PROVIDER NEWS
A Newsletter for Highmark Blue Cross Blue Shield Delaware Providers

HIGHMARK. Delaware
Issue 3, 2017

WELVIE:
ENGAGING MEMBERS IN HEALTH CARE DECISION-MAKING

PROFESSIONAL PROVIDERS

Highmark has announced a partnership with Welvie® to offer a new service beginning in June to our Medicare Advantage, commercial fully insured, and Patient Protection and Affordable Care Act of 2010 (ACA) members.

Welvie's program is a six-step curriculum that helps patients as they work with their doctors to explore all of their treatment options — both surgical and non-surgical — when considering "preference-sensitive" surgeries like cardiac valve procedures, knee arthroscopy, or spine fusion.

Preference-sensitive surgeries are those that have two or more viable alternatives for the presenting condition. And if surgery is right for members, Welvie helps patients prepare for surgery so they may have the best results.

The program's goal is to promote improved health literacy, support member-physician interaction, and enhance members' preparation for surgery.

Watch *Provider News* for more information about Welvie and the help and support it will offer to Highmark members.

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Urgent Reminder: Ensure Accurate Provider Directory Information

PROFESSIONAL PROVIDERS

The Centers for Medicare & Medicaid Services (CMS) requires Highmark to conduct a quarterly outreach to validate provider information.* We use this information to populate our Provider Directory and to ensure correct claims processing.

Our members use Highmark's Provider Directory to make the best, informed decisions when selecting a provider. It is, therefore, to your advantage to make sure your directory information is correct and current.

Highmark is committed to ensuring the information in the Provider Directory meets our standards for quality. **Providers who do not validate their data will be immediately removed from the directory. Your status within Highmark's networks may be impacted.**

CMS requires a quarterly review of all physician information listed in the directory to confirm:

- **The provider name is correct.** For example, if a provider marries, we must ensure the provider's name in the directory matches the name on his/her medical license.
- **The practice name is correct.** For example, is there a difference between the

practice name that is being used when phones are answered, versus the practice name listed in the directory?

- **The provider's specialties are correctly listed.** Is there more than one specialty listed in the directory? Are both specialties being practiced?
- **There aren't providers listed at practice locations where they don't actually practice.** Providers listed must be affiliated with the group. Providers who cover on an occasional basis are not required to be listed. Providers who do not see patients on a regular basis at a location should not be listed at that location.
- **The provider is accepting new patients — or not accepting new patients — at the location.**
- **The provider's street address and phone number are correct.**

Note: Your up-to-date information must include your current address, phone number, and fax number, and any and all required data elements set forth in the provider contract(s) with Highmark.

It's vital that all providers review and update their information in NaviNet®. Information should be updated as soon as a change occurs. All data should be reviewed at a minimum of 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**.

We are currently making outreach calls to providers to verify the accuracy of provider data. If you receive a call, please provide the agent with the requested information.

***IMPORTANT NOTE:** Delaware law also requires accurate information and timely updates to health plan provider directories.

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Visit Our Newly Redesigned Provider Resource Center

Easier Navigation, Device-Friendly Viewing Among Key Improvements

We recently unveiled a fresh new look for our online **Provider Resource Center (PRC)** — your one-stop source for provider manuals, medical policy, and all the information you need to do business with Highmark.

Whether you're visiting the PRC through NaviNet® or via **Helpful Links** on our website, you'll notice the PRC's exciting new design. You'll also see several navigational enhancements that will make your PRC user experience more efficient and productive.

And we've created the new PRC with mobility in mind: the site view adjusts for use on smartphones and tablets, enabling you to access its tools and information on the go.

