Of all the factors contributing to high health care costs, there is one that must be addressed by both employers and health insurers: There are simply too many people who rely on health care to solve all of their health problems, too many who discover too late that the way they live contributes to the quality of their health.

This remains true in spite of all the evidence linking many serious health problems to lifestyle-related behaviors. For example, we know that obesity can lead to diabetes and heart disease and that stress weakens the immune system, opening the way for illnesses. And there is no longer any question on the dangers of smoking — it’s the single largest cause of preventable death in our country today.

Behavior modification is key to the solution. That is why Highmark has launched an exciting new program called Lifestyle

Lifestyle Returns, which became available in the marketplace earlier this year. Its goal is to engage members in lifestyle changes, preventive care, management of chronic conditions and education.

Lifestyle Returns is a consumer-driven program that rewards members for taking responsibility for their health. It’s designed to motivate them to quit smoking, eat sensibly, exercise, take the right prescriptions, as appropriate, get the recommended screenings and use the health care system wisely.

The program includes Worksite Health Promotion classes, YMCA and hospital-based classes, online programs and benefit designs that encourage preventive care, plus an employer-sponsored reward/incentive for members. Some examples of rewards can include a lower employee contribution, a higher level of benefits, an end-of-year rebate or a non-cash incentive.

Recently, Orrstown Bank became the first employer in the region to offer the Lifestyle Returns program to its employees. About 117 staff members located across 13 banking offices and three remote service facilities in Cumberland and Franklin counties are now participating in the program.
Highmark Launches Lifestyle Returns℠
(continued from cover)

What Providers Need to Know
Members who have the Lifestyle Returns program will be encouraged and motivated to seek appropriate preventive services, such as mammography, annual gynecological exams and annual physicals.

They also may be more motivated to discuss healthy lifestyle and behavior modification issues. Remember that you can always direct Highmark members to Blues On Call℠ (1-888-BLUE-428) and their My Shield Online℠ page on our Web site at www.highmarkblueshield.com for lots of helpful information, resources and guidance, including many free services offered by our Preventive Health Services division.

Also, note that to encourage members to obtain appropriate preventive care, they will be given a My Wellness Scorecard, as shown below. Its purpose is to help members record when they’ve received certain services (e.g., mammogram, annual physical, etc.), along with results, then enter the information online. So, members in the Lifestyle Returns program may be more likely to ask for the detailed results of their screening.

Members may also print a copy of the scorecard from our Web site.*

Benefits for preventive care are limited to those services that are covered on the preventive schedule that the employer group provides. Most groups follow Highmark’s Preventive Schedule, but others create their own. Therefore, it’s important to verify benefits before performing or ordering preventive services.

Most services on Highmark’s Preventive Schedule are covered based on age, sex and risk factors. It’s important to follow the schedule carefully and use the appropriate codes. If a member requires a test for a medical reason but falls outside of the age/sex/frequency limits on the schedule and a preventive or screening procedure code is used, the claim will be denied. In these situations, since the member has a medical diagnosis, a medical procedure code should be used so the claim will be processed as medical and not routine.

Member Requirements
Members who have the Lifestyle Returns program built into their coverage will be required to:
- complete online pledge
- complete online Wellness Profile
- complete lifestyle improvement and/or condition management programs, use Blues On Call℠ or receive a flu shot
- obtain appropriate preventive care (screenings/exams)
- use online self-care guides

Note: The online materials listed previously are available on the members’ My Shield Online page at www.highmarkblueshield.com.

Copay Information
Members who participate in Lifestyle Returns will have a new copay for routine physical/routine gynecological exams indicated on their ID cards. You’ll see “RT PHY/RT GYN” on the ID card, as shown here. Note: The copay amount will vary, depending on the employer’s benefit elections.

The Comprehensive Preventive Exam procedure codes included in this copay category include:
- Gyn Exams: G0101, S0610, S0612 and S0613
- Routine Physical Exams (Pediatric): 99381 through 99384, 99391 through 99394, and 99432
- Routine Physical Exams (Adult): 99385 through 99387, 99395 through 99397

Rewards That Last a Lifetime
Lifestyle Returns takes the proven data on health behavior change and creates a new opportunity for members, their employers and Highmark to make a mutual commitment. And, with the support of our network providers, Lifestyle Returns will proactively encourage healthier lifestyles to help prevent and control chronic illness.

National Provider Identifier: What You Need to Know

Are you a covered entity under the Health Insurance Portability and Accountability Act (HIPAA) of 1996? If so, you will be required to obtain a unique National Provider Identifier (NPI) number no later than May 23, 2007.

What is an NPI?
The NPI is a unique identifier that will improve efficiency because it identifies and enumerates health care providers at the national level and eliminates the need for multiple identifiers from different health plans. The 10-digit enumeration won’t contain any embedded demographic information, such as provider type or specialty.

Who Needs to Apply?
The NPI is applicable to both individual providers (e.g., physician, physical therapist, etc.) and organization providers (e.g., group practice, hospital, DME supplier, home health agency, etc.). HIPAA-covered entities include providers who conduct their health care administrative transactions electronically. However, Highmark plans to use the NPI as the identifier for all providers eligible to receive one, regardless of electronic status.

If you aren’t a HIPAA-covered entity, you can still obtain an NPI as long as you are considered to be an eligible provider under HIPAA. Having an NPI doesn’t impose HIPAA-covered entity status on a health care provider.

When and How Should You Apply?
NPIs are now being assigned, and many providers already have obtained their NPIs. You have until May 23, 2007, to obtain an NPI, but you are encouraged to apply now. Highmark will notify you when you can begin using NPIs on standard transactions.

The National Plan and Provider Enumeration System (NPPES) is the central electronic enumerating system in place for this process. You can apply in several ways:
- Complete the Web-based application process online at https://nppes.cms.hhs.gov.
- Download and complete a paper application from the Web site, and mail it to NPPES.
- Call NPPES at 1-800-465-3203 (TTY: 1-800-692-2326) for a paper application.

Report Your NPI to Highmark
So that Highmark can store your NPI, send us a fax or e-mail, as noted below. If you’d like, you may simply forward your NPPES confirmation e-mail. Be sure to include your name, Highmark provider number and NPI on any submission. Thank you, in advance, for your cooperation.

Fax: 1-800-236-8641
E-mail: PDSPNIIPUPDATE@Highmark.com

*The Web site version of the scorecard may appear differently than the one pictured here. 
Every day, the physicians, nurses, medical assistants and other patient care professionals in your office come into close contact with countless patients—from children with a mild sniffle to seniors with chronic conditions. As we enter the 2005-2006 influenza season, chances are that many of those patients will be carrying the flu virus. And it’s highly likely that your patient care staff will become infected—and could incur complications of the virus.

