Behind the Shield

MARCH 2006

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

Health Care Consumers Want Access to Quality Data

As higher deductible health plans grow in popularity, health care consumers have greater out-of-pocket expenses. In turn, they want access to credible quality and cost information to help in their decision making.

This marketplace demand for quality and cost information — also known as "transparency" — is increasing, and Highmark is working to meet this need in a manner that is beneficial to our members. Our goal is to give our members — your patients — the reliable hospital information they need to become more educated, active health care consumers.

There are a multitude of resources available to the consumer to obtain publicly available data on quality. The Internet alone offers hundreds of sites. "Highmark has been evaluating its member Web site — My Shield Online℠ at www.highmarkblueshield.com — to determine what enhancements we can make to provide easy access to cost and quality information about our network providers," says Kim Bellard, Highmark's vice president of eMarketing. "We've been giving our members access to a variety of sources of public quality measures over the past few years, but in March 2006, we'll consolidate several links to make it easier for the consumers to find the information they need. We also wanted to expand on the numbers and types of measures that were reported."

To accomplish this in a user-friendly format, Highmark has contracted with Subimo, LLC, a leader in Web-based health care decision support tools. We will link to Subimo's Healthcare Advisor™ directly from our member Web page. The Healthcare Advisor is a tool that aggregates publicly reported information from the Centers for Medicare & Medicaid Services, Health Forum/AHA, National Research Corporation, Leapfrog Group, state data agencies and other sources. "In doing this, our goal is to give our members clear, accurate information about hospitals in our service area and easy-to-understand guidance about treatment options," says Mr. Bellard.

Subimo captures any available new/refreshed data on a quarterly basis from the primary sources. But the update cycles can vary greatly from primary source to primary source, as well as the age of the data. For example, Leapfrog updates its data multiple times per year and is relatively current; but the Pennsylvania Health Care Cost Containment Council (PHC4) clinical data is more than a year old, as are almost all hospital discharge sources in the country (e.g., the current data from PHC4 is for calendar year 2004).

Highmark continues to explore additional opportunities to share quality and cost data with members and is looking to include physician data as well. As plans progress, we'll share the details with our provider network well in advance of any public release. In the meantime, please watch the NaviNet℠ Plan Central page for links to industry articles on the topic of transparency.

INSIDE

HIGHMARK BLUE SHIELD

Save the Date:

Blue Connections℠ 2006 Spring Meetings

Please mark your calendar now to attend one of the Blue Connections 2006 spring meetings for Highmark Blue Shield network provider office staff members. The meetings will be held across the region this April and May (see chart below). Invitations were recently mailed to the offices of all physicians, doctors of chiropractic, psychiatrists, psychologists and ancillary providers.

Meeting dates, times and locations are as follows:

	Date	Time	Location
April	Tuesday, April 4	9 to 11 a.m.	300 Corporate Center, Auditorium, Camp Hill (off of Erford Road)
	Wednesday, April 5	9 to 11 a.m.	St. Luke's Hospital, Laros Auditorium, Bethlehem
	Thursday, April 6	8:30 to 10:30 a.m.	Reading Hospital, (Thun Jansen Auditorium), West Reading
	Tuesday, April 11	9 to 11 a.m.	Holiday Inn, Carlisle
	Wednesday, April 12	9 to 11 a.m.	Lehigh Valley Hospital, Auditorium, Allentown
	Thursday, April 13	9 to 11 a.m.	Hampton Inn, Fishing Creek Room, Bloomsburg
	Tuesday, April 18	9 to 11 a.m.	Pottsville Hospital & Warne Clinic, School of Nursing Building, Multipurpose Room, Pottsville
	Thursday, April 20	9 to 11 a.m.	Eden Resort Inn & Suites, Grande Ballroom, Lancaster
	Tuesday, April 25	9 to 11 a.m.	Holiday Inn Holidome, Red Rose Room, 2000 Loucks Road, York
	Thursday, April 27	9 to 11 a.m.	Mount Nittany Medical Center, Conference Rooms 1, 2 and 3, State College
May	Tuesday, May 2	9 to 11 a.m.	Gettysburg Hospital, Community Room A, Gettysburg
	Wednesday, May 3	9 to 11 a.m.	Susquehanna Valley Mall, Community Room, Selinsgrove

Attending a Blue Connections meeting enables you to speak with Highmark Provider Relations representatives, ask questions and gain valuable information for your practice. Along with handouts featuring useful tips and reminders, you'll receive updates on the following:

- our Medicare Advantage PPO
- the National Provider Identifier (NPI) initiative
- NaviNet℠
- the Radiology Management Program
- claim submission guidelines

Blue Connections will focus on enhancing efficiencies, specifically how Highmark and its network providers can work together to share information as accurately, quickly and effectively as possible in order to avoid delays.