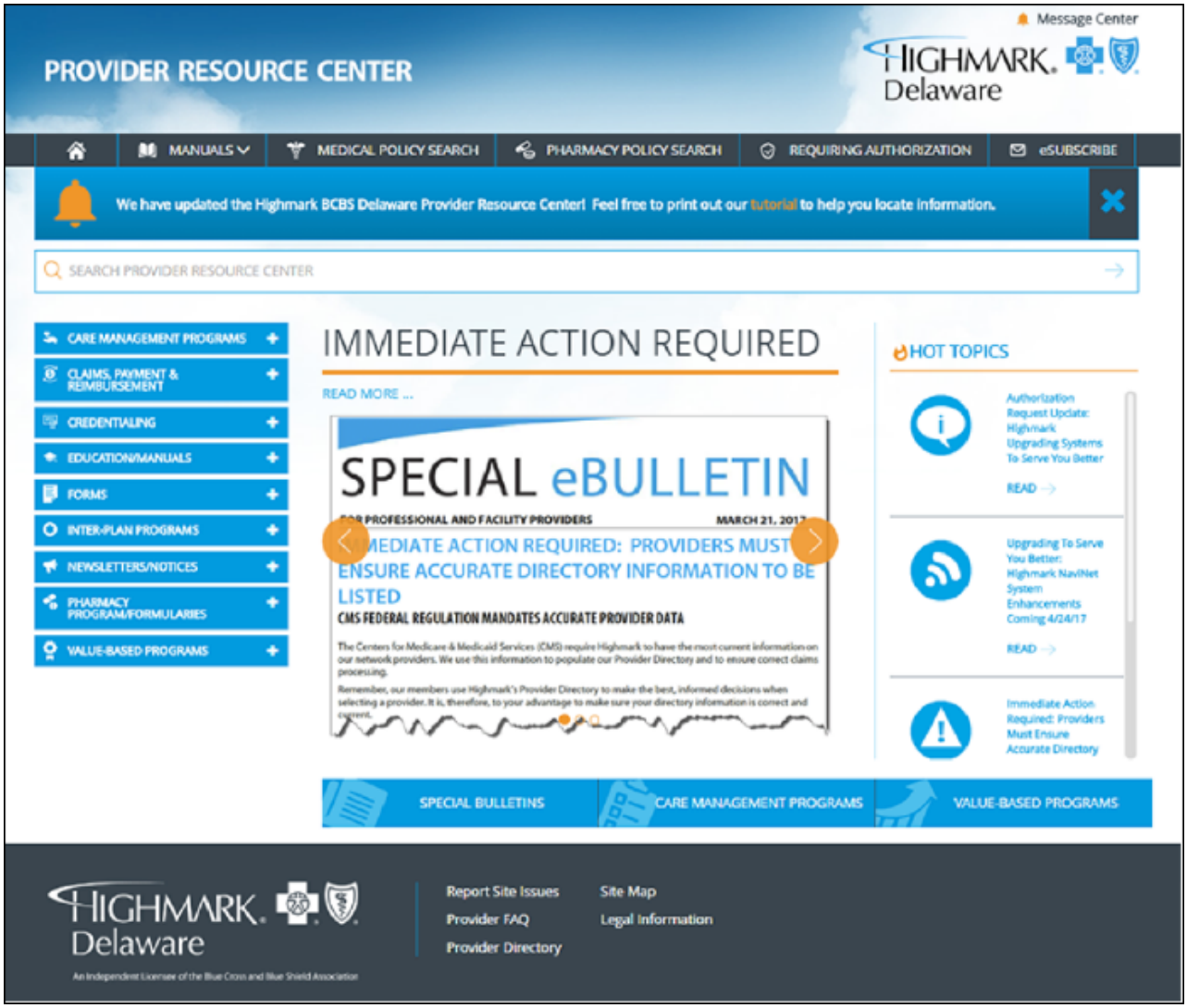
Less clutter

We've significantly condensed the number of links that were listed down the left side of the PRC home page. So that you no longer need to scroll down a lengthy list to find the link you need, we've created nine general information categories, each listed in blue bars at left.

