

CHAPTER 4: PROVIDER RESPONSIBILITIES AND GUIDELINES

UNIT 1: PCPS AND SPECIALISTS




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[What Is My Service Area?](#)

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**

- 
 The PA ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.
- 
 The DE ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.
- 
 The WV ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

4.1 PRIMARY CARE/SPECIALIST ESSENTIALS

Introduction While primary care physicians/practitioners (PCPs) play an important role in managing all aspects of health care for members who select their practice, specialists in Highmark's networks play an equally important role of providing specialty services to Highmark members.

Primary care/specialist communication Highmark network primary care physicians, primary care CRNPs, and specialists, including medical, surgical, and behavioral health, must communicate with one another in order to assure continuity and coordination of care for members. Where the networks support managed care products, Highmark will monitor compliance of the communication procedure as part of the medical record review program.

For additional information, please see the **PCP and Specialist Communication** section in this unit.

Involving members in health care decisions Highmark and providers must continually work together to encourage and support members taking an active role in their health care by:

- Providing consideration for member input when developing treatment plans;
- Informing members of appropriate follow-up care;
- Arranging or providing training in self-care and other measures that impact health status; and
- Addressing barriers to member compliance with prescribed treatments or regimens.

Advising members of treatment options policy Highmark fully encourages and supports our network physicians' efforts to provide advice and counsel and to freely communicate with patients on all medically necessary viable treatment options available, including medication treatment options, regardless of benefit coverage limitations, that may be appropriate for the member's condition or disease, regardless of benefit coverage limitations. Therefore, we do not penalize and have never penalized physicians for discussing medically appropriate care with the patient.

Some managed care plans may include a "gag clause" in their provider contracts that limits a network physician's ability to provide full counsel and advice to enrollees. Highmark's network contracts for all products do not (and never did) contain such a "gag clause" relating to treatment advice (complies with Pennsylvania Act 68 requirements).

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4.1 PRIMARY CARE/SPECIALIST ESSENTIALS, Continued

Advising members of treatment options policy (continued)

Highmark does not prohibit or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising, or advocating on behalf of, an individual who is a patient and enrolled under a Highmark plan, about:

- The patient’s health status, medical care, or treatment options (including any alternative methods of treatments that may be self-administered), including the provision of sufficient information to the individual to provide an opportunity to decide among all relevant treatment options;
- The risks, benefits, and consequences of treatment or non-treatment; or
- The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

Reminder: In cases where the care, services, or supplies are needed from a provider who does not participate with Highmark, authorization must be requested.

Voluntary or involuntary specialist termination from the networks

In the event of the voluntary or involuntary termination of a Highmark provider agreement, the specialist/specialty group must cooperate with Highmark in its efforts to obtain information regarding those members enrolled in managed care products that may be affected by such termination because they are undergoing an ongoing course of treatment or are otherwise active patients of the specialist/specialty group. Such information includes the name, address, and identification number of the affected managed care members.

This information must be provided timely so that affected members may be notified prior to the effective date of the termination. Highmark has a process in place to notify these members as obligated by state regulation and federal law.

Highmark’s communication policy

From time to time, Highmark will announce changes to administrative or reimbursement policies. In cases where such changes have a direct impact on the provider, it is Highmark’s policy to give providers adequate notice regarding these changes. Informational changes will be announced in no less than thirty (30) days, unless required by law or regulation.

4.1 TREATMENT OF IMMEDIATE RELATIVES

Policy

Reimbursement may not be made for charges imposed by a professional provider for his or her immediate relatives or members of his or her household, or for services rendered by a professional provider for himself or herself.

The intent of this exclusion is to bar payment for personal services of professional providers that would ordinarily be furnished gratuitously.

Immediate relative defined

The following relatives of the provider are included in the definition of **immediate relative**:

- *Spouse*
- *Natural parent and child*
- *Adopted child and adoptive parent*
- *Stepparent and stepchild*
- *Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law*
- *Grandparent and grandchild*
- *Sibling, stepbrother, and stepsister*

Why blue italics?

Member of household defined

Member of household is defined as an individual who is claimed as a dependent when filing year-end tax forms. Such a dependent allows a taxpayer to qualify for the dependency exemption.

Services eligible for reimbursement

A professional provider's services rendered to his or her spouse's stepparents are eligible for payment.

Payment may be made for charges imposed on immediate relatives or household members by a professional provider to recover expenses incurred in furnishing covered items or supplies, such as drugs and biologicals, prosthetic devices, etc.



4.1 PCP AND MEDICAL SPECIALIST ACCESSIBILITY EXPECTATIONS

Accessibility expectations for providers

To stay healthy, members must be able to see their physicians when needed. To support this goal, Highmark’s expectations for accessibility of primary care physicians (PCPs), medical specialists, and obstetricians are outlined below. The standards set forth specific time frames in which network providers should respond to member needs based on symptoms.

Physicians are encouraged to see patients with scheduled appointments within fifteen (15) minutes of their scheduled appointment time. A reasonable attempt should be made to notify patients of delays.

Note: Standards for Pennsylvania Children’s Health Insurance Program (CHIP) enrollees are available in [Chapter 2.3: Other Government Programs](#) and may differ from the expectations noted below.

PCP AND MEDICAL SPECIALIST ACCESSIBILITY EXPECTATIONS	
Patient’s Need:	Performance Standard:
Emergency/life threatening care <ul style="list-style-type: none"> Sudden, life-threatening symptom(s) or condition requiring immediate medical treatment (e.g., chest pain, shortness of breath) 	Immediate response
Urgent care appointments <ul style="list-style-type: none"> An urgently needed service is a medical condition that requires rapid clinical intervention as a result of an unforeseen illness, injury, or condition (e.g., high fever, persistent vomiting/diarrhea) 	Office visit within 1 day (24 hours)
Regular and routine care appointments <ul style="list-style-type: none"> Non-urgent but in need of attention appointment (e.g., headache, cold, cough, rash, joint/muscle pain) Routine wellness appointments (e.g., asymptomatic/preventive care, well child/patient exams, physical exams) 	 <ul style="list-style-type: none"> Within 2-7 days (Non-urgent) Within 30 days (Routine wellness)
	 <ul style="list-style-type: none"> Office visit within 3 weeks of member request
After-hours care <ul style="list-style-type: none"> Access to practitioners after the practice’s regular business hours 	Acceptable process in place to respond 24 hours per day, 7 days a week to member issues (answering service that pages the practitioner or answering machine message telling caller how to reach the practitioner after hours)
In-office waiting times <ul style="list-style-type: none"> Practitioners are encouraged to see patients with scheduled appointments within 15 minutes of their scheduled appointment time. A reasonable attempt should be made to notify patients of delays. 	Within 15 minutes <div style="border: 1px solid blue; border-radius: 10px; padding: 5px; display: inline-block;"> What Is My Service Area? </div>

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4.1 PCP AND MEDICAL SPECIALIST ACCESSIBILITY EXPECTATIONS, Continued

MATERNITY CARE EXPECTATIONS (Obstetrics)	
Patient's Need:	Performance Standard:
• Maternity Emergency	Immediate response
• Maternity 1 st Trimester	Within 3 weeks of first request
• Maternity 2 nd Trimester	Within 7 calendar days of first request
• Maternity 3 rd Trimester	Within 3 calendar days of first request
• Maternity High Risk	Within 3 days of identification of high risk

Acceptable after-hours methods

The chart below outlines acceptable methods of handling after-hours calls from your Highmark patients.