Register Today

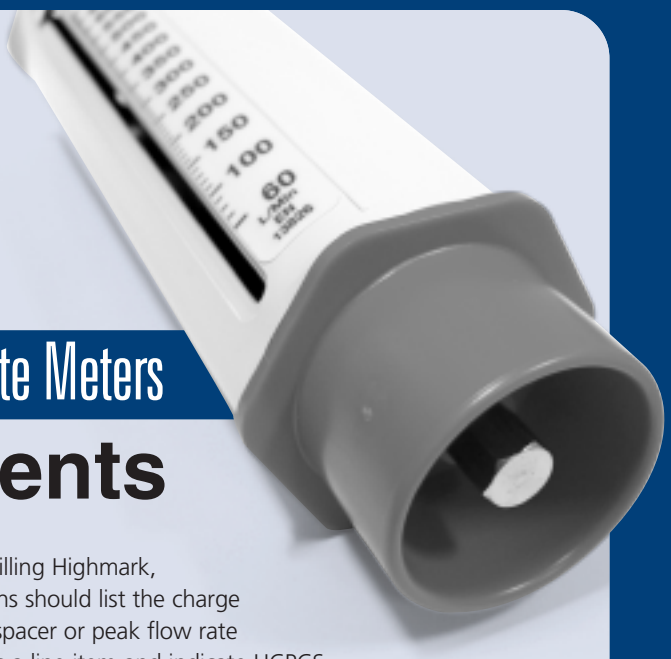
To register, please complete and return the postage-paid reply card that was included with your invitation. Or, you may register online by sending an e-mail to omregister@highmark.com. (Please include your provider/practice name, Highmark ID number, telephone number, date and location of the meeting you will attend and the number of people attending from your office, along with their names.)

We hope to see you this spring!

New Method

for Dispensing Spacers and Peak Flow Rate Meters

for Asthmatic Patients



Many physicians consider proper asthma care as one of the most essential aspects of health for patients of all ages. Spacers can help ensure that asthmatic patients get effective treatment.

As part of Highmark Blue Shield's ongoing efforts to help physicians improve the respiratory care for their asthmatic patients, Highmark has implemented a new procedure that will allow physicians to obtain spacers and peak flow rate meters and dispense them to their asthmatic patients and receive reimbursement for these items from Highmark.

Under this new procedure, physicians can purchase spacers or peak flow rate meters directly from a manufacturer or a durable medical equipment vendor and submit a claim to Highmark for reimbursement when the spacer is dispensed to the patient.

Please note that Blues On Call℠ will no longer distribute free spacers to pediatricians. Pediatricians should use this new procedure to obtain and distribute spacers for their asthmatic patients.

There are several manufacturers/distributors of asthma spacers and peak flow rate meters. Two are:

- **Respironics:** 1-800-345-6443
- **Invacare:** 1-800-333-6900

When billing Highmark, physicians should list the charge for the spacer or peak flow rate meter as a line item and indicate HCPCS Code A4627 (spacer, bag or reservoir, with or without mask, for use with metered dose inhaler) or HCPCS Code A4614 (peak flow rate meter) on the CMS 1500 Claim Form. For the most current allowance for HCPCS Code A4627 or HCPCS Code A4614, you can view the Highmark/PremierBlue℠ Shield fee schedule online via NaviNet℠.

Note: Since asthma spacers and peak flow rate meters are prescription-only items, authorization is not required. Do not file the prescription form with the claim.

Physicians who do not wish to obtain and distribute these items can opt to write a prescription for them and have the patient acquire the spacer or peak flow rate meter from a durable medical equipment vendor.

