Behind the Shield

DECEMBER 2005

A Newsletter for Highmark Blue Shield and HealthGuard Providers in Central Pennsylvania and the Lehigh Valley

New Funding Source Available

to Help Physicians Implement Electronic Prescription Systems

Ken Melani, MD, (left) presents a check for $26.5 million to the Pittsburgh Foundation's president and chief executive officer William E. Trueheart.

On Nov. 15, 2005, Highmark Inc. announced a significant financial commitment to help eligible physicians in the 49 counties of central and western Pennsylvania pursue point-of-care technology in the outpatient practice setting.

"One of the best ways to advance health care is to make a significant investment in upgrading the infrastructure that puts the best tools in the hands of physicians," says Ken Melani, MD, Highmark Inc. president and chief executive officer. "The widespread adoption of health information technology will improve patient safety, increase quality of care and decrease costs."

Highmark also felt strongly that a collaborative, community-based approach was key. "Prior to making the financial commitment, we sought feedback through physician discussion groups and conversations with leaders in the medical community at large," says Donald R. Fischer, MD, MBA, Highmark Inc. senior vice president and chief medical officer. "We also researched similar programs launched by other Blue Plans. The combined input we received was invaluable in aligning our goals with a practical solution that will help interested physicians adopt these new technologies."

The Highmark eHealth Collaborative

Highmark Inc. made a $26.5 million contribution to The Pittsburgh Foundation. The Foundation created the Highmark eHealth Collaborative, a supporting organization of the Foundation, and its goal is to encourage the adoption of health information technology used in patient care. Electronic prescribing was chosen as the first project of the Collaborative because of its direct impact on patient safety.

Note: Highmark Inc. is an independent licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. The Collaborative is not a subsidiary or affiliate of Highmark Inc. and uses the name "Highmark" pursuant to a license agreement.

Funding Available to Eligible Physicians

The Collaborative will provide funding to eligible physicians who wish to acquire and use technology (e.g., a personal computer, PDA, electronic tablet or digital pen) to generate and transmit electronically a prescription to a pharmacy. Physicians may acquire stand-alone, approved electronic prescribing systems or ambulatory electronic health records systems that include an approved electronic prescribing system.

Visit the Collaborative's Web site at **www.highmarkehealth.org** for complete details, including eligibility requirements and the online application.

"We encourage physicians to take advantage of this unique funding opportunity," says Dr. Fischer. "In doing so, you'll help reduce medication errors, eliminate time-consuming administrative work associated with handwritten scripts, better manage the requirements of multiple drug formularies, and most importantly, help ensure patient safety and satisfaction."

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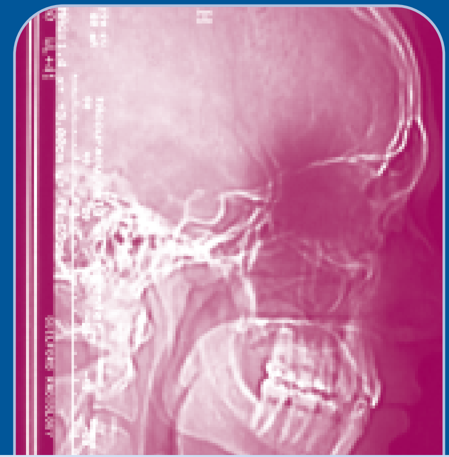
HIGHMARK® BLUE SHIELD

Member Cost Sharing Expands to Include Outpatient Diagnostic Services



Background

Member cost sharing is a growing trend that you've no doubt seen in your patient base. More and more benefit designs are incorporating coinsurance and/or copays to help contain health care costs by requiring their employees to share in the cost of specific services.

To address growing market demand for additional cost sharing provisions, Highmark will introduce new benefit design options that incorporate cost sharing specifically for outpatient diagnostic services, effective Jan. 1, 2006. Generally, these cost sharing provisions will not apply to diagnostic services provided as part of an emergency room visit or for any services received when the member is an inpatient.

What Services Will This Impact?

Outpatient diagnostic services for which cost sharing may apply fall into five separate categories:

Advanced Imaging Diagnostic Services

1. **Advanced Imaging** – including, but not limited to, CT and CTA scans, MRIs, MRAs, PET scans, PET/CT scans

All "Other Diagnostic Services"

2. **Standard Imaging Services** – procedures such as skeletal X-rays, ultrasound and fluoroscopy
3. **Diagnostic Medical Services** – procedures such as electrocardiograms (ECG), electroencephalograms (EEG), echocardiograms, pulmonary studies, stress tests, audiology tests
4. **Laboratory and Pathology Services** – procedures such as non-routine Papanicolaou (PAP) smears, blood tests, urinalysis, biopsies and cultures
5. **Allergy Testing Services** – allergy testing procedures such as percutaneous tests, intracutaneous tests and patch tests

Which Highmark Members Will Have This Benefit?*

Starting in 2006, new benefit design options will be available for our PPO and EPO products, which will incorporate these cost sharing provisions. This means, effective for dates of service on or after Jan. 1, 2006, your PPOBlue® and EPOBlue℠ patients may have a benefit design that includes cost sharing specific to the outpatient diagnostic services noted above.