Named as follows, each of the nine categories expands to reveal related sub-categories when you click the "+" symbol beside each one:

- **Care Management Programs** (including the Physical Medicine Management and Radiology Management programs)
- **Claims, Payment & Reimbursement** (including medical and reimbursement policies)
- **Credentialing**
- **Education/Manuals** (including the *Highmark Blue Shield Office Manual* and *Highmark Facility Manual*)
- **Forms**

- **Inter-Plan Programs** (including the BlueCard® Information Center)
- **Newsletters/Notices** (including *Provider News* and e-Subscribe)
- **Pharmacy Program/Formularies**
- **Value-Based Programs**



Easier to access Quicklinks

At the top of the home page, we've made several of the most popular Quicklinks available in gray buttons oriented horizontally across the page. These include **Manuals**, **Medical Policy Search**, and **Pharmacy Policy Search**.

Since these Quicklinks are among the most popular clicks on the PRC, we wanted to make them even easier for you to access on the new site.

Helpful new features

Message Center

Under the Quicklinks bar, provider alerts from our new Message Center will display in a blue banner with an orange bell icon — noting important Highmark news and other

key information. A link to the Message Center also is available above the Highmark logo at the top right. Just look for the orange bell icon. These provider alerts will appear only periodically to notify you of important information, so please click on them when they are visible.

Hot Topics

Listed down the right side of the home page is a new Hot Topics section. Replacing the Today's Messages page, the Hot Topics section links you to Special Bulletins and other announcements regarding recent or upcoming fee changes, formulary updates, and other changes you should know about. Archived messages will be filed in the Hot Topics Library once they are removed from the Hot Topics section.

New search functions

You can still search the entire PRC by using the search window at the top of the home page. But now, you can conduct an advanced search by clicking the question mark at the far right of the search window, helping you find what you need more quickly.

The medical and pharmacy policy searches are still available from those individual pages. But the new site also lets you search within our provider manuals and in our Special Bulletins & Mailings archive. Simply visit the ***Highmark Blue Shield Office Manual***, ***Highmark Facility Manual***, and **Special Bulletins & Mailings** pages, and use the search window provided on each page.

PRC tutorial

Within the Message Center, we've added a helpful online tutorial to lead you through navigating the new site and its many great tools and features. Watch the tutorial today and encourage your colleagues to do the same, so you'll all be up to speed on the great features of our newly redesigned PRC!

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Attention Professional Providers: Helping You Avoid Routine Claim Rejections

PROFESSIONAL PROVIDERS

Highmark's Provider Relations and Medical Policy areas are reporting that some confusion exists among providers regarding the wording and usage of certain procedure codes when submitting claims. This issue is causing a larger-than-normal amount of claims to be rejected with rejection codes P5173 or P5039.

Rejection Code P5173

Rejection Code P5173

P5173 — In order to process the claim, additional information is required. The claim should be resubmitted with a valid procedure code and an associated diagnosis code.

Providers may misunderstand this rejection code and believe that because the description of the service contains the words "routine" or "screening," the routine or screening diagnosis matches the procedure code. Although the words "routine" or "preventative" are included in the description of the service, it does not mean the service falls into either of those categories.

Examples are procedure codes 88142 and 88175, which have the word "screening" in the description but are considered to be diagnostic pathology services. These are being billed with a routine diagnosis such as V76.2 – special screening for malignant neoplasms of the cervix, or Z11.511 – encounter for screening for HPV.

Another example is procedure code 93010, which has the word "routine" in the description but is considered to be a diagnostic medical service. This service is being billed with a routine diagnosis such as Z13.6 – encounter

for screening for cardiovascular disorders.

In order for claims with these procedure codes or any similar procedure codes to be processed correctly, the diagnosis code must not be considered “routine” or “preventative” when the claim is being submitted.

Rejection Code P5039

Providers continue to report procedure codes with 50, LT, and RT modifiers but only report one unit of service. This causes the claim to reject, and the correction is to change the number of units. When including a modifier on your claim, please be sure to list the associated number of services rendered. For clarification, see the ***Highmark Blue Shield Office Manual***, Chapter 5, Claims Submission, Unit 2, Claims Submission and Billing Information. Specifically, see “Reporting Bilateral Procedures,” on page 50.