Education Resources Also Available

A patient's proper use of the spacers and/or peak flow rate meters is also essential to controlling asthma. Highmark offers resources that can assist you in educating patients on correct spacer and peak flow rate meter use. Patients can speak to a Blues On Call Health Coach anytime by calling 1-888-258-3428 (1-888-BLUE-428). Physicians can also download and print educational materials from the Healthwise Knowledgebase®, which can be accessed through our Provider Resource Center on NaviNet or at **www.highmarkblueshield.com**.

Physicians who have specific questions about this new procedure should contact their Provider Relations representative.

Questions?

Providers with Internet access will find helpful information online at **www.highmarkblueshield.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

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

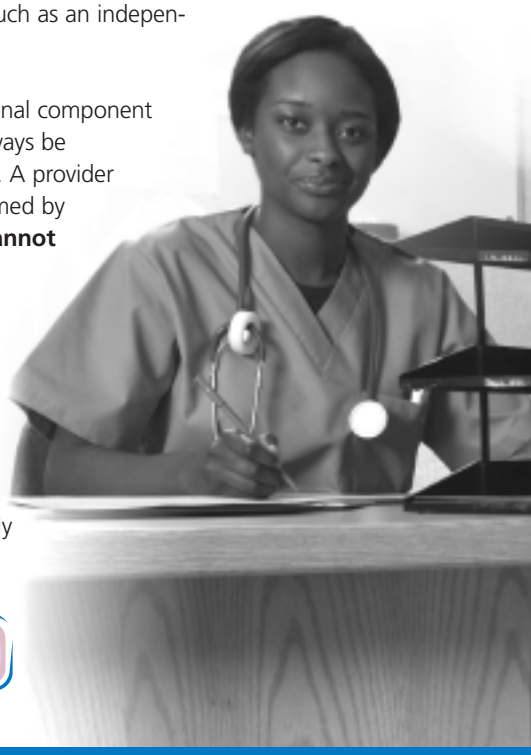
For NaviNet users, this icon following an article means that the material/information is conveniently accessible from Plan Central. Just click on *Resource Center*.

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.

REMINDER:
Billing for Purchased Services

"Purchased" services are those services that are not actually performed by the provider who is ordering them and reporting them to Highmark. The concept typically applies to procedures with separate professional and technical components, such as radiological and diagnostic medical tests.

The professional component (interpretation) may be performed by the patient's physician; however, that physician may have purchased the technical component from another entity, such as an independent diagnostic testing facility.



Professional services, including the professional component (interpretation) of diagnostic tests, must always be reported by the provider who renders them. A provider **cannot** report a professional service performed by another entity. In other words, a provider **cannot** purchase a professional service.

Technical services, such as the technical component of a diagnostic test, **can** be purchased. A provider **can** report the technical component of a service ordered from and rendered by another entity.

For more information on billing appropriately for purchased services, please see the February 2006 issue of *PRN*.

HealthGuard Products Discontinued

Providers are reminded that the HealthGuard products were discontinued as of Jan. 31, 2006.

Please remember these important dates:

- **July 31, 2006:** This is the last day to submit claims to HealthGuard for payment.
- **Oct. 1, 2006:** This is the day that HealthGuard's Internet provider portal will close.

For more details on these key dates, please see the December 2005 issue of *Behind the Shield*, which is available online in our Provider Resource Center.

Highmark's NPI Strategy:

Watch Your Mail for Details

*In early 2006, Highmark will mail to all network providers a Special Bulletin outlining the specific dates for acceptance of National Provider Identifiers (NPIs) on electronic claims.**

As announced previously in *Behind the Shield* and on the NaviNet℠ Plan Central page, 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 an 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.

To give providers ample time for this transition, Highmark has outlined the following timetable for acceptance of NPIs on electronic claims:

