HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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

Issue 8, August 2023

TOP BILLING ERRORS and How to Avoid Them

When the processing of claims is delayed, it's frustrating for everyone involved — providers, administrative personnel, and members.

The chief cause of claim delays is missing, incomplete, or incorrect information. When that happens, then the claim cannot be processed.

What Can You Do

It's important to double-check all appropriate fields before submitting a claim.

To help administrative personnel who submit claims, we've compiled a list of top errors and how to avoid them below.

Use this list as a "cheat sheet" when you do a final review before submitting a claim:

Reporting Error	Correction
Incorrect provider number listed	Generally, the billing provider number is the assignment account, while the performing provider number is the individual practitioner. If practices are unsure which National Provider Identifier (NPI) to use (assignment account/group or individual practitioner/group member), they should contact Highmark Provider Services using the Highmark provider portal.
Performing provider name and number	The performing provider name and provider identification number should be reported on the claim when it is different than the billing provider identification number.
Invalid place of service codes submitted and/or the facility name and number are not listed	Ensure the correct place of service code is being used. When the place of service is different than the billing provider's address (e.g., Hospital or Skilled Nursing Facility), ensure a service facility location and identification number are reported.
NOC (not otherwise classified) codes listed without descriptions	Descriptions of the service provided must be reported on the claim for NOC codes.
Applicable coordination of benefits/other insurance information and/or documentation are not accompanying the claim	Please make an effort to report electronically or attach coordination of benefits/other insurance information.
Member identification numbers are incomplete	List the complete member identification number, including any alpha prefix.
Claims are range-dated, but the number of services does not clearly correspond with the date range (e.g., indication that services were performed 01-01-23 through 01-10-23 but list only five services)	When services span over a period of days, the number of services should correspond on a one-on-one basis if you are range-dating (indicating that services span from one date through another date). If they do not correspond on a one-on-one basis, you should itemize the services.

Submit Healthcare Common Procedure Coding System (HCPCS) codes that are not valid for the time the service was rendered (e.g., billing for a service performed in 2022 with a code that was not in place until 2023 or vice versa)	Report correct procedure codes that are valid for the date of service.
Invalid diagnosis code	Report diagnosis codes that are the highest degree of specificity and valid for the date of service.

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HIGHMARK WESTERN NEW YORK

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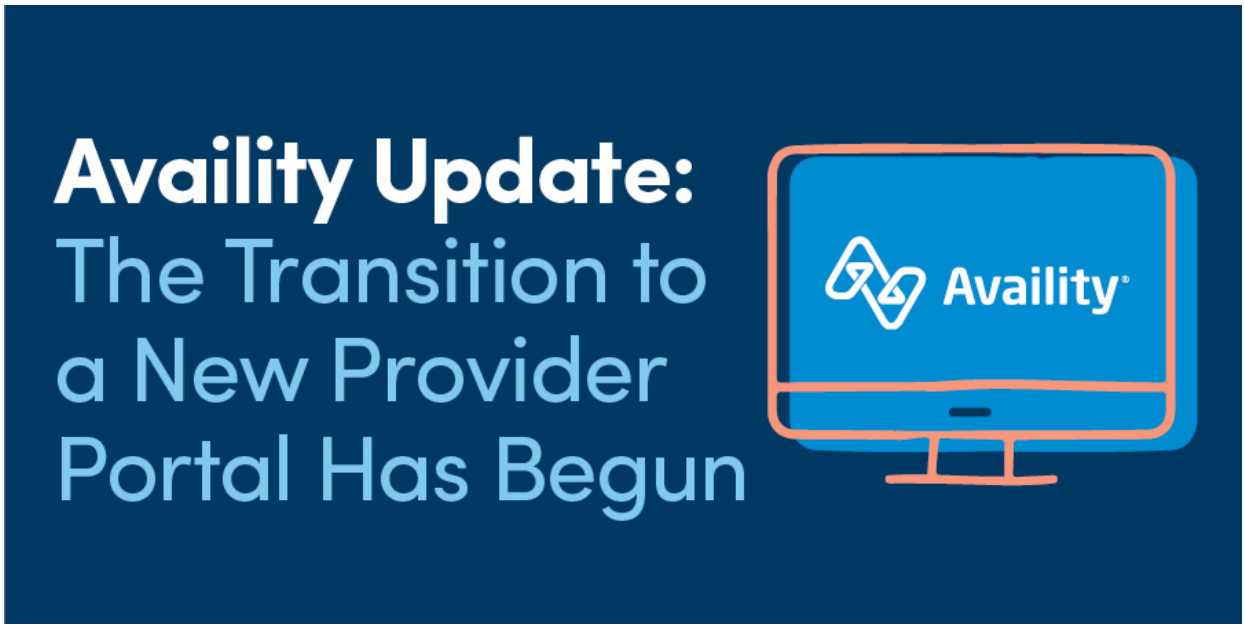

