NOW INCLUDING HEALTHGUARD PRODUCT NEWS!

Behind the Shield

JUNE 2004

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

HealthGuard's Blue Branding Moving Forward

HEALTHGUARD
A HIGHMARK COMPANY
An Independent Licensee of the Blue Cross and Blue Shield Association

Highmark and HealthGuard have already made several strides in advancing the Blue branding of HealthGuard, including the integration of the newsletters that network providers from both Plans regularly receive.

Beginning with this issue, *Behind the Shield* will regularly feature news for both Highmark and HealthGuard providers.

"For practitioners who belong to both the Highmark Blue Shield and HealthGuard networks, receiving one newsletter — rather than two independent publications — will improve the efficiency of provider communication," says Brent J. O'Connell, MD, MHSA, Highmark medical director.

Behind the Shield is published up to five times annually.

Highmark providers continue to have access to NaviNet℠, the free online information system that enables them to perform a variety of administrative transactions easily online. And HealthGuard practitioners will continue to have access to **www.hguard.com** for claims and eligibility information.

BlueExchange℠ Simplifies Electronic Claim Submission

For HealthGuard providers, the network's new Blue designation brings several advantages. Among those benefits is access to BlueExchange, an "electronic gateway" that the Blue Cross and Blue Shield Association established so its member Plans across the country can connect and share information.

In the future, HealthGuard practitioners may provide care and services to out-of-area Blue Plan members — also referred to as BlueCard® patients — from across the region and nation. As of Oct. 1, 2004, HealthGuard providers will have access to BlueExchange, which will simplify the electronic exchange of HIPAA-compliant transactions.

BlueExchange enables you to transmit eligibility, claim status and

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INSIDE

HIGHMARK® BLUE SHIELD
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HealthGuard's Blue Branding Moving Forward

(continued from Cover)

authorization requests electronically for out-of-area members by submitting inquiries to Highmark, which will automatically route them to the member's home Blue plan.

Provider Reps Now Handling All Products

To simplify interactions with providers who belong to both networks, each Provider Relations representative now services all lines of business for both Highmark and HealthGuard. This improvement is helping to ease administrative burdens on providers and their office staffs by offering a "one-stop shop" source for all products.

Join the HealthGuard Network

Highmark practitioners who aren't already in the HealthGuard network are invited to join the thousands of providers who currently participate.

HealthGuard now operates in 10 counties, but efforts are under way to expand the plan's HMO membership into additional counties. To participate in this growing network, you must complete a separate provider contract; however, there is no need for additional credentialing if you are already credentialed in the PremierBlue℠ Shield network.

You'll receive fee-for-service reimbursement (no capitation). For more information, contact your Provider Relations representative, toll-free, at 1-866-731-2045.

Watch *Behind the Shield* for more information.

PCP Role Remains Vital

Despite Referral Elimination*

Although Highmark will eliminate the requirement for referrals from our SelectBlue® product, the role of the PCP in overseeing and guiding members' care will remain as important as ever.

To make health care delivery more efficient with less administrative requirements for physicians, referrals will be eliminated from Highmark's SelectBlue POS program effective July 1, 2004.

However, Highmark will still require its SelectBlue members to choose PCPs. "We'll also continue to encourage members of our PPOBlue℠ and DirectBlue® programs to use PCPs, although it's not a requirement," says Brent J. O'Connell, MD, MHSA, Highmark medical director. "Despite the upcoming elimination of referrals, Highmark still believes that the relationship between a member and a PCP is a vital part of the health care delivery process, especially when important clinical decisions must be made."

Physician-to-Physician Communication Essential

Once referrals are eliminated, members may self-refer to any network specialist and receive the highest level of benefits. For this reason, specialists are asked to please continue to follow Highmark's existing protocols for keeping members' PCPs informed about patient progress, even after referrals are removed.

"Highmark has always believed that frequent communication among PCPs, specialists and other providers is essential to the member's overall good health," Dr. O'Connell says. "Additionally, close contact among practitioners can eliminate duplication of diagnostic testing, medication use and therapy."

Things to Remember

Providers and their office staff should keep in mind the following information regarding Highmark's upcoming referral elimination:

- Preventive services, such as routine adult and pediatric physicals and pediatric immunizations, must be performed by the chosen PCP to be covered. **Claims for preventive care delivered by a physician other than the member's PCP will be denied.**
- Other services, such as adult immunizations, may be provided by any network PCP at the higher level of benefits.
- PCPs may see patients whose ID cards show the name of another PCP as the current family physician. In this case, the specialist copay should be collected from the member for services performed. Most services — except preventive services as outlined above — will be covered at the higher benefit level.
- **Highmark isn't eliminating authorizations.** Authorizations will still be required for any services that currently require them, such as behavioral health services, inpatient care, some outpatient services and DME services.
- Some DME services that required a referral will only require a prescription (provided by the ordering physician) once referrals are removed.
- For dates of service beginning July 1, 2004, NaviNet℠ users who enter referrals (including FastTrack) for SelectBlue members will receive a message notifying them that referrals are no longer needed.

Watch *Behind the Shield* and NaviNet's Plan Central page for more information about Highmark's elimination of referrals.

* Effective January 1, 2005, HealthGuard will eliminate referrals from its HMO and POS products; watch *Behind the Shield* for more information.

Pediatric Practice
Saves Time, Resources with NaviNet℠

The physicians and staff at Jones, Daly, Coldren (JDC) Associates in Cumberland County know a thing or two about connecting with their patients.