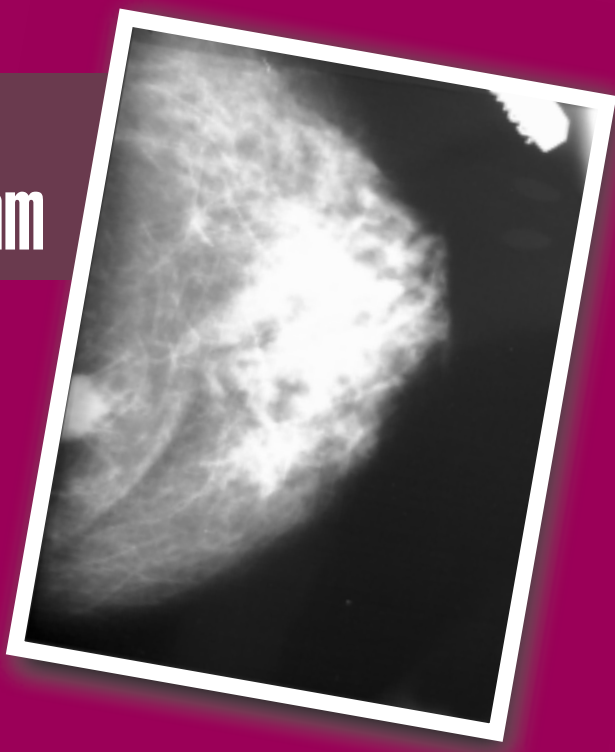
- **Feb. 24, 2006:** Highmark began accepting providers' NPIs along with their Highmark provider numbers on electronic claims; the NPI is optional, but the Highmark provider number is still required.
- **October 2006:** Highmark will begin accepting an NPI, a Highmark provider number or both an NPI and 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, 10-digit 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.

For more information or updates about Highmark's timetable for accepting NPIs on electronic claims (along with details on how to obtain an NPI), watch your mail for the Special Bulletin noted previously, see recent issues of *Behind the Shield* and watch NaviNet's Plan Central page.

**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.*

Medicare Advantage:
2006 Oncology Demonstration Program



In 2005, the Centers for Medicare and Medicaid Services (CMS) initiated a one-year demonstration project for cancer patients undergoing chemotherapy. The project focused on measuring patient outcomes in three areas often experienced by patients receiving chemotherapy: pain, nausea/vomiting and fatigue.

Although the 2005 project has ended, CMS is continuing its efforts to promote evidence-based best practices leading to better outcomes for cancer patients. For 2006, CMS has introduced the 2006 Oncology Demonstration Program. Highmark Blue Shield has elected to offer its own program, based in part upon CMS' 2006 Oncology Demonstration, for its Medicare Advantage product, FreedomBlue℠.

Key features of the 2006 Oncology Demonstration Program are:

- The program is only available to office-based hematologists, oncologists and gynecological oncologists.
- It is limited to those hematologists, oncologists and gynecological oncologists who provide Level 2, 3, 4 or 5 Evaluation & Management (E&M) services to their established patients.
- It is only applicable to those patients with a primary diagnosis of cancer belonging to one of 13 major diagnostic categories: cancer of the breast, colon, rectum, prostate, lung, stomach, esophagus, pancreas, ovary, head and neck, as well as chronic myelogenous leukemia, multiple myeloma and non-Hodgkin's lymphoma.
- As with the 2005 project, participation in this program is voluntary.

Details of the 2006 Oncology Demonstration Program, including coding instructions and reimbursement information, are being mailed to hematologists, oncologists and gynecological oncologists in a Special Bulletin.

Customer Service Tips

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

- The greeting sets the tone for the visit – Make eye contact and use the patient's name and Mr. or Mrs. whenever possible.
- Attitude is a little thing that makes a big difference.
- Avoid using slang and acronyms when communicating with patients.
- Don't consider telephone calls to be interruptions; they are the lifelines of your practice.

You can find more helpful customer service tips in the *Quality Management Resource Binder* under *Clinical Reference Materials* in our Provider Resource Center. Inside the binder, you'll find Patient Satisfaction Office Tips in the *Helpful Links* section.

Notifications for Highmark Providers

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

Appropriate Utilization Decision Making

Highmark makes utilization review decisions based only on appropriateness of care and service and the existence of coverage. In addition, Highmark does not specifically reward practitioners, providers, Highmark employees or other individuals conducting utilization review for issuing denials of coverage or service, nor do they provide any financial incentives to utilization management decision makers to encourage denials of coverage.

Request for Criteria

Highmark uses nationally recognized clinical review criteria, medical policy and Medicare guidelines in determining whether a requested procedure, therapy, medication or equipment meets the requirements of medical necessity. This is done to ensure the delivery of consistent and medically appropriate health care for our members.

