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PROVIDER NEWS

A newsletter for Highmark Blue Cross Blue Shield of Western New York (Highmark BCBSWNY) network providers

Issue 5, May 2023

"Our providers are our customers. Orienting ourselves to try to understand the challenges that providers face — and to meet them where they are, to work with them to make the system function better as a whole — that is really critical to our success," said Kate Musler, Senior Vice President of Provider Network and Payment at Highmark Inc.

Musler transitioned into her new role in January after leading the underwriting team at Highmark since 2019. She has more than 20 years' experience in the health insurance industry — working primarily in actuary and underwriting. That unique perspective shapes how she approaches provider contracting and relationships.

"I have that [sort of] first-person understanding of how the costs impact our members and that helps me put in context the mission of why we need to be good stewards — balancing

the dollar spend on care with the value delivered," she said.

Highmark's value-based care (VBC) strategy emphasizes shared accountability for patient outcomes and expenses with our network providers. Aligning incentives to ensure everyone is working toward common care and cost goals is one of the drivers for Musler's collaborative approach.

"We want to collaborate with providers in a way that enables us to meet our fiduciary duties to our members and enables us to manage their care, but at the same time, doesn't make life hard without reason," Musler said. "We want to ensure we are only asking for and requiring what's needed, and that the way in which we obtain that information and the way in which we share information back is useful and efficient. We're certainly not there — but that's the path we're walking."

The acknowledgement that there are opportunities to drive meaningful change are evident from VBC programs to technology platforms. Highmark is currently working on enhancements to our self-service tools — like the provider portal and Provider Resource Center — and finding ways to make the exchange of information more readily available to our network providers using their preferred channels.

> Musler said, "When you think about the fact that it's 2023 and if I have a question for my cell phone provider, my preferred solution is:
>
> 1. Just log into my account,
> 2. Do an online customer service chat while watching a baseball game, or
> 3. Make a phone call.
>
> "The feedback we hear from providers," she continued, "is that they don't want to get on the phone and have a long, involved conversation. They want answers at their fingertips. That is where we are trying to move."

Better self-service tools will reduce administrative burden, improve office workflows, and simplify complex transactions — allowing providers to focus on delivering care to our members.

"For the provider organization, I think Living Health really means taking that mission of enabling the member-provider interaction and thinking through what that needs to mean for the provider experience everywhere we touch the providers," Musler said. "And we do not intend to operate as a one-way loudspeaker. We would like this to be a conversation. As providers have ideas, we are evaluating how we can potentially incorporate those into our future strategy."

This month, the federal government officially ended the Public Health Emergency (PHE). Musler said that for her, this is a time of reflection on the last three years and the changing

issues we've all faced.

"The healthcare system is in many ways coming out of that period a very different system. Our role is to help support a healthy community of providers, meaning a healthy system available to our members to access care that they need," she said. "We recognize that providers have been through a lot of disruption and have navigated many challenges. We're here to help as much as we can."


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Post-PHE Coverage

1. Will coverage for telehealth services continue now that the Public Health Emergency (PHE) has ended?

Yes, many telehealth flexibilities that expanded during the PHE will remain in place. In fact, for years prior to the PHE, Highmark has allowed the delivery of virtual visits by practitioners.

Highmark is committed to expanding access to quality care for our members and providing new options for more timely and convenient access to meet their needs.

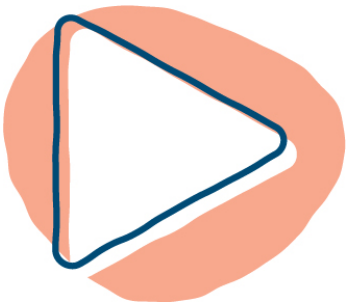
In our efforts to expand services and coverage to more members, we are providing telemedicine coverage options through:

- **Virtual Visits:** Services provided by Highmark in-network providers within the scope of their license, deemed appropriate using their medical judgment, and delivered within the definition of the code billed.
- **Telemedicine:** Services provided by Highmark-approved telemedicine vendors — American Well (Amwell)™ Teladoc™, and Doctor on Demand for New York through December 31, 2023. These approved vendors provide access to a national network of board-certified physicians with 24-hour, seven days-a-week availability.