**Note: See information regarding FreedomBlue℠ Medicare Advantage members on Page 3 (About FreedomBlue).*

How Will The Cost Sharing Be Applied?

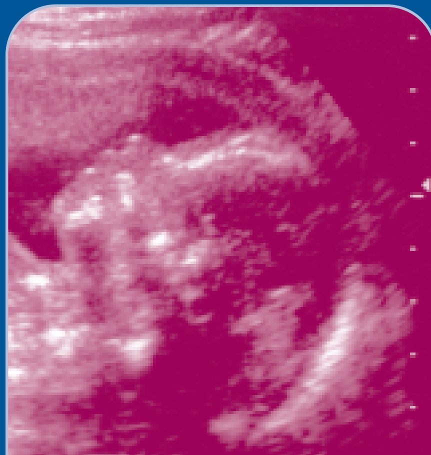
If the member has coinsurance, cost sharing will apply to the total, technical and professional component, and to services associated with the actual diagnostic procedure, including drugs and/or contrast media.

If the member has copays, they will apply only to the total and technical components, *not to the professional component* (i.e., services billed with Modifier 26). Copays will not apply to drugs and/or contrast media, and one copay will apply per date of service and per outpatient diagnostic category (see five categories at left).

Could Multiple Copays Or Coinsurance And Copays Apply On One Date Of Service?

Yes. Here are three examples that could occur, depending on the member's benefit design:

- If a PPOBlue member sees his cardiologist and receives an EKG during the visit, he could be responsible for two copays: an office visit copay and an outpatient diagnostic medical copay for the EKG.
- If a PPOBlue member receives an MRI, then has a spinal X-ray and lab work on the same day – all as outpatient services – she could be responsible for three outpatient diagnostic service copays (advanced imaging, standard imaging and laboratory/pathology).
- If an EPOBlue member sees his cardiologist and receives a stress test while there, he would pay an office visit copay, and then could be responsible for any applicable diagnostic medical coinsurance when the stress test claim is processed.



How Will I Know Which Members Have Cost Sharing?

Cost sharing isn't new. It exists now in the form of copays, coinsurance and deductibles. This change is simply introducing a new option for cost sharing. So, it's really "business as usual" for providers. Like all other benefit information, you'll find these details quickly and easily on NaviNet℠.

Diagnostic benefit information has always been available via NaviNet. However, beginning Jan. 1, 2006, diagnostic services will be specifically listed by the cost sharing categories. The categories — *Advanced Imaging, Standard Imaging, Pathology/ Laboratory, Diagnostic Medical* and *Allergy Testing* — will appear and will show any copays or coinsurance specific to the member's benefit contract.

We've also added a convenient new feature. If a medical policy applies to a diagnostic category, you will now see a link to the policy directly from the *Procedure Code Inquiry* page.

What If The Copay Amount Is Greater Than The Allowance?

In some rare instances, a member's copay amount may be greater than the fee allowance for the outpatient diagnostic service. An example might be a member who receives a basic blood draw for just one laboratory test, and the allowance is $15. In this case, if the provider collected a $20 copay at the time of the service, the member would be due a refund of $5 from the provider when the claim processed.

Variations

Group customers who self-insure their employees may structure their benefits in a different manner. Therefore, you may come across an occasional exception to the general rule. For example, some may have cost sharing components that vary from the standard design detailed here. Cost sharing could apply for different categories of diagnostic services and may include both copays and coinsurance for the same service.

In most cases, diagnostic cost sharing does not apply to services received as part of an emergency room visit. However, again, there may be an employer group who chooses to include cost sharing in this instance.

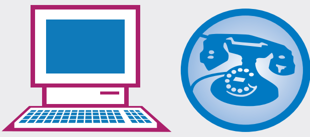
No matter how a patient's benefits are structured, you'll always find the most updated information quickly and easily via NaviNet.

About FreedomBlue

Diagnostic cost sharing will apply to the FreedomBlue℠ Value product option. Cost sharing will have two variations from the details noted above.

