HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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

Issue 8, August 2024

Effective Oct. 1, 2024, Highmark will transition to an exclusively digital prior authorization process. To streamline member care and expedite approvals — while also reducing unnecessary expenditures — all prior authorization requests must be submitted through the Availity® provider portal.

Highmark had previously announced that faxes would be going away this year in *April Provider News*.

This change to electronic submissions offers significant benefits:

- **Faster Processing:** Availity portal submissions are processed up to 75% faster than traditional methods, with some approvals available instantly.
- **Enhanced Efficiency:** Eliminating faxed requests simplifies the process for both providers and Highmark.

- **Increased Cost Savings.** Faxes are more labor-intensive and expensive to process compared to submissions via the provider portal.

Today's Technology

"Electronic submissions for prior authorization requests are the industry standard," said Dr. Timothy Law, Chief Medical Officer and Vice President of Integrated Care Delivery for Highmark. "We are trying to be a conduit to appropriate care rather than a roadblock, and electronic submissions allow us to do that for our providers and our members."

Some Requests Immediately Approved

Submitting authorization requests via the Availity portal not only expedites processing but also results in some procedures receiving immediate approvals, including the following:

- **30520** – Septoplasty or Submucous Resection, with or without cartilage scoring contouring or replacement with graft.
- **31255** – Nasal/Sinus Endoscopy, surgical; with ethmoidectomy, total (anterior and posterior).
- **43775** – Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (i.e., sleeve gastrectomy).
- **42831** – Adenoidectomy, primary; age 12 or over.
- **95811** – Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation.

Note: The use of proper diagnosis codes is required.

Resources

On the Provider Resource Center, there are guides and videos that will walk you through the process of submitting electronic authorization requests via Availity:

- **Guides**
  - Inpatient Authorization Submission (Both Urgent and Non-Urgent)
  - Outpatient Authorization Submission
- **Videos**
  - Electronic Authorization Submission Process (Predictal via Availity)
  - Case Management Referral Process (Predictal via Availity)

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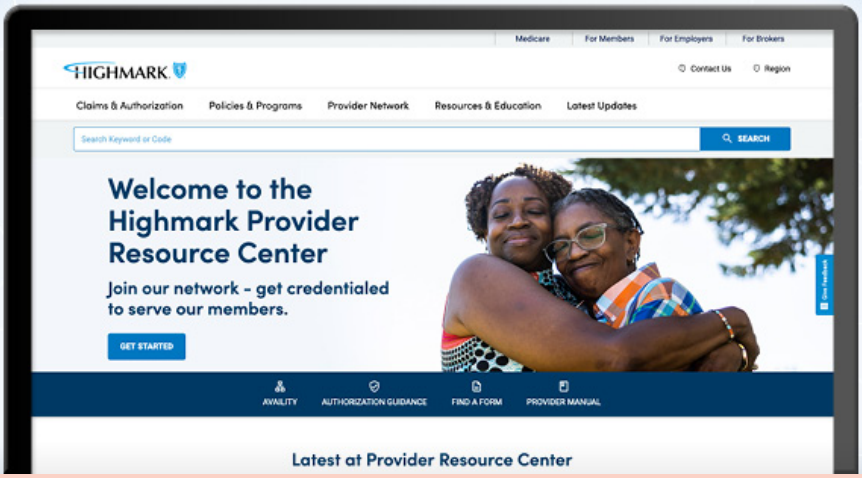
A NEW CENTRALIZED PRC
for All Six Highmark Regions to Launch **This Fall**



Simpler. Streamlined. Better. That's what providers can expect when the new Highmark Provider Resource Center (PRC) debuts this fall, with a targeted launch date of **Oct. 1.**

We launched a beta version of the new PRC for our Central and Southeastern Pennsylvania region back in December 2023 and have been soliciting feedback from you as we work to expand the site to the other Highmark regions.

Simpler

Instead of six regional sites, there is a single, centralized PRC for all Highmark's network across our footprint of Delaware, New York, Pennsylvania, and West Virginia.

Streamlined

The new PRC includes an easier-to-navigate design, information highlighting common reasons for visiting, and an enhanced site search tool. These features enable providers to get the information they need with fewer clicks.

Better

"The redesigned Provider Resource Center will make it easier for providers and their teams to quickly find the information they need, so they can spend less time on administrative work and more time focusing on their patients," said Ashley Blankette, Vice President of Digital Product Management for Highmark.