Note: In-network providers do not need to utilize these vendor services to provide virtual services to Highmark members. These vendors are a separate option and benefit to certain members.

Reminder: Most Highmark members have coverage for telemedicine services; however, benefits can vary by product and group. Always verify benefits.

2. What telehealth (video) services will Highmark Commercial continue to cover now that the PHE has ended?



Virtual Primary Care Physician (PCP) Visits and Virtual Retail Clinic Visits provide our network participating PCPs with the option of delivering primary care services to our members via real-time interactive audio and video telecommunications, or "telemedicine," when appropriate.

Telemedicine enables primary care providers to extend their reach and improve their efficiency and effectiveness while still maintaining high quality care and attention to patient safety.

Virtual PCP Visits and Virtual Retail Clinic Visits are the remote delivery of outpatient primary care services through the use of secure real-time interactive audio and video telecommunications technology. Members can participate in a virtual visit with a PCP from the privacy of their own home, office, or other private setting.

Highmark participating PCPs who have the required telecommunications technology to support Virtual PCP Visits and Virtual Retail Clinic Visits may participate. The services performed must fall under the scope of the provider's license, and the sessions must be conducted following Highmark's service and security guidelines.

Virtual PCP Visits and Virtual Retail Clinic Visits can be conducted for initial, follow-up, or maintenance care; however, providers should give careful consideration in determining whether an in-person office visit for the initial visit would be beneficial in establishing a doctor-patient relationship.

The following guidelines must be adhered to when conducting Virtual PCP Visits and Virtual Retail Clinic Visits:

- **Pennsylvania Only:** Any telecommunications technology used must provide **both audio and video** streams that meet Highmark's technology and security guidelines.
- **Delaware (DE), New York (NY), and West Virginia (WV):** Telemedicine services can be delivered via a real time 2-way, **audio-only** conversation in, DE, NY, and WV, but in DE and NY, the patient must be unable to access the appropriate broadband service or other technology necessary to establish an audio and visual connection.
- All services provided must be medically necessary.

Coding

3. Will Highmark Commercial continue to cover telephone audio-only CPT codes 99441 – 99443?

Yes.

4. Should providers be using modifiers 95 / 93 and Place of Service (POS) codes 02 / 10 for telehealth and audio-only services?

Yes, for the appropriate modality. Here's a guide...

Video and Audio

- **Modifier 95** – Synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system.

Audio Only

- **Modifier 93** – Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system.

Telehealth Services – Outside the Member's Home

- **POS 02** – If services are delivered outside the patient's home in a manner other than face-to-face, claims should always be billed using the place of service POS 02, including telephonic only codes.

Telehealth Services – Inside the Member's Home

- **POS 10** – If services are delivered in the patient's home, use POS 10.

Anytime synchronous audio/video, audio only, or when asynchronous delivery methods are used (e.g., electronic portal) by a provider to deliver care, POS 02 or POS 10 should always be used to ensure correct pricing, eligibility, and benefits are applied.

Failure to follow policy requirements could lead to inappropriate cost share calculations, inappropriate claims pricing, or claim denial.

5. Will Highmark's Medicare Advantage plan(s) continue to follow all CMS telehealth and audio-only guidelines until end of 2024?

Yes, Highmark Medicare Advantage plans will continue to follow CMS guidelines for telemedicine visit coverage and reimbursement. Only the codes identified by CMS as appropriate for telemedicine services will be reimbursed by Highmark for Medicare Advantage members.

For more information on billing and reimbursement for commercial and Medicare Advantage products, please see Highmark Reimbursement Policy (RP)-046: Telemedicine and Telehealth Services.

Visual & Audio Requirements

6. Is a visual component required in the telehealth service?

The answer depends on the state where you practice.

Pennsylvania – Visual Needed

Yes, there must be a visual component. Any telecommunications technology used must provide **both audio AND video** streams that meet Highmark's technology and security guidelines.

West Virginia – Audio-Only

Telemedicine can be delivered via a real time 2-way, **audio-only** conversation in West Virginia.

Delaware and New York – Audio-Only with a Caveat

Audio-only is acceptable only **if a visual and audio connection can't be established** via the appropriate broadband service or other technology.

