**
    - Contact Email: delawareadrc@state.de.us
    - Information Phone: 1-800-223-9074
    - TTY Phone: 302-391-3505

Sources:

1. Hernandez, et al. Prevalence and Correlates of Emotional, Physical, Sexual, and Financial Abuse and Potential Neglect in the United States: The National Elder Mistreatment Study. *Am J Public Health.* 2010; 100(2): 292-297
2. Dong, et al. Elder Self-Neglect and Abuse and Mortality Risk in a Community-Dwelling Population. *JAMA*. 2009, August 5; 302 (5) p.517-526
3. National Council on Aging (**ncoa.org**). Top 10 Financial Scams Targeting Seniors

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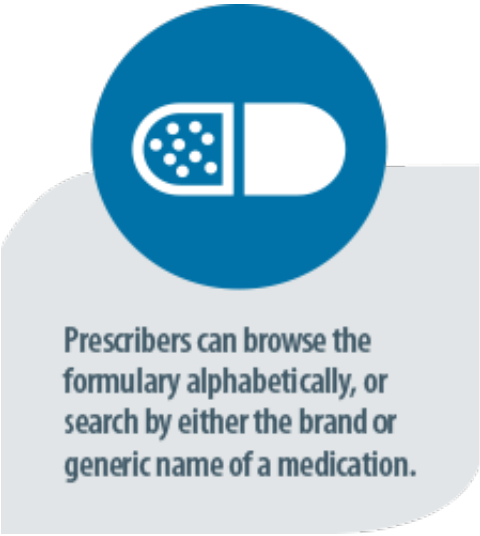
Highmark Health Options News:

Health Options Drug Formulary Available for Prescribers

Highmark Health Options follows the preferred drug list (PDL) of Delaware's Division of Medicaid & Medical Assistance. Additional non-PDL medications, for example, over-the-counter drugs, are included as covered for our members as well.

Please review the entire Highmark Health Options Drug Formulary at highmarkhealthoptions.com/providers/drugcoverage. Prescribers can browse the formulary alphabetically or search by either the brand or generic name of a medication. Prescribers can also search within the therapeutic class of a medication to find a preferred medication.



Some of the medications require prior authorization, have a quantity limit, must be dispensed by a specialty pharmacy, or require step therapy. These medications are marked with a symbol under the **Notes & Restrictions** column.

A prescriber may request a prior authorization for a medication by completing and submitting the **Health Options Medicaid Drug Exception Form**.

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Highmark Health Options News:

2016 HEDIS Audit Results Demonstrate Health Options' 2015 Performance

In 2016, Highmark Health Options conducted its first HEDIS® (Healthcare Effectiveness Data and Information Set) audit to analyze the health plan's 2015 performance measurements. These baseline results were benchmarked against the National Committee for Quality Assurance (NCQA) "Quality Compass" and demonstrated the following performance:

90th percentile

1. Antidepressant medication management
2. Nephropathy screening in diabetes

75th percentile

1. Chlamydia screening in women
2. Childhood immunization
3. Human papilloma vaccination for female adolescents
4. Nutrition and physical activity counseling for teens ages 12–17

These performance findings are used to guide our future quality improvement activities. Health Options is addressing multiple initiatives in 2017 to improve member health outcomes and its HEDIS scores. Based on the 2016 audit's findings, Health Options identified the following opportunities for improvement:

1. Follow-up after hospitalization for mental illness
2. Emergency room visit utilization
3. Cervical cancer screening
4. Comprehensive diabetes care

5. Controlling high blood pressure
6. Prenatal and postpartum care frequency and timeliness
7. Adolescent and child well care
8. Weight and nutrition counseling, ages 3–11; body mass index in all children

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Highmark Health Options News:

Medical Record Review Standards Now Available on Health Options' Website

Highmark Health Options reviews medical records at least annually to confirm consistent evaluation and documentation of medical care provided to its members. The Medical Record Review (MRR) assesses your compliance with multiple standards such as the National Committee for Quality Assurance (NCQA).

The MRR is approved by the Highmark Health Options Health Quality Improvement & Utilization Management Committee to meet state, federal, and regulatory requirements. Examples of these standards include: documentation of continuity and coordination of care, execution of an advanced directive, legibility of written documentation, follow-up visits, and signing and dating of notes.

As a participating provider in the Highmark Health Options network, you are required to comply with the MRR process. Providers will be notified of their results by letter within 45 calendar days of the MRR. Highmark Health Options is not responsible for any costs associated with the review process.

As a participating provider in the Highmark Health Options network, you are required to comply with the Medical Record Review process.

We encourage you to review the **Medical Record Review Standards**. The Medical Record Review Standards have been added to the Health Options website under **Providers > Quality Guidelines and Resources**. You can print a paper copy of these standards from the website for your records.

Highmark Health Options is committed to ensuring a successful, efficient, and

informative review as we assist you in fulfilling this important requirement. If you have questions about your results and what they mean, please contact the Medical Record Integration Team at 412-255-7199.