The current version of the new PRC is just the starting point. Over the next 12–24 months, providers can expect to see further enhancements and upgrades, including:

- **Customized content**
- **Quality visuals**
- **Improved search**
- **Priority messaging**
- **Seamless integration with other Highmark applications**

The new PRC is a critical part of Highmark's ongoing commitment to offer providers robust digital tools that reduce administrative burden, improve office workflows, and simplify complex transactions.

As part of this initiative, Highmark invested in launching Availity Essentials® last year as its new provider portal for many of its payor-provider transactions.

"The new PRC and the Availity portal are two key investments that are helping to transform the provider experience," said Blankette. "Our goal is to create a seamless, supportive, end-to-end

journey when you work with our health plan."

Your Feedback is Requested

As we move closer to the fall launch date, we encourage you to visit the new site at: https://providers.highmark.com and give us your feedback.

Tell us what you like about the new PRC, what works for you, and how can we make improvements by clicking on the **Give Feedback** icon on the right side of the screen.

All the regional PRCs will remain available until the new site officially launches. The URLs for the regional PRCs will be redirected to the new PRC once the site goes live.

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Reimbursement Update:

Daily Maximum to Increase for Most Therapy Services

Effective Nov. 1 2024, Highmark is increasing the Daily Dollar Maximum (DDM) for most therapy services in the Western New York and Northeastern New York regions.

For physical therapy (PT) and occupational therapy (OT) services, the DDM rate is increasing for both Commercial and Medicare Advantage lines of business. For Chiropractic Services, the DDM is increasing for Commercial and remaining the same for Medicare Advantage. See the rates below:

Therapy Services	Current Rate	New Rate
Commercial PT / OT	$48.21	$81.61
Medicare Advantage PT / OT	$45.68	$80.34
Commercial Chiropractic	$40.60	$82.83
Medicare Advantage Chiropractic	$40.60	$40.60

What This Means to You

While the fee schedule will be applied on all services, claims will only pay up to (and not exceed) the Daily Dollar Maximum for the rendering provider specialty. An initial therapy evaluation service (97161, 97162, 97163, 97165, 97166, 97167) is separately payable. Re-evaluation codes (97164, 97168) are applied to the DDM and are not separately payable. For additional information on policy guidelines, please refer to Reimbursement Policy (RP)-067 Specific Service Daily Maximum.

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Collection and Submission of Member Cost Share to Change

To align with New York (NY) State Department of Health's recommendations and to reduce unnecessary health care expenditures, Highmark is making changes to its Health Care Reform Act (HCRA) processes, **effective Nov. 15, 2024**. Highmark notified facility providers on Aug. 12 of this upcoming change via an email that linked to this Special Bulletin.

Currently, Highmark pays the member cost share of the HCRA surcharge to NY State except for Coinsurance. In the case of Coinsurance, our providers currently calculate the HCRA tax on the total Coinsurance, bill the member for the HCRA tax, and then pay that tax to NY State. In addition to Coinsurance, the members' responsibility for the HCRA tax also applies to the Copay and Deductible.

The change that Highmark will be making is to have the provider collect and remit the member's responsibility of the HCRA tax for not only Coinsurance, *but also Copay and Deductible*. To support this change, we will be enhancing our 835 Electronic Remittance Advice file to provide all the necessary details that are needed to remit the HCRA tax to NY

State. This will include what Highmark needs to remit directly to NY State and what the provider will need to remit to NY State based on all member cost share (Copay, Deductible, and Coinsurance).

Effective Nov. 15, 2024, the new enhanced 835 will go into effect and will contain all information that is needed for the provider to correctly remit the HCRA tax to NY State. Providers will no longer need to perform manual calculations on a member Coinsurance, as it will now be contained in the 835.

Highmark is not asking providers to pay any additional monies; however, providers will need to make changes to their administrative processes to collect and submit the entire member portion of HCRA tax to NY State.

Additional Information

For additional information on the upcoming change, including a chart that illustrates four scenarios regarding member responsibility, please read our **Aug. 12 Special Bulletin** which is available on the Provider Resource Center.