Since it was established in the 1960s, the pediatric practice has focused on developing positive working relationships with entire families, according to billing supervisor Sandi Folk, MA. That's why many of JDC's roughly 25,000 patients are second-generation patients.

"We don't take a business-like attitude toward our patients," Ms. Folk says. "That's how we've managed to establish many longstanding family relationships."

In fact, several of those friendships are showcased on a reception area bulletin board in the practice's Mechanicsburg office: Founding partner James F. Daly Jr., MD, and other staff members who are active in the community regularly clip and post newspaper stories and photos featuring the happy accomplishments of current and past patients — from students receiving college scholarships to kids leading their junior high basketball teams to victory.

As those children have grown, so has JDC's reliance on computer information technology to efficiently manage thousands of patient records. That's why the practice uses NaviNet — the free Internet-based information system that enables Highmark practitioners to perform a variety of administrative transactions quickly online without spending time on the telephone. Providers can access **www.hguard.com** for convenient, online access to HealthGuard claims and eligibility information.

The practice first tapped into NaviNet in late 2001 after billing specialist Cres Boden read about it in a Highmark provider newsletter. "I saw the information and called right away and asked when we could get NaviNet," she says.

Within days, Ms. Boden and her colleagues received system passwords and were accessing NaviNet on their PCs. Since the staff had experience with using similar systems, they didn't require NaviNet training — which is available free online to all interested system users on an ongoing basis. "We received a user's manual and were pretty much up and running," Ms. Boden says.

Today, Ms. Folk and her staff use NaviNet 50 to 60 times daily to complete a variety of routine tasks.

"It's easy to navigate through, and it's a real time saver," says billing specialist Tracey Myers, who uses NaviNet five to 10 times daily to check the status of claims. "I can find information in five minutes or less and avoid making a telephone call that could last much longer."

Less Telephone Time, Faster Results

NaviNet has brought significant savings to JDC, one of the Harrisburg area's largest pediatric practices.

The most obvious benefit has been time savings. Prior to receiving NaviNet, Ms. Folk and her three staff members called Highmark up to 30 times a day to check member eligibility and benefits, inquire about claim status and perform other routine inquiries. If each of those calls lasted just 10 minutes, that represented roughly five staff hours per day — time that could have been better spent on more important tasks.

From left to right, NaviNet users Tracey Myers, Cres Boden and Sandi Folk stand near a bulletin board in Jones, Daly, Coldren Associates' Mechanicsburg office that showcases newspaper stories and photos featuring the life achievements of current and past pediatric patients. The three believe that getting NaviNet has helped to streamline the practice's billing operations.

Today, JDC's billing staff members handle those and other everyday transactions themselves via NaviNet in a fraction of the time, and "We rarely call the Provider Service Center," Ms. Boden says.

"I don't like hanging on the phone," she says. "So I get on NaviNet, check a claim's status or a patient's eligibility in a minute or two, and it's done."

Verifying member copays and benefits are among the most common NaviNet transactions JDC performs. "If a patient has lost her ID card or forgotten what the required copay is, we can find that information on NaviNet and show it to her," Ms. Boden says. "We can even print it out and keep it with the patient's chart until we have a copy of the current ID card on file."

Ms. Boden likes NaviNet's *Allowance Inquiry* feature and that the system's claim investigation capability lets her request an appeal if a claim is denied. NaviNet also is useful when billing primary or secondary insurance providers, she says. "I can look up information through the claims inquiry and print it out so we have a payment history from Highmark to provide to the other insurer," Ms. Boden says.

As for the printed word, however, having access to electronically stored information through NaviNet has helped JDC reduce paper use and costs by about 10 percent, according to Ms. Folk. "Now, we can keep just one original copy of documents for patients' charts and not worry about making multiple copies like in the past," she says.

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Cres Boden, a billing specialist at Jones, Daly, Coldren Associates in Cumberland County, talks about the many benefits providers can get from NaviNet, including important news updates on the Plan Central page.

Practice Profile

Practice name
Jones, Daly, Coldren Associates

Office locations
Mechanicsburg (main office) and Camp Hill (satellite office), Cumberland County

Staff
Nine physicians and 35 support staff across two sites

Services
Complete pediatric services and subspecialties including juvenile diabetes, asthma and attention deficit disorder, among others

Patients
Approximately 25,000

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NaviNet Makes Coordination of Benefits Easier

Because JDC is a pediatric practice, newborns and infants are being added as patients nearly every day as families grow. That requires constant verification of insurance information to ensure that infants have been properly added to health insurance plans for the families' financial benefit and to ensure that JDC receives timely reimbursement.

When billing for newborns, Ms. Folk consults NaviNet 20 times a day on average. Coordination of benefits issues that once took nearly all day to resolve with several phone calls now take only about two hours with NaviNet, she says.

The system enables Ms. Folk to cross-check families' insurance information with that provided by the hospital, which is especially important if more than one insurer is involved. "Parents often have two children on one insurance plan and one child on another," Ms. Folk says. "Using NaviNet helps me know that I'm billing the right insurance company. And we can avoid unnecessarily billing the family because we couldn't verify benefits in a timely manner."

NaviNet's Plan Central page, which provides news updates for practitioners upon login, is another helpful feature, Ms. Boden says, because it enables Highmark to notify providers of important benefit changes right away (see story below). For example, in late 2003, "That's how we learned that Highmark was covering FluMist temporarily," she says.

