HIGHMARK WESTERN NEW YORK

# PROVIDER NEWS

A newsletter for Highmark Blue Cross Blue Shield providers in western New York

Issue 3, March 2024

## Highmark Responds to Change Healthcare Cyber Event:

## Funding Assistance Program and Access to Legacy Portals Extended

Highmark is committed to helping providers affected by the Change Healthcare cyber event.

During this unprecedented time, we recognize the unique challenges providers are facing and are prepared to go beyond business-as-usual approaches to assist providers.

### Funding Assistance Program

For participating providers who are experiencing cash flow concerns due to an inability to submit claims, Highmark has launched a Funding Assistance Program.

"We understand that some smaller physician practices and other providers who have been affected by this cyber event have not been able to submit claims and are facing financial hardships," said Kate Musler, Highmark senior vice president of Health Plan Risk Management and Provider Networks. "This assistance program will help those providers get through this

disruption and will also help ensure that our members can continue to access care and utilize the benefits they deserve."

Eligibility for assistance and amount of assistance will be determined based on a variety of factors including inability to use an alternate method to submit claims and current financial need.

Click **here** for more details and how to apply.

> **"This assistance program will help those providers get through this disruption and will also help ensure that our members can continue to access care and utilize the benefits they deserve."**
>
> Kate Musler,
> Highmark senior vice president of Health Plan Risk Management and Provider Networks.

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## Access to Legacy Portals Extended

Highmark is also delaying the shutdown of our legacy provider portals, NaviNet® and HEALTHeNET (NY regions) — which were originally scheduled for decommissioning on March 29 — to **April 26**.

We understand that affected providers are focused on more pressing issues at this time. This extension will give facilities, organizations, and practices more time to fully train their staff and move transactions to Availity®.

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## Risk Manager Update

Access to the Risk Manager analytics platform — which leverages Change Healthcare technology — has been disabled until further notice. As more information becomes available about the status of Risk Manager, we will share that with you via the Provider Resource Center and Availity portal.

Once the Change Healthcare cyber event has been resolved, you will need to create a separate username and password for Risk Manager to access it via Availity.

Best Practice and Pay for Performance and Pending Claims reports can be accessed via **Provider Facing Analytics** in Availity Payer Spaces.

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## Availity Training

Free live training hosted by Availity and Highmark trainers are being offered at the end of March. Click **here** to save your seat. (You must already be registered for the Availity portal to sign up.) You can also access recorded training courses and materials in the Availity Learning Center.

In addition, Availity has the following resources available for providers and their teams:

- Availity.com/Highmark
- Register and Get Started
- Sign-Up Tips for Primary Administrators

Availity®

## Highmark Resources

The Provider Resource Center (PRC) has a variety of resources regarding Availity and the transition to a new portal. From the left menu, click **AVAILITY** and then select:

- Provider Portal Transition
- Frequently Asked Questions

Also, since June 2023, *Provider News* has been running monthly articles on the transition. We encourage you to sign up for our e-subscribe list to ensure you don't miss important updates about Availity and many other topics.

You can access *Provider News* and our e-subscribe list by going to the PRC, selecting **NEWSLETTERS/NOTICES** and then clicking **E-Subscribe For Publications And Notifications** and/or **Provider News**.

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## Familiar Faces Leading **New York Markets** and **Provider Relationships**

**Sarah Cotter**
Vice President and Market Executive

**Sue Gannon**
Vice President of Provider Contracting and Relations

**Highmark Blue Cross Blue Shield continues its commitment to maintaining a local presence in western and northeastern New York with the recent appointments of Sarah Cotter as Vice President and Market Executive and Sue Gannon as Vice President of Provider Contracting and Relations. Both are familiar faces in New York.**

These roles will drive forward Highmark's Living Health strategy by working with our provider partners in new and different ways, advancing our shared goals of improving outcomes, reducing costs, and eliminating barriers in support of that mission.

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**As VP, Market Executive, Sarah Cotter** oversees Highmark's strategic and operational plans, with a large focus on expanding and nurturing provider partnerships for the New York market.

Before Highmark, Cotter was Vice President of Population Health & Client Engagement at HEALTHeLINK where she provided strategic guidance to advance population health and value-based care initiatives and collaborated with key stakeholders to enhance new uses of the local Health Information Exchange.

She also spent more than a decade in various leadership roles at Catholic Medical Partners and Catholic Health.

> "I think my experience with the provider community in western New York helps to give me credibility to begin conversations with partners with a level playing field."
>
> Sarah Cotter,
> Vice President and Market Executive

"I hope that I am able to share that I understand — at least to a certain extent — the challenges that the health care community has been under and continues to face," Cotter said.

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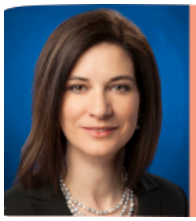
**Sue Gannon, VP, Contracting**, leads the health plan's contract strategy and is the primary liaison with Highmark's trusted provider network.

Gannon is a long-tenured Highmark leader, most recently as Director of Provider Experience. She's also held leadership positions in operations, individual market, and as the chief of staff to the Executive Vice President of Operations.