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The Federal Drug Administration (FDA) has recently approved a blood test screening tool for colon cancer called "Shield" by Guardant Health. However, this new product has **NOT** been approved by the United States Preventive Services Task Force (USPSTF) and is **NOT** currently included on the Highmark Preventive Schedule. Our 2024 Preventive Health Guidelines and Immunization Schedules can be viewed here.

If Shield is ordered by a Highmark provider, **members will be liable for cost share**. The test costs approximately **$895**.

Also, this tool is **NOT** eligible to be used to close Healthcare Effectiveness Data and Information Set (HEDIS®) gaps.

Currently, there are only five procedures/tests that meet the HEDIS measure for Colorectal Cancer Screening:

- Colonoscopy
- CT Colonography

- Fecal Immunochemical Test (FIT) DNA Lab Test (Cologuard)
- Flexible Sigmoidoscopy
- FOBT Lab Test

The U.S. Multi-Society Task Force has classified both the colonoscopy and annual FIT (Cologuard) as tier-1 screening recommendations.

Resources for Patients/Members

On the Provider Resource Center (PRC), practitioners can download the following free educational resources regarding colorectal cancer prevention to share with patients and staff:

- Colorectal Cancer Screening Brochure
- Colorectal Cancer Screening Flyer (Spanish version available)
- Colorectal Cancer Screening Reminder Card

To order copies for your practice, go to the **PRC > EDUCATION/MANUALS > Inventory Request Form > Select Printable Item**. Click the down arrow and then select the items you wish to order. Complete the form and click the **ADD TO ORDER** button.

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.

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

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Providers can now quickly and easily access their monthly Commercial and Medicare Advantage Stars (MA Stars) reports and data through our **Provider Facing Analytics (PFA) Platform** via the Availity® portal.

The first set of monthly reports is available using Static Reports application on the PFA Platform. In addition, the site also hosts the Value Insight Center.

Value Insight Center – Stars Information

The Value Insight Center provides MA Stars quality measure and scoring information, including detailed patient information. Click on the **Stars** tab to access the following:

- **Stars Summary** – compliance and non-compliance percentages for focused measures, triple-weighted measures, and the Medicare Advantage Wellness Visits compliance rate.

- **Stars Measure Analysis** – information by measure, such as Weight, Class, Measure Type, Eligible Population, and more.

The **Data Refresh** tool allows you to get latest attribution, claims, and quality data. This information is more current than what is available on static reports.

Need Access?

Log into Availity. Go to the **Value-Based Reimbursement Programs Resources & Information** page on the Provider Resource Center (PRC). From the left menu of the PRC, click **VALUE-BASED REIMBURSEMENT PROGRAMS > Resources & Information**. Once on the page, select **Provider-Facing Analytics (PFA) Reports Access Instructions** or **Value Insight Center Access Instructions**.

If you need additional assistance or have specific questions regarding the tool, call Provider Service.

Check the PFA Platform regularly for the latest static reports, which will be posted monthly. When new capabilities are added to the platform, they will be featured in *Provider News* and posted on the **Value-Based Reimbursement Programs Resources & Information** page.

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SHORT TAKES:

Tips for Corrected Claims, Annual Fee Schedule, and More

Tips for Submitting Corrected Claims

It is important to file a corrected claim accurately to ensure that Highmark can identify the original claim, understand the correction that is required, and ensure that the corrected claim is not denied as a duplicate.

To reduce errors and possible rejection of your claim resubmission, please follow the guidelines listed in this Special Bulletin.

Annual Fee Schedule Update Will Occur on Nov. 1, 2024

Our annual fee schedule update for commercial and Medicare Advantage products in our New York regions will take effect on Nov. 1, 2024. Updates include some incremental increases and decreases throughout the fee schedule to align with Highmark's fee schedules. Learn more here.

August is National Immunization Awareness Month (NIAM)

NIAM is an excellent time for not only communicating the importance of routine vaccinations, but also for reviewing... Click here to read more.

Annual Phone Survey to Verify Provider Directory Information

Throughout August, the independent research firm Press Ganey will conduct phone surveys with a sampling of providers in Delaware, New York, Pennsylvania, and West Virginia. Survey questions will assess knowledge of the tools available to you and your staff and to verify the products/networks in which you participate through your Highmark contract. To learn more, click here.