Because access to NaviNet is password protected and available only to authorized users, the system helps to improve information security, says Ms. Boden, who serves as JDC's NaviNet Security Officer. Another benefit is that users can log onto the system from any PC with Internet access, which is helpful if staff travel between office sites. "I've even used NaviNet when working from home," Ms. Boden says.

And system support from NaviMedix® has been "very helpful" whenever issues arise, she says.

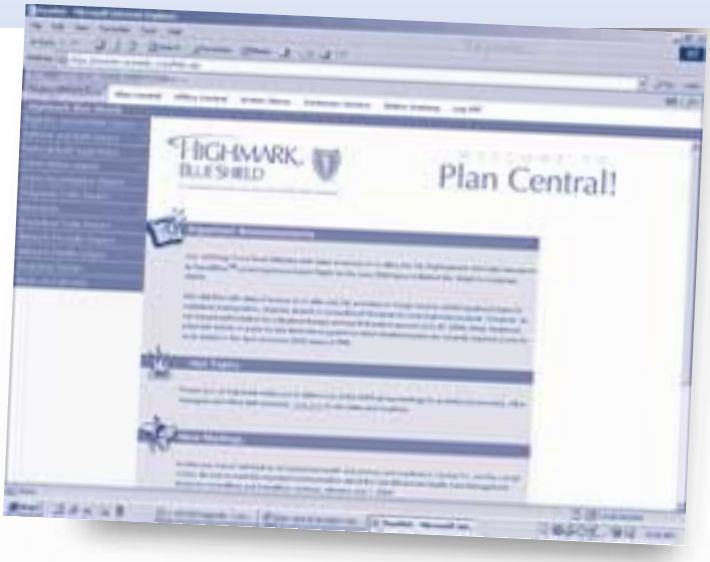
Overall, NaviNet has helped JDC's billing processes function faster and more smoothly because it makes information about Highmark patients more accessible than ever before, Ms. Folk says. "It's definitely worth the effort to learn to use it," she says. "A wealth of knowledge is in NaviNet."

For practices that may be hesitant about adopting NaviNet, Ms. Boden is quick to point out the system's value versus doing business the old-fashioned way. "Everyone has a fear of the unknown, but once you get on NaviNet, you can't imagine working any other way," she says.

NaviNet℠ Users: Read *Plan Central* to Stay Informed!

When you log onto NaviNet, the first page you see, the home page, is called Plan Central. It's where we post important news, announcements, reminders and tips on topics like the NaviNet system and Highmark products and resources. For example, within the last month on Plan Central, we posted news items about:

- avoiding claim rejections by coding to the highest level of specificity (see story on Page 7)
- using NaviNet's new Claim Investigation function
- using HMS Care Management's new Data Collection Tool when requesting authorization for bariatric surgery
- the latest newsletters being available online
- eliminating the need for SelectBlue® referrals and outpatient therapy treatment plans (effective 7/1/04)
- NaviNet system down time and holiday hours for HMS Care Management, enabling providers to plan ahead
- prebooking flu vaccine orders for 2005



The page is designed so you can quickly scan through the topics of the day and click on those that interest you. It takes just a few minutes and avoids the hassle of receiving separate mailings on these topics.

So, if you haven't read Plan Central lately, check it out today!

HealthGuard

Issues New-Look Member ID Cards

Because HealthGuard recently was branded as a Blue Plan, members' ID cards have taken on a new look.

As shown at right, the ID card has been updated to feature the new HealthGuard logo, which includes the Blue Shield symbol.

In April, all HealthGuard members received new cards with instructions to begin using them on May 1, 2004. Although the ID cards now include the Blue Shield logo, **please remember that you should continue to file your claims directly to HealthGuard**. When submitting EDI claims, don't include the alpha prefix in the "Member" or "Subscriber Identification" fields (see related story).

There is no change in laboratory affiliation information: The new HealthGuard ID cards still carry the acronym that tells you which lab to use for that patient.

The line of business (LOB) has been removed from the cards; however, you can now identify what LOB the member has by reading the alpha prefix. The prefixes are as follows:

QZA: Insured HMO
QZB: Insured POS
QZC: Self-Funded HMO
QZD: Self-Funded POS
QZE: Self-Funded PPO
QZF: Self-Funded Indemnity

Quick Tips for Filing HealthGuard Claims

- **File all HealthGuard claims directly to HealthGuard.** Although HealthGuard members have received new ID cards featuring the Blue Shield logo, there is no change in how you file your claims. Please continue to file claims for services provided to HealthGuard members directly to HealthGuard. ***Don't submit your HealthGuard claims to Highmark Blue Shield.***

  You'll notice that on the back of the new HealthGuard ID cards, providers are instructed to file claims with their local Blue Plan. Please remember that HealthGuard is now a Blue Plan — so, as noted above, file all HealthGuard claims directly to HealthGuard and not to Highmark Blue Shield.

- **Skip the Alpha Prefix for Local Claims.**
  The alpha prefix consists of the three alphabetical characters at the beginning of a HealthGuard member's ID number. Insurers use the alpha prefix information to route out-of-area claims on a national level to the appropriate Blue Plan. For HealthGuard business, the alpha prefix isn't needed for local claims. In fact, the HealthGuard platform cannot accept alpha prefixes for local claims. So, to avoid unnecessary delays in remittances, please remember to skip the alpha prefix when reporting the member ID number.