Availity

A group of pilot providers — from all four states served by Highmark — began using Availity® Essentials earlier this month to conduct Highmark-related transactions. A larger pilot group will start using Availity in September. The providers who agreed to participate in the pilot programs represent a diverse cross-section of physicians and organizations, from smaller private practices to large facilities and healthcare groups.

Highmark is using a phased rollout approach — with lots of testing — to ensure a seamless transition from its existing provider portal NaviNet® to Availity Essentials, with full implementation scheduled for **February 5, 2024**.

Next Phase

In October, providers who currently use Availity for other payers will see Highmark as an option in the states where they are contracted. In addition, providers newly contracted

with Highmark can use Availity.

Got Questions about the Transition?

Check out our Frequently Asked Questions (FAQs) page on the Provider Resource Center (PRC). Currently, there are over 20 questions and answers about the move to Availity, including several recently added FAQs. Throughout the transition, we will continue to update this FAQ page as new questions come in.

Training

Availity will offer both live and on-demand training to providers. Training dates and information will be posted on the PRC when available. You also can receive training updates when you sign up for our eSubscribe list.

Transition Timeline

The transition to Availity will occur in stages. Here's the scheduled timeline:

1. **August and September 2023:**

   Highmark engages a pilot group of providers to ensure a seamless transition.

2. **October 22, 2023:**

   Providers who currently use Availity for other payers will see Highmark as an option in the states where they are contracted.

3. **February 5, 2024:**

   Availity will be available for all Highmark providers.

4. **March 2024:**

   Providers will no longer have access to NaviNet or HEALTHeNET (NY).*

*More information on the retiring of existing portal will be distributed as it becomes available. If you don't already receive emails for our provider newsletters, join our eSubscribe list today.

*(**Note:** Highmark Wholecare and Highmark Health Options will not transition to Availity; providers should continue to use their current portals for transactions related to these plans.)*

Availity is an independent company that contracts with Highmark to offer provider portal services.

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

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HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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Issue 8, August 2023

Professional Providers: Annual Fee Schedule Update

Our annual fee schedule update for commercial and Medicare Advantage products will take effect on **October 1, 2023**. Updates include some incremental increases throughout the fee schedule to align with Highmark's fee schedules. **There are no decreases.**

Fee schedules are divided into two sections: "Primary Care" and "Other," so primary care providers (PCPs) and specialists, as well as other providers, can quickly find the fee schedules that apply to their practice.

Accessing Fee Schedules Via NaviNet

- Log on to NaviNet®, click **Health Plans** on the top menu, and select Highmark Blue Cross Blue Shield of Western New York under **My Plans**.
- Then, on the "Workflows for This Plan" left sidebar, click **Resource Center**, which will take you to the secure Provider Resource Center.
- Click **Claims, Payment & Reimbursement** on the left sidebar. Then **Fee Schedule Information** from the drop-down menu.

For additional information on using NaviNet, refer to our NaviNet Guide.

HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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

Issue 8, August 2023

When submitting professional and outpatient institutional claims electronically — with Medicare as the primary payer — providers need to include both claim level dollars and line level payment dollars. **Effective December 1, 2023**, electronic Medicare claims without line level dollar information will be rejected.

To ensure processing, these claim types must be submitted with line level Claim Adjustment Reason Code (CARC) dollars. Currently, Highmark is correcting Medicare claims with missing line level information; that practice will end on November 30, 2023.

Starting **December 1, 2023**, line level payment information must be included with the electronic Medicare claim. Submitted claims missing this information will be returned to the provider for correction and resubmission.

The line level information can be found on the Explanation of Benefits sent by Medicare when it pays a claim.

HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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

Issue 8, August 2023

PIM Forms Must Be Submitted Electronically

Effective October 1, 2023, providers must use electronic Provider Information Management (PIM) forms when updating their Highmark directory information. Paper versions of PIM forms will no longer be accepted after September 30, 2023.