ANSWERING PROCESS	RESPONSE/MESSAGE	COMMENTS
Answering Service or Hospital Service	Caller transferred directly to physician	
	Service pages the physician on call (see comments)	A physician or clinical staff person is expected to return the call within 30 minutes.
Answering Machine	Message must provide the caller with a way to reach the physician on call by telephone or pager	Provide clear instructions on how to record a message on a pager (i.e., "you will hear a series of beeps, please enter your phone number, including area code, by pressing the number keys on your phone, then hang up"). A physician or clinical staff person is expected to return the call within 30 minutes.
	Instruct caller to leave a message (see comment)	A physician or clinical staff person is expected to return the call within 30 minutes.

4.1 PRIMARY CARE PRACTITIONER OVERVIEW

Introduction

Highmark managed care members may select a primary care physician or practitioner (PCP) in accordance with their managed care program requirements. PCPs play an important role in managing all aspects of health care for members who select their practice.

Definition of PCP

A primary care physician or practitioner (PCP) is the medical professional who provides a patient's care and helps them access a range of services. The PCP provides, coordinates, and/or authorizes the health care services covered by the managed care program.

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Practitioners who may serve as PCPs

A physician (MD or DO) who is a family practitioner, general practitioner, internal medicine practitioner, or pediatrician is entitled to participate as a primary care physician (PCP). The physician must complete the credentialing process.

In addition, certified registered nurse practitioners (CRNPs) have the opportunity to offer their clinical expertise as a primary care CRNP to Highmark members. Qualified CRNPs must complete a credentialing application and meet credentialing requirements to receive designation as a primary care CRNP with Highmark. CRNPs who receive primary care CRNP designation with Highmark can only participate in Highmark's provider networks in that capacity; they cannot serve as both a CRNP specialist and a primary care provider.

How PCPs are reimbursed

PCPs in most Highmark networks are paid fee-for-service; however, PCPs participating in the First Priority Health (FPH) managed care network in Pennsylvania's Northeastern Region receive capitation, unless otherwise set forth in your participating provider agreement.

Please see the section in this unit on **First Priority Health Network PCP Payment Methodology** for more information on FPH network payment methodology.

PCP selection requirements

Highmark members enrolled in the following products are required to select a PCP to manage their care:

- **Pennsylvania:**
 - Commercial HMO plans in the Western and Northeastern Regions
 - Medicare Advantage HMO plans -- Security Blue HMO, offered only in the Western Region, and Community Blue Medicare HMO
 - Children's Health Insurance Program (CHIP) plans, including CHIP HMO plans in the Western and Northeastern Regions and also the CHIP PPO Plus product, a gatekeeper Preferred Provider Organization (PPO) product, in the Central Region

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4.1 PRIMARY CARE PRACTITIONER OVERVIEW, Continued

PCP selection requirements (continued)

- **Delaware:** Independent Practice Association (IPA) and Point of Service (POS) products require the selection of a PCP.
- **West Virginia:** Members in Super Blue Select POS plans are required to select a PCP at the time of enrollment.

Traditional indemnity products and PPOs do not require PCP selection. In Pennsylvania, EPO products do not require PCP selection but it is recommended.

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4.1 PRIMARY CARE PRACTITIONER ROLE AND RESPONSIBILITIES

Overview Highmark managed care members may select a primary care physician/practitioner (PCP) in accordance with their managed care program requirements. The PCP provides, coordinates, and/or authorizes the health care services covered by the managed care program.

PCPs play an important role in managing all aspects of health care for members who select their practice. The information to follow serves as an introduction to the roles and responsibilities of the PCP.

PCP responsibilities Responsibilities specific to primary care physicians and primary care CRNPs, if within the scope of their license, include, but are not limited to:

- Office visits
- Inpatient hospital, emergency room, skilled nursing, and home visits
- Routine pediatric and adult immunizations
- Maintenance allergy injections
- Routine diagnostic procedures
- Minor surgeries performed in office (as applicable)
- Lab services performed in the office
- Preventive and early detection interventions
- Most acute and chronic services
- Other services as necessary
- Maintaining organized medical record keeping practices and ensuring accurate medical records
- Maintaining active staff privileges at a minimum of one Highmark contracted hospital*
- Providing 24-hour telephone availability year round
- Providing physician coverage at all times
- Obtaining authorization for services as required
- Informing Medicare Advantage members about advance directives (applicable in Pennsylvania and West Virginia)
- Cooperating with Highmark quality management programs to the extent permitted by federal and state law including, but not limited to, the following:
 - Clinical initiatives
 - Condition management and shared decision making
 - Credentialing
 - Clinical studies
 - Health Plan Employer Data and Information Set (HEDIS®)
 - Providing access to members' medical records
 - Risk Adjustment Data Verification (RADV)

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4.1 PRIMARY CARE PRACTITIONER ROLE AND RESPONSIBILITIES,

Continued

PCP responsibilities (continued)

Note: Routine adult and pediatric physicals and pediatric immunizations must be performed by the member's PCP, if applicable, to receive coverage.

** Primary care CRNPs must have full admitting privileges or a plan of action with a network participating primary care physician with admitting privileges, with consideration to the age range of patients (e.g., a general practitioner who sees patients age 13 years and older should not cover hospital admissions for a CRNP with a pediatric practice who sees patients under 13 years of age).*

Organizational provider communication

Highmark network organizational providers, such as hospitals, emergency facilities, ambulatory surgery centers, home health agencies, and skilled nursing facilities, must promote continuity and coordination of care for network members by communicating with primary care physicians and primary care CRNPs when care is delivered to their patients.

Primary care physicians and primary care CRNPs should expect a written description of the care given to their patients any time services have been rendered by these providers.

4.1 HOW MEMBERS SELECT AND CHANGE PCPS

How members select a PCP

Managed care members with coverage requiring a PCP selection are asked to select a PCP at the time of enrollment.

- **Pennsylvania:** Members with coverage under commercial health maintenance organization (HMO) plans in the Western Region, Medicare Advantage HMO plans in the Western Region, and Children’s Health Insurance Plan (CHIP) HMO and PPO Plus plans are required to select a PCP.
- **Delaware:** Members with Independent Practice Association (IPA) and Point of Service (POS) plans are required to select a PCP.
- **West Virginia:** Members in Super Blue Select POS plans must select a PCP and are informed that benefits will be paid at the lower, self-referred level if they do not select a PCP.

Managed care members who are required to select a PCP may select any network PCP listed in the provider directory they receive at enrollment as long as the following conditions are met:

- The PCP practice is open to new members.
- The member fits into the PCP’s patient age range as specified by specialty, e.g., pediatrics.

Members in PPO/EPO and traditional indemnity plans, including Medicare Advantage Freedom Blue PPO plans in Pennsylvania and West Virginia, are not required to formally select a PCP. These members may select or switch PCPs as they choose without notifying Highmark.

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How members change PCPs

Highmark members may call into Member Service and select a new PCP at any point after enrollment.

IF THE MEMBER CALLS IN...	PCP CHANGES ARE EFFECTIVE...
from the 1 st through the 15 th day of the month,	the first of the next month following the date of the call.
after the 15 th day of the month,	the first of the second month following the date of the call.

For example, if the member calls to select a new PCP on:

- January 4, the change will be effective February 1.
- January 20, the change will be effective March 1.

Transfer of medical records

When a member chooses a new PCP, the original PCP must transfer the member’s complete medical record to the new PCP in a timely manner (at no charge to the member).

4.1 ARRANGING FOR PCP ABSENCE

Introduction

The purpose of this section is to explain what the PCP needs to do before leaving for vacation or other time off.

Making the necessary arrangements

Prior to leaving for an extended period of time off, the PCP should:

1. Find a PCP who participates in the same network(s) as you to provide medical treatment to members during your absence.
2. Resolve payment arrangements, including copayments.
3. Inform office staff of the above arrangements and ask that the covering physician inform his or her office staff of the arrangements.
4. Be sure that your answering service informs patients of the arrangement.

PCP back-up physician form – WV



PCPs in Highmark West Virginia's Point of Service (POS) network select a back-up physician at the time of contracting with Highmark West Virginia by completing the [Primary Care Physician Back-Up Physician Information Form](#).

This form is also accessible from the *Highmark Provider Manual's Tip Sheet Index* available under **ADDITIONAL RESOURCES** at the bottom of the manual's home page.

The PCP may change his/her designated covering physician by submitting a new form. However, use of a non-network physician for coverage must be authorized by Highmark West Virginia. Please contact Highmark Provider Information Management at **1-800-798-7768**.

[What Is My Service Area?](#)

Appointments

Most members will be able to wait for their regular PCP's return. However, there will be some cases when a member will require an office visit during his or her PCP's absence. For such cases, the covering PCP's office staff should make an appointment or arrangements and give the member clear directions.

Authorization requests during the PCP's absence

If the PCP is planning to be away for a short duration (less than five days), the covering PCP can request authorizations and advise members to go to specialists or the emergency room during the PCP's absence.

The covering physician may keep a list of these incidents which he or she then shares when the member's PCP returns. For the treatment that took place during the absence, the member's PCP should submit any authorization requests expeditiously to avoid payment delays.

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4.1 ARRANGING FOR PCP ABSENCE, Continued

**Reimbursement
and
copayments**

We advise physicians to work out their own payment arrangements prior to covering for one another. We do not provide additional reimbursement to practitioners who are covering for other PCPs.

The collection of copayments works the same way. The two physicians involved should come to an agreement as to how this will be handled.

**Informing the
office staff**

It is imperative that both the regular and the covering physicians' office staffs be aware of any temporary coverage arrangements. Failing to notify the office staffs may decrease continuity of care to members.

4.1 MEMBER REMOVAL POLICY AND PROCEDURE

Policy	All Highmark members have a responsibility to maintain a cooperative physician/patient relationship. Documented occurrences of members not fulfilling their responsibilities may result in a practitioner requesting discharge of the member from his or her practice.
Background	The relationship between a PCP and his or her members is crucial in the managed care environment. However, sometimes problems can occur which cause a serious rift in the doctor/patient relationship. In such cases, we ask the PCP to attempt to resolve the matter directly with the member. If this does not correct the problem, the PCP is supported in his or her effort to remove the member from the practice.
Invalid reasons for removing a member	<p>Invalid reasons for removing a member include:</p> <ul style="list-style-type: none"> • Race • Sexual orientation • Age (unless the member’s age is outside of the scope of the practice, e.g., an adult patient in a pediatric practice) • National origin • Diagnosis • Physical disability • Religion • Gender • Health status factors (e.g., medical condition, claims experience, receipt of health care medical history, genetic information, or evidence of insurability) • Health care insurance coverage
Before you request removal...	Removing a member from your practice should be used as a last resort. You must make a sincere attempt to resolve the situation with the member prior to requesting his or her removal. Your efforts must be documented in the member’s chart.

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4.1 MEMBER REMOVAL POLICY AND PROCEDURE, Continued

Procedure for removing a member from your practice

If a problem is identified, the practitioner must communicate the problem to the member or the member’s legal representative, and document the problem in the member’s medical record.

When a PCP has exhausted his/her best efforts to establish an effective relationship and has documented situation(s), the PCP may apply to Highmark to have the member transferred from the PCP’s practice. Written requests for physician/patient relationship termination should be submitted to:

PENNSYLVANIA AND DELAWARE	WEST VIRGINIA
Highmark Member Disenrollment Fifth Avenue Place, Suite 721 120 Fifth Avenue Pittsburgh, PA 15222-3099 Fax: 1-717-635-4219	Highmark West Virginia Provider Services Department 614 Market Street Parkersburg, WV 26102

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NOTE: It is not necessary to send a written request for members with coverage that does not require PCP selection.

The request must contain the following information:

- Member name
- Member ID number and insurance product
- Member address
- Member telephone number

Also included with each request should be statements which document:

- Specific documentation of the nature and timing of the incident(s) which gave rise to the request as evidenced in the medical record.
- The steps which the PCP has taken to resolve the situation and/or to establish an acceptable relationship with the member.
- Other relevant information pertinent to the request for terminating the physician- patient relationship.

A practitioner or designee from the practice must sign the request. A copy of the request should also be sent to the member.

The PCP must provide access to service until the termination date and provide urgent care if necessary. If requested to do so by the member or Highmark, the practitioner must, at no cost to the patient, forward medical records to the new PCP within thirty (30) days.

4.1 HOW TO CLOSE AND RE-OPEN YOUR PRACTICE TO MEMBERS

Introduction This section is intended to explain how to close and re-open your practice to new members.

**Definition:
Closed practice** When a practice is “closed to new members,” it means that the PCP practice is temporarily not available for selection by new members.

**Definition:
New member** A new member is one who has:

- Never been seen by a physician of the practice.
- Not been seen by a physician of the practice within the past 36 months.

Rationale By closing to new members, your practice can limit the number of new members. This can be especially helpful to practices that are new to managed care, or to practices that have a shortage of physicians or office staff.

Guidelines

- Your practice must provide written notice to Highmark sixty (60) days prior to the anticipated closing date and/or re-opening date.
- Closure takes place on the first day of the month following the 60-day period.
- You must continue to accept new members up to the end of the 60-day period when closure is in place. You must accept existing members who choose you as their PCP.
- You must close to all new Highmark plan members.

How to close or re-open your practice To close or to re-open your practice to new members, simply mail or fax written notification on practice letterhead, including practice name, address, vendor number, effective date, and authorized signature for the requested change, to:

- Fax to : 1-800-236-8641
 - Mail to: Highmark Blue Shield
Provider Information Management
P.O. Box 898842
Camp Hill, PA 17089-8842
-

4.1 FIRST PRIORITY HEALTH NETWORK PCP PAYMENT METHODOLOGY

[What Is My Service Area?](#)

Introduction



The First Priority Health (FPH) managed care provider network supports the health maintenance organization (HMO) products in the 13-county Northeastern Region of Pennsylvania, including the Children’s Health Insurance Program (CHIP). There are several reimbursement methodologies available to primary care physicians (PCPs) participating in the FPH network. These include: capitation, billables, copayments, and fee-for-service reimbursement as more specifically set forth in your FPH participating provider agreement.

FPH PCP capitation



Capitation is a prepaid dollar amount, determined actuarially, which is paid to the PCP for each patient who has chosen his/her office. It is calculated to average a fee-for-service equivalent. The dollar amount is based on a predetermined rate per age group, regardless of any one patient’s use of services. The dollar amount varies based on copayment, age category, and provision of venipuncture.

Capitation checks are issued on the first of the month and the dollars paid are for services provided during that month. Capitation services are not prorated. The date on which additions or deletions to your office are effective determines whether your office will receive or repay a full month’s payment.

Changes effective from the first through the fifteenth of the month are calculated for capitation purposes for the entire current month. Changes which are effective from the sixteenth through the end of the month are effective on the first day of the following month.

If you do not have a copy of the capitation rates, please contact Provider Services.

Some examples of services covered under capitation include, but are not limited to:

- Office visits and outpatient services rendered at the PCP’s office.
- Drawing of blood and other laboratory specimens (if the office is located in a laboratory program region, these specimens should be sent to the assigned laboratory provider – please see [Chapter 4.5: Outpatient Radiology and Laboratory](#) for more information).
- Physical examinations, including routine, camp, college, scouts, driver’s license, or school physicals, are covered under capitation once every twelve (12) months. If the member has had a physical examination within less than twelve (12) months and requests another exam for non-medical reasons, it is not a covered service because it is not considered medically necessary and, therefore, the member is responsible for payment.
- EKGs (electrocardiograms).
- Services not listed on the billable list are considered covered under capitation.

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4.1 FIRST PRIORITY HEALTH NETWORK PCP PAYMENT METHODOLOGY, Continued

[What Is My Service Area?](#)

FPH PCP capitation (continued)



Foreign service physical exams, pre-employment physicals, or exams required by insurance companies are not covered; the member is responsible for payment of these services.

IMPORTANT: It is critical that ALL services rendered to members are submitted for payment or adjudication as pre-paid. This includes capitated (prepaid) services in addition to the PCP billable procedures, which are paid fee-for-service. Highmark requires this billing/encounter information in order to monitor clinical activities, comply with accrediting bodies, and provide PCPs with fair capitation payments and accurate reports. All payments for non-medically necessary services and/or non-covered benefits are the member's responsibility.

Capitation roster



The capitation roster is a monthly financial statement intended for use by the provider's business office. In the roster's heading, totaled capitation information for the provider practice is provided, including total number of members, total capitation rate for all members, the total amount of adjustments (if applicable), and the total capitation payment for the month for all members.

The capitation roster also lists, alphabetically, all members enrolled with your practice. Due to the time required to process new members or PCP selection changes, sometimes there is a delay of one to two months before a new member may appear on the roster. The following information is included on the roster for each member:

- Member Name/Member ID
- Date of Birth/Age
- Sex
- Effective Date with PCP
- Copay Amount
- Capitation Rate
- Adjustment Amount/Date, if applicable
- Capitation Payment

The capitation roster is available at the beginning of every month via Highmark Blue Shield NaviNet®. It is accessed from the **Workflows for this Plan** menu on Highmark Plan Central by hovering over **AR Management**, and then selecting **PCP CAP Rosters** from the fly-out menu. The roster is mailed to PCPs without access to NaviNet.

- The roster is generated by "provider group," not by "physicians within the group."
- The roster can be downloaded to a PDF or text file.

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4.1 FIRST PRIORITY HEALTH NETWORK PCP PAYMENT METHODOLOGY, Continued

Capitation roster (continued)



- A 13-month history of rosters will be available at all times within NaviNet.
- Providers receiving Highmark capitation via electronic funds transfer (EFT) will only receive the roster via NaviNet.
- Providers receiving a paper check will receive the roster by mail in addition to the ability to access the roster via NaviNet.

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FPH PCP billables



Billables are certain services the PCP may submit for fee-for-service reimbursement consideration in addition to his/her capitation payments. The PCP must submit claims with all the required information via an 837P electronic claim transaction or a paper claim using an original 1500 Health Insurance Claim Form, Version 02/12 (photocopies, discontinued, or outdated versions will not be accepted).

Please refer to the [PCP Billable Services](#) list for procedures that are billable for fee-for-service reimbursement. This list is also available on the Highmark Blue Shield Provider Resource Centers on the Highmark Blue Shield website and also via NaviNet® – select **EDUCATION/MANUALS**, and then click on **First Priority Health Network Resources**.

FPH PCP copayments



For any office visit where a member seeks “professional medical attention,” the patient is responsible for a copayment at the time services are rendered. Copayments should be collected **only** for office visits billed with an evaluation and management code. Highmark follows the current year evaluation and management codes as published in the American Medical Association CPT Manual.

Please refer to the member’s current ID card or NaviNet’s Eligibility and Benefits Inquiry for the correct copayment amount to be collected. **A member’s copayment cannot exceed the allowed amount (contracted rate). If the allowed amount is less than the member’s designated copayment, providers should only collect up to the allowed amount.**

Please check your remittance advice for the appropriate member liability (copayment, deductible, and/or coinsurance). If you collected the copayment at the time services were rendered and the remittance advice indicates a lower copayment, the member must be reimbursed the difference.

4.1 RISK SCORE ACCURACY (RSA) PROGRAM

Why blue italics?

Introduction

The goal of the Risk Score Accuracy (RSA) Program is to help ensure that quality health care is provided to Highmark Medicare Advantage and Inter-Plan Medicare Advantage members with complex chronic health conditions by assisting provider practices to accurately identify, treat, document, and report appropriate ICD-10-CM and Hierarchical Condition Category (HCC) diagnosis codes to Highmark.

Program overview

Analytics are used to identify persistent (previously reported) and/or suspected diagnosis condition(s) of Program Members, and Participants are asked to address these diagnosis condition(s) during office visits using an Electronic Medical Record (EMR)-based or desktop-based, system-generated form (RSA Tool). Participants must respond to the RSA Tool, document the condition in the Member's medical record, and submit any confirmed condition(s) via claim as indicated in the instructions and Program training materials.

Evaluating each Program Member for the diagnosis condition(s) listed on the RSA Tool helps Highmark improve overall health care quality and possibly reduce future health care costs, as well as allows Highmark to report the accurate health status of each Program Member to the Centers for Medicare & Medicaid Services (CMS).

The Program is available to Participants that have Program Members with diagnosis condition(s) that need to be evaluated during the current year. Participants have the potential to receive program compensation by taking steps toward providing quality health care through assessment of the Program Members and ensuring accurate documentation of confirmed diagnosis conditions during every office visit as a part of this Program. It is important that every office visit with the Program Member be precisely documented in the medical record to provide a complete picture of the Program Member's health for purposes of appropriate treatment and follow-up care.

The information presented in the RSA Tool is derived from diagnosis codes reported in previous years by multiple sources, including PCPs, Specialists, and clinical data, facilities, chart reviews, and other sources. The RSA Tool will only appear for a Program Member who has not been evaluated for the specific diagnosis condition(s) listed on the RSA Tool in the current year.

FOR MORE INFORMATION

*Complete program information is available on the NaviNet® Provider Resource Center. Select **EDUCATION/MANUALS** from the main menu, and then **Risk Adjustment Programs**.*

4.1 UNCONFIRMED DIAGNOSIS CODE (UDC) PROGRAM

Introduction

The Unconfirmed Diagnosis Code (UDC) Program is a clinically-based program that promotes provider/Highmark collaboration to evaluate previously reported and/or suspected diagnosis conditions. These conditions require annual evaluation and/or treatment but may not have been reported to Highmark in the current year. This improves continuity, quality and timely coordination of care for chronic conditions.

The goal of the UDC Program is to ensure that quality health care is provided to Highmark Medicare Advantage and Commercial Affordable Care Act (ACA) members with complex chronic health conditions by accurately identifying, treating, documenting, and reporting the appropriate ICD-10-CM diagnosis codes to Highmark.

Program overview

Using analytics, the program will identify and list persistent (previously reported) and/or suspected diagnosis condition(s) of program members. In-network primary care physicians (PCPs) and physicians with select specialties (“participants”) are asked to address the diagnosis condition(s) with the program member during their scheduled visit within the current program period.

Participants will be provided with the diagnosis condition(s) in various formats and tools (“UDC Forms”). Participants must complete and return the UDC Forms as indicated in the instructions and program materials. Evaluating each program member for the diagnosis condition(s) listed on the form helps Highmark improve overall health care quality and possibly reduce future health care costs, as well as allows Highmark to report the accurate health status of each program member to the Centers for Medicare & Medicaid Services (CMS).

The program is available to all participants who have program members with diagnosis conditions that need to be evaluated during the current program period. Participants will have the potential to receive additional compensation (“program compensation”) by taking steps toward providing quality health care through assessment of the program members and ensuring accurate documentation of confirmed diagnosis conditions during every office visit as a part of this program.

FOR MORE INFORMATION

Complete program information is available on the NaviNet® Provider Resource Center – select **EDUCATION/MANUALS** from the main menu, and then **Risk Adjustment Programs**.

4.1 PCP AND SPECIALIST COMMUNICATION

Overview	Network personal physicians and specialists, including medical, surgical, and behavioral health, must communicate with one another in order to assure continuity and coordination of care for members. The communication procedure is documented below.
Purpose	The goal is to ensure the exchange of information in an effective, timely, and confidential manner to promote appropriate diagnosis and treatment for members.
Requirements	<p>PCPs and specialists, including medical, surgical, and behavioral health specialists, must communicate in each of the following ways to ensure continuity of patient care:</p> <ul style="list-style-type: none"> • Before the member’s visit to the specialist, the PCP must provide relevant clinical information to the specialist. Acceptable forms of communication are formal letters and/or copies of relevant portions of the patient’s medical chart. The Patient Treatment Summary Communication Form is available on the Provider Resource Centers in Pennsylvania and West Virginia -- select FORMS, and then Miscellaneous Forms. • Within ten (10) business days of the first visit, the specialist must provide the PCP with information about his or her visit with the member. Acceptable methods of communication are standardized form, formal letter, and/or copies of relevant portions of the patient’s medical record. • In the case of behavioral health, the member’s consent may be needed for the behavioral health specialist to release information to the PCP. If a patient refuses to give consent, the behavioral health specialist must document this refusal in the patient’s behavioral health treatment record. • The PCP must document his or her review of the reports, lab, X-rays, and other diagnostic tests received from the specialist or facility in the patient’s chart. The PCP must also indicate any subsequent action necessary. The PCP should indicate that he or she has reviewed the information (e.g., by initialing each page).
Member role in communication	Highmark members should not be asked by PCPs or specialists to communicate findings, reports, lab results, etc. to another practitioner.

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4.1 PCP AND SPECIALIST COMMUNICATION, Continued

PCP/behavioral health form



Behavioral health providers in Pennsylvania may use the [Communication Document for Behavioral Health Specialist to Primary Care Physician](#) to communicate with the member's PCP. This form can also be found on the Provider Resource Centers in Pennsylvania – select **FORMS**, and then **Behavioral Health Forms**.

[What Is My Service Area?](#)

Copying and transferring medical records

Providers must ensure members are guaranteed timely access to their medical records, X-rays, and other information that pertains to them. The following requirements apply to the transfer and copying of medical records for Highmark members:

- PCPs must transfer sufficient medical records (or copies thereof) and information to Specialists without charge to the member or Highmark, as is necessary for the Specialist to appropriately treat the member.
- Specialists must provide PCPs, without charge to the member or Highmark, written documentation regarding medical care given or being given to the member. (Additional restrictions may apply to information regarding certain medical conditions such as mental health, substance abuse, and HIV/AIDS.)
- PCPs must transfer, without charge to the member or Highmark, sufficient medical records and information to another if the member requests to change his/her PCP.
- In general, practitioners must transfer to each other appropriate medical information as necessary to ensure quality care for all members. The transfer of medical records must be completed in a timely fashion and without charge to the member or Highmark to ensure continuity of care.
- When releasing records directly to the patient, at the patient's request, the practitioner may charge a reasonable fee to cover copying and postage costs, up to the amount set by state law and as permitted by federal law.

Compliance monitoring

Where the network supports managed care products, Highmark will monitor compliance of the communication procedure as part of the medical record review process. During medical record review, Highmark representatives will check for the provider's initials on the member's chart and ensure that any necessary follow-up actions are addressed.

The goal is to ensure the exchange of information in an effective, timely, and confidential manner to promote appropriate diagnosis and treatment for members.

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4.1 PCP AND SPECIALIST COMMUNICATION, Continued

**Organizational
provider
communication**

Highmark network organizational providers, such as hospitals, emergency facilities, ambulatory surgery centers, home health agencies, and skilled nursing facilities, must promote continuity and coordination of care for Highmark members by communicating with personal physicians when care is delivered to their Highmark members. Personal physicians should expect a written description of the care given to their Highmark members any time services have been rendered by these providers.

4.1 SPECIALIST BASICS

Introduction As a specialist, you play the important role of providing specialty services to our Highmark members.

How specialists are reimbursed Network specialists are paid fee-for-service. For more information on reimbursement methods, see [Chapter 6.7: Payment/EOBs/Remittances](#).

How auxiliary personnel are reimbursed When physicians employ auxiliary personnel (e.g., non-physician such as a certified registered nurse) to assist in rendering services to their Highmark members and include the charges for those services in their own bills, the services of such personnel are considered to be “incident to” the physician’s services. Services of auxiliary personnel are covered when there is a physician’s service rendered to which the services of such personnel are an incidental part and there is direct personal supervision by the physician.

More detailed information about supervision guidelines of ancillary personnel and employment guidelines can be found in Medical Policy Bulletin Z-27: Eligible Providers and Supervision Guidelines.

Highmark’s Medical Policies are available on the Provider Resource Center under **CLAIMS, PAYMENT & REIMBURSEMENT**.

If network participation is terminated In the event of voluntary or involuntary termination the specialist or specialty group from any of Highmark’s networks, upon request, are required to cooperate with network policies in obtaining a list of members that may be affected by such termination because they are undergoing an ongoing course of treatment or are otherwise active plan members. The list must include name, address, and identification number.

Highmark will use the member list to initiate its member notification process to alert them that the specialist or group will no longer be a part of the network.

Directing care to network providers As a provider who participates in a managed care network, it is your obligation to provide services at the most appropriate level and to protect Highmark members from business practices which expose them to unnecessary out-of-pocket expenses. This means, among other things, that when your Highmark members require services that you are not able to provide, you are obligated to direct those members to other providers who participate in the network associated with their benefit program.

For more information on directing care to network providers, please see [Chapter 3.1: Network Participation Overview](#).

4.1 PREVENTIVE CARE RESPONSIBILITIES FOR ALL NETWORK PHYSICIANS

Preventive care

Network physicians have a unique opportunity to recommend or administer certain services and lifestyle improvements that can prevent future illness or injury. Benefits are provided for prevention, early detection, and minimization of ill effects and causes of disease.

Highmark charges its PCPs and specialists with promoting and helping to maintain the health of members through the HEDIS® measures and other preventive services as noted below.

PCP and specialist responsibilities

- Adhere to nationally accepted preventive health guidelines as approved by Highmark.
- Provide or recommend beta-blocker treatment after heart attack and promoting long-term therapy.
- Recommend and promote timely and age-appropriate preventive services, e.g., screening for breast, cervical, colorectal, and prostate cancers.
- Recommend a follow-up behavioral health visit within seven (7) days and no later than thirty (30) days after hospitalization for mental illness and ensuring compliance with medication and long-term follow-up.
- Evaluate members to determine tobacco use. Advise and assist members to cease tobacco use.
- Recommend the Baby Blueprints® program to members who could benefit from participating in this program.
- Provide or recommend adequate care for diabetics, including foot and eye exams.
- Use recommended depression screening tools to identify depression in members and initiate appropriate, ongoing treatment.
- Recommend members to condition management programs when appropriate and available under their benefit plan.
- Provide appropriate and comprehensive care for members with hypertension.
- Prescribe appropriate medications for members based on current national standards of care.
- Promote exercise and physical activity to all members, especially the senior population.

Note: Routine adult and pediatric physicals and pediatric immunizations must be performed by the member's PCP, if applicable, to receive coverage.

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4.1 PREVENTIVE CARE RESPONSIBILITIES FOR ALL NETWORK PHYSICIANS, Continued

Clinical Practice and Preventive Health Guidelines

On an annual basis, Highmark's Quality Management, along with participating network physicians, review and update the *Clinical Practice and Preventive Health Guidelines*.

These guidelines are available online to the provider community as a reference tool to encourage and assist you in planning your patients' care. The guidelines can be found under **EDUCATION/MANUALS** on the Provider Resource Center.

Additional information related to OB/GYN care

- Provide or recommend screening mammograms, cervical cancer screenings, and Chlamydia screenings.
- Recommend Baby Blueprints® to expectant Highmark members so that they may better understand and enjoy every stage of pregnancy and make more informed care and lifestyle decisions.
- Provide or recommend prenatal care, especially in the first trimester.
- Provide or recommend post-partum exams 4-6 weeks after delivery.
- Provide appropriate counseling for menopause.
- Evaluate the risk of child abuse, domestic violence, and elder abuse.
- Evaluate the risk of post-partum depression.