If a PCP or specialist requests a service that a nurse in Healthcare Management Services (HMS) Care Management is unable to approve based on criteria/guidelines, the nurse will refer the request to a Highmark Physician Advisor or Medical Director. A Highmark Medical Director or Physician Advisor may contact the PCP or specialist to discuss the request or to obtain additional clinical information. A decision is made after all of the clinical information has been reviewed.

At any time, the PCP or specialist may request a copy of the criteria/guidelines used in making medical/surgical decisions by calling Highmark at 1-800-421-4744. To request a copy of the criteria/guidelines used in making behavioral health decisions, call 1-800-258-9808.

Highmark Requires 24/7 Coverage for Members

Please be aware of the Highmark credentialing requirement that all network practitioners must provide coverage for members 24 hours a day, seven days a week, either directly or through an on-call arrangement with another participating network practitioner.

This allows a Highmark member or another practitioner the ability to access a practitioner (or his/her designee) directly in urgent or emergent situations. The 24/7 coverage can be accomplished through an answering service, pager or via direct telephone access whereby the practitioner (or his/her designee) can be directly accessed, if needed.

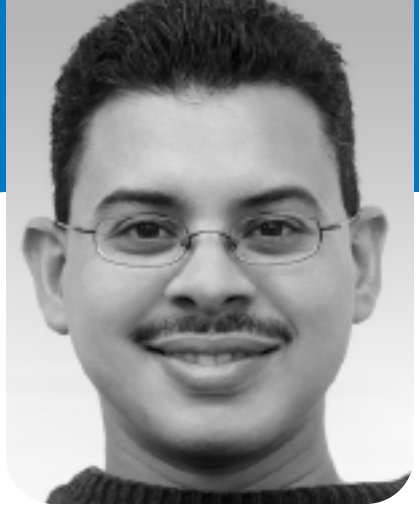
A referral to a crisis line or the nearest ER is NOT acceptable coverage unless there is an arrangement made between the practitioner and the crisis line or ER whereby the practitioner (or his/her designee) can be contacted directly, if needed. It is NOT acceptable for any non-PCP practitioner to refer patients to their PCP after normal business hours.

The following specialties are exempt from this requirement:

- audiology
- speech therapy
- speech language pathology
- physical therapy
- preventive medicine
- dermatopathology
- pathology (only if working outside of the acute care setting)

Waiver of Clinical Privileges

Clinical privileges will not be required for primary care physicians (family practitioners, pediatricians, internists and general practitioners) who document on the credentialing application arrangements for adequate coverage through another network practitioner or network group that are acceptable to Highmark. With the new change, the practitioner would provide the name(s) of the covering physician(s) on the application without an additional co-signed document, as was previously required.



Highmark Striving
to Meet Patients' Language Needs

Our quality improvement efforts are designed to ensure quality care and member satisfaction. To realize these goals, we continually review the aspects of our plan that affect member care and satisfaction and look for ways to improve them. One way to achieve improvements is to share with network practitioners information about the languages that patients in their geographic area may speak and to provide resources for available interpreting services.

Highmark annually assesses languages spoken by the population in our service area and compares these findings to the data that practitioners report on their network applications (Page 1: List languages spoken, other than English). Our 2005 analysis concluded that the following counties had more than 1,000 residents speaking the following primary languages:

Language	Counties in Which Language is Spoken*
Spanish or Spanish Creole	Adams, Berks, Centre, Cumberland, Dauphin, Franklin, Lancaster, Lebanon, Lehigh, Mifflin, Northumberland, Schuylkill, Union, York
Arabic	Lehigh
Chinese	Centre, Lancaster, Lehigh
French (incl. Patois, Cajun)	Dauphin, Lancaster, York
German	Berks, Cumberland, Dauphin, Lancaster, Lehigh, Northampton, York
Italian	Berks, Northampton
Other Slavic Languages	Lehigh
Other West Germanic Languages	Berks, Centre, Lancaster, Lebanon, Lehigh, Mifflin, Schuylkill, Snyder, Union
Russian	Lancaster
Vietnamese	Berks, Dauphin, Lancaster, Lehigh

**The above data is from the 2000 U.S. Census. This information is based on county population and not Highmark membership.*

In addition, telecommunications provider AT&T offers a breakdown of all calls that Highmark customer service representatives received during the year that required interpretation services. Highmark received calls from members speaking five different non-English languages (Spanish, Mandarin, Russian, French and Indonesian). Of the calls Highmark received from non-English-speaking people, the largest percentage (47.1 percent) were from members speaking Spanish.