Electronic PIM forms are accessible via the Provider Resource Center (PRC). From the left menu, select **FORMS** and then click **Provider Information Management Forms**. A wide variety of forms are available, including:

- **Provider Directory Update Form** – for updating a practitioner or group name, address, phone number, email, website address, and specialty.
- **Request for New Practice (Assignment Account)** – for creating a new practice account or updating existing participating practice tax ID.
- **Request to Add a New Practitioner to an Existing Participating Practice** – for updating practitioner's affiliation to an existing participating practice (Assignment Account).
- **Advanced Practice Provider (APP) Enumeration Form** – for enrolling Nurse Practitioners (NPs), Physician Assistants – Certified (PA-Cs), Certified Registered Nurse Anesthetists (CRNAs), and Registered Nurse First Assistant (RNFAs) with your participating practice.

- **Nurse Practitioner Agreement/Acknowledgement** – for participating NPs to change their supervising physician.
- **Supervision Data Form** – participating PA-Cs, CRNAs and RNFAs must use this form to change their supervising physician.
- **NPI Change Form** – for updating an existing individual participating provider or group National Provider Identifier (NPI).
- **Facility-Based Provider Affirmation Statement** – for adding a practitioner to an existing assignment account when the services provided to members services by the networks are delivered exclusively in a participating skilled nursing facility, participating ambulatory surgery center, inpatient hospital and/or freestanding inpatient or outpatient facility setting and for members only because they are directed to the facility setting.

HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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

Issue 8, August 2023

Medically Fragile Children

Medically fragile children are individuals under 21 years of age with a chronic debilitating condition or conditions. A recent law passed in New York State requires insurance policies to provide coverage for the diagnostic assessment and treatment for medically fragile children, including, at a minimum, "considerations and processes" related to:

- Medically necessary covered services; **and**
- Determinations specific to the needs of medically fragile children; **and**
- Stabilization and discharge plans.

On **September 1, 2023**, Highmark will publish **Medical Policy Z-106-001** and **Pharmacy Policy J-1294** on the caring for medically fragile children. In addition, the following authorization forms will be updated and include a section to indicate if the patient is under 21 and considered medically fragile:

- Outpatient and Durable Medical Equipment (DME) Services

- Elective Surgery
- Out-of-Plan Referral
- Medical Specialty Drug Authorization Request Form
- Transplants

The updated forms will be available on September 1, 2023, on the Provider Resource Center. To access, select **AUTHORIZATIONS** from the left menu and click **Authorization Forms**. For the Medical Specialty Drug Authorization Request Form, select **FORMS** from the left menu and click **Medical Injectable Drugs**.

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HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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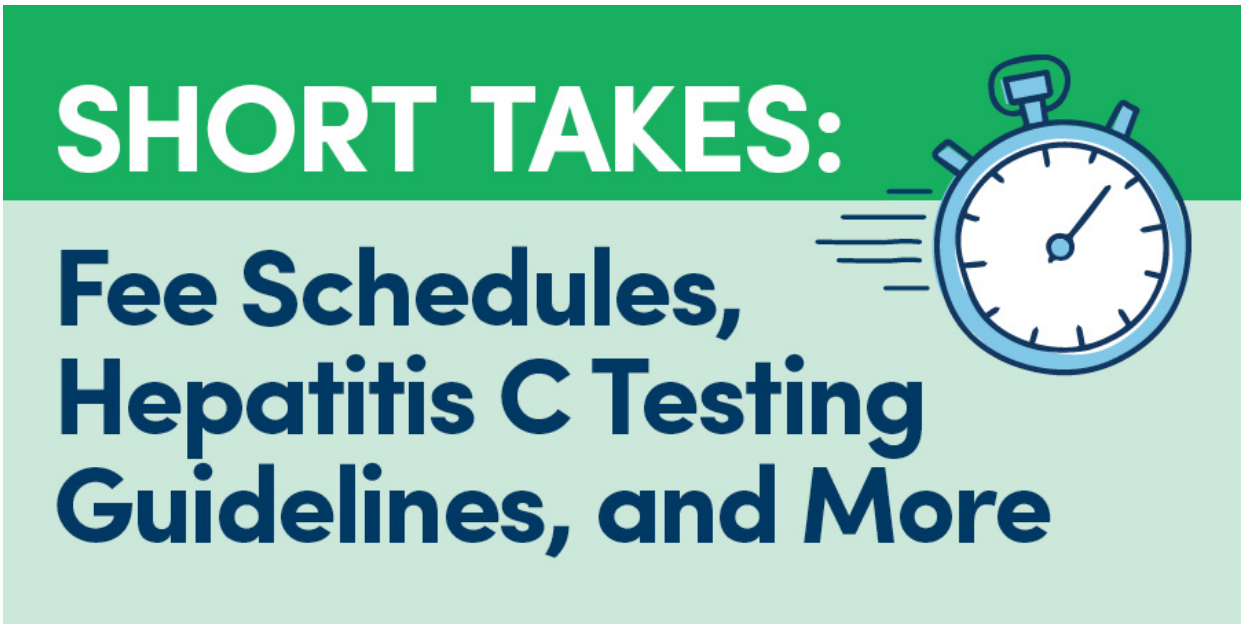

Quarterly Fee Schedules

The standard professional quarterly fee schedules were published on July 25, 2023. To view them on the Provider Resource Center (PRC), log into NaviNet® and select **Resource Center** from the left menu. Once you arrive at the PRC, choose **CLAIMS, PAYMENT & REIMBURSEMENT** from the left menu and click **Fee Schedule Information**.

Hepatitis C Testing – Single-Visit Approach

The Centers for Disease Control and Prevention (CDC) recently updated its guidelines for Hepatitis C Virus (HCV) testing, moving from a two-appointment to a single-visit approach. New guidance for completion of HCV testing supports operational strategies that collect samples at a single visit, and automatic HCV RNA testing on all HCV antibody

reactive samples. Use of strategies that require multiple visits to collect samples should be discontinued.

- Automatic HCV RNA testing on all HCV antibody reactive samples will increase the percentage of patients with current HCV infection who are linked to care and receive curative antiviral therapy.
- Hepatitis C tests are covered under preventive with the diagnosis code **Z11.59**. Encounter for screening for other viral diseases with procedure codes G0472, 86803, 86804, 87520, 87521, 87522, G0472.

Annual SPH Analytics Survey

Over the next several weeks, SPH Analytics (an independent research firm) will be conducting a phone survey with a sample of professional providers to assess knowledge of the tools available to you and your staff to verify the products/networks in which you participate through your Highmark contract. To learn more, click here.

Ultrasound After IUD Insertion

For a physician-approved ultrasound after IUD insertion, there is no cost share for members. The following information should be included on the claim:

- Line-item bill as follows: Post-IUD Placement Ultrasound When Necessary
  - Diagnosis Codes: Z30430, Z30431, or Z30433
  - With Procedure Codes: 76857 or 76830

Medical Policy Update Newsletter

The August newsletter is available here.

Submission of Claims Older than January 1, 2023

As Highmark Blue Cross Blue Shield of Western New York (BCBSWNY) completes its transition to Highmark systems, we will be retiring the use of our existing internal claim adjudication system. This will not affect how you submit claims to us.

Highmark BCBSWNY asks that providers submit all outstanding claims **and** claim adjustments with dates of service **prior to January 1, 2023, to us by October 1, 2023**. While most claims may be submitted within 365 days from the date of service, this will help us

process claims older than January 1, 2023, more quickly during this transition period. For more information, read the recent **Special Bulletin**.

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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 8, August 2023

September is National Childhood Obesity Awareness Month

Childhood obesity is a growing problem. Nearly 15 million children — that's one out of five kids! — are considered obese[1].

A childhood marked by obesity means today's youth are facing problems once seen only in adults, such as type 2 diabetes, high blood pressure, and heart disease[2].

The most recent findings[3] from the Centers for Disease Control and Prevention (CDC) document some troubling trends for children and adolescents aged 2–19 years:

- The prevalence of obesity was 19.7% and affected about **14.7 million** children and adolescents.
- Obesity prevalence was 12.7% among 2- to 5-year-olds, 20.7% among 6- to 11-year-olds, and 22.2% among 12- to 19-year-olds. Childhood obesity is also more common among certain populations.
    - Obesity prevalence was 26.2% among Hispanic children, 24.8% among non-Hispanic Black children, 16.6% among non-Hispanic White children, and 9.0% among non-Hispanic Asian children.
- Obesity-related conditions include high blood pressure, high cholesterol, type 2 diabetes, breathing problems such as asthma and sleep apnea, and joint problems.

What You Can Do

During National Childhood Obesity Awareness Month, you can take action by sharing available resources with parents... guides and tools that can get children on a path to healthy eating and active play[4]. The following government resources promote physical activity and healthier eating for children and adolescents:

- Physical Activity Guidelines for Americans
- CDC's interactive Move Your Way (available in Spanish)
- Screen Time vs. Lean Time
- MyPlate

In addition, Highmark has a variety of educational resources on combatting childhood obesity that can be downloaded from the Provider Resource Center (PRC):

- Childhood Obesity Preventive Health Benefit
- Preventive Health Reminder Poster

You can access those resources by going to the PRC, selecting **EDUCATION/MANUALS** from the left menu, and clicking **Educational Resources – Member And Provider**.

References

[1]Obesity is defined as a body mass index (BMI) at or above the 95th percentile of the CDC sex-specific BMI-for-age growth charts.

[2]Office of Disease Prevention and Health Promotion, https://health.gov/news/news-and-announcements/2018/09/toolkit-national-childhood-obesity-awareness-month.

[3]Read the CDC National Center for Health Statistics (NCHS) data brief.

[4]U.S. Department of Agriculture, https://wicworks.fns.usda.gov/resources/national-childhood-obesity-month.

Highmark does not recommend particular treatments or health care services. This information is not intended to be a substitute for professional medical advice, diagnosis, or treatment. You should determine the appropriate treatment and follow-up with your patient. Coverage of services is subject to the terms of each member's benefit plan. Additionally, state laws and regulations governing health insurance, health plans and coverage may apply and will vary from state to state.

HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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Issue 8, August 2023

Medical Record Retrievals

We do our best to minimize the disruption of medical record requests to your practice as we work to meet continued documentation requirements. Whenever possible, we streamline our outreach to help manage multiple requests.

Coordinating Medical Record Retrieval for Other Blue Plans

Highmark Blue Cross Blue Shield of Western New York will be requesting medical records from you on behalf of other Blue Cross Blue Shield and/or Blue Shield Plans when necessary. These requests are generally made for Medicare Advantage patients who are covered by out-of-area Blue Plans, but receive care in New York state.

You may also receive medical record requests from Inovalon. The company is authorized to retrieve medical records for out-of-area Blue Plan patients who are covered under Affordable Care Act (ACA) programs and Medicare.

Records are requested in support of Healthcare Effectiveness Data and Information Set (HEDIS®); risk adjustment; government-required programs, including the ACA; Health and

Human Services; or Centers for Medicare and Medicaid Services (CMS) star-measure reviews. We ask that you respond to all requests from us and Inovalon.

Medical Record Retrieval – A Year-Round Process

Timely and effective medical record retrieval is important to ensuring optimal quality reporting and complete and accurate risk scores. Blue Plans participate in medical record retrieval projects year-round. Earlier in the year, you may have received medical record requests regarding these programs:

- Commercial Risk Adjustment (CRA) (2022 Benefit Year)
- Medicare Advantage Risk Adjustment Data Validation (RADV)
- HEDIS

Currently, the following programs are (or will soon be) requesting medical records:

Program	Start Date	End Date
Medicare Advantage Risk Adjustment (MRA)	April 2023	December 2023
Commercial Risk Adjustment Data Validation Audit (HRADV)	June 2023	December 2023
Commercial Risk Adjustment (CRA) ***(2023 Benefit Year)***	October 2023	April 2024

Working with Inovalon

Our vendor, Inovalon, is contractually bound to follow HIPAA (Health Insurance Portability and Accountability Act) regulations and preserve all patient-protected health information (PHI). Medical records may be submitted to Inovalon in the following ways:

- **Fax:** 877-221-0604
- **FedEx:** For further instruction on returning records via FedEx, please call **800-463-3339**
- Secure email to EMRService@inovalon.com

If you have questions about delivery options, please call Inovalon at **844-682-9764**.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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Issue 8, August 2023

Imaging for Uncomplicated Low Back Pain

Each year, approximately 2.5 million Americans visit an outpatient clinical setting for low back pain (LBP). It is estimated that 75% of adults will experience low back pain at some time in their lives.