That is why Highmark asks you to please promote flu vaccination not only among your patients but also among your direct patient care staff.

Surprising Statistics
Each year across America, five to 20 percent of the population gets influenza, more than 200,000 people are hospitalized from flu complications and about 36,000 people die from the virus, according to the Centers for Disease Control and Prevention (CDC). Yet, a surprisingly low number of health care workers receive the flu vaccine.

Last year in Pennsylvania, just 35.7 percent of health care workers received the flu vaccine, according to the Behavioral Risk Factor Surveillance System (BRFSS) survey, an ongoing, state-based, telephonic survey that monitors influenza vaccination. That number represents a slight dip from the 40.1 percent of health care workers across the state who received a flu shot in 2003.

Despite last year’s vaccine shortage, the CDC included health care workers with direct patient contact as one of eight high-risk groups who should receive immunization. For 2005, the CDC’s Advisory Committee on Immunization Practices has updated its recommendation as follows: “All health-care personnel should be vaccinated against influenza, and facilities that employ health care workers should be encouraged to provide vaccine to workers in ways that maximize uptake.”

Ideas for Promoting Vaccination to Your Staff
Of course, vaccination can’t be forced on anyone—including health care workers. From misperceptions or anxieties about the vaccine, to indifference about the virus, to a fear of needles, the reasons are many as to why individuals ignore or avoid flu immunization.

But perhaps these ideas may help you in promoting immunization among your patient care staff:

► Create a culture where all patient care staff, including top physicians, commit to influenza immunization and establish immunization goals.
► Display positive messages about influenza immunization throughout the office, including employee break rooms.
► Encourage employees to receive immunization and then serve as advocates for influenza immunization for fellow health care workers and patients.
► Provide education to dispel myths about immunization and use all possible means to deliver the information.
► Create a team to develop an employee influenza vaccination program with a year-round focus.
► Offer vaccination free of charge to all staff—including full-time and part-time employees.

In the end, delivering this simple message to staff who are on the front lines of the flu battle may be all that you need to do: By getting a flu shot, you’re doing your part to protect yourself and your high-risk patients against the virus, not to mention safeguarding your colleagues at work and your family members at home.

To track the latest vaccine availability information and get updates to immunization guidelines, you may want to frequently visit the CDC’s Web site at www.cdc.gov.

Administrative Codes to Remember This Flu Season

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Applies to</th>
</tr>
</thead>
<tbody>
<tr>
<td>90655</td>
<td>Influenza virus vaccine, split virus, preservative free</td>
<td>Children 6 to 35 months</td>
</tr>
<tr>
<td>90656</td>
<td>Influenza virus vaccine, split virus, preservative free</td>
<td>Individuals ages 3 years and older (new code)</td>
</tr>
<tr>
<td>90657</td>
<td>Influenza virus vaccine, split virus</td>
<td>Children 6 to 35 months</td>
</tr>
<tr>
<td>90658</td>
<td>Influenza virus vaccine, split virus</td>
<td>Individuals ages 3 years and older</td>
</tr>
</tbody>
</table>

Diagnosis Code To Be Used
Please report diagnosis code V04.81. Please note that diagnosis code V04.8 is no longer the most specific code available. Claims using code V04.8 will be rejected.

Procedure Codes To Be Used
HCPCS procedure code 90659, which was previously used for reporting flu shots, has been deleted. This season, providers should use the following codes for reporting flu vaccine injections:

HCPCS code 90660, which was previously used for reporting flu vaccine injections, has been deleted.

Claims using code 90660 will be rejected.
Questions?
Providers with Internet access will find helpful information online at www.highmarkblueshield.com and www.highmark.com. NavNetSM users should use NavNet for all routine inquiries. But if you need to contact us, below are the telephone numbers exclusively for providers:

HIGHMARK
1-866-731-2045
   Option 1 – Claim status, benefits and enrollment
   Option 2 – Customer Service
   Option 3 – Forms orders
   Option 4 – Provider Relations representatives
   Option 5 – Radiology Management Program
1-866-731-8080 – HMS pre-certification/authorization requests (including behavioral health authorizations)
1-866-634-6468 – Requests for HMS peer-to-peer conversations
1-800-992-0246 – EDI Operations (electronic billing)
1-866-488-0548 – Questions concerning Medicare Part B

HEALTHGUARD
1-800-513-0980 – Customer Service (claim status, coverage/benefits, policy/procedures and enrollment/eligibility; fax: 717-581-4580)
1-800-269-4606 – Utilization Management voice mail pre-certifications for inpatient admissions and ambulatory surgeries (digital pager: 717-951-6041, after-hours/weekend requests)
1-800-513-1914 – Fax line for referral and pre-certification forms
1-866-731-2045, Option 4 – Provider Relations representatives

Comments/Suggestions Welcome
We want Behind the Shield to meet your needs for timely, effective communication. If you have any suggestions, comments or ideas for articles in future issues, please call your Provider Relations representative, toll-free, at 1-866-731-2045, Option 4, or write to the senior editor at:
   Behind the Shield
   Highmark Blue Shield
   Fax: 412-544-5234
   adam.burau@highmark.com

For More Information
For NavNet users, this icon following an article means that the material/information is conveniently accessible from Plan Central. Just click on Resource Center.

For providers who don’t yet have NavNet access, this icon means that the material/information is available on Highmark’s Web site at www.highmarkblueshield.com. Just click on Provider Resource Center in the lower, right corner.

New Effective Date Announced for Prior Authorization
To accommodate the needs of our network providers, Highmark has delayed by one month the effective date for the Prior Authorization component of its Radiology Management Program, from March 1, 2006, to April 1, 2006. Specifically, providers wanted earlier access to the National Imaging Associates (NIA) Inc. Call Center and the NavNet authorization functionality, so that they could begin to request auths for dates of service falling on or after the implementation date. To honor this request and meet our own internal requirements, a one-month delay is necessary.

Watch Your Mail for Prior Authorization Guide
Network providers who routinely order imaging scans for their Highmark patients are asked to please watch their mail for the Prior Authorization Reference Guide for Ordering Physicians.

This handy reference guide will give you a wealth of information regarding the Prior Authorization process, which will require providers to obtain an authorization number when ordering selected outpatient, non-emergency, advanced imaging procedures for their Highmark patients. (This process doesn’t apply to imaging procedures performed as part of an emergency room visit or inpatient stay.) The booklet also will be available soon on our Provider Resource Center, under the Highmark Radiology Management Program link.