1. **Cost sharing will be applied on a "per provider, per service type, per day" basis. This means that a member who goes to a provider in the morning and receives a bone density test, then later that afternoon goes to a different provider for a chest X-ray, will be required to pay two separate copays, if both procedure codes are identified as cost sharing services. This is because FreedomBlue members will be charged any applicable copays, even if multiple, same-day services are in the same diagnostic category when performed by multiple providers. See categories on Page 2. (In the example here, a commercial member would be charged only one copay, even if different providers performed the services. This is because commercial members will be charged one copay per diagnostic category, per day, regardless of who performs the service.)**

2. **Some diagnostic codes will not be assessed a copay when the service is received in conjunction with a member's Initial Preventive Physical Exam (IPPE). This is a once-in-a-lifetime benefit for a member, and it must be performed within six months of the effective date of enrollment into FreedomBlue. To be sure your member's copays are waived for the IPPE and related services, your office must bill Procedure Code G0344 for the IPPE, in addition to any laboratory, EKG or other studies ordered as part of the IPPE. You may collect a copay for the office visit.**



Questions?

Providers with Internet access will find helpful information online at **www.highmarkblueshield.com** and **www.hguard.com**. NaviNet℠ users should use NaviNet for all routine inquiries. But if you need to contact us, below are the telephone numbers exclusively for providers.

HIGHMARK

1-866-731-2045
- 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

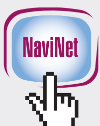
Margaret LeMasters, Managing Editor
Adam Burau, Senior Editor
Matthew Clark, Contributing Editor

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 NaviNet 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 NaviNet 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.

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Attention Oncology/ Breast Surgeons:

Authorization Not Required for Breast Reconstruction Following Mastectomy

Reconstructive surgery and prosthetic devices incident to a mastectomy are considered to be medically necessary under the Women's Health Security Act of 1997. This act, also known as Act 51-1997, defines reconstructive surgery to include all surgery on the affected breast and surgery on the contralateral normal breast to re-establish symmetry between the two breasts or to alleviate functional impairment caused by the mastectomy.

Therefore, reconstructive surgery following a mastectomy does not require authorization from Highmark Healthcare Management Services (HMS). Breast reconstruction for cosmetic reasons or breast reconstruction procedures that are considered to be experimental may require authorization from HMS.

For additional information, refer to Highmark Medical Policy S-129. You can find this and other Highmark medical policy information on our Provider Resource Center via NaviNet℠ or at **www.highmarkblueshield.com**.

QualityBLUE℠ A Physician Pay-for-Performance Program

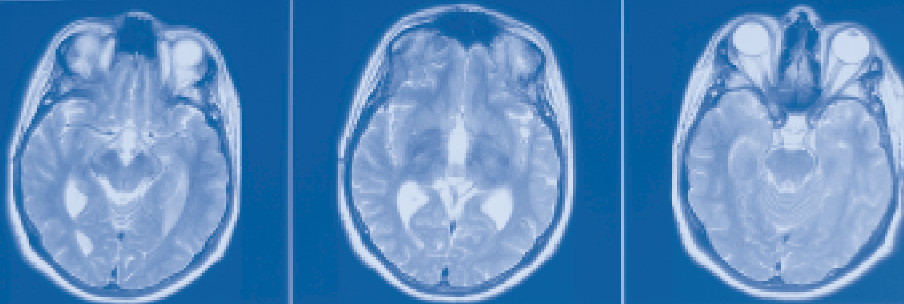
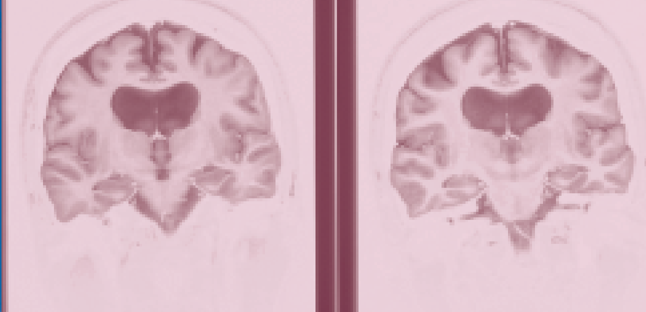
Program Aims to Improve Care Quality, Reward Physicians

In spring 2005, Highmark introduced QualityBLUE, a pay-for-performance program, to reward PCPs who provide accessible, efficient, high-quality health care. QualityBLUE offers eligible family practice, general practice, internal medicine and pediatric providers an opportunity to earn an additional reimbursement (with payments to begin in April 2006) as an "add on" to the fee schedule for select evaluation and management (E&M) services. Practices that meet the program's quality criteria will receive these incentives.