If you currently see non-English-speaking Highmark members in your office, an excerpt from the article, "Using Bilingual Staff Members as Interpreters" from *Family Practice Management* (11[7]:34-36, 2004, © American Academy of Family Physicians) offers the following eight points to keep in mind:

1. Use the universal form of the language whenever possible (free of regional words and dialects).
2. Refrain from assuming the role of interviewer or decision maker.
3. Let the patient lead the discussion.
4. Translate everything.
5. Be aware of culturally significant issues that affect patient care, and translate in a way that conveys the cultural framework.
6. Meet the patient prior to the medical encounter.
7. Develop interpreter-physician work plans for each patient.
8. Seek continuing education.

The complete article can be found at: **http://www.medscape.com/viewarticle/484539** and includes resources for interpretation services. One service highlighted in the article is 1-800-TRANSLATE, which offers 24/7 services on a fee-for-service basis. Also, **http://www.booksmythe.com** sells for a nominal cost a pocket reference guide for doctors that translates common medical phrases and terminology into Spanish, French or Russian.

In an effort to better serve the Highmark members in your respective counties, as well as potential future members, please review your credentialing/recredentialing application. If you speak any of the previously mentioned languages or any foreign language that isn't included in your profile, you can update your information by contacting Provider Data Services at 1-866-763-3224. Finally, we'd like to ask that when hiring future staff, please consider individuals who speak languages which are relevant to your patient population and geographic location.

Patient Outreach Programs

Identify Healthy Lifestyle Barriers

Highmark continues to implement successful patient outreach programs that we hope will inspire our members to make healthy choices. One of our more innovative programs uses technology to gather informative and useful results that will help us — and you — to better address the health needs of our members. Over the past few months, we've used a telephone-based, speech-enabled outreach campaign to interact with our members on topics such as hypertension, osteoporosis, mammography, cervical cancer screenings and glaucoma screenings.

Using automated speech-recognition technology, we can conduct one-on-one conversations with our members, offering focused feedback to their responses. These outreach programs gather information and identify any barriers to making healthy lifestyle changes. Members pick up the telephone to hear a supportive, personable human voice that engages them in an interactive conversation and encourages healthy behavior.

A recent program focusing on mammography and cervical cancer screenings was particularly revealing. Using speech-enabled outreach, we contacted approximately 26,500 members who were eligible for either mammograms or pap tests to find out whether or not they had these screenings in the past year. About 76 percent of respondents revealed that they hadn't had a mammogram. We then led these members through some questions that helped us to better understand barriers to receiving a mammogram:

- For example, were they too busy to schedule a mammogram? These women were gently reminded that the mammogram only takes 30 minutes — just half an hour of prevention that can go a long way toward maintaining their health.
- Did they have trouble getting to a mammography facility? These women were directed to the Highmark Web site, where they could locate a nearby facility.

Anyone who couldn't be reached was left a friendly, HIPAA-compliant message that left a call-back number and encouraged the member to visit her doctor on a regular basis as part of a healthy lifestyle.

The campaign also revealed some other interesting findings: Members who reported having mammograms were asked what motivated them to get the test and how they would convince a friend or family member to get one.

Women responded to these open-ended questions with comments such as:

- [A] physician recommended the test.
- "Probably somebody making the appointment for me [could convince me to have the test]."
- "Evening office hours [could convince me to have the test]."
- "Just the doctor's suggestion [could convince me to have the test]."
- "[To convince someone else,] I would say it's easier to have a test than have to have an operation."
- "[To convince someone else, I'd say] remember that breast cancer kills."
- "[To convince someone else, I'd say] examine yourself every month without fail. And anything that feels soft or sore, go to a doctor or go have a mammogram done."

We'll be using the program results, including valuable, candid comments like those noted here, to better understand how we can work with you to motivate our members to act in healthful ways.

So please stay tuned as we work to introduce other patient outreach programs on key health issues, such as diabetes and colorectal screening. It's our hope that you, too, will be able to use these results to assist in providing the superior care our members — your patients — expect and deserve.