Until Prior Authorization goes into effect for dates of service of April 1, 2006, and beyond, ordering providers are asked to please continue to follow the Prior Notification Phase process; the current Prior Notification Phase is an interim step to prepare network ordering providers and to offer a period to become acquainted with the guidelines. Your cooperation, as the ordering physician, is greatly appreciated.

Selected Privileging Guidelines Changed
Highmark has nearly completed the Privileging Phase of its Radiology Management Program, a period that involves privileging the imaging network to ensure that all providers meet appropriate quality and patient safety guidelines.

Throughout this process, the following revisions were made to the program’s privileging guidelines:

► A new limited obstetrical ultrasound diagnostic imaging procedure (DIP) level (U-53) has been created.
► Cardiac stress tests must now be performed only under the direct supervision of credentialed physicians who have Advanced Cardiac Life Support (ACLS) certification.
► The minimum required hours of operation for CT/MR imaging providers have been reduced to 40 hours per week. The requirement for weekend and evening hours has been eliminated, although non-standard hours are still encouraged.

The most-up-to-date version of the complete set of privileging guidelines is available on Highmark’s online Provider Resource Center, under the Highmark Radiology Management Program link. Also provided there are the Prior Notification Phase Reference Guide for Ordering Physicians and a list of the DIP levels.

Watch Behind the Shield and the NavNet Plan Central page for program updates.
In the fall of 2004, Magellan Health Services conducted a Behavioral Health Member Satisfaction Survey on Highmark Blue Shield’s behalf. The survey tool combined questions from three separate sources, the Consumer Assessment of Health Plans Survey (CAHPS®), Performance Measures for Managed Behavioral Healthcare Programs (PERMS) and Experience of Care and Health Outcomes (ECHO®). The survey included key aspects of member satisfaction, such as access to practitioners and treatment and the service provided by the health plan. Two hundred and ninety-six members responded out of 550 eligible members, for a response rate of 54 percent.

Summary of Results:

<table>
<thead>
<tr>
<th></th>
<th>Top Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2004</td>
</tr>
<tr>
<td><strong>Overall Satisfaction</strong></td>
<td></td>
</tr>
<tr>
<td>Treatment received from therapist/counselor</td>
<td>92.6%</td>
</tr>
<tr>
<td>Therapist/counselor’s skill matched member’s concerns</td>
<td>92.1%</td>
</tr>
<tr>
<td>Services received from Highmark</td>
<td>96.7%</td>
</tr>
<tr>
<td><strong>Access to Services</strong></td>
<td></td>
</tr>
<tr>
<td>Getting necessary treatment</td>
<td>89.3%</td>
</tr>
<tr>
<td>Easy to find a therapist/counselor</td>
<td>92.4%</td>
</tr>
<tr>
<td>Delay in care while waiting for approval from Highmark</td>
<td>95.4%</td>
</tr>
<tr>
<td><strong>Therapist/Counselor Treatment</strong></td>
<td></td>
</tr>
<tr>
<td>Ability to function at work and/or home has changed</td>
<td>80.4%</td>
</tr>
<tr>
<td>Spent enough time with member</td>
<td>95.9%</td>
</tr>
<tr>
<td>Listened carefully to the member’s concerns</td>
<td>95.9%</td>
</tr>
<tr>
<td>Explained treatment plan</td>
<td>92.5%</td>
</tr>
<tr>
<td>Responded in timely manner outside of normal business hours</td>
<td>89.7%</td>
</tr>
<tr>
<td>Got through to the therapist/counselor by phone</td>
<td>82.7%</td>
</tr>
<tr>
<td><strong>Office Staff and Service</strong></td>
<td></td>
</tr>
<tr>
<td>Treated member with courtesy and respect</td>
<td>97.4%</td>
</tr>
<tr>
<td>As helpful as they should be</td>
<td>96.1%</td>
</tr>
<tr>
<td>Days waiting between appointments that were offered</td>
<td>66.0%</td>
</tr>
<tr>
<td>Wait 15 minutes past appointment time</td>
<td>88.3%</td>
</tr>
</tbody>
</table>

**Analysis**

A strong commitment to customer service by Highmark and its behavioral health network providers is reflected in these member satisfaction scores.

- **Overall**, member satisfaction remains very high.
- **Members** are very satisfied, as shown by the increase in the satisfaction levels, with:
  - getting necessary treatment
  - the ease of finding a therapist/counselor
  - the lack of delay waiting for approval from Highmark
  - the time their therapist/counselor spends with them

- While satisfaction rates with behavioral health care and services are high, there is a general declining trend from 2003 to 2004 in various questions in the following categories:
  - overall satisfaction
  - therapist/counselor treatment
  - office staff and service

We appreciate the ongoing support and service you provide to our members and thank you for the many ways you and your staff contribute to maintaining high-quality and timely services.

*Medical management for behavioral health services was transitioned from Magellan Health Services to Highmark on July 1, 2005.

---

**INTRODUCING EPOBLUE SM, Coming in January 2006**

Highmark Blue Shield has launched a new product called the Exclusive Provider Organization, or EPOBlue℠. We believe this product will be favored by our national group customers; therefore, we don’t anticipate a large volume of membership to reside within central Pennsylvania and the Lehigh Valley. However, on occasion, you may see an EPOBlue member. If so, here’s what you need to know.

**How does EPOBlue work?**

EPOBlue is designed like a PPO product, and it will follow the medical management guidelines in place for our PPO product line, including authorization for inpatient admissions and for certain non-emergency, advanced imaging procedures through our radiology management program. However, there are no out-of-network benefits. Across the country, EPOBlue utilizes the local Blue Plan’s PPO network. But here in central Pennsylvania and the Lehigh Valley, the product utilizes the PremierBlue℠ Shield network.

- **Network:** PremierBlue Shield
- **Fee Schedule:** PremierBlue Shield
- **Benefit Design:** In-network coverage only; no out-of-network coverage, except emergency care; no PCP; ID card will indicate copay amount; check all other benefits information via NaviNet℠, OASIS or InfoFax.

**Why EPOBlue?**

EPOBlue was created to meet the following needs of Highmark’s group business:

- It is for national group customers who like HMOs, but dislike the administrative burden of choosing different locally based HMOs for their employees across the country, where networks and requirements vary. EPOBlue allows the group customer to offer all of their employees, no matter in which states they reside, a consistent benefit design, network and administration.

- It is for local group customers who are interested in a closed network PPO. EPOBlue offers the flexibility of a PPO product, with no out-of-network benefits.
Update for Highmark and HealthGuard Provider Office Staff:
Helping Patients With Diabetes — You Can Make a Difference

An estimated 18.2 million Americans, or 6.3 percent of the population, have diabetes — the sixth leading cause of death in the United States, according to the United States Department of Health and Human Services.