Use of Telehealth Vendors

7. Will we be required to use specific telemedicine vendors for connectivity versus the telehealth methods we use today?

In-network providers do not need to utilize Highmark-approved telemedicine vendors to provide virtual services to Highmark members. These vendors are a separate option and benefit to certain members. In-network practitioners can provide virtual services within the scope of their license, deemed appropriate using their medical judgment, and delivered within the definition of the code billed.

Reimbursement

8. Are any new telehealth services being added?

Yes. As of July 6, codes will be eligible in Delaware, Pennsylvania, and West Virginia. For more information, see the New and Updated Reimbursement Policies article in both the April and May issues of *Provider News*.

Specialist Visits

9. Is Highmark following Medicare guidelines that permit specialists to perform telehealth services when patients are at home as the originating site through December 31, 2024?

Yes, Highmark is following CMS guidelines. The specialist virtual visit is an outpatient telehealth service that is a real-time interactive audio and video transmission of a physician-patient encounter from one site to another using telecommunications technology.

The patient is located at an "originating site." An originating site can be a medical site (e.g., PCP's office, outpatient facility) or a non-medical site (e.g., **member's home** or office) and is connected to a specialist at a "distant site." The benefit provides coverage for the services of the specialist at the distant site and also for an access fee billed by the medical originating site where the patient is located, when applicable.

Inpatient Telehealth

10. Are inpatient telehealth services changing or not changing with the end of the Public Health Emergency (PHE)?

Anything that is a covered service and can be done virtually — including inpatient telehealth services — will remain on the coverage list. The documentation and coding must be accurate and appropriate.

HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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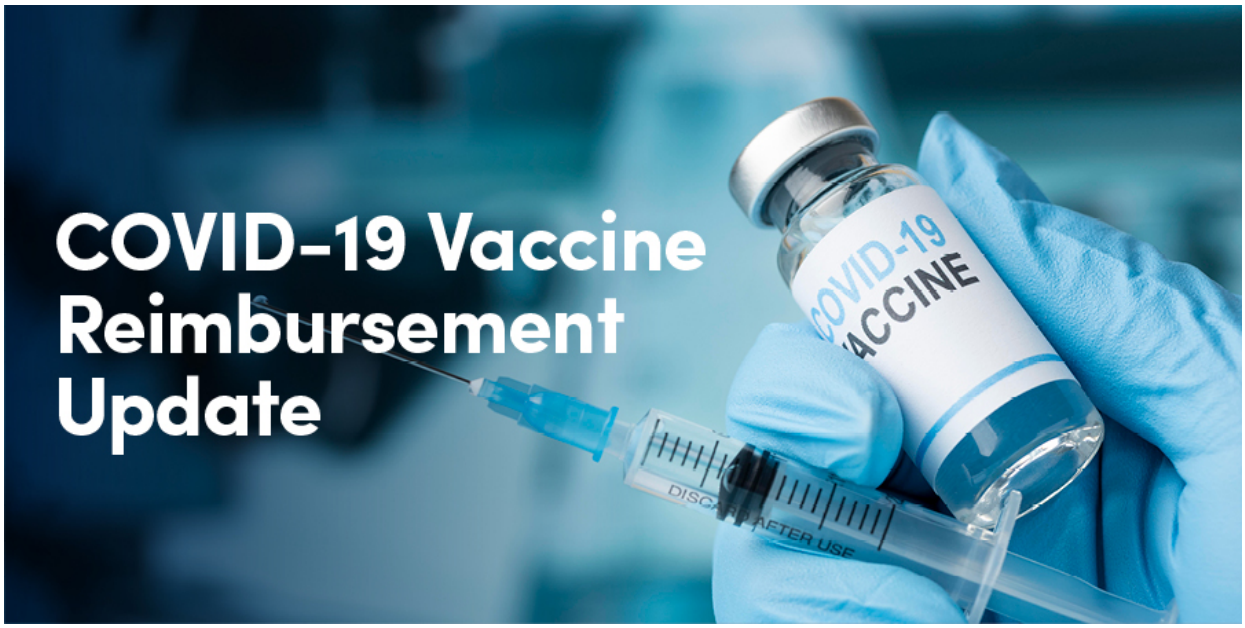
Issue 5, May 2023



Effective October 1, 2023, COVID-19 vaccine administration reimbursement will reflect current pricing rules and no longer follow the mandated $40 reimbursement fee.