Express Scripts Pharmacy to No Longer Stock a Limited Set of Medications

Effective Aug. 19, 2024, Express Scripts Pharmacy is no longer stocking a limited set of medications for all lines of business. Members currently receiving impacted drugs have the option to fill an alternative drug at Express Script home delivery, but those who want to or need to continue filling the impacted drugs will need to do so from an alternative, in-network retail pharmacy. For more information and to see the list of impacted medications, click here.

Farxiga Added to Medicare Formularies as a Tier 3 Preferred Brand Name

As of **Aug. 1, 2024**, Highmark has added Farxiga to its Medicare formularies as a Tier 3 Preferred Brand Name Drug. This change will help to reduce prescription drug costs for our members. To read the **Special Bulletin**, go here.

Professional Providers: Sign and Return Group Contracts

Highmark Blue Cross Blue Shield is beginning the process of moving professional providers in its New York markets onto Highmark Professional Agreements. Group agreements will reduce the administrative burden of requiring each practitioner to sign an individual contract. Instead, the practice will sign for all participating practitioners. Once your office receives your group contract, we ask that you sign it and send it back promptly.

Highmark Expands Free Market Health to Our Pharmacy Market in New York

Beginning August 2024, Highmark will welcome Free Market Health (FMH) into our pharmacy market in our New York regions:

- Highmark Blue Cross Blue Shield (WNY)
- Highmark Blue Shield (NENY)

Free Market Health's care driven marketplace seamlessly connects members to a curated selection of high-quality specialty pharmacies. FMH's technology platform enables us to make sure our members receive the most clinically appropriate care at the most competitive pricing. To learn more, click here.

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As we approach the 2024-2025 flu season, it's crucial to emphasize the importance of **two doses of influenza vaccine** for children aged 6 months to 8 years old, especially for those who are receiving their first flu vaccine ever.

Why Two Doses?

- **Optimal Immune Response** – A single dose of flu vaccine may not provide sufficient protection for young children, especially those receiving their first-ever flu vaccine. Two doses — spaced at least 4 weeks apart — will allow their immune systems to develop a stronger and more lasting response.
- **Reduced Risk of Flu Complications** – Children are particularly vulnerable to severe flu complications like ear infections and pneumonia, which can result in

hospitalization. Two doses significantly reduce their risk of experiencing these complications.

- **Protecting the Community** – Vaccinating children helps protect not only themselves but also vulnerable individuals in their community, including infants too young to be vaccinated and those with weakened immune systems.

Research Supports Two Doses

Studies have shown that two doses of influenza vaccine in the same season may be more effective than alternative priming strategies. A study published in the *Pediatric Infectious Disease Journal*[1] found that children who completed the two-dose series in a previous flu season had higher vaccine effectiveness (VE) against influenza A(H3N2) and B in the current flu season compared to those who received only one dose.

Notably, children 2-8 years old who did **not** complete the priming two-dose series were 2.4 times more likely to become ill with influenza A(H3N2) in the current season.

Furthermore, a more recent study[2] found that two doses of influenza vaccine given four weeks apart were more effective in protecting influenza vaccine-naïve children aged 6 months to 2 years. This study found a VE of 53% for children who received two doses compared to a VE of 23% for one dose.

Key Points for Clinicians

- **Timing Matters** –The ideal time to get vaccinated is *before* the flu season peaks, typically in October or November, but the vaccine can be administered throughout winter and early spring.
- **No Age Restrictions** – Both the inactivated influenza vaccine (IIV) and the live attenuated influenza vaccine (LAIV) are available for children 6 months to 8 years old.
- **Administer Dose 2** – Even if the child turns 9 years old between receipt of dose 1 and dose 2, the child should receive the second dose.
- **Informed Consent** – Ensure parents understand the benefits and risks of both vaccine options and make informed decisions.
- **Educate Parents** – Clearly communicate the benefits of two-dose vaccination to parents, emphasizing the enhanced protection and potential for long-term benefits.

Discuss root causes of vaccine hesitancy and address health literacy concerns if they arise.

Resources for Parents

- www.cdc.gov/flu
- www.healthychildren.org

By embracing the 2-dose recommendations, clinicians can play a vital role in maximizing influenza protection for children and reducing the burden of influenza illness.

References

1. Thompson, M. G., Clippard, J., Petrie, J. G., Jackson, M. L., McLean, H. Q., Gaglani, M., ... & Fry, A. M. (2016). Influenza vaccine effectiveness for fully and partially vaccinated children 6 months to 8 years old during 2011–2012 and 2012–2013: The importance of two priming doses. Pediatric Infectious Disease Journal, 35(3), 299–308.