As a member of a physician’s office staff, you can have a positive impact on helping patients manage their diabetes. Patients look to their physicians as the experts, but it’s you who answers the phone when they call, and yours may be the face they think of when they’re off to “see the doctor.” You schedule their appointments, take their messages and call in their prescriptions. You weigh them, check their blood pressures, obtain their histories and set them up in the exam room.

It’s you who reinforces “what the doctor told them;” and it’s you who has the opportunity to supply those all-important last words of encouragement before they walk out your door.

By being understanding, supportive and encouraging, you can reinforce to patients the importance of following through with all tests that can help them manage their disease and stay healthy.

Summary of Recommended Tests for Diabetic Patients

- A1c – every 3-6 months (Goal <7%)
- LDL-C – every year (Goal <100 mg/dl)
- Dilated retinal eye exam – every year with an eye care specialist
  (This medical eye exam is a covered medical benefit for all Highmark members with diabetes. A dilated retinal exam for diabetes is different from a routine exam for glasses, and a separate vision plan is not needed.)
- Kidney monitoring – urine microalbumin every year

In addition, remember the following for your diabetic patients:
- blood pressure and weight – at every visit
- comprehensive foot exam – at every diabetes visit
- flu vaccine – every year
- pneumonia vaccine – usually one shot in a lifetime

Free Resources Available

For Highmark patients:
To assist physician office staff in helping patients understand their chronic conditions and the importance of managing them, Highmark’s Blues On Call® program has health coaches who can provide patients with physician-approved information on a variety of topics, including diabetes. To reach a health coach, your Highmark patients can call 1-888-258-3428 (1-888-BLUE-428). Your Highmark patients also can access Blues On Call’s Healthwise Knowledgebase® — a comprehensive, evidence-based resource of accurate, physician-approved information for medical consumers — on their My Shield Online page at: www.highmarkblueshield.com.

For HealthGuard patients:
You and your HealthGuard patients can access valuable information online about managing diabetes and staying healthy. At www.hguard.com, printable diabetes education sheets are available and feature such topics as exercising, taking herbal supplements, preparing holiday meals and more. From the HealthGuard home page, click on Member Services, then Health Management at HealthGuard. Select Diabetes from the toolbar at left to display links to each patient education sheet.

For all patients:
Another resource is Quality Insights of Pennsylvania, a quality improvement organization. Quality Insights has created PROMOTE (Practice Resources to Optimize Medical Office Team Excellence) for health care professionals as part of a physician office improvement program. Quality Insights has a complete tool kit, including patient education materials, posters, log books and documentation tools. All materials are shipped directly to your office, whenever you need them, free of charge, and in whatever quantity you require. To order free materials, contact Quality Insights at:
Quality Insights of Pennsylvania
2601 Market Place Street, Suite 320
Harrisburg, PA 17110
Telephone: 1-877-346-6180, ext. 7824
Fax: 717-671-5970
E-mail: www.qipa.org/Feedback.asp

Together, we can improve the lives of your patients and our members to help them live longer, healthier lives.

Diabetes and Disparity

African Americans are 1.5 times more likely to have diabetes than Caucasians.
- 8.4 percent of all non-Hispanic Caucasians aged 20 and older have diabetes while
- 11.4 percent of all non-Hispanic African Americans aged 20 and older have diabetes

African Americans with diabetes have a 27 percent higher death rate than Caucasians with the disease.

Highmark’s own data shows that African Americans in the Medicare group are significantly less likely to have LDL cholesterol testing than their Caucasian counterparts.

Who is at Risk for Diabetes?

Anyone with one or more of the following should be considered for screening for diabetes:
- age 45 or older
- overweight
- physically inactive
- family history of diabetes (parent, brother or sister)
- women who have given birth to a baby weighing more than 9 pounds
- African Americans, Hispanic Americans/Latinos, Native Americans, Asian Americans, Pacific Islanders
The major cause of blindness in people with diabetes is diabetic retinopathy.

Diabetic retinopathy is a term used for abnormalities of the small blood vessels of the retina (the back of the eye) caused by diabetes. These abnormalities include weakening of the blood vessel walls or leakage from the blood vessels that can cause bleeding into the fluid-filled center of the eye or swelling of the retina, and lead to blindness.

The keys to preventing diabetes-related eye problems are:
1. good control of blood glucose levels
2. a healthy diet and exercise program
3. proper eye care

The Diabetes Control and Complications Trial (DCCT), a 10-year study of people with diabetes, showed that improved blood glucose control prevents or delays diabetic retinopathy. Therapy that keeps blood sugar levels as close to normal as possible reduced damage to the eyes by 76 percent. (New England Journal of Medicine, Sept. 30, 1993) Because a person with diabetes can have retinopathy and not know it, a regular comprehensive eye exam by an eye care professional is essential to detect retinopathy early and possibly prevent blindness.

For Highmark and HealthGuard members with a diagnosis of diabetes, a yearly dilated eye exam by an eye care professional (ophthalmologist or optometrist) is covered under their medical insurance. They do not need a separate “vision plan” to take advantage of this sight-saving examination.

Remember, if your Highmark patients would like to find out more about diabetes or any other condition, encourage them to call Blues On Call® at 1-888-BLUE-428 (1-888-258-3428). Blues On Call is available 24 hours a day and connects your patients to a specially-trained Nurse Health Coach who will answer questions about any health concern; discuss treatment options for any condition, including diabetes; and provide other valuable resources and support to help them work with you to make good decisions. Blues On Call also offers helpful educational mailings, follow-up calls or e-mails and ongoing support to help your patients manage their disease and lead the healthiest lifestyle possible. HealthGuard patients can access valuable information online about managing diabetes, heart disease and hypertension and staying healthy. At www.hguard.com, printable patient education sheets are available and cover a wide variety of topics pertaining to these conditions. From the HealthGuard home page, members should click on Member Services, then Health Management at HealthGuard. Select Diabetes or the desired chronic condition from the toolbar at left to display links to each patient education sheet.

Covered medical benefits for diabetes include:
- A1c testing to assess blood sugar control every 3-6 months
- LDL cholesterol testing yearly, or more often, as needed
- dilated eye exam by an eye care professional yearly, or more often, as needed
- yearly microalbumin urine test to monitor for kidney disease

Please encourage your patients to regularly have these life-saving tests.
Notifications for Providers

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

CORRECTION:
Practitioner Access Standards for Highmark and HealthGuard

The Highmark and HealthGuard practitioner access standards article included in the June 2005 issue of *Behind the Shield* contained incorrect information regarding the Standards for Accessibility of PCPs and medical specialists. The correct information is reflected in the table at right. Highmark and HealthGuard strive to provide accurate information at all times and regret the error.

### PCP and Medical Specialist Standards

<table>
<thead>
<tr>
<th>Patient’s Need:</th>
<th>Performance Standard:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency/life-threatening care</td>
<td>Immediate response</td>
</tr>
<tr>
<td>Urgent care appointments</td>
<td>Office visit within 1 day</td>
</tr>
<tr>
<td>Regular and routine care appointments (symptomatic conditions)</td>
<td>Office visit within two to seven days</td>
</tr>
<tr>
<td>Regular and routine care appointments (no symptoms, wellness/preventive exams)</td>
<td>Office visit within 30 days</td>
</tr>
<tr>
<td>After-hours access</td>
<td>24 hours a day/seven days a week; response by telephone within 30 minutes</td>
</tr>
<tr>
<td>In-office waiting time</td>
<td>Within 15 minutes</td>
</tr>
</tbody>
</table>

Peer-to-Peer Conversations: Availability of Physicians, Behavioral Health Practitioners and Pharmacist Reviewers

Highmark and HealthGuard provide you with an opportunity to discuss Utilization Management denial decisions with a clinical peer reviewer prior to or following notification of a denial determination. Clinical peer reviewers are licensed, 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 below:

<table>
<thead>
<tr>
<th>Practitioner/Ordering Provider:</th>
<th>UM Issue:</th>
<th>Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Highmark</td>
<td>Behavioral health</td>
<td>1-866-634-6468  1-800-322-4824</td>
</tr>
<tr>
<td>• HealthGuard</td>
<td>Pharmacy services</td>
<td>Telephone number identified in determination letter 1-717-581-4555</td>
</tr>
<tr>
<td>Behavioral health providers</td>
<td>Behavioral health</td>
<td>1-866-634-6468  1-800-322-4824</td>
</tr>
<tr>
<td>• Highmark</td>
<td>Pharmacy services</td>
<td>Telephone number identified in determination letter 1-717-581-4555</td>
</tr>
<tr>
<td>• HealthGuard</td>
<td>Pharmacy services</td>
<td>Telephone number identified in determination letter 1-717-581-4555</td>
</tr>
</tbody>
</table>

**Quality Management**

Our quality improvement efforts are designed to ensure quality care and member satisfaction. To do this, we continually review the aspects of our plan that affect member care and satisfaction and look for ways to improve them.

We work closely with the physician community, and our quality efforts also extend to other internal areas, such as Member Service. In both clinical and administrative areas, we use user surveys and other tools to get feedback on how we’re doing; then, we use these results to guide our future quality efforts.

For a detailed description of Highmark’s and HealthGuard’s Quality Management Program, an update on our progress toward meeting our goals, information on our clinical practice/preventive health guidelines or to provide input, please write to:

*Quality Management Department*
 to Linda Ruhl, PA-C
 Highmark Blue Shield/HealthGuard
 Fifth Avenue Place
 120 Fifth Avenue, Suite P4501
 Pittsburgh, PA 15222

**Member Rights & Responsibilities**

SelectBlue® members have certain rights and responsibilities that are a vital part of membership with a managed care plan. These rights and responsibilities are included in the SelectBlue member handbook and are reviewed annually in the member newsletter.

We also make these available online for our network providers to help you maintain awareness and support your relationship with your patients. (From [www.highmarkblueshield.com](http://www.highmarkblueshield.com), click on the provider link in the lower right corner, hover on Administrative Reference Materials and click on Highmark Blue Shield Reference Guide. See Section 5.25 and 5.26.) A paper copy of the Member Rights & Responsibilities is available upon request.

For HealthGuard products, the Member Rights and Responsibilities are available at [www.hguard.com](http://www.hguard.com) and in the member handbook and are referenced annually in the member newsletter.

**Physician Advice/Counsel**

Highmark and HealthGuard remind you that our network contracts for all products do not — and never did — contain a “gag clause” relating to treatment advice. We fully encourage and support our network physicians’ efforts to provide advice and counsel on all medically necessary treatment options, including medication treatment options, that may be appropriate for the member’s condition or disease regardless of benefit coverage limitations.

**Condition Management: How Blues On Call™ Can Support Your Practice and How We Identify Members for Participation**

To support your important work with patients who have chronic conditions, Highmark offers comprehensive and convenient services through our Blues On Call program. Integrated condition management through Blues On Call is focused on enhancing your ability to provide high-quality, evidence-based care to your patients with these common conditions:

- diabetes mellitus
- coronary artery disease
- congestive heart failure
- asthma
- chronic obstructive pulmonary disease

Via Blues On Call, specially trained Health Coaches (registered nurses, dietitians and respiratory therapists) can reinforce your messages and your treatment plan.

Using medical and prescription drug claims data, as well as voluntary survey data, we identify people with these conditions. We then implement interventions to segments of the population, including outbound calls and mailings, to educate members about standards of care and to encourage them to take advantage of the support offered through Blues On Call.

We also encourage our network physicians to refer their patients, as appropriate. So, if you have a patient with one or more of the conditions noted here (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).

*This notice applies to Highmark providers only.*
In 2005, Highmark is marking the five-year milestone for NaviNet, the Internet-based system that we launched in 2000 to help providers save time and eliminate paper transactions.

Our sincere thanks to all who have embraced this new technology that has streamlined the communication flow between us!

Here’s a sampling of the major NaviNet functions we’ve developed over the past five years, with your feedback:

- authorization inquiry and request
- eligibility, benefits and claim status inquiries
- code and allowance inquiries
- recredentialing
- provider information change
- claim investigation
- accounts receivable dashboard

(see related story)

A new Accounts Receivable (AR) Dashboard function is now available to all NaviNet users to assist with claims processing and management. This new tool takes claims information from various Highmark resources and displays it in a single application.

The AR Dashboard puts you, the user, in the driver’s seat when it comes to monitoring your practice’s accounts receivable data. Like the gauges on your car’s dashboard, it provides the data that can help you accelerate or change direction, monitor your progress toward a goal and decide when to “take ’er in for a checkup.”

With the initial launch, the AR Dashboard tool enables you to view your pended (non-finalized) claims by their age and pended category and will show the volume and charges associated with each aging category (i.e., less than 30 days, 30 to 44 days and more than 45 days). For later this year, we’re working toward adding paid (finalized) claims data, as well.

As an added convenience, you can automatically extract the information to a spreadsheet for further review.

Please note: Highmark will no longer send paper claim receipt and status notices to providers with access to NaviNet’s AR Dashboard tool because they have continuous access to claim status information via NaviNet.

Be sure to check out the AR Dashboard manual now available on NaviNet’s Resource Center page. Just hover on Administrative Reference Materials and click on Dashboard Training Manual. And, if your staff requires training or a refresher course on using any of the other NaviNet applications, please direct them to NaviNet’s Customer Service page (NaviNet Customer Care section). There, they will find easy-to-use training modules called User Guides.

To further enhance NaviNet, Highmark has implemented the Provider Accounts Receivable (AR) Dashboard, a new functionality to assist you with claims processing and management.

NaviNet Marks Fifth Anniversary!

In 2005, Highmark is marking the five-year milestone for NaviNet, the Internet-based system that we launched in 2000 to help providers save time and eliminate paper transactions.

Our sincere thanks to all who have embraced this new technology that has streamlined the communication flow between us!

Here’s a sampling of the major NaviNet functions we’ve developed over the past five years, with your feedback:

- authorization inquiry and request
- eligibility, benefits and claim status inquiries
- code and allowance inquiries
- recredentialing
- provider information change
- claim investigation
- accounts receivable dashboard (see related story)
Central Region
Behavioral Health Training Sessions

Highmark Blue Shield Provider Relations hosted three training sessions for PremierBlueSM Shield behavioral health practitioners Sept. 21, 22 and 23 in Bethlehem, New Cumberland and Lancaster. The sessions covered the outpatient behavioral health authorization process, NaviNetSM and other issues.

Bethlehem

In Bethlehem, Arthur Kusserow, MSW, director of Behavioral Health Utilization and Case Management, explains the outpatient behavioral health authorization process to providers.

Lancaster

Sherry Reed of Provider Relations speaks with a provider during the training session in Lancaster.

In Lancaster, Lonnie Marshall, DO, medical director of Behavioral Health at Highmark, and Arthur Kusserow, MSW, answer a provider’s questions.

New Cumberland

In New Cumberland, Amy Riggleman, left, Navimedix field account representative, and Gayle Kowalski, Navimedix Provider Services manager, demonstrate the online outpatient behavioral health authorization function of NaviNet for providers.

Ed Wargo, director of Physician Recruitment and Relations, speaks with a behavioral health provider during the New Cumberland training session.

Customer Service Tips

Whether in a restaurant, retail store or auto repair center, customers expect to receive prompt, quality service and be treated with courtesy and respect. The same is true whenever a patient visits his or her physician’s office. Here are some helpful tips for keeping your patients happy:

- Check the appearance of the office — make sure it’s neat and professional.
- The greeting sets the tone for the visit — smile! Nothing makes you more approachable than a smile.
- Be prepared to answer frequently asked questions.
- Make a conscious effort to use positive words and phrases, such as: my pleasure, will do, yes, you bet, of course, sure and absolutely.
- The high road to service is traveled with integrity, compassion and understanding. People don’t care how much we know until they know how much we care.

Watch Behind the Shield and the Provider Resource Center (which is accessible via NaviNetSM and www.highmarkblueshield.com) for more customer service tips and information to help you enhance your interactions with patients.

NaviNet users can also access additional customer service data. To access the information, click Resource Center on the Plan Central welcome page, hover on Clinical Reference Materials and select Quality Management Resource Binder. Inside the binder, you’ll find Patient Satisfaction Office Tips in the Helpful Links section.
Introducing BlueRxSM 
Medicare Prescription Drug Plan

The Medicare Modernization Act (MMA) of 2003 makes outpatient prescription drug coverage available to all Medicare beneficiaries starting January 2006. The Centers for Medicare and Medicaid Services (CMS) has contracted with private companies, like Highmark Blue Shield, to provide the new Medicare coverage. Beginning Nov. 15, 2005, beneficiaries can enroll in stand-alone prescription drug plans (PDPs) and get all other Medicare benefits from the traditional Medicare fee-for-service program, or they can enroll in a Medicare Advantage plan, like FreedomBlueSM PPO, that covers all Medicare benefits and provides plan options for prescription drug coverage.

CMS-Defined Standard Medicare Prescription Drug Coverage
Under the CMS-defined standard benefit, individuals will pay a monthly premium, estimated by the federal government to be $32.59 per month in the Pennsylvania and West Virginia region in 2006. The CMS-defined minimum standard benefit has a $250 deductible, covers 75 percent of total drug costs up to $2,250, zero coverage from $2,250 until $3,600 in total member out-of-pocket drug costs (known as the coverage gap) and 95 percent of drug costs above $3,600 total member out-of-pocket drug costs.

Introducing BlueRx
Highmark’s BlueRx will be the only stand-alone regional Medicare prescription drug coverage option that carries the Blue branding in Pennsylvania and West Virginia. BlueRx is also available to employer groups and union groups.

BlueRx will offer three Medicare prescription drug plan options to individuals: Basic, Plus and Complete. All three plans will offer enrollees no deductibles, affordable generic and brand copayments* for annual drug costs up to $2,250 and will also provide catastrophic coverage. The Plus and Complete plans will also include non-formulary coverage up to $2,250, and the Complete plan will provide coverage of generic drugs through the coverage gap.

* Basic: $10 generic, $30 brand; Plus: $10 generic; $25 brand formulary; $45 brand non-formulary; Complete: $8 generic, $20/$40 brand

Highmark and other plans began marketing their Medicare PDPs on Oct. 1, 2005. Medicare beneficiaries will be able to enroll in a Medicare PDP during the initial election period, which runs from Nov. 15, 2005, through May 15, 2006. Those who are eligible who do not enroll by May 15, 2006, may have to pay a penalty if they choose to enroll at a later time.

FreedomBlue Also Includes Drug Coverage
Those enrolled in FreedomBlue’s individual products will have two prescription drug benefit options available, which will no longer be subject to a quarterly prescription drug maximum.

- FreedomBlue will offer a standard benefit that covers the first $2,250 annually of total drug costs, with a gap in coverage from $2,250 until $3,600 in total member out-of-pocket drug costs. After $3,600 in member out-of-pocket drug expenses, FreedomBlue will pay 95 percent of covered drug costs. Copayments are $10 for generic drugs and $30 for brand-name drugs.
- FreedomBlue will also offer an enhanced prescription drug benefit with lower copayments of $8 for generic drugs and $20 for brand-name drugs. This plan fills the coverage gap from $2,250 in total drug costs until $3,600 in total member out-of-pocket drug expenses with generic prescription drug coverage after an $8 copayment. After $3,600 in member out-of-pocket drug expenses, FreedomBlue will pay 95 percent of covered drug costs.