Providers should continue to:

- Use the established procedure codes for administration of the COVID-19 vaccines
- Follow immunization schedule guidance — recommended by the Centers for Disease Control and Prevention (CDC) — for administration of the COVID-19 vaccines

The CDC will issue the Morbidity and Mortality Weekly Report for COVID-19 guidance along with influenza vaccine guidance in the fall of 2023.

Employer Groups

Employer Groups that did **NOT** have general out-of-network (OON) vaccine coverage prior to the Public Health Emergency (PHE) will no longer cover OON COVID-19 vaccines

effective **June 1, 2023**.

Groups that did have OON vaccine coverage prior to PHE will retain OON coverage for the COVID-19 vaccine after June 1, 2023.

Medicare Advantage (MA) – No Pricing Changes

MA plans will continue to follow Centers for Medicare and Medicaid Services (CMS) guidance for vaccine pricing through 2023, with no pricing changes anticipated until 2024.

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HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

A newsletter for Highmark Blue Cross Blue Shield of Western New York (Highmark BCBSWNY) network providers

Issue 5, May 2023

Chronic conditions present challenges, not only from a diagnosis and treatment perspective, but also from a documentation standpoint. Accurate disease burden capture of your patients' complete health status can increase the quality of care that they receive today and into the future.

To help you and your team fully and accurately document patients' chronic conditions, the Revenue Program Management (RPM) team has released a series of brief, informative videos — in collaboration with Dr. Frank Colangelo, an internist and primary care physician — on the following topics:

- Diabetes
- Congestive Heart Failure (CHF)
- Chronic Obstructive Pulmonary Disease (COPD)
- Major Depressive Disorder (MDD)
- Vascular Disease
- Dementia
- Chronic Kidney Disease (CKD)

- Senile Purpura
- Chronic Conditions – Commonly Missed Diagnoses

"These videos share tips on the importance of accurate and detailed documentation and how it supports patient care and appropriate government reimbursement," said Olga Ziegler, Vice President of RPM for Highmark.

"Although medical record documentation and coding are an integral part of health care," continued Ziegler, "the appropriate way to code is not typically taught in medical school."

Featuring Dr. Colangelo, the videos provide a list of "dos and don'ts" for achieving accurate disease burden capture.

For example, in the COPD video , Dr. Colangelo advises:

> *Don't equate and substitute COPD with "asthma," "bronchospasm," "wheezing," "shortness of breath." These conditions — although carrying various degrees of symptomatic similarities with COPD or emphysema — are not specific, and do not equate to COPD, emphysema, or chronic obstructive bronchitis.*

In the dementia video , Dr. Colangelo shares these recommendations:

> *Evaluate patients for early dementia with memory loss that affects day-to-day activities, disorientation to time or place, impaired judgment and abstract thinking, problems with language, changes in mood or behavior, difficulty performing familiar tasks, or cognitive impairment... Capture dementia with any behavioral issues such as anxiety, mood disturbance, wandering, anger, combativeness, restlessness, rocking, etc.*

The videos are posted on the Provider Resource Center (PRC), no login required to access. Select **EDUCATION/MANUALS** from the left menu and then click **Coding Education/HCC University**.

HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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Issue 5, May 2023

Effective September 1, 2023, Highmark will begin auditing outpatient Emergency Department facility claims to ensure the correct procedure codes are being billed.

Originally, audits were to begin on May 1, 2023. However, due to additional updates to Reimbursement Policy (RP)-037: Emergency Evaluation and Management Coding Guidelines, the effective date for the audits has been moved until September 1, 2023.

These audits are designed to determine the appropriate and fair level of facility reimbursement for emergency department services based on the Centers for Medicare and Medicaid Services (CMS) criteria for the appropriate procedure code. Highmark will review the diagnoses submitted, as well as the services performed to ascertain the appropriate level of care for the visit, on a scale of one (1) through five (5).

The auditing process may result in a different reimbursement than expected, with Highmark updating the procedure code listed on the claim to the correct procedure code.

On **May 1, 2023**, Highmark updated and republished RP-037 with a full description of these changes.

How to Determine If Your Claim Was Changed

If the audit determines your claim warrants the level of care at which the claim was billed, the claim will not be changed. If we determine the claim warrants a different level of care, Highmark will add a new line with the correct procedure code and reimburse you at the updated rate.

If Highmark lowers your level of care, you will be able to see the new procedure code on the Explanation of Benefits (EOB). The code you originally submitted on the claim and the code Highmark added to the claim will be stored in our systems for CMS audits. However, the EOB will only show the corrected procedure code.

To view **EOBs** via NaviNet®, select **AR Management** from the left menu and then click **EOB and Remittance** from the fly-out menu.

Appealing the Updated Rate

If you disagree with the level of care that Highmark determined through the audit, you can file an appeal with Highmark. To appeal, you will need to submit all related medical records to Highmark's Medical Review team as outlined in the *Highmark Provider Manual's* Chapter 5, Unit 5: Denials, Grievances & Appeals.

To locate the *Highmark Provider Manual*, hover over **MANUALS** in the quick access bar at the top of the Provider Resource Center and select **HIGHMARK PROVIDER MANUAL**.

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HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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Issue 5, May 2023

Facility Claims for Medical Injectables: Site of Care Issues

Highmark Blue Cross Blue Shield of Western New York (BCBSWNY) is seeing an uptick in denied claims — submitted by physicians — for medical injectables at facilities.

If the Site of Care on the authorization doesn't match the claim, Highmark will reject the claim.

Physician-Requested, Facility-Dispensed

Please ensure when completing the authorization form that a Site of Care **IS** lled out. This is most important when you are requesting an authorization for medical injectables which will be dispensed in a hospital/facility setting.

If the Site of Care is left blank on the claim, it will default to Physician Office. If that doesn't match the authorization, the claim will be denied.

For example, if the service is performed at a hospital/facility, but the authorization has Physician Office as the Site of Care, the claim will be denied.

Doublecheck the Site of Care on all claims to ensure it matches the authorization. If the Site of Care on the authorization has changed, providers should le an updated authorization request.

For the correct medical injectable authorization form, go here.

HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

A newsletter for Highmark Blue Cross Blue Shield of Western New York (Highmark BCBSWNY) network providers

Issue 5, May 2023

Case Management Referrals

You can submit automated referrals for Clinical Care and Wellness (CC&W) case management programs via NaviNet®. This feature will help connect Highmark members with chronic conditions and complex medical needs with the right clinical support.

To access this feature:

- Log into NaviNet and select the appropriate Health Plan.
- Under **Workflows for this Plan** on the left menu, click **Case Management Referral and Inquiry**. This will take you to the **Clinical Care & Wellness** page.
- Click the **Create New Referral** button under **Submit New Referral to CC&W**.
- Follow the steps to create and submit the referral.

The **2023 Reference Guide to Highmark Member Programs** — complete with useful information and helpful resources — is available on the Provider Resource Center (PRC) to further your understanding of the full range of programs and services available to all Highmark members.

To view the guide, go to the PRC, select **EDUCATION/MANUALS**, and then click **Reference Guide Of Highmark Member Programs**.

We encourage you to review this guide to help identify Highmark members who can benefit from the programs and services we offer. See the article in this month's *Provider News* for more information about the Reference Guide.

HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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Issue 5, May 2023

Reference Guide Of Highmark Member Programs

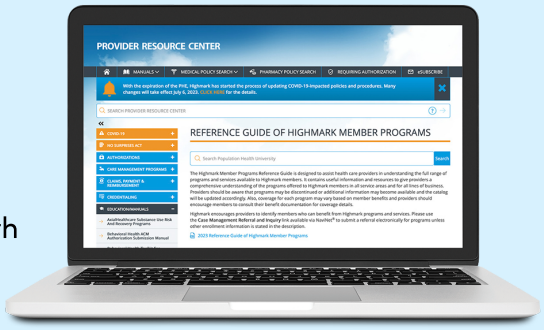
When our members visit your office or facility this year, they may have questions about the programs and services available to them through Highmark. These patients may be new to Highmark or they may be existing members who were previously unaware of current resources.

That is why we want to give you notice of Highmark Member programs and services available to commercial and Medicare Advantage members in 2023. To help you and your staff answer questions, we recently published an overview of these programs and services on the Highmark Provider Resource Center (PRC).

The 2023 Reference Guide of Highmark Member Programs includes the following sections:

- Clinical Care
- Disease Management
- Specialty Case Management
- Diabetes
- Wellness and Prevention

- Comprehensive Lifestyle
- SDOH (Social Determinants of Health)
- Home Support
- Behavioral Health
- Specialized Mental and Behavioral Health
- Substance Use Disorder



To access the guide, go to the PRC, select **EDUCATION/MANUALS**, and then click **Reference Guide Of Highmark Member Programs**.

Full Range of Programs and Services

The Reference Guide is designed to create awareness about the full range of programs and services available to Highmark members. It contains useful information and resources to give you and your team a comprehensive understanding of the programs offered to Highmark members in all service areas and for all lines of business.

Please be aware that programs may be discontinued or additional information may become available; if that occurs, the guide will be updated accordingly. Also, coverage for each program may vary based on member benefits and members should consult their individual plans for coverage details.

Highmark encourages providers to identify members who can benefit from Highmark programs and services. Please use the Case Management Referral and Inquiry link available via NaviNet® to submit a referral electronically for programs unless other enrollment information is stated in the description.

For more about Case Management Referrals, see the article in this month's *Provider News*.

HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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Issue 5, May 2023

For planned and unplanned transitions between care settings — for example, home to hospital, or hospital to skilled nursing care — the referring provider is expected to:

- Share the care plan with the receiving setting within one business day of notification of the transition
- Inform the member (or the member's responsible party) of the care transition process, and about changes to their health status and plan of care

Qualified Medicare Beneficiaries Program

Federal law bars Medicare providers from collecting Medicare Part A and Medicare Part B beneficiary deductibles, coinsurance, or copayments from those enrolled in the Qualified Medicare Beneficiaries (QMB) Program. QMB is a dual-eligible program that exempts individuals from Medicare cost-sharing liability (see Section 1902(n)(3)(B) of the Social Security Act, as modified by 4714 of the Balanced Budget Act of 1997). Balance billing prohibitions also may apply to other dual-eligible beneficiaries in Medicare Advantage

(MA) plans if the state Medicaid program holds these individuals harmless for Part A and Part B cost-sharing.

Non-Discrimination Policies

In addition, MA enrollees cannot be discriminated against in the delivery of health care services consistent with the benefits covered in their policy based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

Discrimination based on "source of payment" means, for example, that MA providers cannot refuse to serve enrollees because they receive assistance with Medicare cost-sharing from a state Medicaid program.

Dual Eligibility

Members who are eligible for both Medicare and Medicaid (dually eligible) may have certain services covered by the Medicaid programs. To find out which benefits are covered by the member's Medicaid benefit, please call Provider Service at **800-950-0051**.

HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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Issue 5, May 2023

Expanded Credentialing Section: More Electronic Options

Starting **June 1, 2023**, the Credentialing section on the Highmark Blue Cross Blue Shield of Western New York (BCBSWNY) Provider Resource Center (PRC) will be expanding, offering additional electronic resources to streamline the credentialing process for professional and organizational providers.

The expanded Credentialing section will enable medical providers to complete multiple credentialing forms and processes electronically from one web location, while eliminating the need to fax or email multiple forms. To learn more, go here.

New Provider Data Maintenance Tool for Validating and Updating Directory Information

Beginning **June 1, 2023**, professional providers will be able to validate their Highmark Provider Directory information within the new Provider Data Maintenance (PDM) tool in

NaviNet® in addition to the forms currently available, as required every 90 days.

The PDM tool will streamline the validation process by providing an easy-to-use electronic application to update, validate, and attest to the accuracy of your information in one application. PDM also indicates the last time your information was validated and the due date for the next validation deadline.

For more information, read the full story from last month's *Provider News*.

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HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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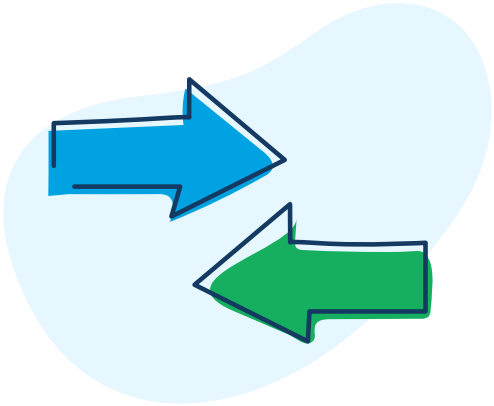
Issue 5, May 2023

New and Updated Reimbursement Policies



Highmark regularly issues new or updated reimbursement policies. Keep an eye on the Provider Resource Center (PRC) homepage for Special Bulletins announcing upcoming policy changes and the Reimbursement Policy page for specific policy updates.

Below is a list of recently updated and upcoming Reimbursement Policies (RPs):

RECENTLY UPDATED

May 1 (Effective September 1):

RP-037 Emergency Evaluation and Management Coding Guidelines
An updated version of this policy with more detailed direction on the analyzing of code levels is available for review on the PRC, but it will not be effective until **September 1, 2023**. *(For more information, click to read the Special Bulletin.)*

May 8

RP-024 Eye Procedures Done in Stages or Sessions
This policy was reviewed as part of our standard review process. No changes in direction were made.

May 15

RP-028 Insertion and Removal of Tympanic Ventilation Tubes
This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-029 Surgical Techniques, Procedures and Related Services
This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-031 Fractures and Dislocations
This policy was reviewed as part of our standard review process. No changes in direction were made.

UPCOMING

May 29

Updates to these RPs will become effective on **May 29, 2023**, but have been published to the PRC early due to the Memorial Day holiday.

RP-003 Convenience Kits, Drug and Biological Wastage
Direction for modifier JZ and skin substitute wastage has been added. The name of the policy was changed, having formerly been *Drug Wastage and Convenience Kits*.

RP-026 Portable Radiography and ECG Services
A "Related Highmark Policies" section was added.

RP-041 Services Not Separately Reimbursed
Codes 38204, 90889, 92605, 92606, 92618, 93740, and R0076 were added for Commercial products. These codes will be considered not separately reimbursed and rejected as non-billable to the member.

RP-048 Independent Diagnostic Testing Facility (IDTF)
This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-050 Inpatient Readmissions
This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-051 Multiple Procedure Payment Reduction for Therapy Services
This policy was reviewed as part of our standard review process. No changes

in direction were made.

RP-057 Evaluation & Management Services
The policy was updated to align with recent changes to Centers for Medicare and Medicaid Services (CMS) guidance for selecting the level of a reported Evaluation and Management (E/M) service and the eligibility for E/M reimbursement based on the fulfillment of the required criteria. As of January 1, 2023, all Evaluation and Management services are now selected and scored based on medical decision-making (MDM) or time.

RP-064 Government Supplied Vaccinations and Antibody Treatments
Direction was updated for the following codes that had the emergency use authorization rescinded: 0001A – 0004A, 0011A, 0012A, 0013A, 0051A, 0052A – 0054A, 0064A, 0071A – 0074A, 0081A – 0083A, 0091A – 0094A, 0111A – 0113A, 91300, 91301, 91305 – 91309, and 99311.

Codes 0121A, 0141A, 0142A, 0151A, 0171A, and 0172A were added.

REMINDER: RP-075 Appropriate Use Criteria for Advanced Diagnostic Imaging
This new policy — which was made available for review on the PRC on February 27, 2023 *(click to read the Special Bulletin)* — is now in effect. Highmark created RP-075 to provide direction to practitioners on how to successfully increase the rate of advanced diagnostic imaging services based on Appropriate Use Criteria. This policy follows CMS' current *suggested* direction. CMS has not indicated when, or if, this direction will become mandatory. Providers are encouraged to follow the direction in this policy, but it is not mandatory.

June 5

RP-042 Global Surgery and Subsequent Services
This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-043 Care Management
This policy was reviewed as part of our standard review process. No changes in direction were made.

June 12

RP-055 Nominal Charges
This policy was reviewed as part of our standard review process. No changes

in direction were made.

RP-056 Delivery Payment Equivalency
This policy was reviewed as part of our standard review process. No changes in direction were made.

July 10

RP-015 Professional and Technical Components for Applicable Services
The Public Health Emergency (PHE) exception note will be removed. Codes 99000 and 99001 will return to pre-PHE policy direction. *(The PHE ended on May 11, 2023.)*

RP-016 Physician Laboratory and Pathology Services
The PHE exception note will be removed. Codes 99000 and 99001 will return to pre-PHE policy direction. *(The PHE ended on May 11, 2023.)*

RP-027 Hemodialysis and Peritoneal Dialysis
Policy exception notes pertaining to the PHE — *which ended on May 11, 2023* — will be removed. A definitions section will be added.

RP-041 Services Not Separately Reimbursed
PHE exception notes and end-dated codes G2023, G2024, and U0005 will be removed. Codes 99000, 99001, 90887, 99024, 99374, 99377, 99378, 99379, 99380, and 99483 will return to pre-PHE direction. *(The PHE ended on May 11, 2023.)*

RP-054 Ambulance Services
The PHE exception note for destination requirements will be removed. *(The PHE ended on May 11, 2023.)*

August 31 (Effective September 1):

RP-019N Drugs and Biologicals
An updated version of this policy will be available for review on the PRC on August 31, 2023, and will be effective beginning **September 1, 2023**. Drug tiering is being eliminated for Delaware, Pennsylvania, and West Virginia. To access this reimbursement policy, log into NaviNet® and select Resource Center from the left menu. Once redirected to the PRC, select **CLAIMS, PAYMENT & REIMBURSEMENT** in the left menu and then click **Reimbursement Policy**.

HIGHMARK. WESTERN NEW YORK

PROVIDER NEWS

A newsletter for Highmark Blue Cross Blue Shield of Western New York (Highmark BCBSWNY) network providers

Issue 5, May 2023

Authorization Updates

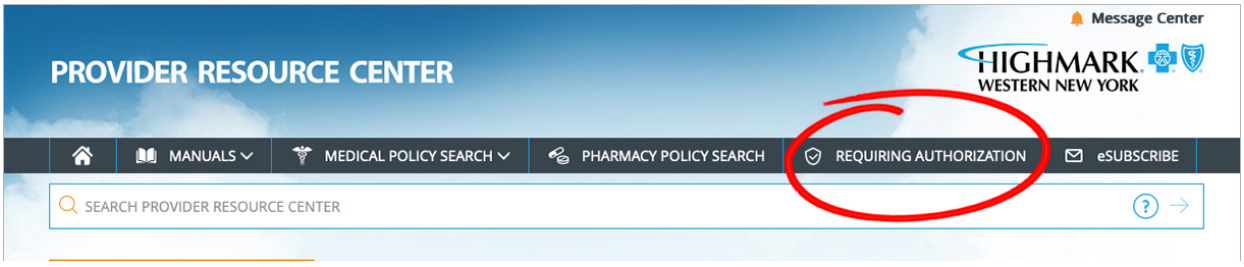
During the year, Highmark adjusts the **List of Procedures and Durable Medical Equipment (DME) Requiring Authorization**. For information regarding authorizations required for a member's specific benefit plan, providers may:

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

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

Upcoming Prior Authorization Changes

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.

NaviNet® is the preferred method for:

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

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Staying Up to Date With the *Highmark Provider Manual*

Ensure you are regularly reviewing the *Highmark Provider Manual* for our most recent guidance on:

- Participation Rules
- Credentialing/Recredentialing Criteria and Procedures
- Medical Record Criteria
- Requirements for 24/7 Coverage

Some recent noteworthy changes include:

- **New HTML Format** – We recently transitioned the contents of the entire *Highmark Provider Manual* from a PDF-based platform to a web-based one. The new format makes it easier to view and search the manual, including within individual chapters and units. Read the full article about the change in the April *Provider News*.
- **Chapter 2, Unit 6: The BlueCard** – The amount for itemizing high-dollar host claims was lowered from $250,000 to $100,000. In addition, the method for submitting those claims has changed to fax and email, rather than physical mail.
- **Chapter 3, Unit 2: Professional Provider Credentialing and Chapter 3, Unit 3: Professional Provider Guidelines** – Information related to credentialing for New York providers has been updated.

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Issue 5, May 2023

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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HIGHMARK WESTERN NEW YORK

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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.