Diabetes Update for Office Staff:

A Closer Look at Microalbumin Testing

Most physician office staff professionals have heard of the urine microalbumin test for people with diabetes. But, it's always good to remind ourselves about microalbumin and why diabetic patients should get the test.

Albumin is one of a group of simple proteins found in animals and plants. Albumin in the blood has many functions, including the maintenance of a proper balance of fluids between the blood and other tissues. In humans, it has special relevance to people with diabetes because its presence in urine is an early indicator of diabetic kidney disease.

One important job of the kidneys is to filter protein by-products and water from the bloodstream. In the early stage of diabetic kidney disease, the kidneys begin removing too much albumin from the blood. As a result, very tiny amounts of albumin, or microalbumin, begin to show up in the urine, a condition known as microalbuminuria. Microalbuminuria is not uncommon in people who have had diabetes for five or more years.

Fortunately, there is a specific laboratory test to check for microalbuminuria, called a urine microalbumin test. (The usual urine dipstick tests for protein are not sensitive enough for this purpose.)

For most diabetics, the urine microalbumin test should be done yearly to screen for early diabetic kidney disease. If the test is positive, measures can be taken — including lowering blood pressure and tightening blood glucose control — to slow or prevent the development of more serious stages of the disease.

If you have questions or comments regarding microalbumin testing or have ideas for a future article on diabetes, please contact Norma Nolte, CRNP, at Highmark at 412-544-2747 or via e-mail at norma.nolte@highmark.com.

The American Diabetes Association recommends the following tests for people with diabetes:

Test/Exam	Frequency	Goal
Microalbumin urine test	yearly	negative (no microalbumin)
Dilated eye exam	yearly	negative (no evidence of diabetic eye disease)
Hemoglobin A1C blood test	2-4 times a year	as close to normal as possible (less than 6%)
LDL cholesterol test	yearly	less than 100
Blood pressure	at every routine visit	less than 130/80

NaviNet™ News

NaviNet users are reminded that, effective March 1, 2006, NaviNet became the preferred source of information for member eligibility and benefit inquiries for NaviNet-enabled practices.

This means that practices who have NaviNet in at least one office location will be redirected to NaviNet if they call Customer Service for routine member eligibility and benefit inquiries that can easily be answered online. Customer Service will remain available for non-routine inquiries that require analysis and/or research.

A letter dated Jan. 18, 2006, was mailed to all NaviNet-enabled practices to explain this change. The letter is also available electronically on the Provider Resource Center under the *Publications & Mailings* link; click *Special Bulletins & Mailings* from the fly-out menu, and access the letter under the *NaviNet* link.

HIGHMARK BLUE SHIELD

An Independent Licensee of the Blue Cross and Blue Shield Association

Camp Hill, Pennsylvania 17089
www.highmarkblueshield.com

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

HIGHMARK PPOBlue — A Preferred-Provider Program

HIGHMARK DirectBlue — An Open Access Program

HIGHMARK EPOBLUE

HIGHMARK SelectBlue — A Point-of-Service Program

HIGHMARK ClassicBlue — Traditional Programs

HIGHMARK FREEDOMBLUE

Reminder:

Effective Date for Radiology Management Program Prior Authorization Component is April 1

Our network providers who order imaging scans for their Highmark patients are reminded that the prior authorization component of Highmark's Radiology Management Program takes effect for services performed on or after April 1, 2006. For more information, please see the Prior Authorization Reference Guide, which was mailed to all applicable providers in January. The guide is also available on the Provider Resource Center, which is available via NaviNet℠ or www.highmarkblueshield.com, under the *Highmark Radiology Management Program* link.

IMPORTANT NOTE: The program's prior notification phase has now ended. For advanced imaging procedures to be performed between now and March 31, 2006, no prior *notification* will be needed. You may simply order the imaging tests to occur during that time period without contacting National Imaging Associates Inc. (NIA), the imaging management firm that is supporting the program. **However, please remember that prior *authorization* is effective for services to be performed April 1, 2006, and after; therefore, for service dates of April 1, 2006, and beyond, all ordering providers must contact NIA prior to ordering any of the selected non-emergency, advanced imaging procedures for their Highmark patients.**

HAVE A GREATER HAND IN YOUR HEALTH: