PROVIDER NEWS

A NEWSLETTER FOR HIGHMARK BLUE CROSS BLUE SHIELD DELAWARE PROVIDERS

HIGHMARK. Delaware

JANUARY 2014

PROVIDER NEWS WILL BE ENHANCED IN 2014!

NEWS FOR ALL PROVIDER TYPES

NEWS FOR FACILITY PROVIDERS ONLY

AUDIENCE-SPECIFIC ICONS

Provider News is published for both our professional providers and our facility providers — which means that sometimes topics in this newsletter can overlap audiences. Next year, in an effort to help you quickly target the content that is important to you and your staff, *Provider News* will begin to feature the icons that were introduced this spring on NaviNet® Plan Central. These icons, shown here, will appear at the beginning of each story, so you can quickly identify if the information is relevant to you and your office staff.

SCHEDULE CHANGES AND ELECTRONIC CAPABILITIES

Next year, *Provider News* will be published bi-monthly, with the first issue available online in late February or early March 2014. This first issue will unveil our new electronic and more interactive format, which will be easier to use and navigate. Each edition will include a cover story on the front or "landing" page, bordered by links to other key feature stories and an interactive table of contents. You'll be able to simply click the headlines or images for the stories you want to read.

Also, there will be convenient links that enable you to e-Subscribe to the newsletter, view archived issues of *Provider News*, and offer your comments and suggestions. Never before has *Provider News* been so dynamic, accessible and easy to read! And, each issue will continue to be archived on the Provider Resource Center, under the *Publications and Mailings* link, for your future reference.

NEWS FOR PROFESSIONAL PROVIDERS ONLY

E-SUBSCRIBE TODAY TO GET *PROVIDER NEWS* SENT RIGHT TO YOUR DESKTOP!

If you haven't already e-Subscribed to *Provider News,* doing so takes just minutes and will make reading this newsletter even more convenient for you. Providers who e-Subscribe will receive an email notification when the latest newsletter is available online, and the email will contain a link to the publication. If you e-Subscribe to *Provider News*, you'll no longer receive a fax notification, helping cut down on the paper coming into your office. So, get on board by visiting Highmark Delaware's **e-Subscribe** page today!

INSIDE THIS ISSUE:

BLUECARD NEWS

ELECTRONIC PROVIDER ACCESS FOR AUTHORIZATION INFORMATION

The Blue Cross and Blue Shield Plans are launching a new tool on **Jan. 1, 2014**, that will give providers the ability to access out-of-area members' Blue Plan (Home Plan) provider portals to conduct electronic pre-service review. Electronic Provider Access (EPA) will enable providers to use their local Blue Plan provider portal to gain access to an out-of-area member's Home Plan provider portal, through a secure routing mechanism. Once in the Home Plan provider portal, the out-of-area provider will have the same access to electronic pre-service review capabilities as the Home Plan's local providers.

***Definition:* Pre-service Review**
The term pre-service review is used to refer to pre-notification, pre-certification, pre-authorization and prior approval, amongst other pre-claim processes.

EPA will give out-of-area providers access to the member's Home Plan portal, through local Blue Plan portals, to conduct pre-service review. The provider will continue to use the local Blue Plan portal, following the local plan's authentication process. As a Highmark Delaware provider, you will initiate this process via NaviNet®.

The ability to access the Home Plan's portal for pre-service review will result in:

- More efficient pre-service review process.
- Reduced administrative costs to both the provider and the Blue Plan.
- Improved provider and member satisfaction.

The availability of EPA on Jan. 1, 2014, will vary depending upon the capabilities of each Home Plan. Some Home Plans will be fully implemented and have electronic pre-service review for many services, while others will not yet have implemented electronic pre-service review capabilities.

Please watch Plan Central and Today's Messages for more information and detailed instructions related to this enhancement.

NEED HELP SUBMITTING BLUECARD CLAIMS?

The BlueCard® Program gives our members access to doctors and hospitals almost everywhere, and makes it easier for you to file claims when you see an out-of-area member. We understand that navigating the submissions of these claims can sometimes be tricky, so we've put together a guide that will help you when you need to submit a BlueCard claim. You can find the guide on our dedicated **BlueCard Program** page of the Provider Resource Center. Simply select *BlueCard* from the menu on the left-hand side of the page and then choose *BlueCard Information Center* > *BlueCard Submission Tips*.

You can also find a program overview, frequently asked questions and much more, including a router that will display the medical policy and pre-certification/pre-authorization information for out-of-area members.

The *Highmark Blue Shield Office Manual* also offers information you may find valuable on the BlueCard program, including how to identify BlueCard members and how to verify their eligibility and benefits. The office manual is also available on the Provider Resource Center, under *Administrative Reference Materials*. You can find the BlueCard information in **Chapter 3, Unit 5**.

HIGHMARK DELAWARE'S WEBSITE HAS A NEW LOOK

You'll notice that our website, **www.highmarkbcbsde.com**, has a new look.

Now the site has a cleaner, more refined design, and still features a wealth of information about our products, network providers and other vital topics like health care reform. Plus, users can still access our helpful consumer tools, such as our network provider directory, for support in making health care decisions.

And, with one easy click, you can continue to reach our Provider Resource Center. The link to the Resource Center is now located at the bottom of the page, under *Helpful Links*, as shown to the right.

• Provider Resource Center

On the Resource Center, as always, you can find everything from medical policy information, to recent Special Bulletins and Facility Bulletins, to our drug formularies, to the Office Manual — all of the things you need to continue doing business with Highmark Delaware.

OUR HEALTH CARE REFORM SITE NOW HAS INFORMATION SPECIFICALLY FOR PROVIDERS!

Visit **www.highmarkonhealthreform.com** and click *For Providers* in the light blue bar at the bottom of the home page for health care reform information geared toward you.

IMPORTANT: KEEP ASSIGNMENT ACCOUNT DATA CURRENT TO AVOID CLAIM REJECTIONS

CLAIMS WITH INCORRECT PROVIDER INFORMATION TO REJECT IN THE FUTURE

Providers are reminded that it is important for assignment accounts to keep up-to-date information on all physicians and practitioners who are part of an assignment account. Doing so will avoid rejections of claims that contain a name or ID number of a practitioner who is not listed on the assignment account. Until recently, due to a system coding issue, claims that included practitioners who were not listed on an assignment account may have processed and paid. That systems issue has been corrected.

Therefore, it is especially important that you verify and add/correct the names and ID numbers for all practitioners who are part of an assignment account. **Highmark Delaware will soon begin to reject claims that include the name or ID number of a practitioner who is not listed on an assignment account. When an effective date for these rejections is established, providers will be notified.**

VERIFY/UPDATE YOUR INFORMATION QUICKLY AND EASILY ON NAVINET

You can quickly and easily verify or update your assignment account information using the *Provider File Management* transaction on NaviNet®. This transaction lets you view and update your Highmark Delaware Provider File, and is a great way to make sure that all your addresses, networks, practitioners, and credentialed services (if applicable) are correct for your office. Accurate and up-to-date information in your file will ensure correct representation in the Provider Directory and ensure that payments of your claims are timely and correct. Please note that any providers being added to the assignment account will need to complete the Highmark Delaware credentialing process prior to submitting claims to us. If you are adding new providers to your practice, please have them initiate the credentialing process as soon as possible to ensure they are fully credentialed.

STEPS

1. From the Plan Central menu, click ***Provider File Management***.
2. If your office contains multiple billing provider numbers, select the number you want to review and click ***Go***. All items underlined in blue are links to access the information provided within the title.
3. Click the ***View Group Details*** link to access your group level numbers, Provider Relations Representative, networks, etc.
4. To access Patient Review, click on the Practitioner whose information you wish to access, and click the ***Patient Review*** link.

TIPS

- Click the ***Change Group*** button to return to the Billing Provider list so you can choose a different vendor.
- The ***Add/Edit*** buttons allow you to make updates to the information identified on the button.
- Instructional business rule pop-up windows will guide you through your processes. Please read them carefully.
- There is no Start/Save option. All updates, additions, etc. must be done at one time.
- To view and print a copy of your submitted changes, click ***Review Submitted Changes***.

If you have any questions, please contact your Highmark Delaware Provider Relations Representative.

NOTE FOR PROVIDERS NOT NAVINET-ENABLED

For those providers not NaviNet-enabled, the Highmark Provider Form (#9101) is available on the Provider Resource Center – select *Provider Forms*, and then click on *Provider Information Forms*. Next, select **Practitioner Demographic Change Form (Highmark Provider Form).**

2014 BRINGS CHANGES TO THE FEP SERVICE BENEFIT PLAN

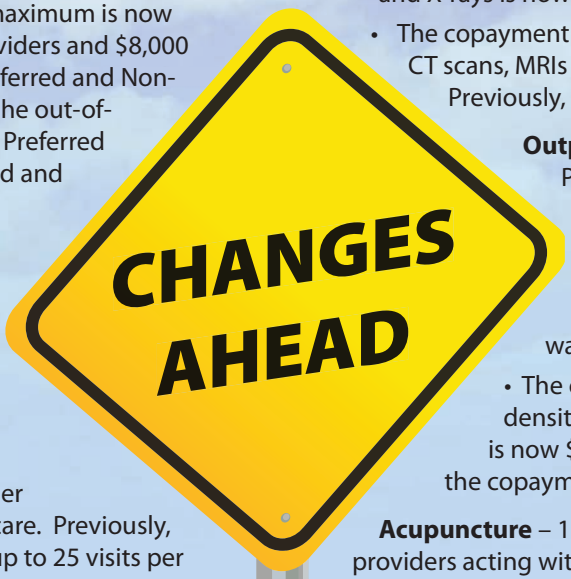
The New Year and the Affordable Care Act will result in changes to the Federal Employee Plan (FEP) BCBS Service Benefit Plan for both Standard and Basic Options. These changes are listed below.

CHANGES TO STANDARD OPTION ONLY

Catastrophic Maximum – For Self and Family contracts, the catastrophic out-of-pocket maximum is now $6,000 per year for Preferred Providers and $8,000 per year for a combination of Preferred and Non-preferred providers. Previously, the out-of-pocket maximum was $5,000 for Preferred providers and $7,000 for Preferred and Non-preferred providers.

Deductible – The calendar year deductible is now included in the out-of-pocket catastrophic protection maximum. Previously, the out-of-pocket maximum did not include the calendar year deductible.

Home Nursing Care – 50 visits per calendar year for home nursing care. Previously, benefits were only available for up to 25 visits per calendar year.



CHANGES TO BASIC OPTION ONLY

Catastrophic Maximum –

- For Self Only contracts, the catastrophic out-of-pocket maximum for coinsurance and copayments is now $5,500 per year for the use of Preferred providers. For Self and Family Contracts, the maximum is now $7,000 per year for Preferred providers. Previously, the catastrophic out-of-pocket maximum was $5,000 for both Self Only and Self and Family Contracts.
- The coinsurance amount for non-preferred brand-name drugs purchased at Preferred retail pharmacies now counts toward the annual catastrophic maximum. Previously, this amount was not included in the out-of-pocket maximum.

Neurological Tests – Neurological testing performed by a Preferred professional provider is now $40. Previously, there were no copayments for these services.

Diagnostic Tests – Performed in a Preferred professional provider setting:

- The copayment for tests such as EEGs, ultrasounds, and X-rays is now $40. Previously, the copay was $25.
- The copayment for tests such as bone density, CT scans, MRIs and sleep studies is now $100. Previously, the copayment was $75.

Outpatient Diagnostic Tests – Performed in a Preferred, Member or non-member facility:

- The copayment for tests such as EEGs, ultrasounds, and X-rays is now $40. Previously, the copayment was $25.
- The copayment for tests such as bone density, CT scans, MRIs and sleep studies is now $150 per day per facility. Previously, the copayment was $100 per day per facility.

Acupuncture – 10 visits per year by Preferred providers acting within the scope of their license or certification in the state where the services are provided. Previously, benefits were only available when performed by a physician.

Surgical Procedures – The copayment for surgical services performed outside of the office setting is now $200 per performing surgeon. Previously, the copayment was $150 per performing surgeon.

Inpatient Admission –

- The copayment for an inpatient admission to a Preferred facility is $175 per day up to a maximum of $875 for unlimited days. Previously, the copayment was $150 per day up to a maximum of $750 for unlimited days.
- The copayment for a maternity inpatient admission to a Preferred facility is $175. Previously, the copayment was $150.

Continued on page 6

2014 BRINGS CHANGES TO THE FEP SERVICE BENEFIT PLAN

Continued from page 5

CHANGES TO BOTH STANDARD AND BASIC OPTION

BRCA Testing –

- We now provide preventive care benefits for testing for deleterious mutations in BRCA1 and BRCA2 genes in females, age 18 and over, who have not personally been diagnosed with breast or ovarian cancer. Benefits are limited to one BRCA test per lifetime whether the test is covered under preventive care benefits or is covered under diagnostic testing benefits. Previously, preventive care benefits were not available for this service.
- We now limit benefits for diagnostic BRCA testing for members with a personal history of cancer to one test per lifetime whether the test is covered under preventive care benefits or diagnostic testing. Previously, benefits for diagnostic BRCA testing were not subject to a limit.

Wigs – We now provide benefits for wigs for hair loss due to cancer treatment, limited to a maximum of $350 for one wig per lifetime. Previously, benefits were only available for wigs for hair loss due to chemotherapy for the treatment of cancer.

Chiropractic Services – Benefits for chiropractic care are no longer limited to one office visit and one set of X-rays per year.

Diabetic Supplies –

- We now provide benefits for insulin and diabetic supplies ONLY when obtained from a retail pharmacy, or mail order (for Standard Option only). This requirement does not apply if the member has Medicare Part B as primary. Previously, diabetic supplies could be obtained from physicians and other health care providers.
- Members can now receive free select diabetic meters from ACCU-CHECK or One Touch. Strips for meters can be obtained for Tier 2 cost share through the pharmacy program.
- Alcohol swabs are now covered with a written prescription under the Tier 2 cost share from the pharmacy program.

Vitamin D Supplements – We now provide benefits in full for Vitamin D supplements for adults, age 65 and over. Previously, benefits were not available for Vitamin D supplements.

Heart – Lung Transplants – We no longer provide benefits for heart-lung transplants performed at Blue Distinction Centers for Transplants®. Previously, benefits were available for this transplant performed at these types of facilities.

NAVIGATING NAVINET

"Navigating NaviNet®" is now a recurring feature of Provider News. *Here, you will have the chance to learn about new or updated Highmark Delaware NaviNet transactions, and explore functions you may not have known were available to you. If you would like us to feature a certain transaction or function, please contact your Provider Relations Representative or send an email to the editor at* ***megan.pettingill@highmark.com***.

OUTPATIENT AUTHORIZATION SUBMISSION

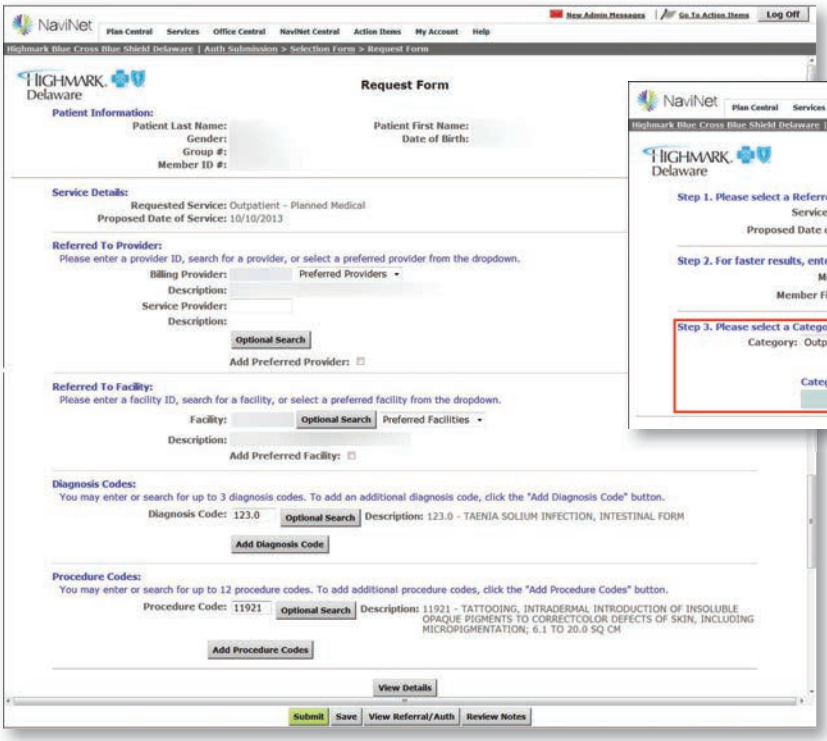
For a long time, you have been asking us about electronic outpatient authorization submission – and we're pleased to say that it's now available!

In October, we made updates to the Highmark Delaware NaviNet system, and you can now submit outpatient medical and surgical authorization requests online. To access the new types of outpatient authorization requests, log on to NaviNet and choose *Authorization Submission* > *Auth Submission*. These screenshots will help you through the process.

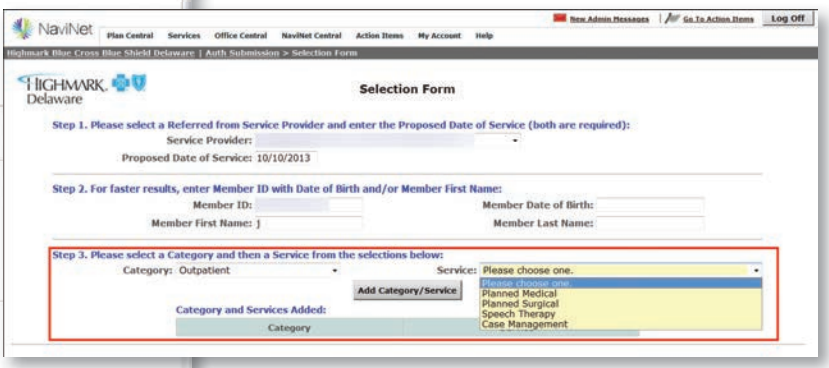
On the *Selection Form* screen, please complete all the fields presented to you.

Once all the required information has been entered in the *Request Form* screen, click *Submit*. (You can even add the referred to facility or provider as "preferred," which will save you time if you frequently request authorizations for them.)

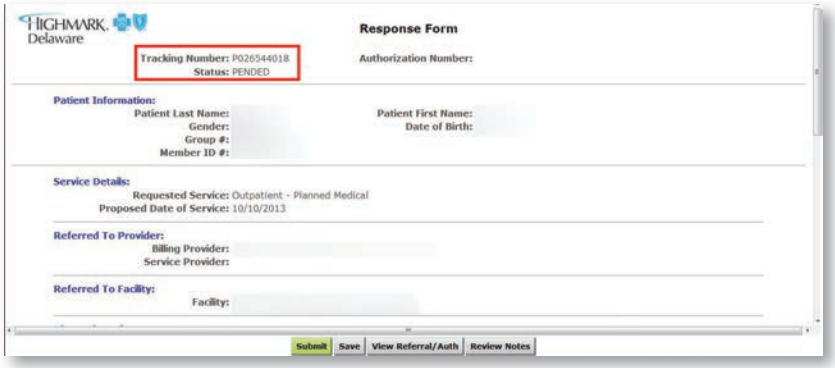
After clicking *Submit*, you will be brought to the *Response Form* screen which has a tracking number for your pended authorization.



Request Form



Selection Form



Response Form

REMINDER ABOUT FDA STRATEGY REGARDING OPIOID MEDICATION USE

Choosing the most appropriate and effective pain medication may become the biggest challenge a doctor and patient will face.

If inappropriately treated, a patient's pain can be debilitating and affect his or her standard of living/functioning and ability to earn an income. The use of the opioid family of drugs has risen in popularity in recent years, and although these drugs can do wonders for people with pain, if used chronically, they may become habit-forming. Today, misuse and abuse of these medications is an ongoing problem in our society, and if these medications are used incorrectly, overdose and death can occur.

Although opioids can do wonders for people with pain, if used chronically, they may become habit-forming.

To address this issue, the Food and Drug Administration (FDA) requires health care providers who prescribe extended-release and long-acting opioids to follow its Risk Evaluation and Mitigation Strategy (REMS). The goals of this initiative are to make sure that patients know how to use these medications properly and to educate health care professionals on how to safely prescribe opioids.

Pharmaceutical companies are required to provide continued education for prescribers based on FDA-approved materials and guidelines. Prescribers are required to use approved medication guides and patient counseling tools.

Pharmaceutical companies are also responsible for completing ongoing assessments/audits to monitor for compliance with the FDA requirements and with improvements in care related to the REMS program.

Providers are encouraged to follow these basic standards of care when prescribing opioids for pain management:

- Complete a comprehensive medical history and physical examination.
- Obtain appropriate diagnostic, therapeutic and laboratory results.
- Conduct appropriate adjunct consultations.
- Clearly define and discuss treatment objectives.
- Accurately and completely document medications, including date, type, dosage and quantity prescribed.
- Conduct periodic follow-up and review of the treatment plan.

Establish an annual Pain Management Agreement, such as the one available through the American Academy of Pain Management (**www.aapainmanage.org; aapm@aapainmanage.org**; 13947 Mono Way, Sonora, CA 95370; telephone, 209-533-9744; fax, 209-533-9750).

HIGHMARK DELAWARE'S 2014 HOLIDAY SCHEDULE

To assist you with planning for the new year, here is a list of Highmark Delaware's 2014 scheduled holidays. Please note that although our offices will be closed on these dates, you will still have access to eligibility, benefits, claim status and other valuable information via NaviNet®.

HOLIDAY	DATE	DAY OF WEEK
New Year's Day	Jan. 1	Wednesday
Martin Luther King, Jr. Day	Jan. 20	Monday
Memorial Day	May 26	Monday
Independence Day	July 4	Friday
Labor Day	Sept. 1	Monday
Thanksgiving Day	Nov. 27	Thursday
Day after Thanksgiving	Nov. 28	Friday
Christmas Eve	Dec. 24	Wednesday
Christmas Day	Dec. 25	Thursday

LIST OF OUTPATIENT PROCEDURES/SERVICES REQUIRING PRIOR AUTHORIZATION CHANGING ON JAN. 1, 2014

To keep care affordable and accessible to members, Highmark Delaware maintains certain administrative requirements to ensure that the services our members receive are medically necessary, provided in the appropriate setting and are cost-effective. One of these requirements is the authorization of certain non-emergent, outpatient products, medications and services. Examples of the products, medications and services on our outpatient prior authorization list include DMEPOS, certain outpatient medical-surgical procedures and certain medical injectable drugs.

Beginning Jan. 1, prior authorization will be required for Highmark Delaware EPO and PPO products (in addition to IPA and POS products) **and** all specialists will be required to obtain prior authorizations.

Our list of outpatient procedures/services that require prior authorization will change on Jan. 1, 2014. Other important changes regarding the list of outpatient procedures/services requiring prior authorization will also be effective on Jan. 1, 2014:

- Prior authorization for procedures/services on the list will be required for EPO and PPO products (in addition to IPA and POS products); and
- All specialists in the Highmark Delaware network will be required to obtain a prior authorization for procedures/services on the list.

The all-inclusive and most up-to-date list is available under *Administrative Reference Materials* on our Provider Resource Center, which is accessible via our NaviNet® system or under *Helpful Links* at **www.highmarkbcbsde.com**. On an ongoing basis, we will make periodic adjustments to this list and will notify you whenever procedure codes are added or deleted.

Providers can obtain authorization for services on this list via the NaviNet *Authorization Submission* transaction, one of the newest additions to Highmark Delaware's NaviNet system. See the "Navigating NaviNet" article on page 7 for more information on this transaction. Providers who don't have NaviNet can use the HIPAA Health Services Review (278) electronic transactions or call Medical Management and Policy, toll-free, at 1-800-547-3627, Option 2.

Please remember that authorization for the products/services on our list may not be required for all members. Be sure to check members' benefits before delivering care to verify if authorization is required. You can do this via the *Eligibility and Benefits* function of NaviNet, or if you are not NaviNet-enabled, by calling 1-800-547-3627, Option 6.

You can find more information about these changes in the recently issued Special Bulletins PR 13-66 and PR 13-72, available online via the Provider Resource Center.

MEDICAL POLICY UPDATES

Below is a list of medical policies with updates that will be effective between Dec. 30 and Jan. 6, 2014. For more information, please refer to Special Bulletin PR 13-68, which was recently sent to all providers. Remember that our medical policies are available online via the Provider Resource Center, which is accessible through NaviNet® or under *Helpful Links* on our website, **www.highmarkbcbsde.com**. Once there, select *Medical & Claims Payment Guidelines* from the menu on the left-hand side. You can then search our Medical Policies by one (or a combination) of the following options: keywords, code or number. These policies listed below will be updated online on their effective date.

- B-13
- E-9
- I-28
- I-97
- L-28
- O-24
- R-6
- R-14
- R-21
- S-12
- S-28
- S-97
- S-118
- S-121
- S-127
- S-144
- V-16
- X-51
- X-58
- Y-1
- Y-2
- Y-11
- Z-26
- Z-61

ATTENTION PRIMARY CARE PHYSICIANS:

REMINDER REGARDING HIGHMARK DELAWARE'S 2014 PREVENTIVE HEALTH SCHEDULE AND CORRECT CODING

Network primary care physicians are reminded that most, but not all, Highmark Delaware members have coverage for routine preventive care services according to the standard Highmark Delaware Preventive Schedule*.

The Highmark Delaware Preventive Schedule included with our benefit plans represents the most current standards for care, based on scientific literature, recommendations issued by national health care organizations and network physician input. Highmark Delaware reviews the schedule annually and makes any necessary changes each January.

On Jan. 1, you can find the 2014 Preventive Health Guidelines by accessing our Provider Resource Center via NaviNet® or under the *Helpful Links* section of our website. Simply hover on *Clinical Reference Materials*, then select *Clinical Practice and Preventive Health Guidelines*. You'll find specific preventive schedules for:

- Adults ages 65+ (including immunization schedule)
- Adults ages 19 to 64 (including immunization schedule)
- Children ages 7 to 18 years (including immunization schedule)
- Children ages 0 to 6 years (including immunization schedule)
- Prenatal/Perinatal patients

As a reminder, preventive services are routine services provided to a patient who is not presenting with symptoms.

Please remember that if you perform or prescribe routine preventive services that are not on the schedule, the services will not be covered. If/when this occurs, please be sure to discuss the non-covered services with our members, so that they understand they will be responsible for the cost. Services such as routine urinalysis, Vitamin D testing, Creatine Kinase testing, Thyroxine testing and some other lab services aren't included on the Highmark Delaware Preventive Schedule.

USE PROPER CODING WHEN SUBMITTING CLAIMS

When submitting claims for preventive services on the schedule, please be sure to report the appropriate preventive service procedure code and a routine "asymptomatic" diagnosis code. **(Even when reporting a screening procedure, you must still report the appropriate "routine" diagnosis code.)**

If services provided are medically necessary, please report a procedure code and diagnosis code appropriate for the medical condition and report to the highest level of specificity. (For your claims to be paid, the member must have coverage under the standard Highmark Delaware Preventive Schedule.)

If you have any general questions regarding the Preventive Schedule, please call our Provider Services Department.

**Please note that most, but not all, Highmark Delaware customer groups follow the Highmark Delaware Preventive Schedule, meaning not all members may have coverage for services on the schedule. Therefore, when providing services for Highmark Delaware members, please remember to always check the member's benefits via NaviNet or by using the appropriate HIPAA electronic transactions to determine if services are covered and if any associated member cost-sharing applies. (If you do not have access to NaviNet, please call Provider Services to obtain benefits and eligibility.)*

EARN A CHANCE TO WIN A GIFT CARD:

SUBMIT VOLUNTARY RACE AND ETHNICITY INFORMATION VIA NAVINET

In the most recent issue of *Provider News*, we featured our Health Equity & Quality Services (HEQS) Department, which works to reduce and eliminate health disparities and improve the delivery of culturally and linguistically appropriate services to our members.

HEQS is holding a campaign to encourage providers to voluntarily enter their race and ethnicity data into NaviNet®. We're collecting this data to help ensure that our practitioner network is able to serve our diverse membership and is responsive to member needs.

All providers who submit this voluntary information in 2013 using NaviNet's *Provider File Management* function will be entered into a random prize drawing to win a $50 VISA® gift card. Four prize winners are named each quarter. You only have to submit your race and ethnicity information into NaviNet once to be eligible for the quarterly drawings.

For campaign rules and detailed instructions visit our online Provider Resource Center, which is accessible via NaviNet or under *Helpful Links* on our website. Click *Health Equity & Quality Services*, at left, and then click on *Provider Race/Ethnicity Campaign 2013*.

Please rest assured that your race and ethnicity information **won't** be displayed in our online provider directory or used in the credentialing or re-credentialing process. But this data may be used to perform network management and quality improvement functions, such as outreach to providers and members concerning chronic health conditions that disproportionately impact specific patient populations. In rare instances, limited race and ethnicity information may be provided to a member when the member's access to medical care is best served by providing such information.

For more information, please refer to the letter mailed to your office in early November.

HIGHMARK DELAWARE MEMBERS ARE ENCOURAGED TO BE "SUPER SMART" CONSUMERS WITH SAVINGS ADVISOR

As health care costs continue to rise and the marketplace experiences change, we are committed to providing our members with ways to maximize their benefits and reduce their out-of-pocket expenses. Over the last year, we have announced many transparency tools that help consumers make more informed choices for their health care treatments.

In January 2014, we will introduce the newest transparency resource – Savings Advisor. Through this program, eligible members* are shown simple ways to save money on the health care services and prescriptions they already use. Each month, personalized savings alerts will be sent to participating members via text message or email. After receiving an alert, members can then log into their member website to retrieve a more detailed message, which explains how much they can save by, for example, switching to a generic drug or using a lower-cost pharmacy.

We know that you are in the best position to help your patients decide on the most appropriate treatment options, and we hope Savings Advisor can assist you and your patients with making cost-saving decisions.

*During the initial roll-out of the program, Savings Advisor will be offered to a handful of our national group customers.

IMPORTANT MESSAGE FOR DMEPOS PROVIDERS WHO DISPENSE DIABETIC SUPPLIES

We routinely monitor reimbursement levels to make sure they are appropriate and competitive in the marketplace. Please note that we have elected not to apply the Centers for Medicare & Medicaid Services (CMS) competitive bid reimbursement amounts for diabetic supplies. However, effective with dates of service on/after Jan. 1, 2014, we will implement the following reimbursement amounts for the noted diabetic supply codes for all commercial networks/products.

HCPCS	DESCRIPTION	MODIFIER	DELAWARE COMMERCIAL
A4233	Alkalin batt for glucose mon	Non-KL (non Mail Order)	$0.53
		KL (Mail Order)	$0.45
A4234	J-cell batt for glucose mon	Non-KL (non Mail Order)	$2.38
		KL (Mail Order)	$2.05
A4235	Lithium batt for glucose mon	Non-KL (non Mail Order)	$1.53
		KL (Mail Order)	$1.32
A4236	Silvr oxide batt glucose mon	Non-KL (non Mail Order)	$1.10
		KL (Mail Order)	$0.95
A4253	Blood glucose/ reagent strips	Non-KL (non Mail Order)	$23.43
		KL (Mail Order)	$20.15
A4256	Calibrator solution/chips	Non-KL (non Mail Order)	$7.47
		KL (Mail Order)	$6.42
A4258	Lancet device each	Non-KL (non Mail Order)	$11.79
		KL (Mail Order)	$10.14
A4259	Lancets per box	Non-KL (non Mail Order)	$7.07
		KL (Mail Order)	$6.08

QUARTERLY FORMULARY UPDATES AVAILABLE ONLINE

Highmark Delaware regularly updates its prescription drug formularies and related pharmaceutical management procedures. To keep our network physicians apprised of these changes, we provide quarterly formulary updates in the form of Special Bulletins.

These Special Bulletins are available online on the NaviNet® Plan Central page and on the Resource Center's Today's Messages page to alert physicians when new quarterly formulary update Special Bulletins are available.

Providers who don't have Internet access or don't yet have NaviNet may request paper copies.

SPECIAL BULLETIN SUMMARY

Below is a list of the Special Bulletins that we have distributed since the last issue of *Provider News* was published in September. If you would like to re-read any of these bulletins, they are all available electronically on the Provider Resource Center. Click *Special Bulletins & Mailings* under *Publications and Mailings* to find the complete list, as well as previous issues of *Provider News.*

DATE	AUDIENCE	TITLE
10/14/13	Participating Volunteer Fire Companies	Increased Reimbursement Amounts, Effective 1/1/14
10/15/13	All Participating Providers and Facilities	Highmark Delaware 2014 Holiday Schedule
10/28/13	Facilities	Service Facility Location Required Field When Billing Services in a Location Other Than Facility Billing Address
10/29/13	Ordering Physicians and DME Providers	Eligible Members Can Receive Breast Pumps, Lactation Counseling Without Cost Sharing
11/1/13	All Participating Providers and Facilities	Six Procedure Codes to be Added to Radiology Management Program, Effective Jan. 13, 2014
11/27/13	All Participating Providers and Facilities	Highmark Delaware Radiology Management Program Update
12/2/13	All Participating Providers and Facilities	4th Quarter Formulary Update
12/3/13	All Participating Providers and Facilities	Highmark Delaware's List of Outpatient Procedures/Services Requiring Prior Authorization Changing on 1/1/14
12/5/13	All PCPs and Specialists	Cost Transparency Tool Updated
12/5/13	All Professional Providers	Medical Policy and Updates
12/12/13	Select Specialists	Outpatient Prior Authorization Will Be Required By All Specialists in Highmark Delaware's Network, Effective 1/1/14

USE NAVINET TO VERIFY HIGHMARK DELAWARE MEMBERS' BENEFITS

FIND DETAILS ON HIGH-DEDUCTIBLE HEALTH PLANS AND HRAs

We think that it's important to help our members become more aware of the cost of health care services and their health care spending decisions. So, we offer a variety of health plan options designed with this in mind.

Many of our members are enrolled in a high-deductible health plan (HDHP) with a Health Reimbursement Arrangement (HRA). **You may not know this, but many of our HDHP members also have employer HRA funding that covers all, or a portion of, their deductible.**

NaviNet® makes it easy to verify a member's benefits, including health plan and HRA details. You can determine if there is employer HRA funding and whether the member or the employer pays toward the deductible first. To see this information, choose the *Eligibility and Benefits Inquiry* function from the left-hand side of Highmark Delaware's Plan Central page and then choose *HRA Coverage Detail*. Using NaviNet to determine this information can save you time and help you avoid issuing refunds.

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USE NAVINET TO VERIFY HIGHMARK DELAWARE MEMBERS' BENEFITS

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COPAYMENTS, COINSURANCE AND DEDUCTIBLE COLLECTION

As a reminder, you are allowed to collect all patient liability either: 1) at the time of service or 2) following claims adjudication. As a reminder, Highmark Delaware requires PCPs and specialists to collect all applicable out-of-pocket costs, including copayments, coinsurance and deductibles as required by the member's plan, except where such collection is prohibited or restricted by applicable laws. Remember to use NaviNet to verify a Highmark Delaware member's eligibility and benefits, including copayments, coinsurance and deductibles.

ATTENTION PAPER CLAIM SUBMITTERS: HIGHMARK DELAWARE WILL BEGIN TO ACCEPT NEW 02/12 1500 CLAIM FORM ON FEB. 10, 2014

The National Uniform Claim Committee (NUCC) recently approved a revised 1500 Health Insurance Claim Form (version 02/12) to replace the current form (version 08/05). The most significant changes to the form are the addition of eight diagnosis code fields in Item Number 21 (to accommodate ICD-10 reporting needs) and the addition of the QR code field at the top left of the form.

Although the 02/12 version has been approved, we cannot accept claim submissions on the new version of the form until next year. If you submit any claims during 2013 using the 02/12 1500 form, they will be returned to you and you will need to resubmit them using the current 08/05 1500 form. We will begin accepting the 02/12 version of the form on Feb. 10, 2014.

On April 1, 2014, only the new 02/12 version of the form will be accepted. Please share this information with your clearinghouse, billing service or software vendor. You can find additional details about the claim form at **www.nucc.org**.

We will begin accepting the 02/12 version of the form on Feb. 10, 2014.

SUBMIT CLAIMS ELECTRONICALLY — SAVE TIME AND MONEY!

We encourage all of our providers to submit their claims electronically. Electronic claims submission is a valuable method of streamlining claim submission and processing and eliminating wasted time, money and resources. Today's technology can help you simplify business operations, cut costs and be more environmentally friendly.

If you have questions about how to reduce paper claim submissions and become electronically enabled, please contact your Provider Relations Representative or call EDI Operations, toll-free, at 1-800-992-0246, Monday through Friday, from 8 a.m. to 5 p.m.

TEMPORARY SAFE HARBOR PROVISION ENDS 1/1/14 FOR CERTAIN GROUP CUSTOMERS

Health care reform requires certain group health plans and carriers to cover contraceptive and sterilization services with no cost sharing on or after Aug. 1, 2012. Members of religious employer groups that are considered to be church groups and other houses of worship are exempt from this requirement. Additionally, non-profit organizations that object to these services on a religious basis have been given what the government refers to as a temporary "safe harbor" from enforcement. Those groups that are eligible for the safe harbor are not required to provide coverage for contraceptive services during a limited time period.

In accordance with recent health care reform regulations, that safe harbor period will end when the group health plan renews on or after Jan. 1, 2014, and will be replaced with what is now being referred to as an "Accommodation." Accommodation requirements are as follows:

- The organization must oppose providing coverage for some or all of the contraceptive services on account of religious objections; and
- The organization is organized and operates as a non-profit entity; and
- The organization holds itself out as a religious organization; and
- The organization self-certifies that it satisfies the first three criteria, and specifies those contraceptive services for which the organization will not maintain, administer or fund coverage.