QualityBLUE is being offered to practices that:

- participate in the PremierBlue℠ Shield network and the Medicare Advantage PPO network
- are NaviNet℠ enabled
- achieve a 12-month claims volume of >$40,000 for Highmark-paid E&M services, based on the allowed fees (for statistical validity)
- achieve an electronic claim submission rate of >75 percent.

For more details, please see the Winter 2005 issue of *Clinical Views*, which is viewable online in the Provider Resource Center.

Behavioral Health Medication Management: HEDIS® Specifications

The Highmark Behavioral Health Clinical Quality Improvement Committee is led by network practitioners. The group meets regularly to discuss any new developments in the field, as well as to analyze data on the care our members are receiving. The committee analyzes the results of the HEDIS compliance studies and recently identified appropriate antidepressant medication management as an area for improvement.

We encourage network practitioners to consider the following HEDIS Antidepressant Medication Management Effectiveness of Care Specifications:

- **Optimal Practitioner Contacts:** Members 18 years of age and older who are diagnosed with a new episode of depression and started on antidepressant medication should have at least three follow-up contacts with a PCP or behavioral health specialist *and* remain on the medication through the 12-week Acute Treatment Phase. At least one of the three follow-up contacts should be with a prescribing practitioner.
- **Effective Acute Treatment Phase:** An effective Acute Treatment Phase is defined as members 18 years of age and older who are diagnosed with a new episode of depression, treated with antidepressant medication and remain on an antidepressant during the 12-week Acute Treatment Phase.
- **Effective Continuation Treatment Phase:** An effective Continuation Treatment Phase is defined as members 18 years of age and older who are diagnosed with a new episode of depression, treated with antidepressant medication and remain on an antidepressant for at least six months.

Depression Coding Guide

Please note the following guide to assist with depression coding:

ICD-9 CM Codes to Identify Major Depression*

ICD-9 CM Codes	Description
296.2	Major depressive disorder, single episode
296.3	Major depressive disorder, recurrent episode
298.0	Depressive type psychosis
300.4	Neurotic depression/dysthymia
309.1	Adjustment reaction with prolonged depression reaction
311	Depressive disorder, not elsewhere classified

**Brief depressive reaction (309.0) is not used for diagnosis, since it includes grief reaction (believed to be the most common use of this code). Additionally, other possible codes that could indicate depression diagnosis (e.g., 296.4-296.9, 309.0 and 309.28) are not on this list because these codes are less specific in identifying eligible members.*

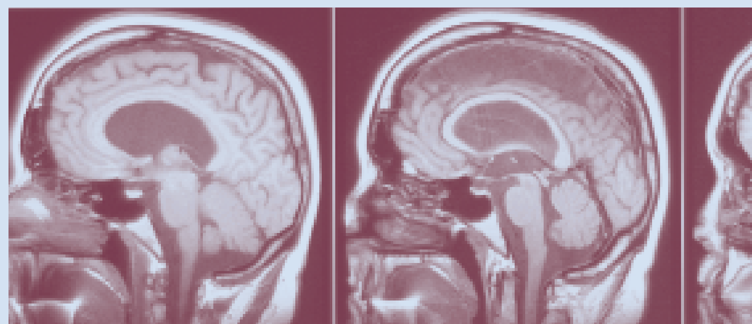
Evaluation and Management (E&M) Codes (usually used by PCPs)

E&M Codes	Description
99201 – 99205	Office or other outpatient services (new patient)
99211 – 99215	Office or other outpatient services (established patient)
99241 – 99245	Office or other outpatient consultations (new or established patient)
99341 – 99345	Home visit for the evaluation and management of a new patient
99347 – 99350	Home visit for the evaluation and management of an established patient
99384 – 99387	Initial preventive medicine evaluation and management of an individual
99394 – 99397	Periodic preventive medicine re-evaluation of an individual
99401 – 99404	Preventive medicine counseling and/or risk factor reduction intervention

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**.

- 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*.



SelectBlue® 2005

Highmark Member Satisfaction Survey Results

On an annual basis, Highmark gathers data on member satisfaction using the Consumer Assessment of Health Plans Survey (CAHPS®), a tool developed by the National Committee for Quality Assurance (NCQA). The survey includes key aspects of member satisfaction, such as the relationship between the patient and physician and the service provided by the health plan. The CAHPS® survey results are part of the Pennsylvania Department of Health managed care regulations and the NCQA requirements. The survey of SelectBlue members was conducted in the spring of 2005 with a sample of 1,100 members and a response rate of 46 percent.

Summary of Results

The top scores (percentage of patients who reported they were satisfied) for each of the six composite categories and four overall rating categories are listed in the table below.