As a reminder, NaviNet should always be your primary source for information. Many routine claims issues can be resolved using NaviNet.

If you don’t have NaviNet, visit **navinet.net** today to get 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.

Rejection Code P5039

P5039 – In order to process the claim, additional information is required. The claim should be resubmitted with a valid modifier and associated number of services rendered.

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Important Update for Highmark Health Options Providers

Highmark Health Options providers will no longer receive updates in this newsletter. A new e-newsletter called *Provider Update* will alert you to important changes that impact you and our members. We will send information that is more urgent via ***Hospital News*** and ***Special Bulletins*** mailings. You can access the *Provider Update* newsletter at www.highmarkhealthoptions.com/providers/newsletter.

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Reminders About Submitting Medical Records

PROFESSIONAL PROVIDERS

From time to time, you may have questions about submitting medical records to Highmark. The ***Highmark Blue Shield Office Manual*** contains information that explains if/when medical records are necessary to submit and how to submit them. The manual is accessible via the **Manuals** quick link bar on the Provider Resource Center.

As a reminder of where to find this information, key sections of the office manual are listed below.

Medical Records Documentation and Responsibilities
Chapter 2, Unit 3

Medical Records Review
Chapter 2, Unit 3

Medical Records Request – BlueCard® Host
Chapter 3, Unit 5

Unconfirmed Diagnosis Code Program
Chapter 3, Unit 6

Expedited Review of Initial Determinations and Appeals
Chapter 3, Unit 6

Medical Necessity Criteria
Chapter 4, Unit 1

Modifiers
Chapter 5, Unit 2

Claim Audits
Chapter 6, Unit 3

For other questions about submitting medical records to Highmark, please call

Provider Service.

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Hypertension Management Program Offers Free Blood Pressure Monitors to At-Risk FEP Members

PROFESSIONAL PROVIDERS

The Blue Cross and Blue Shield Federal Employee Program (FEP) and the American Medical Association (AMA) have partnered to support and promote screening and treatment of hypertension for FEP members.

You can improve blood pressure control in your practice by having your patients measure their own blood pressure at home. Self-measured blood pressure monitoring may be a more accurate predictor of hypertension than clinical monitoring. Patients who self-measure their blood pressure are more apt to be actively involved in their medical treatment, thus helping them to better manage their condition.

FEP has initiated the Hypertension Management Program to provide free electronic blood pressure monitors to FEP enrollees over age 18 who have a diagnosis of hypertension, or who have high blood pressure without a hypertension diagnosis. Self-measured blood pressure monitoring is not only easy and cost effective, but may also improve medication compliance.

If your FEP patient completes a Blue Health Assessment (BHA) and reports that he or she has high blood pressure and you and your patient discuss and agree to home monitoring, your patient is eligible for a free blood pressure monitor. The BHA, a

health-risk assessment, is the first step in the FEP Wellness Incentive Program. You can help your patients understand the importance of monitoring and managing their high blood pressure by sharing the Controlling High Blood Pressure flier with them.

Blood pressure control resources and other FEP heart health programs

As part of the collaboration between FEP and the AMA, we're making the following downloadable AMA hypertension information fact sheets available to your practice:

- Measure Accurately and Promote Self-Measured Blood Pressure Monitoring at Home
- Clinical Competency: Self-Measured Blood Pressure at Home
- How to Check a Home Blood Pressure Monitor for Accuracy

You can find more information about other FEP programs that support heart health at fepblue.org.

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Warning to Providers About Fraudulent Prescription Scam

PROFESSIONAL PROVIDERS

Highmark's Financial Investigations and Provider Review unit has been made aware of a new scam involving fraudulent prescriptions being faxed to physicians. We've received complaints from Highmark members who have received unwanted large quantities of medications and supplies. These complaints prompted us to conduct numerous investigations into these suspected fraudulent prescriptions.