Medicaid Recipients Encouraged to Enroll in a Medicare Prescription Drug Plan
Medicaid will no longer offer Prescription Drug benefits, effective Jan. 1, 2006. In 2005, CMS is encouraging dually eligible individuals — beneficiaries enrolled in both Medicare and Medicaid — to enroll in a Medicare PDP before Jan. 1, 2006. Those who do not enroll in a Medicare PDP by that date will be automatically enrolled in a random plan being offered in their region by CMS. Full-benefit, dually eligible individuals who enroll in BlueRx will pay no premiums or deductibles. Full-benefit, dually eligible individuals who enroll in other PDPs may or may not be responsible for a premium. Dually eligible individuals already enrolled in a Highmark Medicare Advantage plan in 2005 will not be automatically enrolled in a random PDP plan. Highmark will facilitate their enrollment into a Medicare Advantage prescription drug plan offered by Highmark.

Highmark Has Senior-Specific Formulary
Highmark’s Pharmacy and Therapeutics Committee, comprised of network physicians and pharmacists, developed a formulary specifically for the senior population. The Formulary Book, which was distributed to all network pharmacists and physicians earlier this year, has three formularies:

1. The Highmark Select/Choice Formulary
2. The Highmark Open Formulary
3. The Highmark Medicare-Approved Select/Choice Formulary.*

* FreedomBlue members can only obtain their prescriptions from the Highmark Medicare-Approved Select/Choice Formulary.

Members with a Select Formulary benefit have coverage only for those medications listed in the applicable Select/Choice Formulary section of the Formulary Book. Members with the Choice Formulary benefit may pay a lower copay/coinsurance for medications listed in the applicable Select/Choice Formulary section, and a higher copay/coinsurance for non-formulary medications.

When it is medically appropriate, you are encouraged to prescribe formulary drugs. The complete formulary is also available on the Provider Resource Center, accessible via NaviNetSM or at www.highmarkblueshield.com under the Pharmacy/Formulary Information link.

Highmark has developed and continues to expand a nationwide pharmacy network that will offer significant access to our Medicare prescription drug plan members.
Key Dates for HealthGuard Providers
As previously announced, the HealthGuard products will be discontinued as of Jan. 31, 2006. Following are some key dates of which HealthGuard providers should be aware regarding this product termination.

Last Day to Submit Claims to HealthGuard is July 31, 2006
Network providers are advised that July 31, 2006, will be the last day that electronic and paper claims will be accepted for payment.

If you file your claims electronically, please note that as of Aug. 1, 2006, any claims received by Emdeon Corporation (formerly known as WebMD Corporation) for HealthGuard will be rejected and returned to the sender.

Network practitioners are strongly encouraged to submit claims — both paper and electronic — for any services provided to HealthGuard patients immediately following care delivery.

Paper claims should be sent to:
HealthGuard
Attention: Claims
280 Granite Run Drive
Lancaster, PA 17601-6810

HealthGuard Internet Portal to Close Oct. 1, 2006
HealthGuard's Internet provider portal, which enables practitioners to check member eligibility, claim status and authorization status and perform other key transactions, will be available through Sept. 30, 2006. Provided by a third-party connection, the Internet portal will cease to be available beginning Oct. 1, 2006.

Behavioral Health News
NCQA Key Standards Updates
ValueOptions’ Northeast Service Center is committed to maintaining its excellence in care and service and to fulfilling NCQA Accreditation Standards for Behavioral Health. These standards address the following care and service categories:
► QI Program Structure and Operations
► Access, Availability and Cultural Needs
► Satisfaction Programs
► Treatment Records/Criteria/Practice Guidelines
► Coordination of Care/Quality Improvement Activity/Initiatives
► Utilization Information/Guidelines
► Members Rights and HIPAA
► Preventive Health Programs
► Other Quality Improvement Activity

For important standards updates, visit www.valueoptions.com/providers. If you don’t have Web access, please contact Carrie Turner by telephone, toll-free, at 1-800-322-4824, Ext. 2827, for a paper copy of the most recent NCQA standards.

Coordinating Care: Keeping PCPs and Other Key Practitioners “in the Loop”
When a patient has multiple providers, communication becomes essential to promote quality health care, ensure safe practice and prevent potential medical errors or complications.

Communication needs to occur at all levels, including:
► between behavioral health therapists and/or psychiatrists
► between behavioral health practitioners and the PCP

How are We Doing?
Results of the 2004 HealthGuard/ValueOptions patient satisfaction survey indicated that 73.6 percent of members agreed that coordination occurs between behavioral health therapists fairly often. However, when members were asked if their therapist has discussed treatment with their personal physician, only slightly more than one quarter (26.5 percent) believe that this action has occurred.

Audits of treatment records from 2004, however, find that coordination with the PCP is occurring more frequently than patients perceive, but it is still occurring less than half of the time; 47.3 percent of practitioners document either coordination of care with the PCP or that this coordination was declined by the enrollee. This rate has dropped sharply from audits conducted the previous year (2003), when three-quarters of practitioners were documenting coordination with the PCP.

Practitioner representatives on the ValueOptions Northeast Service Center Provider Advisory Committee hypothesize that the mandates of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 may be inhibiting practitioners from active coordination. While HIPAA has placed safeguards against unauthorized disclosure of personal information, the intent is to protect privacy, not interfere with needed coordination of care.

Communicating with the PCP
An important step toward improvement of behavioral health care is to ensure that members do not “slip through the cracks.” Coordination of care addresses this issue, especially at critical times in the treatment process. Key times for communicating with the patient’s other care providers include:
► initiation of treatment
► initiation or change in pharmacotherapy
► changes in health status
► laboratory findings

One way to ensure that the PCP receives copies of lab results is to encourage the patient to work through the PCP’s office or to request that a copy of the result also be sent to the PCP.

ValueOptions has developed a form that is compliant with HIPAA regulations to help you document permission from your patients to coordinate care. If you would like a copy of this form for use in your office, please call the Quality Management Department, toll-free, at 1-800-322-4824, Ext. 2827, and request the “Sample Practitioner Form Authorizing PHI Exchange.”
Highmark Offers
Antidepressant Medication Management Tool Kit

Highmark has developed a free Antidepressant Medication Management Tool Kit, which is available to network practitioners. The tool kit includes the following resources:

**Patient Resources**
- Major Depressive Disorder brochure
- Frequently Asked Questions about Antidepressant Medication
- The U.S. Preventive Services Task Force “Two Question Screen” poster
- Antidepressant “Rx Pad”

**Practitioner Resources**
- Geriatric Depression Scale
- Patient Health Questionnaire (PHQ–9)
- Blues On Call™ Assessment/Referral Form
- 2005 Depression Clinical Practice Guidelines Key Points
- Succinct Guidelines for Treating Depression

To order a tool kit, please fax your request to Mark Zine, Network Credentialing, at 412-544-2619, or e-mail him at mark.zine@highmark.com.