Analysis

A strong commitment to customer service by Highmark and its providers is reflected in these member satisfaction scores. Many components of the survey showed a high rate of member satisfaction. Two ratings (Specialist and all Health Care) and three composites (Getting Needed Care, Getting Care Quickly and Courteous and Helpful Office Staff) were in the top 10 percent of all plans nationally.

The high scores in these areas are a reflection of the commitment of each network practitioner and office staff member to the care and service of every patient. 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 our member satisfaction ratings!

	Top Scores	
Composite/Rating	**2005**	**2004**
Composite 1: Getting Needed Care	87.0%	81.3%
Composite 2: Getting Care Quickly	85.5%	85.3%
Composite 3: How Well Doctors Communicate	93.6%	93.8%
Composite 4: Courteous and Helpful Office Staff	95.9%	93.7%
Composite 5: Customer Service	73.2%	75.3%
Composite 6: Claims Processing	91.8%	89.3%
Rating of Personal Doctor	78.6%	77.7%
Rating of Specialist	83.4%	81.8%
Rating of Health Care	83.1%	80.0%
Rating of Health Plan	72.0%	71.2%

One rating (Personal Doctor) and one composite (Customer Service) was equal to or scored less than the top 50 percent of all plans nationally. Highmark will continue to develop quality improvement initiatives in an ongoing attempt to improve the quality of service that is provided to our members in these areas.

In an effort to assist physicians and their practice staff to improve patient accessibility to physician services, we continue to provide Customer Service tips through the Provider Resource Center, which is accessible via NaviNet℠ and at **www.highmarkblueshield.com**, as well as in the *Quality Management Resource Binder* available from your Network Quality Management Specialist — the registered nurse from Highmark who visits your office for credentialing purposes and clinical quality initiatives.

We work hard to ensure that our members receive quality care and that the health plan provides high quality and timely service. Your participation in this effort is greatly appreciated!

Highmark Outlines Timetable for Submitting NPIs on Electronic Claims*

As you've read in recent issues of *Behind the Shield*, health care providers who are considered to be covered entities under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 are required to obtain a unique National Provider Identifier (NPI) number and begin using it on all electronic transactions no later than May 23, 2007.

On that date, Highmark will require **all** NPI-eligible providers to begin using NPIs on electronic claims; therefore, even if you're not considered to be a HIPAA-covered entity, you'll need to obtain an NPI for use when submitting claims to Highmark. (If you are considered to be an eligible provider under HIPAA, you can obtain an NPI, regardless of your electronic filing status.)

To assist in this transition, Highmark has outlined the following general timetable for acceptance of NPIs on electronic claims; watch your mail and the NaviNet℠ Plan Central page for updates regarding exact deadlines:

- **February 2006:** Highmark will begin accepting providers' NPIs along with their Highmark provider numbers on electronic claims; the NPI will be optional, but the Highmark provider number will still be required.
- **Fall 2006:** Highmark will accept an NPI, a Highmark provider number or both an NPI and a Highmark provider number on electronic claim submissions.
- **May 23, 2007:** Highmark will require the use of NPIs on all electronic claims submitted and will no longer accept Highmark provider numbers on electronic claims.

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.

Obtaining an NPI

NPIs are now being assigned, and many providers already have obtained their NPIs. Although you have until May 23, 2007, to obtain an NPI, you are encouraged to apply now.

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.

Reporting 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. EDI submitters also will need to register their NPIs with Highmark's EDI Department beginning in July 2006 to activate their NPIs for submitting electronic claims.

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

**The processes for submission of paper claims remain the same at this time. More information on the NPI and revised paper claim formats will follow at a later date.*

NaviNet News

Reminder:

Use NaviNet℠ for Claim Investigations, Inquiries

NaviNet-enabled providers are reminded that effective July 1, 2005, you are required to use NaviNet for claim investigations and inquiries. Also, you will need to check NaviNet for a response to a claims inquiry; a response will not be automatically sent via e-mail to you with the results of your inquiry review.

Complete Authorizations for Behavioral Health Services Via NaviNet

Behavioral health practitioners are reminded that authorizations for behavioral health services may now be obtained via NaviNet. Simply use the system's Authorization function and choose the appropriate menu options for the service for which you are requesting authorization.

Mammography Reminder:

Women Listen to Their Physicians

Research suggests that the number one barrier preventing women from getting a mammogram is: "I feel it is not needed because my physician has never recommended that I have one."

Breast cancer has a profound psychological impact on American women and their families. It is the most common cancer among women in the United States in every major ethnic group. Only lung cancer accounts for more cancer deaths in women. Advancing age is the strongest risk factor for breast cancer.