Note: The Accommodation is available to student health plans that meet these criteria.

Therefore, non-profit group health plans that meet the above requirements and certify to an Accommodation will not be obligated to provide contraceptive and sterilization coverage. To address this coverage gap, health care reform further mandates that insurers and carriers for Accommodation groups must provide contraceptive coverage directly to the group health plans' female members with no cost to the group or to the member.

MEMBER IDENTIFICATION CARD

Members of an Accommodation group who elect contraceptive coverage will receive a separate (second) Highmark Delaware member identification (ID) card. This card will represent coverage for contraceptive-related services only and it carries unique group and member ID numbers that are different from those that appear on the member's standard medical (non-contraceptive) member ID card.* Providers will recognize this separate card because it clearly states "Contraceptive Coverage" on the lower, right portion of the front of the card, as shown here in this sample card:

Members are being instructed to present this ID card to their provider when seeking contraceptive services. Further, please note that a member will present one of two types of ID cards for contraceptive coverage: One card notes contraceptive coverage and contraceptive prescription drug coverage, and the other card notes contraceptive coverage only (no contraceptive prescription drug coverage). Cards that display the "Rx" symbol at bottom right on the front of the card (as shown in the sample card above) denote that the member has contraceptive coverage and contraceptive prescription drug coverage; if the "Rx" symbol is absent, the member has contraceptive coverage only and no contraceptive prescription drug coverage.

Please note: For the purposes of claim submission, if an Accommodation group member has a contraceptive procedure at the same time as a non-contraceptive procedure, your claims must be billed separately under the appropriate ID that is applicable to the specific service.

BE SURE TO CHECK MEMBER ELIGIBILITY AND BENEFITS

To verify members' coverage, please always use the NaviNet® Eligibility and Benefits function or use the HIPAA 270/271 Eligibility transaction prior to providing services. (**Note:** Be sure to use the member's separate ID card for contraceptive coverage when checking eligibility and benefits for contraceptive services, as that card carries unique group and member ID numbers that are different from those that appear on his/her standard medical [non-contraceptive] member ID card.)

*Members of non-Accommodation Highmark Delaware customer groups will continue to have contraceptive coverage as they have had in the past. Providers should file claims for contraceptive services for members of non-Accommodation groups using the member ID and group numbers that are displayed on the individual member's standard Highmark Delaware medical insurance card.

HEALTH CARE REFORM FYI: RISK ADJUSTMENT

The ACA brings many changes and new requirements for health care providers to comply with the law. You may have been so busy implementing EHRs and complying with reporting requirements for quality measures that you haven't begun to think about the even greater importance of coding accuracy, given the ACA risk stabilizer programs.

To create a system in which payers and their networks of providers are compensated for the risk associated with the patients they treat (known as risk-adjusted payments), a complete and accurate capture of each individual patient's health status through claims and encounter data is critical. But risk adjustment is very technical in nature.

To help you understand the importance of accurate medical documentation and coding — and how this can translate to quality data that promotes the financial health of your practice and improves care delivery — we have added detailed information about risk adjustment to the provider section of **www.highmarkonhealthreform.com**.

We encourage you to visit this section of our health care reform website and consider how risk adjustment, along with other ACA requirements, may impact your practice or facility. For many of you, risk adjustment isn't a new concept — if you've been treating Medicare or Medicaid patients or have entered into a risk-sharing arrangement, then you already understand the importance of accurate medical diagnosis coding and how it can affect your practice or facility.

For providers who aren't familiar with this concept, the website offers an overview of the new commercial risk adjustment program, which is one of three programs established by the ACA, and the program's goals. You'll learn more about what might be putting your business at risk in terms of medical documentation and coding practices — such as if you're frequently correcting coding errors, and whether your coding practices are helping to improve care. And, you'll get tips on how to get the best results for your office or facility under this ACA requirement.

To access this helpful risk adjustment information, visit **www.highmarkonhealthreform.com** and click *For Providers* in the light blue bar at the bottom of the home page. Then, choose *Provider Impacts* from the menu on the right. Check the site often for news, tips and updates.

COMMENTS/SUGGESTIONS WELCOME

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Megan Pettingill, Editor
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We want *Provider News* to meet your needs for timely, effective communication. If you have any suggestions, comments or ideas for articles in future issues, please call your Provider Relations Representative or write to the editor at **megan.pettingill@highmark.com.**

LEGAL INFORMATION

Note: This publication may contain certain administrative requirements, policies, procedures or other similar requirements of Highmark Delaware (or changes thereto) which are binding upon Highmark Delaware and its contracted providers. Pursuant to their contract, Highmark Delaware and such providers must comply with any requirements included herein unless and until such item(s) are subsequently modified in whole or in part.

CONTACT US!

Highmark Delaware remains committed to providing you with information and the help you may need. There are lots of ways to reach us if you have questions, but your first call should be to our Provider Services Department, where representatives are available to assist you M–F, 8:30 a.m. to 5:00 p.m.

You also have a designated Provider Relations Representative who you can contact for assistance. If you're not sure who your Representative is, you can find out by logging on to NaviNet® and clicking on *Resource Center* from the left-hand side. Once there, select *Provider Relations Representative* from the menu.

Here are a few more numbers that we recommend keeping for reference:

Provider Services
1-800-346-6262

Member Services
1-800-633-2563

Pharmacy Services
1-800-600-2227

Highmark Delaware Case and Condition Management
1-888-258-3428

Medical Management & Policy
1-800-572-2872

National Imaging Associates, Inc. (NIA)
1-888-972-9642

BlueCard
1-800-676-BLUE(2583)