**Online Resources**
We also encourage you to view resources we have available online in our Provider Resource Center, accessible via NaviNet® or [www.highmarkblueshield.com](http://www.highmarkblueshield.com).
- Depression Clinical Practice Guidelines — You’ll find the link under Clinical Reference Materials.
- The Communication Document for Behavioral Health Specialist to PCP form — You’ll find the link under Provider Forms.

---

**Attention Electronic Filers:**
**HIPAA ERA Contingency Plan Ending Dec. 12, 2005**

If you receive electronic remittance advices (ERAs) from Highmark, please be advised that we will discontinue the creation of non-HIPAA-compliant ERA formats effective Dec. 12, 2005.

As of the Dec. 16, 2005, remittance cycle, ERAs transmitted by Highmark, for any of the payers for which we process claims, will be in the HIPAA-mandated version only. All providers, billing services and clearinghouses will only receive the HIPAA-mandated format for ERA. This notification is a follow-up to previous announcements regarding Highmark’s HIPAA contingency plan for electronic transactions.

If you are unsure of your ERA compliance status, please contact your software vendor, billing service or clearinghouse to determine the necessary steps to achieve compliance. For more information, please read the Special Bulletin, dated October 2005, which is available on our Provider Resource Center, under Special Bulletins & Mailings.
Highmark to Expand Preventive Schedule, Benefits to Address Obesity Epidemic

Highmark Blue Shield is addressing the growing epidemic of childhood obesity by expanding the Highmark Preventive Schedule to include coverage for services for the identification and management of obesity. All accounts whose benefits package includes the Highmark Preventive Schedule will receive the updated schedule. The expanded benefits will become effective on Jan. 1, 2006.

This effort is part of a larger initiative that Highmark launched in 2002 to help fight this disease and its comorbidities, namely development and early onset of Type II diabetes and coronary artery disease.

The Highmark Preventive Schedule is being updated to reflect these changes for children ages 0 to 18 years:

- Children with a body mass index (BMI) in the 95th percentile or is up to and including the 95th percentile or is up to and including the 95th percentile are eligible for one preventive follow-up office visit per year, specifically for obesity; and one set of recommended laboratory studies (lipid profile, hemoglobin HbA1c, AST, ALT and fasting glucose).

- Children with a BMI in the 85th percentile are eligible for one preventive follow-up office visit per year, specifically for obesity, with blood pressure taken and no additional laboratory studies.

Because of these preventive schedule changes, Highmark is helping health care professionals address the symptoms of obesity while children are still young and to help them form good nutrition and exercise habits as they grow toward adulthood.

PA K-4 Students to Receive BMI Screenings

This school year, Pennsylvania families with children in kindergarten through fourth grade will be notified of their children’s body mass index (BMI) percentile through the statewide Growth Screening Program.

Through this initiative — an effort of the Pennsylvania Departments of Health and Education — both public and private schools will be conducting BMI evaluations and sending letters to each student's parents or guardians containing information about the child's BMI status.

Children whose BMI is greater than the 85th percentile or is up to and including the 95th percentile are identified as being at risk for becoming overweight, and students with BMIs greater than the 95th percentile are classified as being overweight. The letter will recommend that parents or guardians share the information with their child’s health care provider. For details about the BMI screenings and letters, parents should contact their children’s schools.

Highmark has partnered with the Pennsylvania Medical Society (PMS) and the Pennsylvania Departments of Welfare, Health, Insurance and Education to make resources available to all Pennsylvania health care providers through PMS. Additionally, Highmark offers a Childhood Obesity Physician Tool Kit, which is available on our online Provider Resource Center through NaviNet® or at www.highmarkblueshield.com. These resources will support the effort to screen, identify and treat children who are at risk for becoming overweight or are already overweight.

Highmark believes that together we can make a difference in improving the future health of children in Pennsylvania. For more information, visit the PMS Web site at www.pamedsoc.org/obesity. More information about the Growth Screening Program may be found at the Pennsylvania Advocates for Nutrition and Activity Web site at www.panaonline.org.

Addressing Obesity Among Adults

Highmark has also made inroads to prevent and treat obesity in the adult population by increasing emphasis on worksite wellness programs for its employer group customers and by creating Lifestyle Returns, which offers incentives to members who take more responsibility for their health.

Highmark has also made these changes to the Highmark Preventive Schedule, effective Jan. 1, 2006, for members ages 19 to 65+

- Added obesity screening

- Adults with a BMI over 30 are eligible for two follow-up preventive office visits and two nutritional counseling visits per year, specifically for obesity, and one set of recommended laboratory studies (lipid profile, hemoglobin HbA1c, AST, ALT and fasting glucose).

Attention

DME Providers:
Notify Highmark, Members of Product Recalls

Durable medical equipment (DME) providers are asked to notify Highmark and impacted Highmark members in the event of any known product recalls.

Whether implied or required by their network agreements with Highmark, DME providers should notify both Highmark and all affected Highmark members if any piece of durable medical or respiratory equipment furnished or serviced by the provider is recalled or withdrawn from the market by a manufacturer due to any known or suspected defect or deficiency.

This provision applies to all three FDA-defined levels of product recalls. Notifications of recalls should be directed to your Provider Relations representative.
This newsletter is primarily geared toward medical practitioners and their office staff, with information about:

Highmark Blue Shield and HealthGuard are independent licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. Highmark Blue Shield serves the 21 counties of central Pennsylvania and the Lehigh Valley as a full-service health plan. HealthGuard is a health maintenance organization serving south-central Pennsylvania. Blue Shield and the Shield symbol, SelectBlue, DirectBlue and ClassicBlue are registered marks and Blues On Call, PPOBlue, FreedomBlue, EPOBlue, My Shield Online and BlueRx are service marks of the Blue Cross and Blue Shield Association. Highmark is a registered mark of Highmark Inc. Lifestyle Returns is a service mark of Highmark Inc. CAHPS and ECHO are registered trademarks of the Agency for Healthcare Research and Quality. Healthwise Knowledgebase is a registered trademark of Health Dialog Services Corp.

NaviNet is a registered service mark of NaviMedix Inc.