A screening mammogram is the most effective method of detecting breast cancer in its earliest and most treatable stage. Mammograms are important because they may catch the cancer early, when more treatment options are available and survival rates are higher.

It is critical to educate women about breast cancer risk factors and the importance of early detection. Primary care providers and Ob-Gyns are critical agents in communicating this information to women. Part of the process involves acquiring skills to educate women with information that promotes informed screening decisions and strategies to translate these decisions into action.

This can be accomplished by:

- recommending mammograms to all women meeting the risk and age requirements, and
- providing information about mammography facilities that meet the requirements of Highmark's Radiology Management Program

The Highmark 2005 Adult Immunization and Preventive Schedule recommends a mammogram, with or without clinical breast exam, every 1 to 2 years for women age 40 and older. Women age 70 and above should continue to receive regular screening as long as their health status permits breast cancer treatment.

Pennsylvania state law mandates payment associated with a mammogram every year for women 40 years of age and older and with any mammogram based on physician's recommendations for women under 40 years of age. Even though most Highmark products pay for mammograms, some employer groups and/or plans administered by Highmark will not pay for part or all of the recommended or state-mandated mammograms. Some flexibility in specific cases will require deviation from this guideline recommendation. All providers are responsible for individualizing to the specific clinical characteristics of each patient.

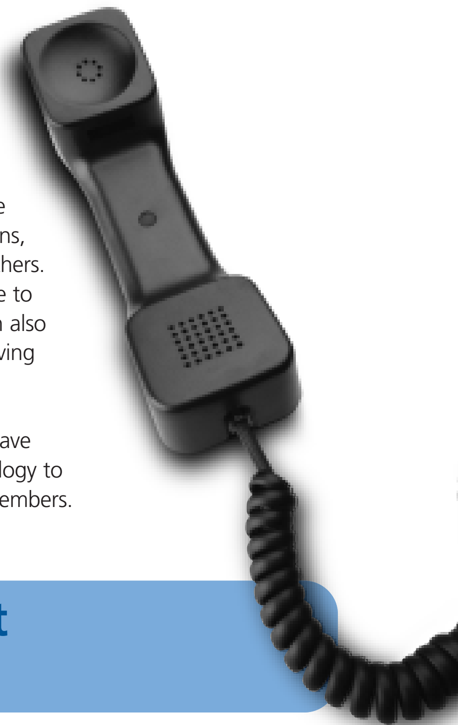
For information on additional preventive health screening guidelines, please visit our Provider Resource Center via NaviNet℠ or at **www.highmarkblueshield.com**. Simply hover over *Clinical Reference Materials* and click on *Clinical Practice and Preventive Guidelines*.

Attention PCPs: Please Advise Highmark Patients Regarding Possible Late Flu Shots

In recent weeks, Highmark has learned that some network primary care physician practices have received only partial shipments of the influenza vaccine they ordered from vaccine manufacturers for the 2005-2006 flu season. Incomplete or late vaccine shipments may cause some of your patients to become concerned about when they can receive a flu shot. To reassure patients, please let them know that even if the vaccine isn't available until December or January, it's still worth getting a flu shot to protect against the virus. Highmark thanks you for your partnership in keeping our members healthy!

Updates for Medicare Advantage Network Providers

FreedomBlue℠ Health Outreach Telephone Campaign Launched



Highmark wants our Medicare Advantage network providers to know that we're contacting selected FreedomBlue members via telephone who have specific conditions to provide them with valuable health information and to remind them about receiving key health screenings and other care.

The first phase of this effort began in October and involves contacting female members within a targeted age range to remind them of the importance of getting regular mammograms and Pap tests.

Future campaigns will either focus on preventive health issues or address certain chronic conditions, such as coronary artery disease, diabetes and others. The computerized calls use a live-sounding voice to provide health information to members and can also solicit their feedback on potential barriers to having certain health services completed.

In the past, Health Dialog and Blues On Call℠ have used the computerized, speech-enabled technology to conduct similar outreach efforts to Highmark members.

Orthotic and Prosthetic Devices to be Subject to 15% Coinsurance for FreedomBlue

Effective Jan. 1, 2006, FreedomBlue members will be responsible for a 15 percent coinsurance on orthotic and prosthetic (O&P) devices. Currently, a 15 percent coinsurance applies to durable medical equipment (DME). Effective Jan. 1, 2006, the 15 percent coinsurance will also apply to O&P.