HealthGuard Announces **Provider Manual Updates**

The HealthGuard Provider Manual was recently updated to include changes to practitioners' contact information, listings for new network providers and revisions to important policies and procedures.

Updated each January and July, the HealthGuard Provider Manual is a valuable reference tool that puts a wealth of information about HealthGuard at your fingertips. You and your office staff will find everything you need to know about referral and billing procedures, coverage and benefits limits, pharmacy services, quality improvement and more.

All physicians receive a current HealthGuard Provider Manual for use in their practice offices. The updated manual was made available on compact disc (CD), as HealthGuard is working to reduce the amount of paper-based information that we exchange with providers and the printing and postage expenses associated with doing so.

Information contained in the Provider Manual is available online: You can search **www.hguard.com** for providers by name or specialty by clicking on *Provider Search* on the home page. To access clinical reference materials, HealthGuard policies and procedures and claims and eligibility information, click on *Provider Services* in the home page menu.

Modafinil to Require Prior Authorization

HealthGuard's Pharmacy and Therapeutics Committee announced that effective July 1, 2004, modafinil (Provigil) will require prior authorization.

Members currently receiving modafinil will be able to continue therapy without prior authorization.

Modafinil is FDA approved to improve wakefulness in patients with excessive sleepiness associated with narcolepsy, obstructive sleep apnea/hypopnea syndrome and shift work sleep disorder.

Modafinil ***isn't*** FDA approved for the reduction of daytime sleepiness associated with multiple sclerosis, Parkinson's disease, Alzheimer's disease or idiopathic hypersomnia. This medication also isn't indicated for the treatment of depression or attention deficit hyperactivity disorder. For unlabeled indications, there is insufficient evidence from controlled studies to substantiate treatment at this time.

Coverage of modafinil will be provided when:

- the member has a diagnosis of narcolepsy (as documented by MSLT or other appropriate testing) ***or***
- the medication is used as adjunctive therapy in patients with obstructive sleep apnea/hypopnea syndrome, receiving and compliant with CPAP ***or***
- the member has diagnosis of shift work sleep disorder and other causes of excessive sleepiness or insomnia have been ruled out

Coverage won't be provided for other uses of modafinil.

References:

1. Provigil (modafinil) product labeling; Cephalon Inc.; Feb. 2004
2. Provigil (modafinil) tablets supplemental NDA; briefing document for peripheral and central nervous system drugs advisory committee meeting; Sept. 25, 2003 (found online at **http://www.fda.gov/ohrms/dockets/ac/03/briefing/3979B2_01_Cephalon-Provigil.pdf**, March 30, 2004)

Authorization for Bariatric Surgery

Highmark requires the following information to be submitted with an authorization request for bariatric surgery:

- BMI
- comorbidities
- details on MD-supervised exercise/nutrition therapy
- details on evaluation for psychological/psychiatric conditions that would prohibit compliance
- a specific description of the procedure requested and the date of surgery

Also, please be aware that for any date of service request for April 1, 2004, and beyond, Highmark requires that you submit a copy of the medical record containing all necessary information in order to process requests for obesity surgery.

HIPAA Reminder:

Report Highest Specificity of Coding

According to the most current ICD-9-CM manual, providers are required to report diagnostic codes to the highest degree of specificity.

To maintain compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Highmark won't accept claims if the diagnosis code isn't carried to the fourth or fifth digit when required. Highmark will, therefore, reject claims not reported to the highest degree of specificity. Since rejected claims cannot be adjusted, the provider will be required to correct the diagnosis code and resubmit the claim. This policy applies to all providers — including ancillary service providers — and all Highmark products.

When reporting reflux esophagitis, for example, you must report code 530.11. Reporting code 530 (diseases of the esophagus) or 530.1(esophagitis) isn't acceptable. Most ICD-9-CM coding manuals include a color-coded system designating diagnosis codes that require four or five digits.

HIGHMARK Prescription Benefit News

Highmark Blue Shield maintains a prescription drug formulary of FDA-approved medications to support delivery of quality health care and to help keep pharmacy costs in check for our members.

Comprised of network physicians and pharmacists, Highmark's Pharmacy and Therapeutics Committee oversees the formulary and updates it regularly by adding and deleting medications based on their safety, efficacy, quality and cost. The committee revises the formulary quarterly to add new products, and a Special Bulletin is mailed to all Participating and PremierBlue℠ Shield network physicians. Formulary deletions occur semi-annually — on January 1 and July 1 — after network providers and members who are impacted are given a minimum of 30 days' notice.

Physicians are encouraged to prescribe medications included in the formulary whenever possible.

The following prescription drugs were ***added*** to the formulary, effective March 26, 2004:

- Lexiva™ (fosamprenavir)
- PEG-Intron® Redipen™ (peginterferon alfa-2b)
- Raptiva™ (efalizumab)
- Relpax® (eletriptan)
- Zomig® Nasal (zolmitriptan nasal spray)

The following brand-name medications ***will be deleted*** from the formulary effective July 1, 2004, because their generic equivalents are already on the formulary. (For patients with a closed formulary, physicians may request coverage of these products using the *Prescription Drug Medication Request Form*, which can be found on Page 9 of the 2004 Highmark Blue Shield Formulary manual.)