Evidence has shown that unnecessary or routine imaging (X-ray, MRI, CT scans) for low back pain is **NOT** associated with improved outcomes. This exposes patients to unnecessary harms, such as radiation and unneeded treatment. Most individuals who experience low back pain will improve within the first two weeks of onset. Avoiding imaging for patients when there is no indication of underlying conditions can prevent unnecessary harm and reduce health care costs.[1]

HEDIS Measure

Healthcare Effectiveness Data and Information Set (HEDIS®) quality measure ***Use of Imaging for Low Back Pain (LBP)*** evaluates adults ages 18–75 with a principal ICD-10

diagnosis of uncomplicated LBP* who **did not** receive imaging studies (plain X-ray, MRI, or CT scan) within 28 days of diagnosis.

The care settings include outpatient evaluations, telemedicine/telehealth, emergency department, observation level of care, physical therapy, and osteopathic/chiropractic manipulative treatment.

Noncompliance occurs **when an imaging study is performed** for uncomplicated LBP within 28 days of initial diagnosis.

Exclusions

The following conditions are **not** considered uncomplicated and would exclude the member from the LBP measure. Imaging within 28 days would be acceptable for the following conditions (this is not a complete list):

- Discitis, unspecified, lumbar region
- Discitis, unspecified, lumbosacral region
- Muscle spasm of back
- Contusion of lower back
- Unspecified superficial injury of lower back

Recognizing that each patient is unique, National Committee of Quality Assurance (NCQA) has identified exclusions for medical conditions that may require imaging within 28 days of initial diagnosis. If any of these conditions exist, include diagnosis on your submitted claim.[2]

- Cancer or members in hospice/palliative care
- Recent trauma/fractures (anytime during three months prior to diagnosis)
- IV drug abuse (12 months prior)
- Neurologic impairment (12 months prior)
- Human immunodeficiency virus (HIV)
- Spinal infection (12 months prior)
- Kidney/major organ transplant
- Prolonged use of corticosteroids (90 consecutive days of treatment within 12 months prior)
- Osteoporosis medication therapy
- History of lumbar surgeries
- Spondylopathy
- Recent history uncomplicated low back pain (six months prior)

(Note: This list is not all-inclusive. This information is not about a change in policy, but a reference to quality improvement activities).

How to Improve HEDIS Scores

- Avoid ordering diagnostic studies (x-rays, CT, or MRI Scans) within 28 days of diagnosis for a new onset of uncomplicated LBP in the absence of an excluded medical condition.
- Document in medical record all findings and use correct coding. Use exclusionary codes if applicable (as noted above) to justify if imaging is warranted.
- Provide patient education on conservative treatments. Recommendations include:
    - Use of non-steroidal anti-inflammatory drugs (NSAIDS) and, if appropriate, muscle relaxers.
    - Exercise to strengthen the core and low back.
    - Move and be active to limit muscle stiffening.
    - Place pillow while resting or sleeping between legs if sleeping on side or under knees when sleeping on back to reduce back discomfort.

Please refer to John Hopkins HealthCare LLC's "LBP – Use of Imaging Studies for Low Back Pain" for additional information: Use of Imaging Studies for Low Back Pain (hopkinsmedicine.org).

References

Highmark does not recommend particular treatments or health care services. This information is not intended to be a substitute for professional medical advice, diagnosis, or treatment. You should determine the appropriate treatment and follow-up with your patient. Coverage of services is subject to the terms of each member's benefit plan. Additionally, state laws and regulations governing health insurance, health plans and coverage may apply and will vary from state to state.

[1]NCQA HEDIS Measures and Technical Resources: https://www.ncqa.org/hedis/measures/use-of-imaging-studies-for-low-back-pain.

[2]Information taken from HEDIS MY 2023 Volume 2: Technical Specifications.

[*](ICD-10 Uncomplicated Low Back Pain Codes: M47.26-M47.898; M48.061-M48.08; M51.16-M51.87; M53.2X6-M53.88; M54.16-M54.9; M99.03-M99.84; S33.100A-S33.9XXA; S39.002A-S39.92XS)

HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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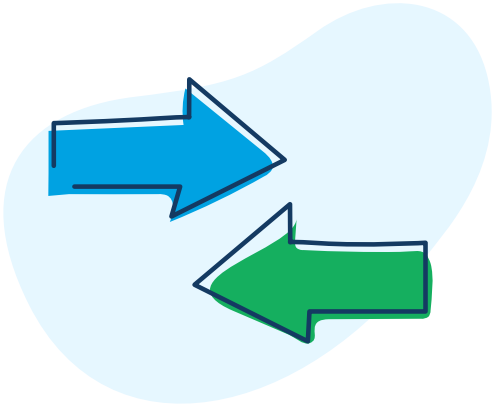
Issue 8, August 2023

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 recently updated and upcoming Reimbursement Policies (RPs):

RECENTLY UPDATED

August 7

RP-032 Pain Management
This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-034 Prolonged Detention or Critical Care
This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-041 Services Not Separately Reimbursed
This policy was made applicable to facility (UB) claims.