Therefore, beginning Jan. 1, 2006, the O&P and DME benefit for FreedomBlue members is as follows:

- 15 percent coinsurance on O&P and DME items, up to a $500 annual out-of-pocket maximum.*

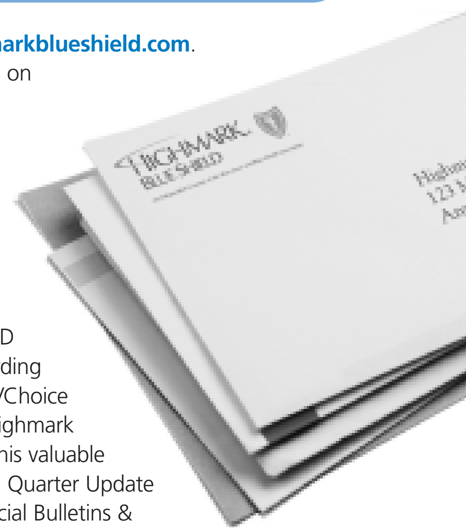
**There is a single $500 annual out-of-pocket maximum for O&P and DME items (combined).*

Important Mailings

Highmark recently mailed two important Special Bulletins to network providers, one regarding FreedomBlue benefits changes for 2006 and another about the new Highmark Medicare-Approved Select/Choice Formulary.

- Dated Oct. 1, 2005, a Special Bulletin titled "Highmark Blue Shield Expanding Medicare Advantage Product Offerings in 2006" was mailed to all participating Medicare Advantage network providers. This important update included information about a no-cost product option for consumers in central Pennsylvania, lower premiums for FreedomBlue Deluxe members, additional prescription drug coverage for FreedomBlue Standard and other key updates. This communication is available electronically on Highmark's Provider Resource Center, which is available via NaviNet℠ and **www.highmarkblueshield.com**. Look under the *Medicare Advantage* link on the Special Bulletins & Mailings page.

- Mailed in late November, the Highmark Drug Formulary 4th Quarter Update includes key information about the new Highmark Medicare-Approved Select/Choice Formulary and how it applies to members enrolled in FreedomBlue and BlueRx℠, Highmark's new Medicare Part D Prescription Drug plan. Information regarding the Highmark Medicare-Approved Select/Choice Formulary will be included in all future Highmark formulary updates, so please watch for this valuable news. The Highmark Drug Formulary 4th Quarter Update is available on the Resource Center's Special Bulletins & Mailings page under the *Formulary/Drug* link.



Radiology Management Update:

Watch Your Mail for Prior Authorization Guide

NaviNet℠ Authorization Function To Be Available Feb. 13, 2006

In January, Highmark will mail the *Prior Authorization Reference Guide* to all PremierBlue℠ Shield MDs, DOs, chiropractors, podiatrists, CRNPs, nurse midwives and nurse anesthetists. The guide will provide detailed information about the Prior Authorization component of Highmark's Radiology Management Program. Effective with dates of service on or after April 1, 2006, network practitioners who wish to order selected outpatient, non-emergency, advanced imaging procedures (selected CT scans, selected MRI and MRA scans and PET scans) for their Highmark patients will need to obtain authorization for these services prior to scheduling them.

Beginning Feb. 13, 2006, NaviNet users will be able to use NaviNet to request authorizations for imaging scans to be scheduled for dates of service beginning April 1, 2006, and beyond. Watch *Behind the Shield* and NaviNet's Plan Central page for updates. Beginning Jan. 1, 2006, all imaging providers must be privileged.

Privileged Imaging Providers Announced

A key component of Highmark's Radiology Management Program is privileging the imaging network to ensure that providers meet certain quality standards.

In addition to the 38 hospitals in the region, the imaging providers listed in the table at right have been privileged to perform advanced imaging scans (MR, CT and/or PET), as of Dec. 1, 2005. For the most up-to-date list, please check our Provider Resource Center at **www.highmarkblueshield.com**. The list is available under the *Highmark Radiology Management Program* link.

If you are a privileged imaging provider and wish to add additional services or additional sites, you need to submit a privileging application obtained from National Imaging Associates Inc.'s (NIA's) Web site at **www.RadMD.com** or from the Provider Resource Center at **www.highmarkblueshield.com.** Also, the provider's Highmark billing number needs to receive privileged status.

Privileging Guidelines Now Allow Tele-radiology

The program's privileging guidelines were recently updated to allow tele-radiology under certain circumstances. Please refer to the current privileging guidelines on the Provider Resource Center for details. If this change impacts your practice, you may complete and submit a supplemental tele-radiology privileging application, which also is available on the Resource Center.