Documentation

Network physicians should submit accurate encounters/claims and document their preventive care services and recommendations in the member's chart.

If performed by a specialist, the intervention, including dates they were performed and their results, should be communicated in writing to the PCP.

Likewise, information about such interventions performed by the PCP should be communicated to a specialist when the information is pertinent to the condition the specialist is treating.

4.1 OB/GYN REQUIREMENTS AND PROCEDURES

Overview	<p>Obstetricians and gynecologists (OB/GYNs) in Highmark's networks play a very important role by providing health care to our female members. Women have direct access to any network OB/GYN for their health care needs.</p>
Direct access	<p>Direct access to women's health care means that no members in need of gynecological or obstetrical services need to obtain referrals from their primary care physicians/practitioners (PCPs).</p> <p>Direct access offers the following advantages for members seeing a credentialed network OB/GYN:</p> <ul style="list-style-type: none"> • No referral for annual routine gynecological exam • No referral for sick visits • No referral for follow-up care • No referral for maternity services <p>Direct access does not extend to services provided by OB/GYN residents or to gynecological services provided in a hospital clinic setting.</p>
Communication procedure	<p>Direct access enables members to have contact with their OB/GYNs without going through their PCPs. While this enhances member satisfaction, communication between OB/GYNs and PCPs is still vital, especially when routine annual gynecological exams and mammograms are provided.</p> <p>The following should be faxed or mailed within thirty (30) days to the member's PCP for each office visit:</p> <ul style="list-style-type: none"> • Clinical findings • Test results • Treatment plans • A summary report at the conclusion of the treatment period • Acceptable formats include typed letters, physician forms, and progress notes
OB/GYN referrals	<p>If an OB/GYN sees a member and determines that the member may need the services of another specialty practitioner, the OB/GYN should recommend that the member return to their PCP. OB/GYNs are not authorized to refer members to other specialty practitioners.</p> <p>If a member requests a visit for symptoms that do not appear to be gynecological in nature, the OB/GYN should refer the member back to her PCP.</p>

4.1 OBSTETRICAL SERVICES

Overview Highmark members have direct access to women’s health care and are not required to obtain referrals from their primary care physicians/practitioners (PCPs) for maternity care.

Verifying benefits Highmark recommends that you always verify benefits prior to providing service to our members. Because member benefits can vary, you are reminded to be sure to verify benefits for these special circumstances:

- Dependent daughter’s eligibility for maternity benefits
- Coverage for tubal ligation
- Hospital employees and their dependents -- some may have coverage or high-level coverage only at their employer hospitals

To verify benefits, please use the **Eligibility and Benefits** feature on NaviNet.® If you do not have access to NaviNet, please call Provider Services for your service area to speak to a customer service representative:

- PA Western Region: **1-800-547-3627**
- PA Central, Eastern, and Northeastern Regions: **1-866-731-8080**
- Delaware: **1-800-346-6262**
- West Virginia: **1-800-543-7822**

Note: Maternity authorizations are not necessary unless the care is provided out-of-network.

[What Is My Service Area?](#)

Case management available

Case management is a systematic, proactive, and collaborative approach to effective assessment, monitoring, and evaluation of options and services required to meet an individual member’s health needs. Case management is a collaborative process involving the physician, the patient and support system, the case manager, and other health care service providers to encourage and assist patients to achieve their optimum level of wellness, self-management, and functional capability.

In cases where the obstetrician feels there is a need for case management due to a high-risk pregnancy, please contact case management staff to discuss your patient’s needs.

- Pennsylvania: **1-800-596-9443**
 - Delaware: **1-800-572-2872**
 - West Virginia: **1-800-344-5245**
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4.1 OBSTETRICAL SERVICES, Continued

Baby Blueprints® program available!

Baby Blueprints® is a free program that offers expectant Highmark members educational information on all aspects of pregnancy through multiple printed and online resources during each trimester of pregnancy. Topics include prenatal care, proper use of medications, avoiding alcohol and tobacco, working, travel considerations, nutrition and weight gain, exercise, body changes, and many others.

For more information on this program, please visit [Chapter 2.4: Benefit Plan Programs](#).

Spontaneous abortion

In the case of a spontaneous abortion, the obstetrician should retrospectively bill for all prenatal visits.

Directing members for appropriate care

If a member requests a visit for symptoms that do not appear to be obstetrical or gynecological in nature, please direct the member to contact her PCP.

OB/GYN network participation

For Highmark network participation requirements and procedures, please see [Chapter 3.3: Professional Provider Guidelines](#).

4.1 GYNECOLOGICAL SERVICES

Overview Highmark members have direct access to women’s health care and are not required to obtain referrals from their primary care physicians/practitioners (PCPs) for gynecological services. Direct access offers the following advantages for members seeing a credentialed network OB/GYN:

- No referral for annual routine gynecological exam
- No referral for sick visits
- No referral for follow-up care

Annual routine gynecological exams Annual routine gynecological exams include, but are not limited to, the following services:

- Pelvic exam
- Pap test
- Clinical breast exam
- Interval history

Follow-up visits Follow-up visits may include the following services:

- Screening mammography
- Diagnostic mammography
- Selected diagnostic and surgical procedures, **only** if not on the list of procedures requiring pre-authorization
- Lab services referred by the OB/GYN
- Additional office visits, if necessary

Mammography A prescription is required to order a mammogram.

Mammography screening vs. diagnostic mammography A **screening mammogram** is an ordinary check-up intended to detect any problems. A **diagnostic mammogram** is a test intended to follow-up on a confirmed or suspected irregularity or diagnosis.

[What Is My Service Area?](#)

Infertility services require a benefit Not all members have a benefit to cover testing and/or treatment for infertility and/or assisted fertilization. To verify coverage, please use the **Eligibility and Benefits** feature on NaviNet.® For inquiries that cannot be handled via NaviNet, please call the Provider Service Center for your service area:

- PA Western Region: **1-800- 547-3627**
- PA Central, Eastern, and Northeastern Regions: **1-866-731-8080**
- Delaware: **1-800-346-6262**
- West Virginia: **1-800-543-7822**

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4.1 GYNECOLOGICAL SERVICES, Continued

Directing members for appropriate care

If a member requests a visit for symptoms that do not appear to be gynecological in nature, please direct the member to contact her PCP.

OB/GYN network participation

For Highmark network participation requirements and procedures, please see [Chapter 3.3: Professional Provider Guidelines](#).