In her elevated role, she will build upon her provider relationships and continue to move the health plan's Living Health strategy forward to bring better value and improved health to the communities it serves.



> "I saw this role as an opportunity to utilize my local market knowledge to enhance how Highmark partners with the provider community to drive value for the patient and the provider."
>
> Sue Gannon,
> Vice President of Provider Contracting and Relations

"I understand the important role the provider plays coordinating care for patients and how challenging that can be in today's environment," said Gannon.

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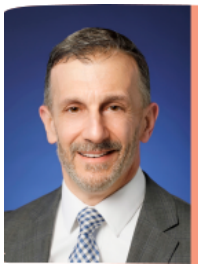
Cotter and Gannon will work closely together with **Dr. Michael Edbauer, President of Highmark Western and Northeastern New York**, each with a unique focus on our network providers and provider partnerships.



> "Sarah and Sue are experienced local leaders who have a deep understanding of health care in the communities we serve. I look forward to partnering with them, as our market's provider-facing leadership, to advance our Living Health Strategy and create a better experience for clinicians and our customers."
>
> Dr. Michael Edbauer,
> President of Highmark Western and Northeastern New York

"I think we all bring a slightly different perspective but an aligned one: that is to make the payer-provider relationship as seamless as possible," said Cotter.

What Cotter describes is at the heart of Highmark's Living Health strategy that puts payers and providers closer together — to reduce fragmentation and administrative burden — allowing providers to spend more time face-to-face with their patients, helping them before health issues arise. It's an initiative both Gannon and Cotter are excited about.

"Living Health is one of the reasons I am at Highmark," Gannon said. "It focuses on patient outcomes as well as improved experiences for patients and providers. My first thought when introduced to Living Health was — preventive care. To me that is what Living Health is — ensuring the patient and the provider have what they need to avoid unnecessary illness."

Cotter said, "I loved the way the Living Health model was described to me in the interview process, and I thought it was a great opportunity to take my experience of the pain points I felt on the provider side and bring that to the payer and help with working strategically with partners across New York to create a new, more efficient way of doing business together."

In 2024, the health care industry continues to face urgent challenges including residual delayed utilization following the COVID-19 pandemic, rising costs due to inflation and increased wages, and workforce shortages.

Gannon said it's important to her to listen to providers and understand the challenges they face in delivering high-quality care while partnering with them to contain cost, improve health outcomes, and decrease unnecessary utilization.

Listening to providers, especially smaller practices, continues to guide Highmark as it makes decisions that further support care — such as recently being the first Blue Plan in the country to offer a Funding Assistance Program during the recent Change Healthcare cyber event.

"I feel it is important for the payer-provider relationship to have a common understanding of the market dynamics, especially with regard to reimbursement. As value-based care models continue to evolve, they are allowing providers the freedom to care for their patients in the most efficient way, leading to better outcomes and a better patient and provider experience," said Gannon.

Cotter echoed the importance of the relationship building with our providers — something she plans to focus on.

"I think Highmark is making an investment in both people and technology, and trying to find ways to make the process work better for our provider partners," Cotter said. "I'm eager to learn more about the Highmark services and partnerships across different markets that I can help leverage to make New York even more successful."

"I would like to say a huge **THANK YOU** for your patience as we all learned together how to navigate new systems and policies. The big hurdles are behind us now and we can focus on the future. With the Highmark affiliation comes access to programs to help best manage a patient's care," Gannon said.

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Based on feedback from providers who attended our recent live training webinars on prior authorization submission for outpatient physical medicine and home health services, Highmark has decided to move back the effective date from April 1, as previously announced, to May 1. We are committed to providing you with the best experience possible and this additional time will ensure that providers, practices, and members are prepared for this change.

**Effective May 1, 2024**, Highmark Blue Cross Blue Shield providers will need to request authorization for these services. Please note, authorization is not required for the initial evaluation.

## PT, OT, and Chiro – Commercial Plans

The following outpatient services — for members in **Commercial** plans — will require prior authorization now **starting May 1, 2024**:

- Physical therapy (PT)
- Occupational therapy (OT)
- Chiropractic (Chiro)

**Administrative Services Only (ASO), Federal Employee Program (FEP), and Medicare Advantage are excluded.*

## Home Health – Commercial Plans and ASO Groups

For Highmark Blue Cross Blue Shield members in **Commercial plans and ASO groups**, providers will need to request authorization for Home Health (HH), now **effective May 1, 2024**.

***Note:*** *Medicare Advantage is excluded from the prior auth requirement; FEP prior auth not required for initial visits, per the plan limit. If a member needs additional visits (beyond the plan limit), then prior authorization is required.*

## Preauthorization

Providers will be able to submit electronic preauthorization requests beginning **April 26, 2024**, for services occurring on or after **May 1, 2024**. The original preauth request date was March 21, when implementation was scheduled for April 1.

## Training

To help providers with this upcoming change, recordings of live training sessions are available on the Provider Resource Center by clicking **here**. The recordings are listed under the **Instructional Videos**.

## Submitting Auth Requests Electronically – Faster Approvals

Availity® is where you will submit electronic prior authorization requests via the Predictal™ Auth Automation Hub, which will connect you seamlessly to Helion Arc. These applications enable offices to submit, update, and query medical authorization requests. *Submitting prior authorization requests electronically leads to* ***faster approvals***.

## Accessing Predictal

From Availity's main page, there are two ways to reach Predictal:

**OPTION 1:** Click **Payer Spaces** on the task bar and choose your Highmark plan. From Highmark Blue Cross Blue Shield Payer Spaces, scroll down to **Applications** and click the **Predictal** tile.

**OPTION 2:** Click **Patient Registration** from the task bar, choose **Authorizations & Referrals** from the drop-down menu, and then select **Authorization Request**. You will need to fill in the requested information before being routed to **Predictal**.

## Authorization Checklist

The checklist below will help you and your staff prepare for the change occurring on May 1:

✅ **Are you and your team registered with Availity?**

To register, go here. For more information about the transition to Availity, see the links below:

- Provider Portal Transition
- Frequently Asked Questions

✅ **Have you signed up for any training sessions on how to use Availity?**

To get started, log in to Availity:

- Access the **Help & Training** tab on the homepage:
- Click **Get Trained** from the drop-down menu to view recorded demos and webinars.

✅ **Have you used Predictal to submit an authorization request?**

The PRC has resources on the Procedures/Service Requiring Prior Authorization page that will walk you through the electronic auth submission process.

## What is Helion?

Helion is a health care technology and services company that helps payers cultivate high-performing networks while empowering providers to operate at their best — and in doing so, help patients heal better. You can learn more about Helion here.

## Have you and your team signed up for one of the live training sessions offered by Highmark?

See the list of training sessions for physical medicine and home health providers mentioned above.

## Have more questions?

Visit the **Procedures/Service Requiring Prior Authorization** page on the PRC.

If you need assistance regarding electronic authorization workflows, you can email us at ElecAuthSubmit@highmark.com.

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# HEDIS® Reporting: Transition to ECDS-Only Reporting Underway

**Electronic Clinical Data Systems (ECDS) is a HEDIS® reporting standard for health plans collecting and submitting quality measures to the National Committee for Quality Assurance (NCQA).***

In addition to ECDS, there are three other standards for currently reporting HEDIS data:

- **Administrative** – Data collected from office visits, hospitalizations, and pharmacy data.
- **Hybrid** – Administrative data pulled from claims as well as patient medical records.
- **Survey** – Information collected from member questionnaires.

The NCQA's goal is to move most, if not all, HEDIS measures to ECDS by 2030. Currently, 16 HEDIS measures use ECDS. See the list below.

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## Changes Occurring This Year

For measurement year (MY) 2024, NCQA is transitioning the following measures from a hybrid standard to ECDS-only reporting:

- *Colorectal Cancer Screening*
- *Follow-Up Care for Children Prescribed ADHD Medication*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics*

Last year, the Breast Cancer Screening transitioned to ECDS. For MY 2025, these three measurements are being considered for ECDS transition:

- *Childhood Immunization Status*
- *Immunizations for Adolescents*
- *Cervical Cancer Screening*

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## How will ECDS affect the HEDIS process?

Instead of relying on a sample patient size, ECDS will allow for measurement of the total eligible HEDIS population. Also, with ECDS, data can be collected year-round rather than just 12 weeks for hybrid measures. Both of these enhancements will result in better and more accurate data.

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## What Impact Will ECDS Have on Providers

One benefit is that more time can be focused on patient care rather than retrieving medical records for practices subscribing to and submitting their Electronic Medical Record (EMR) data to local Health Information Exchanges (HIEs).

In addition, as more accurate patient data becomes available through ECDS, the management of preventive care strategies is expected to shift from a retrospective focus to a more prospective one.

**Current HEDIS Measures Using the ECDS Reporting Standard:**

- Childhood Immunization Status (CIS-E)
- Immunization for Adolescents (IMA-E)
- Breast Cancer Screening (BCS-E)
- Cervical Cancer Screening (CCS-E)
- Colorectal Cancer Screening (COL-E)
- Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)
- Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)
- Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DSM-E)

- Depression Remission or Response for Adolescents and Adults (DRR-E)
- Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)
- Adult Immunization Status (AIS-E)
- Prenatal Immunization Status (PRS-E)
- Prenatal Depression Screening and Follow-up (PRD-E)
- Postpartum Depression Screening and Follow-up (PDS-E)
- Social Need Screening and Intervention (SNS-E)
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)

For more information about ECDS, go here.

**HEDIS® — which stands for Healthcare Effectiveness Data and Information Set — is a registered trademark of the National Committee for Quality Assurance (NCQA)*

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# Population Health Management – Helping Members Achieve Better Health

**Population Health Management (PHM) involves identifying and helping individuals achieve the highest quality of life possible. Health is influenced by a variety of factors, ranging from behavioral and psychological to medical and genetic, as well as social, financial, and cultural issues.**

To improve the quadruple aim — better health care, better patient experience, lower health care costs, and higher clinician satisfaction — it is necessary to perform measurement, monitoring, analysis, and interpretation about the health status of populations and subpopulations, including the impact of social determinants on health.

## Improving Patient Health

PHM services are offered to Highmark Blue Cross Blue Shield and Highmark Blue Shield members as part of their health insurance plan.

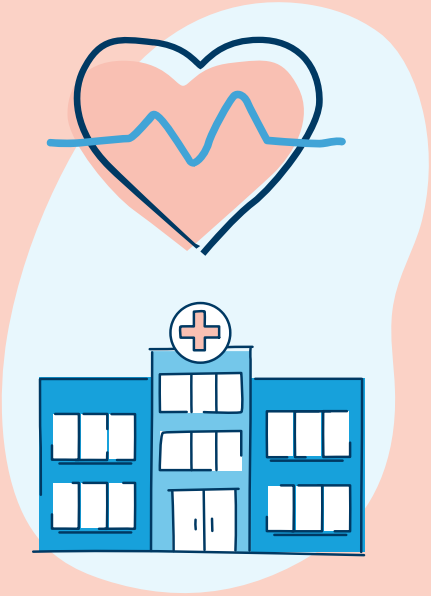
Through a series of clinically supervised interventions, PHM targets health care needs or conditions to help patients and caregivers:

- Optimize care
- Prevent future complications
- Maximize opportunities for wellness at all points along a member's personal health care journey.

## Who Can Benefit from PHM?

PHM programs use clinical, utilization and predictive modeling indicators to help identify members who could benefit from such services. Indicators include, but are not limited to, the following:

- High-risk diagnoses
- Complex disease processes (including HIV)
- Catastrophic medical events
- High-cost cases
- Quality of care
- Situational and discharge planning needs
- Psycho-social issues
- Financial issues
- Complex care coordination needs
- Multiple admissions and readmissions
- Multiple emergency department (ED) visits and lack of care coordination
- Medication adherence issues
- Health risk assessment screenings



These programs focus on whole person health — addressing medical, behavioral, emotional, and economic needs. Through outreach and education, patients receive help implementing care plans and goals, and have access to behavioral health and social services support through community partnerships.

If you feel a patient would benefit from Population Health Management, please call us at **800-950-0051**.

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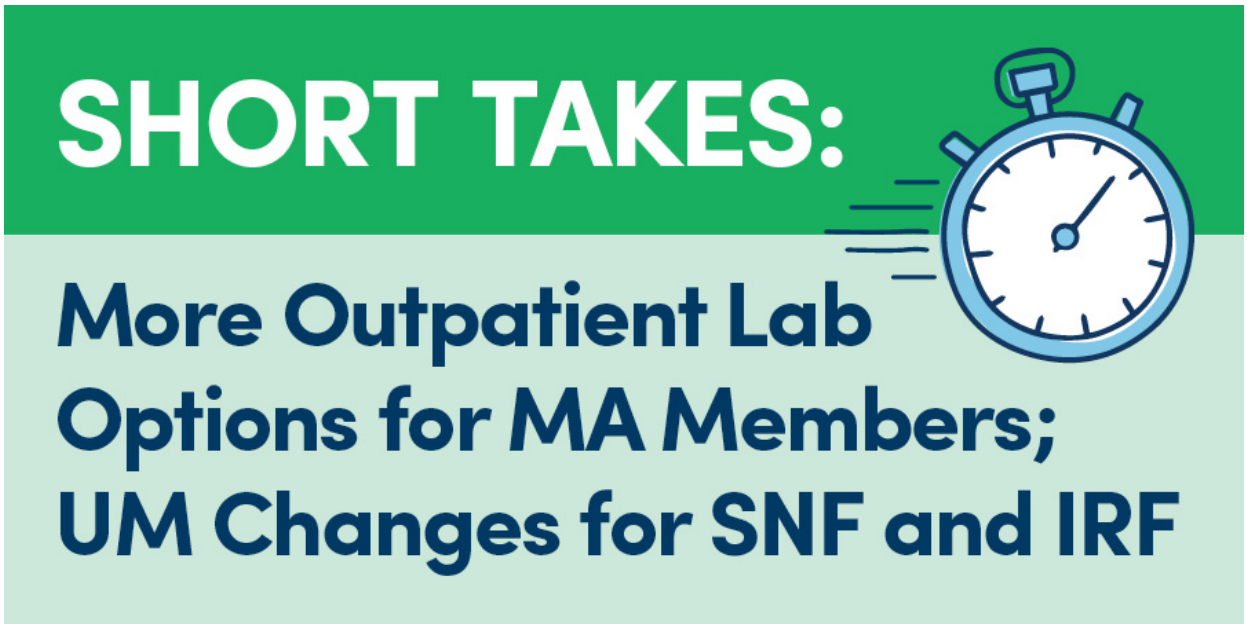


## Medicare Advantage: Quest No Longer Exclusive Lab for Outpatient Services

Quest Diagnostics is no longer the required outpatient laboratory for Medicare Advantage members in New York state. Highmark Blue Cross Blue Shield and Highmark Blue Shield members in both the Medicare Advantage HMO and PPO plans are now able to use any in-network labs for outpatient laboratory services. This change went into effect on **January 1, 2024**. For more information, click here.

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## UM for SNF, IRF, and Inpatient Hospice Being Integrated into Helion Arc

Effective **April 1, 2024**, Highmark Blue Cross Blue Shield is integrating Helion Arc into the utilization management (UM) process for the following services and lines of business:

| Services | Lines of Business |
|---|---|
| Skilled Nursing Facility (SNF) | Medicare Advantage and Commercial |

| | |
|---|---|
| Inpatient Rehabilitation Facility (IRF) | Medicare Advantage and Commercial |
| Inpatient Hospice | Commercial only |

This change will result in faster approvals for prior authorization requests, **submitted electronically**, for appropriate services. To learn more, go here.

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## April Coding Webinar: Alzheimer's/Dementia

"Alzheimer's/Dementia" will be the topic for the Coding and Quality Knowledge College webinar on **Wednesday April 10, 2024, at 12:15 p.m.**

Throughout the year, the college presents webinars aimed at providing education on the proper coding of medical diagnoses, along with the associated quality measurements that impact documentation.

Starting with the April webinar, the Coding and Quality Knowledge College will move from a quarterly to a monthly schedule. Here's the topic schedule for the rest of the year:

- **April 10** – Alzheimer's/Dementia
- **May 8** – Substance Use/Abuse/Dependence
- **June 12** – Diabetes with Complications
- **July 10** – Cancer
- **Aug. 14** – Respiratory Conditions
- **Sept. 11** – V28 Updates*
- **Oct. 9** – Depression
- **Nov. 13** – BMI, Morbid Obesity, and Malnutrition

2024

- **Dec. 11** – Cardiac Conditions

All webinars are held **12:15 – 12:45 p.m. EST** on the second Wednesday of the month.

## Continuing Medical Education (CME) Credits

Attendees are eligible to receive 0.5 CME credit. Preregistration is required and an Allegheny Health Network (AHN) CME account is needed to receive credit. You can learn more about the Coding and Quality Knowledge College on the Provider Resource Center (PRC):

- Select **EDUCATION/MANUALS** from the left menu
- Click **Coding Education/HCC University**

Once there, you can find instructions to create an AHN CME account, register for the next class, or view past coding webinars. To register for the April webinar on **Alzheimer's/Dementia**, go here.

**V28 will be the new Centers for Medicare and Medicaid Services (CMS) Payment Model. The current payment system is a combination of both the V24 (which was the previous model) and V28 models. The V28 model goes into full effect for dates of service starting Jan. 1, 2025.*

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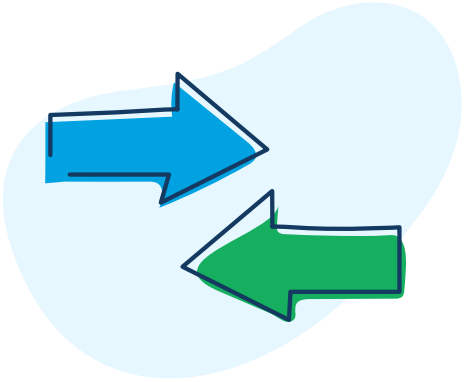
## New and Updated Reimbursement Policies



Highmark regularly issues new or updated reimbursement policies. Keep an eye on this newsletter and the Provider Resource Center (PRC) homepage for announcements regarding upcoming policy changes. As specific policy changes go into effect, the updated policies can be found on the Reimbursement Policy page of the PRC.

**Below is a list of recent and upcoming updates to reimbursement policies (RPs):**

### RECENTLY UPDATED

#### March 11, 2024

**RP-065** Modifier Reduction Glossary
New modifiers FX, FY, UN, UP, UQ, UR, US, and 56 were added, along with information on their purpose and associated policies.

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#### March 18, 2024

**MRP-005** Repairs, Maintenance, and Replacement of Durable Medical Equipment
Effective **March 18, 2024**, this policy was archived. The direction of this policy was merged into a new version of RP-069 (see below), which went into effect **March 18, 2024**.

**RP-035** Correct Coding Guidelines
The American Medical Association's (AMA) Current Procedural Terminology (CPT)

Assistant was added to the list of guidelines and resources in the "Reimbursement Guidelines" section of this policy.

**RP-069** DME Maintenance, Repair, and Replacement
This policy was updated to include Medicare Advantage direction merged from MRP-005 (see above).

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## UPCOMING

### April 1, 2024

**RP-006** Multiple Endoscopy Procedures
New York Commercial products are being applied to this policy direction effective **April 1, 2024**.

**RP-034** Prolonged Detention or Critical Care
Code 93598 will be added to the "Prolonged Detention or Critical Care" section of this policy.

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### April 29, 2024

**RP-041** Services Not Separately Reimbursed
Code 76140 will be added and will no longer be a separately reimbursed service.

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### May 1, 2024

**RP-006** Multiple Endoscopy Procedures
New York Medicare Advantage products are being applied to this policy direction effective **May 1, 2024**.

**RP-026** Portable Radiography and ECG Services – Modifiers UN, UP, UQ, UR, US
Direction for "U" modifier reductions reported with code R0075 will be made applicable for Commercial.

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### June 24, 2024

**NEW: RP-077** Intraoperative Neurophysiological Monitoring
Highmark has created RP-077 to provide direction on reimbursement for Intraoperative Neurophysiological Monitoring (IONM) services. *(NOTE: This policy will be available on the PRC on the effective date of June 24, 2024.)*

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# Authorization Updates

During the year, Highmark adjusts the **List of Procedures and Durable Medical Equipment (DME) Requiring Authorization**. For information regarding authorizations required for a member's specific benefit plan, providers may:

- Call the number on the back of the member's card,
- Check the member's eligibility and benefits via Availity®, or
- Search BlueExchange through the provider's local provider portal.

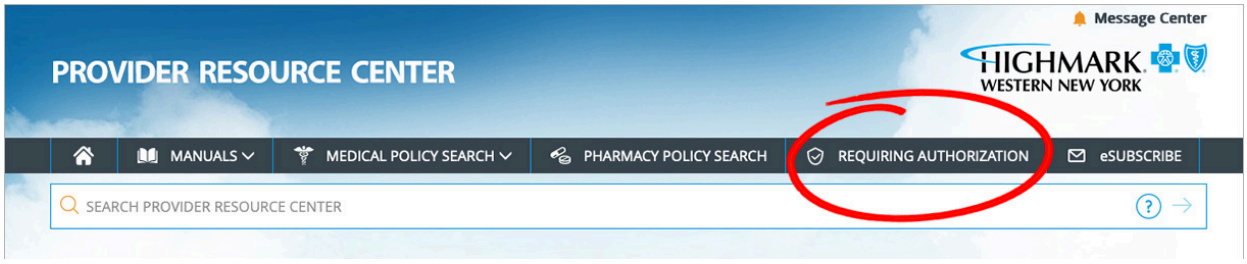
These changes are announced in the form of Special Bulletins and other communications posted on Highmark's Provider Resource Center (PRC). The most recent updates regarding prior authorization are below:

NEW DATE: PT, OT, Chiro, and Home Health: Prior Auth Changes Now Occurring on May 1, 2024

UM for SNF, IRF, and Inpatient Hospice Being Integrated into Helion Arc

CoverMyMeds Auth Requests: Always Include BIN, PCN, and RXGroup Information

To view the full List of Procedures/DME Requiring Authorization, click **REQUIRING AUTHORIZATION** in the gray bar near the top of the PRC homepage.




Once redirected to the **Procedures/Service Requiring Authorization** page, click **View the List of Procedures/DME Requiring Authorization** under **PRIOR AUTHORIZATION CODE LISTS**.

*Please note that the Highmark member must be eligible on the date of service and the service must be a covered benefit for Highmark to pay the claim.*

Availity® is the preferred method for:

- Checking member benefits and eligibility
- Verifying whether an authorization is needed
- Obtaining authorization for services

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# Important Highmark Reminders

## Appropriate Utilization Decision Making

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

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## Request for Criteria

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

If a primary care physician (PCP) or specialist requests a service that a clinician in Utilization Management is unable to approve based on criteria/guidelines, the clinician will refer the request to a Highmark Physician Reviewer. The reviewer may contact the PCP or specialist to discuss the request or to obtain additional clinical information.

A decision is made after all the clinical information has been reviewed.

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

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## Patient Notification of Approvals, Denials

All network providers are expected to notify their patients who are Highmark members of both approval and denial-of-coverage decisions as soon as possible upon their office receiving notification of the decision from Highmark or a delegated entity of Highmark.

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## Member Rights and Responsibilities

Our members have certain rights and responsibilities that are a vital part of membership with a managed care or PPO plan. These rights and responsibilities are included in the member handbooks and are reviewed annually in the member newsletter.

We also make them available online for our network providers to help you maintain awareness and support your relationship with your patients who are Highmark members.

To review members' rights and responsibilities, review Chapter 1, Unit 5 of the *Highmark Provider Manual*. A paper copy of the Member Rights and Responsibilities is available upon request.

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## Peer-to-Peer Conversations: Availability of Physicians, Behavioral Health Practitioners, and Pharmacist Reviewers*

Highmark provides you with an opportunity to discuss utilization review denial decisions with a clinical peer reviewer following notification of a denial determination. Clinical peer reviewers are licensed and board-certified physicians, licensed behavioral health care practitioners, and licensed pharmacists who are available to discuss review determinations during normal business hours.

Your call will be connected directly to the peer reviewer involved in the initial review determination if he or she is available. If the original peer reviewer isn't available when you call, another clinical peer will be made available to discuss the denial determination within one business day of your request. To request a peer-to-peer conversation, you may call the appropriate number listed in the chart below.

***IMPORTANT NOTE: The peer-to-peer review process is no longer available for Medicare Advantage members. See Chapter 5, Units 3 and 5 of the *Highmark Provider Manual* for details.**

| Practitioner/Ordering Provider | UM Issue | Telephone Number |
|---|---|---|
| **Practitioners** | Medical/Surgical UM Decisions | 866-634-6468 |
| **Behavioral Health Providers** | Behavioral Health | 866-634-6468 |

| | | |
|---|---|---|
| **Pharmacists** | Pharmacy Services | Telephone number identified on determination letter |
| **Practitioners** | Advanced Radiology Imaging | Telephone number identified on determination letter |
| **Practitioners** | Radiation Therapy | Telephone number identified on determination letter |
| **Practitioners** | Physical Medicine | Telephone number identified on determination letter |

## Provider Accessibility Expectations

To stay healthy, our members must be able to see their physicians when needed. Highmark has set forth specific time frame standards in which network providers should respond to member needs based on symptoms.

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

More specific information on Highmark's time frame requirements is available in Chapter 1, Unit 4 of the *Highmark Provider Manual*.

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HIGHMARK WESTERN NEW YORK

# PROVIDER NEWS

A newsletter for Highmark Blue Cross Blue Shield providers in western New York

Issue 3, March 2024

## Directory Information – Here's How to Attest

When Highmark members are looking for a primary care physician (PCP) or specialist, they expect that our online provider directory presents information that is accurate and current.

That's why it is essential to ensure that your practice information on file with Highmark remains up to date.

**Please be aware that providers who don't validate their data quarterly may be removed from the directory and their status within Highmark's networks may be impacted.**

### Reviewing Data Is Vital for You

The Centers for Medicare and Medicaid Services (CMS) requires Highmark to reach out to you every quarter and ask you to validate your provider directory information. We use this information to populate our online provider directory and to help ensure correct claims processing.

**Your thorough review of your directory information confirms:**

- **Each practitioner's name** is correct and matches the name on his/her medical license.
- **Each practitioner's National Provider Identifier (NPI) is correct.**
- **The practice name is correct** and matches the name used when you answer the phone.
- **All specialties are correctly liste**d and are currently being practiced.

- **Practitioners listed at a location** currently see members and schedule appointments at that office on a regular basis.
    - All practitioners listed must be affiliated with the group. Practitioners who cover, read test results, or are hospitalists should not be listed in the provider directory.
- **The practitioner is accepting new patients** — or not accepting new patients — at the location.
- **The practitioner's address**, suite number (if any), and phone number are correct.

## Professional Providers – Use the PDM Tool

Professional providers are now required to validate their Highmark Provider Directory information within the Provider Data Maintenance (PDM) tool every 90 days.

To access PDM, sign in to Availity®, choose the state you practice in, click **Payer Spaces** from the task bar, and then select the Highmark plan you participate in. Once you arrive at the **Payer Spaces** page, scroll down, and select **Provider Data Maintenance** under **Applications**.

## Facility, Ancillary, and Medicaid Providers – Use Atlas

The attestation process through Atlas is quick and easy. Just follow these steps...

1. **Go to hub.primeatlas.com.**
2. **Log in.**
3. **Review your information.**
4. **If no changes, confirm.**
5. **If there are changes, update your information.**

If you haven't attested your provider directory information this quarter, you will receive a letter from Atlas to review your provider information. Some providers may also receive emails from Highmark about validating their directory information through the Atlas website. To ensure delivery of emails from Highmark, please add the following email address, resourcecenter@highmark.com, to your address book.

During the attestation process, always double-check your current email address(es) to ensure that you can receive electronic communications from Highmark without delay.

If you need additional information regarding the attestation process, Atlas' step-by-step guide is available on the Provider Resource Center.

HIGHMARK WESTERN NEW YORK

# PROVIDER NEWS

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## About This Newsletter

*Provider News* is a valuable resource for health care providers who participate in our networks. Published monthly on the last Monday of the month*, *Provider News* conveys important product, policy, and administrative information, including billing, claims, and program updates.

The publication also features the latest news, information, tips, and reminders about our products and services, as well as relevant interviews, articles, and stories, for health care professionals who serve Highmark members.

Regular topics include:

- New and Updated Reimbursement Policies
- Authorization Updates
- Staying Up to Date with the *Highmark Provider Manual*

*When a holiday falls on the last Monday of the month, *Provider News* will be published on the preceding Friday.

### Another Valuable Resource

For medical policy and claims administration updates, including coding guidelines and procedure code revisions, please refer to the ***Medical Policy Update Newsletter***.

You can access both *Provider News* and the Medical Policy Update Newsletter on the Provider Resource Center from the **NEWSLETTERS/NOTICES** link on the sidebar. Email subscriptions are available via the **eSubscribe** button on the PRC taskbar.

### Comments/Suggestions Welcome

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 email the *Provider News* team at ResourceCenter@Highmark.com.

 

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# Legal Information



Highmark Blue Cross Blue Shield of Western New York (Highmark BCBSWNY) is a trade name of Highmark Western and Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield Association. Blue Shield and the Shield symbol are registered marks, and BlueCard and Blue Distinction are registered trademarks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield companies. BlueCard, Blue Distinction, Blue Distinction Center, and the Federal Employee Program are registered marks and Blues On Call is a service mark of the Blue Cross and Blue Shield Association.

Information on this website is issued by Highmark BCBSWNY, which serves the 8 counties in western New York.

NaviNet is a registered trademark of NaviNet, Inc., which is an independent company that provides a secure, web-based portal between providers and health care insurance companies.

Highmark BCBSWNY has adopted Highmark Inc. medical policies as its own policies applicable to Highmark BCBSWNY members who have moved to the "Highmark System" (i.e., *information systems of Highmark Health and/or its subsidiaries/affiliates*). Please note that for providers with Highmark BCBSWNY members who remain on the BCBSWNY Legacy System (i.e., have not yet moved to the Highmark System), certain BCBSWNY Legacy System medical protocols (found at bcbswny.com) shall apply and control until the earlier of such time as such member is no longer on the BCBSWNY Legacy System or Highmark BCBSWNY communicates otherwise to you.

Current Procedural Terminology (CPT) is a registered trademark of the American Medical Association. HEDIS and Quality Compass are registered trademarks of the National

Committee for Quality Assurance (NCQA). Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a registered trademark of the Agency for Healthcare Research and Quality. CORE is a registered trademark of CAQH. InterQual is a registered trademark of McKesson Health Solutions, LLC.

View the BCBSWNY Privacy Policy.

# QUICK REFERENCE

## HIGHMARK PROVIDER SERVICE CENTERS

Please use NaviNet® for all of your routine eligibility, benefit, and claim inquiries.
For non-routine inquiries that require analysis and/or research, contact Highmark's Provider Services.

What Is My Service Area?

### PENNSYLVANIA:

- Western Region: Professional Providers **1-800-547-3627**; Facilities **1-800-242-0514**
  **Hours of Availability:** 8 a.m. to 5 p.m. EST, Monday through Friday
- Central & Northeastern Regions: Professional Providers **1-866-731-8080**; Facilities **1-866-803-3708**
  **Hours of Availability:** 8 a.m. to 5 p.m. EST, Monday through Friday
- Eastern Region **1-800-975-7290**
  **Hours of Availability:** 9 a.m. to 12 noon, 1 p.m. to 4:30 p.m. EST, Monday through Friday.
- Medicare Advantage:
  - Freedom Blue PPO: **1-866-588-6967**
  - Community Blue Medicare HMO: **1-888-234-5374**
  - Community Blue Medicare PPO: **1-866-588-6967**
  - Security Blue HMO (Western Region only): **1-866-517-8585**
- Behavioral Health:
  - Western & Northeastern Regions: **1-800-258-9808**
  - Central & Eastern Regions: **1-800-628-0816**

### DELAWARE:

- Highmark Delaware Provider Services: **1-800-346-6262**
  **Hours of Availability:** 8:30 a.m. to 5 p.m. EST, Monday through Friday
- Behavioral Health: **1-800-421-4577**

### WEST VIRGINIA:

- Highmark West Virginia Medical: **1-800-543-7822**
- Highmark Senior Solutions Medicare Advantage Freedom Blue PPO: **1-888-459-4020**
  **Hours of Availability:** 8 a.m. to 8 p.m. EST, Monday through Sunday
- Behavioral Health: **1-800-344-5245**

### NEW YORK:

- Highmark Blue Cross Blue Shield of Western New York: **1-800-950-0051 or (716) 884-3461**
- Highmark Blue Shield of Northeastern New York: **1-800-444-4552 or (518) 220-5620**
  **Hours of Availability:** 8 a.m. to 8 p.m. EST, Monday through Sunday
- Behavioral Health: **1-844-946-6264**
  - Fax: Behavioral Health Outpatient: **1-822-581-1867;** Behavioral Health Inpatient **1-833-581-1866**

**Please listen carefully to the available options to reach the appropriate area for your inquiry.**

## HIGHMARK CLINICAL SERVICES

NaviNet® is the preferred for authorization requests. Contact Clinical Services for inquiries that cannot be handled via NaviNet.® **Hours of Availability:** Monday-Friday 8:30 a.m.-7 p.m.; Saturday & Sunday 8:30 a.m.-4:30 p.m. for urgent issues.

### PENNSYLVANIA:

- Western Region:
  - Medical Services: Professional Providers **1-800-547-3627**; Facilities **1-800-242-0514**
  - Behavioral Health: **1-800-258-9808**

- Central Region:
  - Medical Services: Professional Providers **1-866-731-8080**; Facilities **1-866-803-3708**
  - Behavioral Health: **1-800-628-0816**
- Northeastern Region: Medical Services **1-800-452-8507**; Behavioral Health **1-800-258-9808**
- Eastern Region: Call Independence Blue Cross at **1-800-862-3648**

**DELAWARE:**

- Medical Services **1-800-572-2872**; Behavioral Health **1-800-421-4577**

**WEST VIRGINIA:**

- Highmark West Virginia Products for Medical and Behavioral Health Services: **1-800-344-5245**
- Medicare Advantage Freedom Blue PPO: **1-800-269-6389**

**NEW YORK:**

- Medical Services: **1-844-946-6263**
  - Fax: Medical Outpatient **1-833-619-5745**; Medical Inpatient **1-833-581-1868**

**Please see the *Highmark Provider Manual's* Chapter 1.2 for additional contact information.**