County	Practice Name and Telephone Number
Berks	• Centre Imaging; 610-374-9000 • Diagnostic Health Corporation, d.b.a. Health South Diagnostic Center of Reading; 610-478-8797
Centre	• Geisinger Medical Group; 814-231-4560
Cumberland	• Central Penn MRI Center; 717-975-0444 • Heritage Medical Group LLP; 717-737-3037 • Walnut Bottom Radiology; 717-245-0071
Dauphin	• Tristan Associates; 717-652-9105
Lancaster	• Lancaster Outpatient Imaging LLC; 717-293-0709 • Lancaster PET Partnership; 717-544-3030 • MRI Group; 717-291-1016
Lebanon	• GSH Imaging Center/Lebanon MRI; 717-270-4580 • Lebanon Diagnostic Imaging; 717-306-4400
Lehigh	• Lehigh Magnetic Imaging; 610-740-9500 • Lehigh Valley Diagnostic Imaging; 610-435-1600 • Medical Associates of the Lehigh Valley, d.b.a. Clear View Imaging; 610-530-1515
Montour	• Geisinger Clinic; 570-271-6309
Northampton	• Advanced Radiology and Cardiovascular Center; 610-253-0439 • CHS Professional Practice PC; 610-861-8080 • Easton Radiology Associates; 610-923-7884 • Northampton Imaging Specialists; 610-250-9170 • Radiology and MRI of Bethlehem, Inc.; 610-867-5851 • Star Open MRI; 610-253-0439 • Valley Advanced Imaging, LLC; 610-865-4738 • Zoom Imaging; 610-861-3080
Union	• Tristan Associates, d.b.a. Susquehanna Valley Imaging; 1-888-522-5540
York	• Alpha Advanced CT, LLC; 717-505-5070 • MY Magnet, d.b.a. MRI of York; 717-843-0835 • York Imaging Center; 717-843-8983

HealthGuard News

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

HealthGuard network providers are advised that electronic and paper claims must be submitted within 180 days from the date of service, and claims won't be accepted for payment after July 31, 2006.

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. Similarly, paper claims received on or after Aug. 1, 2006, will be returned to the sender. You cannot bill the member; members will be held harmless.

For these reasons, HealthGuard 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

If you have any questions regarding submission of claims for HealthGuard patients, please contact your Provider Relations representative, toll-free, at 1-866-731-2045. We thank you for your support during this product shutdown period.

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.

Notifications for Highmark and HealthGuard Providers

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

Notification for Practitioners Regarding Delegated Entities for Utilization Management

Highmark maintains Utilization Management (UM) policies and procedures to assist our members in receiving appropriate and medically necessary care. Through these processes, determinations regarding your patients' coverage for health care services may be made by Highmark or with the assistance of outside vendors that contract with Highmark and who specialize in certain areas, such as mental health or durable medical equipment services. Highmark and these vendors make UM decisions based on appropriateness of care and service and the existence of coverage for the services by your patient's benefit program.

All vendors must meet the applicable regulatory and accreditation standards and agree to participate in annual oversight activities.

For more information on the UM process, see the *Highmark Blue Shield Reference Guide* (available in our online Provider Resource Center under *Administrative Reference Materials*) or contact Highmark Healthcare Management Services at 1-866-731-8080.

Credentialing

Please reference NaviNet℠ for information regarding Highmark's credentialing criteria and procedures.

Camp Hill, Pennsylvania 17089
www.highmarkblueshield.com
www.hguard.com

This newsletter is primarily geared toward medical practitioners and their office staff, with information about:

Introducing Cash Management System Access

Highmark has worked closely with providers to identify ways to supply information that would make their financial operations more efficient. Tools such as the Electronic Funds Transfer (EFT) maintenance process and the Provider Accounts Receivable Dashboard have already given providers more control over their data. Now Highmark is giving providers read-only access to the Highmark Cash Management System via NaviNet[SM], effective Oct. 17, 2005. Access to the application is available to those NaviNet users who currently have access to the Claim Status Inquiry function; the NaviNet Security Officer will be able to modify this access if required.

Accessing the Cash Management System

When NaviNet users log on, they now have a new transaction button named AR Management. The Cash Management button will display when the user hovers on the AR Management button. The Cash Management information is displayed on three screens:

- Highmark Weekly Provider Payment and History Inquiry, which will provide a weekly payment accumulation and a summary of payments received for the current year.
- Payment Details, which will display additional information on individual payments.
- Related Claims, which will display payment information on a claim basis.

For additional information, see the Highmark Cash Management System User Guide on NaviNet or contact NaviNet Customer Care at 1-888-482-8057.

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, PremierBlue, PPOBlue, FreedomBlue, EPOBlue, QualityBLUE and BlueRx are service marks of the Blue Cross and Blue Shield Association. Highmark is a registered mark of Highmark Inc.

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HEDIS is a registered trademark of the National Committee for Quality Assurance.

NaviNet is a registered service mark of NaviMedix Inc.

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