2. Abraham, C., & Stockwell, M. S. (2020). The clinical importance of a second dose of influenza vaccination in young children. JAMA Pediatrics, 174(7), 643-644. https://doi.org/10.1001/jamapediatrics.2020.0377

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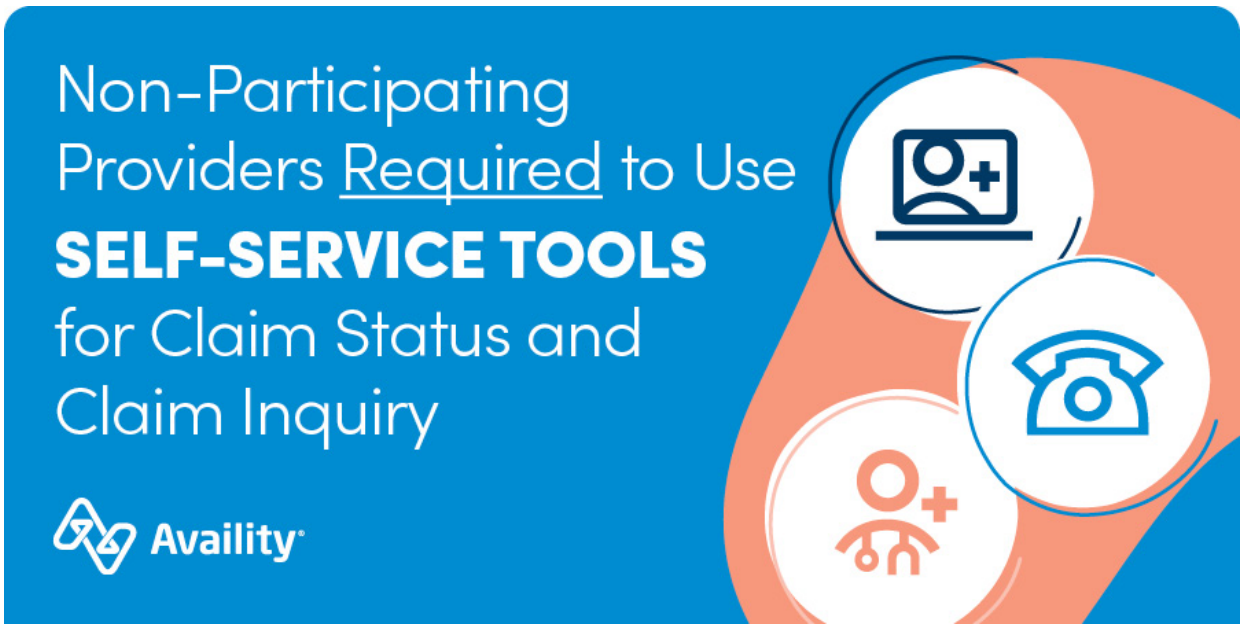

Effective **Sept. 30, 2024**, all non-participating providers — those in Delaware, Pennsylvania, New York, and West Virginia who are not currently contracted with Highmark — will be required to use Availity or our Interactive Voice Response (IVR) system to check claim status or submit a claim inquiry for a Highmark member.

This change is for commercial, Federal Employee Program (FEP), and BlueCard (Medicare Advantage excluded) claims.

For out-of-area non-participating provider BlueCard claims for Highmark members, please use your local plan's provider portal to check status and submit claim inquiries.

These self-service tools are available 24/7 and can provide the quickest answers to your claim questions.

1. **Availity Essentials, Highmark's Provider Portal** – the primary method for submitting transactions to Highmark.

   Because Availity is a multi-payer platform, **even if you are not contracted with Highmark**, you can register your organization to transact with Highmark and other payers across the country.

   If your organization is not already registered with Availity, go to the Register and Get Started with Availity Essentials webpage for details on how to register. We recommend you begin the Availity registration process now to ensure you have access prior to **Sept. 30**.

   For more information on how to check claim status or submit a claim inquiry in Availity, we have a special section on the Highmark Provider Resource Center.

2. **Interactive Voice Response (IVR)** – An automated, interactive telephone system that allows providers to inquire about claim status.