4.1 BREAST PUMPS AND LACTATION COUNSELING

Introduction Under the Affordable Care Act of 2010 (ACA), specific women's preventive health care services are required to be covered for eligible health plan members without cost sharing to members. Such services include breastfeeding support, supplies, and lactation counseling services.

Coverage at a glance Breastfeeding support, counseling, and supplies are covered ACA Women's Preventive Health Services Mandate with no cost sharing to the member when performed by **in-network** providers.

- Out-of-network coverage is pursuant to the terms of the member's individual benefits.
- Out-of-network cost sharing and balance billing may apply.
- Only durable medical equipment (DME) providers can bill for breast pumps and supplies.

Verify eligibility and benefits You can verify whether a Highmark member is covered under the federal Women's Preventive Health Mandate via NaviNet® or the applicable HIPAA electronic transactions. In NaviNet's **Eligibility and Benefits Inquiry**, select **Additional Benefit Provisions**, and then select Other Services from the pop-up box. Scroll to **Women's Health Services** to determine if your patient is covered under the federal mandate.

Breastfeeding pumps and supplies Breastfeeding pumps and supplies are covered without cost sharing for women covered under the ACA Women's Preventive Health Services Mandate. Eligible members are entitled to one breast pump per pregnancy when supplied by any network participating durable medical equipment supplier.

Eligible Highmark members can order high-quality breast pumps directly from two of the leading manufacturers in the industry: Ameda and Medela. Members can call the selected manufacturer or place an order online in advance of their delivery. The manufacturer will confirm a member's eligibility and submit claims to Highmark for processing. Eligible members can be directed to contact the manufacturers as follows:

MANUFACTURER	PUMP	WEBSITE	PHONE/HOURS
Ameda	Purely Yours Electric Breast Pump with Dual Collection Kit	www.insured.amedadirect.com	Phone: 1-877-791-0064 Hours: 8 a.m. - 6 p.m.
Medela	Pump in Style Advanced Breast Pump Starter Set	www.medeladelivers.com	Phone: 1-800-866-2825 Hours: Monday – Friday, 9 a.m. - 6 p.m.

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4.1 BREAST PUMPS AND LACTATION COUNSELING, Continued

Breastfeeding supplies procedure codes

For eligible members whose coverage falls under the ACA women's health mandate, breast pumps and supplies are covered without member cost sharing when provided by participating DME providers. The following are eligible procedure codes for breastfeeding pumps and supplies:

PROCEDURE CODE	DESCRIPTION
E0602	Manual breast pump
E0603	Electrical breast pump
A4281	Tubing for breast pump replacement
A4282	Adapter for breast pump replacement
A4283	Cap replacement for breast pump bottle
A4284	Breast shield and splash protector
A4285	Polycarbonate bottle
A4286	Locking ring

Lactation counseling/support

Based on the ACA mandate, lactation services are eligible with no member cost sharing as follows:

- When provided by credentialed physicians who can employ lactation consultants or use their nursing staff to provide support. (This includes services provided by a physician assistant [PA] or certified registered nurse practitioner [CRNP] when under the supervision of a credentialed physician. Lactation consultants are not credentialed and cannot receive direct payment for their services.)
- When billed using the appropriate procedure codes — **99401, 99402, and 99403** — and the appropriate diagnosis code of **Z39.1**.

Additionally, breastfeeding counseling/support is eligible with no age limit or frequency restrictions, and lactation counseling/support is considered to be a preventive service.

Please also note the following:

- When the service is provided by the pediatrician, then it is integral to the baby exam.
- When a lactation consultant provides the service in the pediatrician office, the billing is for the mother.
- When the services are provided as part of the maternity hospitalization, the payment is bundled and paid per the facility contract and integral to that admission.
- The service is part of the standard preventive schedule for non-grandfathered groups (NGF); please check NaviNet for benefit coverage.

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4.1 BREAST PUMPS AND LACTATION COUNSELING, Continued

FOR MORE INFORMATION

Highmark **Medical Policy E-37** includes medical guidelines not outlined in the ACA mandate; however, these medical policy guidelines would apply to those groups that do not follow the Women's Health Federal Mandate. The policy addresses:

- Newborns who are detained in the hospital after the mother is discharged
- Babies who have congenital anomalies that interfere with feeding

Highmark Medical Policy can be accessed from the Provider Resource Center by selecting **CLAIMS, PAYMENT & REIMBURSEMENT** from the main menu.

4.1 DOCTOR MATCH

Introduction



In western Pennsylvania and Delaware, an online compatibility tool is available to help Highmark members choose a PCP or OB/GYN. Doctor Match is designed to match prospective patients with doctors who share a similar health care philosophy. By participating in Doctor Match, you can help new patients find you and grow your practice.

[What Is My Service Area?](#)

How it works

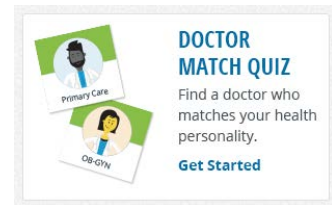


To participate in Doctor Match, PCPs and OB/GYNs complete a physician survey that asks about their personal treatment philosophy and communication style. Highmark members who are looking for a new PCP or OB/GYN answer similar questions to identify the qualities they are looking for in a doctor. And then the member is provided with a list of physicians whose perspectives on health care are closest to theirs.

Member access to tool



Highmark members can access the Doctor Match Quiz from the home page on the public website or when they log in to their secure member account. They just click on “Get Started” and answer the questions presented.



They will be presented with a list of prospective doctors with your detailed practice profile information from the Highmark Provider Directory.

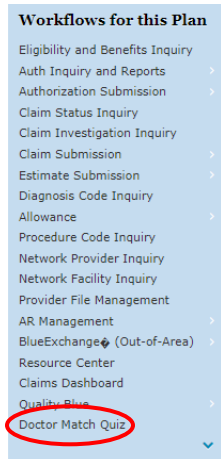
Provider access to survey



PCPs and OB/GYNs can access the Doctor Match Quiz in NaviNet®. From Highmark Plan Central, select **Doctor Match Quiz** from the options under **Workflows for this Plan** (you may have to click on the down arrow to view all menu options).

The quiz is quick and easy – it takes only 5 to 7 minutes to complete. And it can be retaken at any time if you feel some of your answers may differ over time.

Reminder! Including a photo in your online directory profile is important to many potential patients. Your photo can be easily uploaded through **Provider File Management** in NaviNet.® For complete instructions for uploading your photo, click on the **Tip Sheet** icon.



[TIP SHEET](#)