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Notifications for Providers

Several times annually, Highmark notifies providers of important policies and guidelines.
The following notifications are for your information and reference.

Preventive Health Guidelines and Clinical Practice Guidelines Available Online

Highmark and participating network physicians annually review and update the Preventive Health Guidelines and Clinical Practice Guidelines, which are distributed to the practitioner community as a reference tool to encourage and assist you in planning your patients' care. To help make the information more accessible and convenient for you, we post the complete set of guidelines online. Just visit highmarkbcbsde.com and click **Provider Resource Center** under **Helpful Links**. (NaviNet® users, simply click on **Resource Center** from the Plan Central page.) Next, go to **Clinical Reference Materials**, and then select **Clinical Practice and Preventive Health Guidelines**.

The Preventive Health Guidelines include:

- adult (under and over 65)
- pediatrics
- prenatal/perinatal

There are Clinical Practice Guidelines for the following conditions/patient needs:

- ADHD
- COPD
- asthma
- cholesterol
- stable ischemic

- depression
- smoking cessation
- management
- diabetes
- substance abuse
- heart disease
- heart failure
- hypertension
- osteoporosis

Please ask your clinical support staff to bookmark this web page as a handy reference tool to help plan your patients' care. To obtain a paper copy of the guidelines, write to:

Highmark
Barb Cole, Director, Accreditation and Compliance
Fifth Avenue Place
120 Fifth Avenue, Suite P4425
Pittsburgh, PA 15222

Appropriate Utilization Decision-Making

Highmark makes utilization review decisions based only on appropriateness of care and service and the existence of coverage. In addition, Highmark does not specifically 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 management decision-makers to encourage denials of coverage.

Request for Criteria

Highmark uses 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. This is done to ensure the delivery of consistent and medically appropriate health care for our members.

If a PCP or specialist requests a service that a clinician in Medical Management & Policy is unable to approve based on criteria/guidelines, the clinician will refer the request to a Highmark Physician Reviewer. A Highmark Physician Reviewer may contact the PCP or specialist to discuss the request or to obtain additional clinical information. A decision is made after all of the clinical information has been reviewed.

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

Help Your Patients Manage Chronic Conditions

You know that many of your patients struggle with one or more health conditions that may slow them down, cause pain, and interfere with quality of life. Those conditions can take a toll on work, family and social life.

You also know the good news: that even serious health conditions can be managed and that the need for emergency care and unnecessary hospitalization can be reduced. Condition management programs are available to Highmark members who need help managing chronic health conditions, including:

- asthma
- diabetes
- congestive heart failure
- coronary artery disease
- chronic obstructive pulmonary disease
- depression
- hypertension
- high cholesterol
- high-risk pregnancy
- inflammatory bowel disease
- metabolic syndrome
- migraine
- musculoskeletal pain
- osteoporosis
- upper GI

A Highmark Health Coach — a registered nurse or health care specialist who teams up with you, the doctor — can help your patients develop the skills they need to

manage their conditions and improve their health and quality of life. Our condition management programs cover all aspects of dealing with a chronic condition, such as understanding a new diagnosis, taking the right medicine at the right time, managing symptoms and changing habits and behaviors that affect overall health. Our Health Coaches provide patients with materials and resources designed to be supportive of your plan of care. There is no cost to the member for these programs.

So, if you have a patient with one or more of the conditions noted above (or any other health concerns), you can refer the patient to Blues On Call by asking him or her to call 1-888-BLUE-428 (1-888-258-3428). Physicians can also refer patients directly by completing the Blues On Call℠ referral form and faxing it to the toll-free number on the form. The form is available online in our Provider Resource Center; click on **Blues On Call**, choose **Practice Resources**, and select the form name from the available links.

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 Highmark patients. (From the Resource Center, click on **Administrative Reference Materials**, then ***Highmark Blue Shield Office Manual***. You'll find the Member Rights and Responsibilities in Chapter 3, Unit 2.) 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 Management (UM) denial decisions with a clinical peer reviewer following notification of a denial determination. Clinical peer reviewers are licensed and board-certified physicians, licensed behavioral health care practitioners, and licensed pharmacists, and they are available to

discuss review determinations during normal business hours. Your call will be connected directly to the peer reviewer involved in the initial review determination, if he or she is available. If the original peer reviewer 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:

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

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Quarterly Formulary Updates Available Online

We regularly update our prescription drug formularies and related pharmaceutical management procedures. To keep our in-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 **Today's Messages** 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/Formulary Information** page, which is accessible from the main menu on the Provider Resource Center.

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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.

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

Laura Pieczynski, Manager, Copywriting
Adam Burau, 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 **adam.burau@highmarkhealth.org**.

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Contact Us

Providers with Internet access will find helpful information online at highmarkbcbsde.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.

Provider Service
1-800-346-6262

Convenient self-service prompts available.

Member Service
1-800-633-2563

Pharmacy Services
1-800-600-2227

Medical Management & Policy
1-800-572-2872

BlueCard
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Contains helpful information for Highmark Health Options providers, too!

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