August 14

RP-035 Correct Coding Guidelines
This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-052 Surgical Team
This policy was reviewed as part of our standard review process. No changes in direction were made.

UPCOMING

RP-010 Update

RP-010 Incident To Billing Services and Advanced Practice Provider Reductions

For West Virginia: West Virginia was inadvertently checked as an applicable Commercial market in the current version of RP-010. This will be corrected in the updated policy. Highmark will continue to reimburse for these services for Medicare Advantage products, as well as for Mid-Level Practitioners and Advanced Practice Providers who have been enumerated and bill using their own provider ID.*

For Pennsylvania: Incident To services for Commercial products will no longer be recognized, effective **January 1, 2024**. Highmark will continue to reimburse for these services for Medicare Advantage products, as well as for Mid-Level Practitioners and Advanced Practice Providers.*

For Delaware: Only non-Primary Care Physician (PCP) Incident To services will no longer be applicable to the policy, effective **January 1, 2024**. PCP Incident To services will still be covered. Highmark will also continue to reimburse for these services for Medicare Advantage products, as well as for Mid-Level Practitioners and Advanced Practice Providers.*

For New York: New York was inadvertently checked as an applicable Commercial market in the current version of RP-010. This will be corrected in the updated policy. Highmark will continue to reimburse for these services for Medicare Advantage products, as well as for Mid-Level Practitioners and Advanced Practice Providers who have been enumerated and bill using their own provider ID.*

**Direction for continued reimbursement for Mid-Level Practitioners and Advanced Practice Providers will be published in a new policy, RP-068 (see*

***NEW:* RP-068** *further down in this article), effective on September 25, 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**.

September 25

NEW: RP-068 Mid-Level Practitioners and Advanced Practice Providers
Highmark has created RP-068 to provide direction on reimbursement for Mid-Level Practitioners and Advanced Practice Providers. *(NOTE: This policy will be available on the PRC on September 25, 2023.)*

October 30

RP-026 Portable Radiography and ECG Services – Modifiers UN, UP, UQ, UR, US
This policy will be made applicable to Medicare Advantage. Additional direction will be added for modifiers UN, UP, UQ, UR, and US when submitted with code R0075 (a transportation service code). These modifiers are also required to be included on all related claims, and the Commercial section will be updated with direction to reflect this requirement.

HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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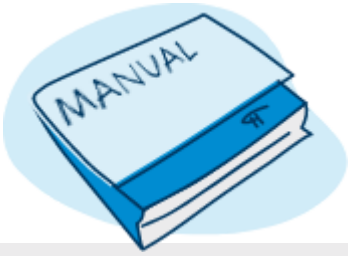
Issue 8, August 2023

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



Recent noteworthy changes occurred in the following sections:

- **Chapter 2, Unit 6:** The BlueCard Program > 2.6 NAIC Codes > PENNSYLVANIA
- **Chapter 3, Unit 2:** Professional Provider Credentialing > 3.2 Highmark Network Credentialing Policy > 24/7 AVAILABILITY REQUIREMENTS
- **Chapter 3, Unit 2:** Professional Provider Credentialing > 3.2 Credentialing Requirements For Facility-Based Providers > FACILITY-BASED PRACTITIONER CREDENTIALING POLICY
- **Chapter 3, Unit 4:** Organizational Provider Participation (Facility/Ancillary) > 3.4 Urgent Care Centers/Medical Aid Units > Billing Guidelines
- **Chapter 6, Unit 2:** Electronic Claim Submission > 6.2 NAIC Codes > PENNSYLVANIA

For detailed descriptions of these recent changes, visit the Highmark Provider Manual Changes page.

HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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

Issue 8, August 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

PROVIDER NEWS

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

Issue 8, August 2023

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.

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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

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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.