- Alphagan® (brimonidine)
- Bactroban® ointment (mupirocin)
- Glucotrol® XL (glipizide extended release)
- Lotensin® (benazepril)
- Lotensin® HCT (benazepril/hydrochlorothiazide)
- Paxil® (paroxetine hcl)
- Serzone® (nefazodone hcl)
- Zaroxolyn® (metolazone)

Clinical Pharmacy Initiatives

Quantity Level Limit Program

Effective April 1, 2004, the following medication has been added to the Quantity Level Limit Program:

- Climara Pro™ (estradiol / levonorgestrel)

Climara Pro is limited to eight patches per 34-day supply (retail) and 16 patches per 35- to 90-day supply (mail order).

Prior Authorization Program

As of April 1, 2004, the following medication has been added to the Prior Authorization Program:

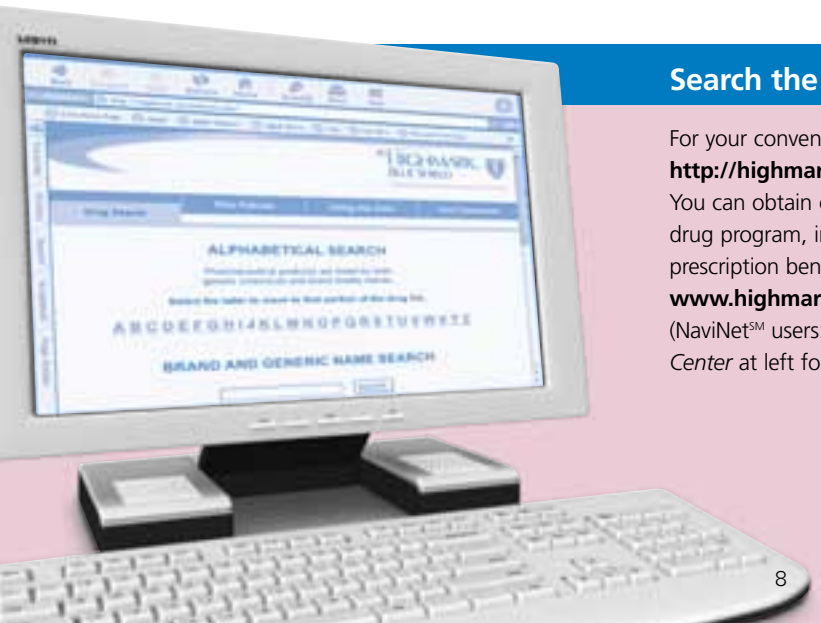
- Raptiva™ (efalizumab)

Correction — Testosterone (Androgens) Prior Authorization Policy

The therapeutic measurement used to determine low testosterone levels in hypogonadal men was reported incorrectly in the February 2004 Formulary Update. Requests for androgens will be approved for primary or secondary hypogonadism in males who have a total testosterone level of < 270 ng/ml. Androgens also will be approved as palliative treatment in female patients with metastatic breast cancer.

Managed Prescription Drug Coverage (MR_XC) Program

Recently, GlaxoSmithKline, the manufacturer of migraine therapy medication Imitrex,® created a new package for all tablet dosage forms. This new package contains nine tablets in a single, foil-wrapped container as opposed to the unit-dose blister pack that was used previously. The manufacturer recommends that this new package not be separated. In response to this, Highmark has increased the quantity of Imitrex tablets that are covered, from 800 mg every 25 days to 900 mg every 25 days. This will give pharmacies the flexibility to use the old packages, when available, and will accommodate the new packaging as well.



Search the Highmark Formulary Quickly Online

For your convenience, you can search the Highmark formulary online at **http://highmark.formularies.com** by drug name or therapeutic class. You can obtain other helpful information about Highmark's prescription drug program, including details about clinical pharmacy initiatives and prescription benefit changes, from our online Provider Resource Center at **www.highmarkblueshield.com**, under *Pharmacy/Formulary Information*. (NaviNet℠ users: From the Plan Central page, simply click on *Resource Center* at left for quick access.)

HIGHMARK Pharmacy News

Authorization for Certain Injectable Drugs to be Available Through NaviNet℠

Effective July 12, 2004, PremierBlue℠ Shield physicians will be able to use NaviNet to request authorizations for the following injectable medications for their DirectBlue® and SelectBlue® patients:

- J0585 – Botox® (botulinum toxin type A)
- J0587 – Myobloc® (botulinum toxin type B)
- J1745 – Remicade® (infliximab)
- J1563, J1564 – Immune globulin intravenous products (IVIG)
- J0215 – Amevive® (alefacept)
- S0107 – Xolair® (omalizumab)

Effective July 12, 2004, to access NaviNet's Injectable Drug Authorization Tool, hover on *Referral/Auth Submission* and select *Referral and Auth Submission*. Then, select *Injectable Drugs* from the Category drop-down menu. Next, from the Service drop-down menu, select the injectable drug(s) for which you need an authorization, and click *Submit*. It's that simple!

Watch NaviNet's Plan Central page and *Behind the Shield* for more details.

This new, time-saving functionality eliminates the need to place a telephone call to Healthcare Management Services (HMS) and is just one more reason to use NaviNet. So, if you don't already have NaviNet, call 1-888-482-8057 to order it today!

Fisher's SPS Now Medmark Inc.

Effective March 19, 2004, Fisher's SPS, the specialty pharmacy vendor for Highmark's Injectables Program, has changed its name to Medmark Inc. You can reach Medmark at 1-888-347-3416 to place orders for certain injectable medications that are included in the program.