We've learned that telemarketing companies are contacting members and obtaining their primary care physician's contact information. Then, the companies fax prescriptions to the physician's office to obtain his or her authorization.

How to avoid the faxed prescription scheme

Highmark urges you to pay attention to any prescriptions or certificates of medical necessity (CMN) received through fax from pharmacies or suppliers indicating that the patient has requested the medication or supplies. Be on the alert for the following types of requests:

- Acid reflux or GERD medication (omeprazole sodium bicarbonate)
- Braces – knee, neck, back, or wrist
- Compound creams
- Diabetic supplies, blood glucose meters, alcohol pads, test strips, lancet devices, control solutions, and lancets
- Non-steroidal anti-inflammatory drugs such as mefenamic acid or fenoprofen calcium
- Scar and skin creams (Urevaz or fluocinonide)
- TENS units and associated supplies, such as electrodes, leads, and batteries
- Topical pain creams (lidocaine, diclofenac sodium, Vanatol LQ, and combination packs)
- Vitamins

Red Flags

- The prescription or CMN typically will be completed with the medication or supplies and SIG (label or directions) already filled in, including the number of refills.
- The quantity of the medication will be high. Most ointments, gels, and creams are dispensed in grams. Most tubes and jars come in sizes of 35.4, 50, or 100 gram sizes. The questionable prescriptions could list the quantity anywhere from 248 to 744 grams.
- The requesting pharmacy will usually be out of state.
- The prescription could list multiple options in categories such as topical pain therapy; wellness; scar or dermatitis; eczema; general or diabetic neuropathy; inflammatory pain; arthritis; acid reflux; or GERD.

The list of medications can change. Please review any prescription carefully that your office did not initiate. If you are not sure that the patient actually requested the medication, please do not approve the request.

If you believe your office has received questionable prescriptions, you may contact the Highmark Fraud Hotline at 1-800-438-2478. You also may fax the

suspicious prescription to us for further review at 717-635-4590.

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Updates to Locum Tenens Policy and Credentialing Rights Information

Highmark recently announced the following important credentialing policy updates for our network practitioners:

Change to locum tenens policy coming 8/22/17

Beginning Tuesday, Aug. 22, 2017, Highmark will update its locum tenens policy to shorten the credentialing timeframe for physicians who practice temporarily in place of network physicians. As of Aug. 22, locum tenens physicians who practice as substitutes for at least 60 days must complete initial credentialing with Highmark. (The current practice limit is six months before credentialing is required.)

Chapters 2.2, 2.3, and 2.4 of the *Highmark Blue Shield Office Manual* will be updated to reflect this change. The change won't be noted in the manual until Aug. 22.

For information on other locum tenens provider requirements, see the *Highmark Blue Shield Office Manual*.

Credentialing rights information updated in manual

Highmark recently updated the Practitioner Credentialing Rights section in the *Highmark Blue Shield Office Manual*. This section is found in Chapter 2, Unit 2, of the manual.

The updates are noted in blue italics on pages 14 through 16 and address the following topics:

- The practitioner's right to review certain information submitted about him/her from outside sources during the credentialing process
- Notification of discrepancy between practitioner- and source-submitted information
- The right to correct any erroneous information
- The right to be informed of his/her credentialing status
- Communication regarding availability of practitioner credentialing rights information

Consult the *Highmark Blue Shield Office Manual* for complete credentialing information.

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Medicare Advantage News

Key FAQs About Medicare Compliance and 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 and 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
- Medicare Parts C&D Fraud, Waste, and Abuse (FWA) Training

Q **Who must complete these trainings?**

A Individuals associated with your organization who work with Highmark's Medicare Advantage and/or Medicare Part D Prescription Drug Plan (PDP) patients and who fall into one of these categories:

- employee
- governing-body member
- temporary worker
- contractor
- subcontractor
- volunteer

Why does CMS require these individuals to complete these trainings?