Injectables Program Review

Highmark Blue Shield's Injectables Program is a streamlined program through which PremierBlue Shield physicians order certain injectable medications for their PPOBlue℠, DirectBlue®, SelectBlue®, Access Care II PPO and Federal Employee Program patients.

The program is designed to:

- better identify and help you meet the needs of your PPOBlue, DirectBlue, SelectBlue, Access Care II PPO and Federal Employee Program patients who require certain injectable medications
- eliminate or reduce the need for you to purchase, store and bill for these medications
- control the rising costs of these drugs

Medmark Inc., formerly Fisher's SPS, is the specialty pharmacy provider for this program. To reach Medmark, call 1-888-347-3416.

The following drugs are currently included in the program:

- Amevive® (alefacept)
- Antihemophilic factor products
- Botox® (botulinum toxin type A)
- Hyalgan® (sodium hyaluronate)
- Immune globulin intravenous products (IVIG)
- Myobloc® (botulinum toxin type B)
- Supartz® (sodium hyaluronate)
- Synagis® (palivizumab)
- Synvisc® (hylan G-F 20)
- Thyrogen® (thyrotropin alfa for injection)
- Xolair® (omalizumab)

In today's fast-paced world of health care, practitioners are busier than ever.

NaviNet℠

Makes Recredentialing Easier

Completing paper forms and searching for various pieces of printed information can make recredentialing a time-consuming process. Follow-up communications to add or clarify information can cause further delays.

However, NaviNet's* recredentialing transaction will soon be available for PremierBlue℠ Shield providers! This exciting new tool makes it easier for practitioners with NaviNet access to save time by completing the recredentialing application online. NaviNet-enabled providers who are due for recredentialing on or after August 1, 2004, will be asked to complete the process via NaviNet.

If you're not yet NaviNet-enabled, or haven't yet considered the NaviNet option, the recredentialing transaction may be one of the best reasons yet for pursuing access to the system. The NaviNet recredentialing transaction not only makes completing the information easier, it also checks your entries **before** accepting them. Here's how it works:

- If you have obtained your own user name and password from NaviMedix, several months prior to the end of your credentialing cycle, you'll receive an online notice (a message, indicated by a colored flag, that requires a response from you) alerting you that your recredentialing application is due.
- The notice will include an electronic recredentialing application form that is pre-populated with the information we already have on file for you, which saves you time. You can designate your office manager or another member of your office staff to complete the non-private information on the form or do it yourself.
- There's no more handwriting. And you can complete the form at your own pace. The system allows you to complete portions of the form and return to it later. It also gives you a summary detailing the portions of the form that have been completed and which ones are still in progress.
- NaviNet system logic prevents certain errors, such as incorrect time of day listings for office hours. For example, office hours mistakenly entered as 9 p.m. to 5 p.m. would prompt an error message.
- System logic also prevents you from submitting the application form with missing information and tells you what items still need to be completed.

Once you've reviewed all information, you can submit a complete, clear and easy-to-read application with just a click of a mouse. The system also allows you to print a complete paper copy of the application for your records. However, your application will be stored in your Complete Action Item log for 37 months, until your next recredentialing period.

Our goal is to continue to make NaviNet available as quickly as possible to the rest of our providers interested in this unique, time-saving application. If your practice wants to learn more about NaviNet or request access, contact your Provider Relations representative.

* NaviNet, created and supported by a vendor called NaviMedix, is a free, real-time system linking physician offices and facilities with Highmark via the Internet. Recredentialing is just one of many functions that NaviNet offers.

Recredentialing Tips

Beginning August 1, 2004, you can view a step-by-step guide of how to complete your recredentialing application via NaviNet:

- From the NaviNet tool bar, choose *Customer Service*, then *NaviNet Customer Care*.
- Under *User Guides*, choose *Highmark Blue Shield,* then scroll down to *Action Items*.
- Click *How do I use NaviNet for recredentialing?*

Notifications for Highmark Providers

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

Appropriate Utilization Decision Making

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

Request for Criteria

Highmark Blue Shield uses nationally recognized 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 the decision by calling 1-800-421-4744.

Clinical Practice and Preventive Health Guidelines Available Online

Highmark's Clinical Practice and Preventive Health Guidelines are distributed to the practitioner community via the online Provider Resource Center through NaviNet℠ and **www.highmarkblueshield.com** as a reference tool to assist you in planning your patients' care. Highmark's Quality Management Department, along with network physicians, annually reviews and updates the Clinical Practice and Preventive Health Guidelines.

To obtain a paper copy of the guidelines or to submit comments, write to:
Quality Management Department
c/o Linda Ruhl, PA-C, Director, QM
Highmark Blue Shield
Fifth Avenue Place, Suite P4501
120 Fifth Avenue
Pittsburgh, PA 15222

Member Notification of Specialist Termination

The National Committee for Quality Assurance (NCQA) standards require health plans to ensure that "contracts with specialists and specialty group practices require timely notification to organization members affected by the termination of a specialist or the entire specialty group." Our current PremierBlue℠ Shield specialist contract already contains language that complies with this NCQA standard. The specific text is as follows: "Provider agrees that in the event of voluntary or involuntary termination of provider from the PremierBlue Shield network, provider will cooperate with Highmark Blue Shield in obtaining a list of active patients, including name, address and identification number." Highmark has a process in place to notify members being seen on an ongoing basis when a specialist/specialty group will no longer be available in the network, as obligated by state regulation and federal law.

Clarification: Obtaining Health Services For CHIP Members

To further clarify a notice that was published in the March 2004 issue of *Behind the Shield*: Effective **April 1, 2004**, all **Highmark-contracted** CHIP Keystone Health Plan Central HMO members were converted to Highmark Blue Shield PPOBlue℠. Note: PremierBlue℠ Shield providers should continue to contact Magellan Behavioral Health for authorizations of inpatient and outpatient behavioral health services for these members. **This change doesn't impact Capital Blue Cross-contracted CHIP Keystone Health Plan Central HMO members.**

FYI for PremierBlue Shield Providers:

Office Site and Medical Record Evaluations

PremierBlue℠ Shield network PCPs, Ob/Gyns and high-volume behavioral health practitioners participate in office site and medical/treatment record documentation reviews upon joining the network and when opening new or relocated office sites. Practice sites must achieve 80 percent compliance on both the office site and medical record review evaluations. Practice sites not realizing 80 percent compliance will continue to have follow-up evaluations at six-month intervals until the acceptable compliance rate is met. Dual-credentialed practitioners must follow the above standards; however, they also must achieve 90 percent compliance on preventive service evaluations.

At the conclusion of each review, practices are asked to assess the office site and medical record evaluation process and recommend areas for improvement. In 2003, 93 percent of practices surveyed gave an "Excellent" or "Very Good" rating for their overall level of satisfaction with the evaluation process. The rating was 67 percent in 2002. In addition, there were significantly high satisfaction scores (illustrated in the following table) relating to the professionalism, courtesy, knowledge and helpfulness of the registered nurses performing the evaluations.

Category	2002 Rating	2003 Rating
Rating of recommendations offered to office	75% (Very Helpful/Helpful)	94% (Very Helpful/Helpful)
Ability of office to implement recommendations	87% (Yes)	94% (Yes)
Helpfulness of information shared with offices	94% (Excellent/Very Good)	98% (Excellent/Very Good)
Rating of on-site survey nurse:		
Professionalism	83%	99%
Courtesy	84%	99%
Knowledge	80%	98%
Helpfulness	78%	98%
	(Excellent/Very Good)	(Excellent/Very Good)
Overall level of satisfaction with site survey	67% (Very Helpful/Helpful)	93% (Excellent/Very Good)

National Provider Identifiers

to Be Required Starting in 2005

Federal Government to Assign NPIs to HIPAA-Covered Entities

Health care providers who are considered to be covered entities under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 will be required to obtain a unique national provider identifier (NPI) number beginning May 23, 2005. Covered entities include health care providers who conduct their administrative transactions electronically.

The NPI system 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 National Provider System (NPS), a central electronic enumerating system operating under federal direction, will assign the new 10-character NPIs. A provider's NPI won't contain any imbedded demographic information about the health care provider, such as provider type or specialty.

Applying for an NPI

Providers must wait until May 23, 2005, to apply for an NPI. You have until May 23, 2007, to obtain an NPI. Providers won't be charged a fee to be assigned NPIs, nor will they be charged to update their data with NPS.

You must notify NPS of changes in your required data within 30 calendar days of any changes.

For a complete listing of the NPS required data elements, descriptions and usage, visit the HIPAA pages of Highmark's Web site at **www.highmarkblueshield.com**.

The application and update forms will be available electronically through a secure Web-based transaction and in paper form.

Billing Software Must Accommodate NPI

Although the NPI compliance date is approximately three years away, please plan ahead for it now. Make sure your billing software or billing vendor can accommodate this new 10-digit identifier.

If you aren't a HIPAA-covered entity, you can still obtain an NPI. Having an NPI doesn't impose covered-entity status on a health care provider.

Why the NPI?

The national provider identifier (NPI) was developed because HIPAA regulations require the use of such identifiers in HIPAA standard transactions. The U.S. Department of Health and Human Services issued the final rule regarding NPIs in the Jan. 23, 2004, Federal Register. This decision is available on the Centers for Medicare and Medicaid Services Web site at **www.cms.gov**.

Information Security:

Choosing a NaviNet℠ Security Officer

The HIPAA security standards require that covered entities (e.g., payers, providers and clearinghouses) designate a security officer who is responsible for overseeing information security (including physical security as it relates to limiting inappropriate access to information technology) within the covered entity.

To maintain the highest possible level of security on NaviNet, Highmark requires physician practices and facilities to designate an individual as their NaviNet Security Officer.

The NaviNet Security Officer is an employee of the physician office/health center who has been selected to serve as the primary contact with NaviMedix® Inc. regarding security issues. Security Officer responsibilities include:

- ensuring that every staff member who will access NaviNet will have his or her own unique password
- ensuring that these unique passwords aren't shared with anyone
- contacting NaviMedix to report additions and terminations of NaviNet users
- reactivating or deactivating users
- resetting user passwords for staff members who forget their passwords
- contacting NaviMedix if someone else takes on the Security Officer role for NaviNet

Who Should Be a Security Officer?
Because the Security Officer is the primary contact for security-related issues, often the individual who is the designated contact person also serves as the Security Officer. The Security Officer could be the practice administrator, office manager or someone from the practice's information technology department. Larger practices may designate multiple Security Officers.

The Security Officer doesn't need a lot of technical knowledge, but he or she should be comfortable using NaviNet. As a Security Officer, he or she will be able to reset user passwords, as well as deactivate and reactivate users.

Designating a Security Officer has many benefits. It may be a step toward HIPAA compliance for the provider office. It empowers the practice to manage user security and no longer be reliant on NaviMedix Customer Care for simple tasks, such as activating or deactivating a user or resetting a password.

For more information about choosing a NaviNet Security Officer, visit the *NaviNet Customer Care* page under the *Customer Service* toolbar on Plan Central. Select *Security Officer* under *Frequently Asked Questions*.

Highmark's UMI Initiative On Track

Highmark is on schedule to assign unique member identifiers (UMIs) to all members in 2004.

Earlier this spring, network providers began seeing Highmark patients presenting ID cards bearing their new UMIs. All members are expected to receive new cards featuring UMIs by year's end.

To address group and member privacy concerns about the use of Social Security Numbers (SSNs) as members' health insurance ID numbers, Highmark began assigning random UMIs to members in October 2003 to replace their SSN-based ID numbers.

If your Highmark patients have any questions about this ID number change, please advise them to call Highmark Member Service at the toll-free telephone number on their ID cards.

The SMART™ Registry Is Coming!

Innovative Tool Will Help Highmark PCPs Care for Patients with Chronic Conditions

Imagine having a report sent to your office that highlights which of your Highmark patients with diabetes are due for HgbA1c tests or retinal exams.

Also included would be helpful information about the unique care needs of your patients with asthma, CAD, CHF, COPD and diabetes.

Such a tool — called the SMART Registry — will soon be available to Highmark PCPs to support them in caring for patients who have these chronic conditions.*

The SMART Registry puts patient-specific information at your fingertips in an easy-to-read spreadsheet format. The report includes testing, treatment and pharmaceutical information obtained from available claims and pharmacy data.

"The SMART Registry is meant to assist physicians in providing integrated care to chronically ill patients, which can often be a challenge," says Brent J. O'Connell, MD, MHSA, Highmark medical director. "This valuable report will help you monitor key clinical indicators for patients with these conditions and ensure that the right care is delivered to them at the right time."

The SMART Registry will work in tandem with Blues On Call℠; PCPs can refer patients to Blues On Call Health Coaches who can provide additional patient education and support to follow your treatment plan.

Along with individual patient information, the SMART Registry features practice-level and peer group reports that provide patient demographic information and let physicians see how their overall approach to treating diabetes, CHF, CAD, COPD and asthma relates to that of other network practices.

The SMART Registry will be provided twice annually to all Highmark PCPs beginning in fall 2004. Currently, Highmark has distributed the initial SMART Registry to 44 randomly selected network practices to give PCPs an advance look and let them try the tool.

"Providing the SMART Registry to PCPs is mainly about supporting them in delivering effective, evidence-based care for some of our nation's most problematic chronic conditions," Dr. O'Connell says. "This effort represents another way that Highmark is collaborating with physicians to bring the best care possible to members."

*The SMART Registry doesn't include information about HealthGuard patients.

Highmark Blue Connections℠ Spring 2004 MEETINGS

Thanks to all Highmark providers who attended this year's Expo and Office Manager meetings, held throughout the Central Region from April 7 through May 25. We enjoyed meeting with all of you and answering your questions! Attending the Blue Connections meetings enables providers to receive tips about claims processing, updates regarding policies and procedures, a wealth of information about Highmark products and more. Below are photos from some of this spring's meetings.

New Cumberland Expo Meeting

During a breakout session, Allen Brenneman, manager of EDI Operations, tells providers about the benefits of electronic claim submission and how it can make their practices more efficient.

At the Expo exhibit session, Blues On Call℠ provider service specialist Lisa Eisel, RN, listens to a provider's question about the SMART™ Registry. This valuable tool will soon be introduced to Central Region physicians to help them care for members with chronic conditions (see story on Page 14).

Ed Wargo, director, Physician Recruitment and Relations, discusses the changing economics of health care during his keynote address to providers.

Medical policy administrator Anita Osman chats with a provider in the Expo exhibit area about policy reviews and changes.

State College Office Manager Meeting

Hank Parsons and Melissa Jakab Stem of Provider Relations discuss details about 49-county access for DirectBlue® and SelectBlue® members.

Hank Parsons of Provider Relations offers details about the unique member identifier to providers.

Kimberly Mitchell of Provider Relations addresses questions regarding 49-county access for DirectBlue and SelectBlue members, which begins July 1, 2004.

Provider Relations representative Hank Parsons talks to office managers about the benefits of NaviNet℠.

HIGHMARK BLUE SHIELD
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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:

Highmark PPOBlue — A Preferred-Provider Program
Highmark DirectBlue — An Open Access Program
Highmark SelectBlue — A Point-of-Service Program
Highmark ClassicBlue — Traditional Programs
HealthGuard HMO — A Health Maintenance Organization
HealthGuard PPO — A Preferred-Provider Program
HealthGuard POS — A Point-of-Service Program

Attention Behavioral Health Practitioners:

Correction to Highmark Behavioral Health Unit Telephone Number

Behavioral health practitioners are reminded that, effective with dates of service on or after July 1, 2004, SelectBlue® and DirectBlue® will have an outpatient management component. In order to receive reimbursement for covered services for SelectBlue and DirectBlue patients, those services must be authorized.

To obtain behavioral health service authorizations for SelectBlue and DirectBlue patients, practitioners should call the Highmark Behavioral Health Unit at 1-866-731-8080. The telephone number that appeared in the March 2004 issue of *Behind the Shield* and in a letter to behavioral health practitioners (dated April 2004) was incorrect.