CMS expects Highmark and its other Medicare-plan sponsors to ensure that all
organizations receiving Medicare dollars understand how to comply with the laws, regulations, guidelines, and policies that come with the Medicare program and how to prevent, detect, and correct Medicare fraud, waste, and abuse.

When does CMS require these individuals to complete these trainings?

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)

Where can individuals go to access these trainings?

Individuals have three options for completing these training requirements. They can:

- Complete both trainings located on 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.
- Complete your organization's General Compliance Training and Fraud, Waste, and Abuse Training as long as it includes all of the content included in CMS's trainings, without any modifications.

What proof must be provided that the trainings were completed?

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 contract with Highmark, plus an additional 10 years.

Are there any exceptions to these guidelines?

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.

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Medicare Advantage News

You May Be Asked to Submit Member Charts for Retrospective Review

In coming weeks, you may be asked to submit individual member medical records to Highmark for review to comply with Centers for Medicare & Medicaid Services (CMS) requirements.

CMS requires Highmark to ensure the accuracy and integrity of diagnosis codes that providers have submitted on claims for payment. Those codes must have been documented in members' medical records as a result of face-to-face visits with them.

All diagnoses must be coded according to the CMS *International Classification of Diseases (ICD) Clinical Modification Guidelines for Coding and Reporting.*

Highmark began the chart retrieval process April 3, and providers are being contacted randomly to participate through Oct. 20.

What information is being reviewed?

Member medical records are being reviewed to verify that complete and accurate documentation exists to support confirmed or suspected chronic illnesses and conditions diagnosed during patient visits.

In some cases, diagnosis-related information contained in medical records doesn't get reported to Highmark via claims data. This program is intended to get a complete account of all diagnosis codes supported by medical record documentation and to evaluate the specificity of ICD-10-CM coding.

The initiative complies with applicable laws, rules and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

When and how will I be contacted?

You may be contacted any time from now through Oct. 20. If you are selected to participate in the chart review process, one of three approved Highmark vendors will contact your office or facility:

- CIOX Health (formerly known as ECS and Healthport)
- Verscend (formerly known as Verisk)
- ArroHealth (formerly known as MedSave)

According to the provisions of your Highmark provider agreement, you are required to supply copies of any requested member medical records to the vendor that contacts you. The vendor won't ask you to submit original records. However, complete medical records must be submitted within 30 days of request and without charge.

The vendor will contact you most likely by telephone to verify the list of Highmark members' names and to discuss methods for submitting their individual records. Then the formal request and list will be mailed or faxed to you.

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Notifications for Providers

PROFESSIONAL PROVIDERS

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

See *Highmark Blue Shield Office Manual* for Participation Rules; Credentialing/Recredentialing Criteria and Procedures; Medical Record Criteria; and 24/7 Coverage Requirements

In-network providers should consult the ***Highmark Blue Shield Office Manual*** for information outlining the health plan's network participation rules; credentialing/recredentialing criteria and procedures; medical record criteria; and 24/7 coverage requirements. The manual is available under the **Education/Manuals** link on Highmark's online Provider Resource Center, which is accessible via NaviNet® or under Helpful Links at highmarkbcbsde.com.

Information on these vital topics can be found in "Chapter 2: Provider Participation and Responsibilities," in the following sub-units:

Participation rules:
Unit 1: "How to Participate in Highmark's Networks"
Unit 5: "Specialist Basics"

Credentialing/recredentialing criteria and procedures:
Unit 2: "Network Credentialing Procedures"

Medical record criteria:
Unit 3: "Network Requirements and Procedures"

24/7 coverage requirements:
Unit 2: "Network Credentialing Procedures"

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Quarterly Formulary Updates Available Online

PROFESSIONAL PROVIDERS

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 in the Provider Resource Center's **Hot Topics** section 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 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
Joe Deemer, Copy Editor
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**.

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
1-800-676-BLUE (2583)

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