   

   - You can access the following claim information via the IVR:
     - Charges
     - Process date
     - Member responsibility
   - Be prepared with the provider's NPI number; member's Highmark ID or Social Security number; member birthdate; and date of service.

Beginning **Sept. 30, 2024**, non-participating providers who call Highmark Provider Service Center for questions relating to claim status or claim inquiry will be directed to use Availity or the IVR.

Effective July 2023, Highmark participating providers in Delaware, Pennsylvania, and West Virginia were required to use Availity or the IVR for claim status and claim inquiry. The same requirement went into effect in New York in August 2024.

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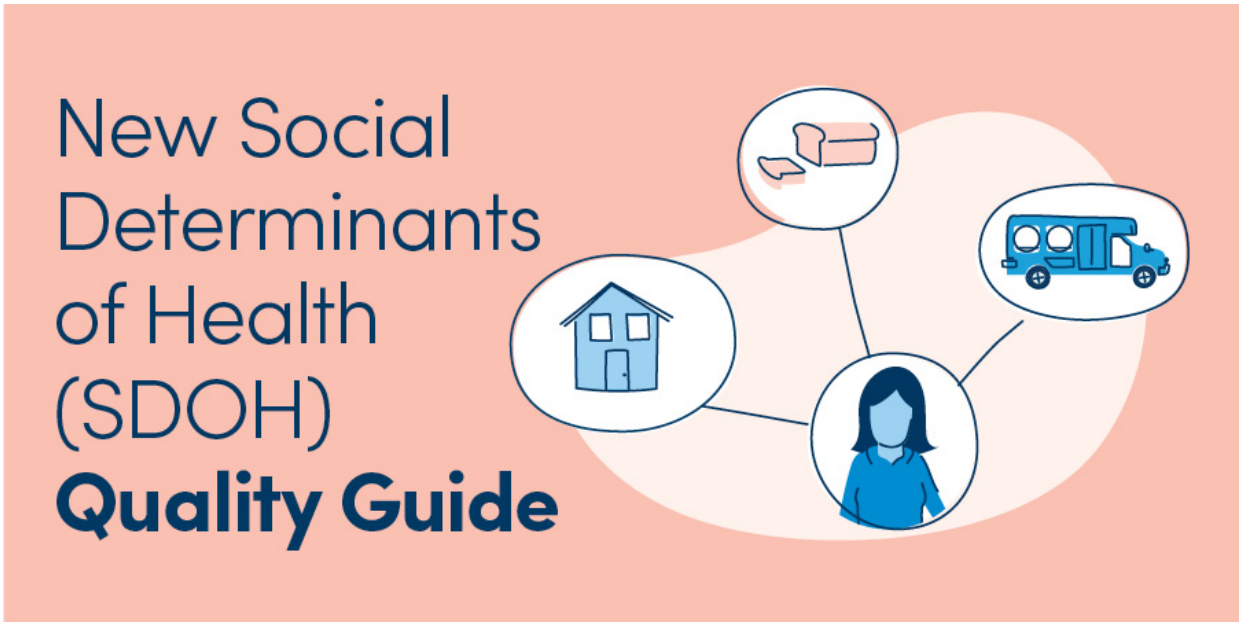

Did you know that SDOH can impact up to 80% of a patient's health?

Helping patients overcome challenges posed by SDOH greatly enhances their ability to live healthier lives.

Our new guide on the Provider Resource Center has information about how to successfully implement SDOH processes into your practice. Topics covered include:

- **Overview of SDOH**
- **SDOH Assessment Screening Tools**
- **Implementation Tips and Recommendations**
- **Coding**
- **Resources for Social Needs**

By understanding and addressing SDOH, providers can improve the health and well-being of their patients. Click here to access the guide.

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The Federal Employee Program (FEP) is issuing new ID cards for members enrolled in FEP Blue Standard and FEP Blue Basic. The rollout of the new cards starts in August and will continue through October.

Members who receive the new ID card should begin using it immediately to access medical and pharmacy benefits.

The new card includes a QR code that connects members to fepblue.org for benefit information, including deductibles and out-of-pocket maximum limits.

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Reminder: Filing Contiguous County Claims for Highmark Members and Non-Highmark Members

Highmark contracts with providers located in counties that are part of another Blue Plan's service areas but border Highmark service areas. These Highmark contiguous county provider contracts apply only to Highmark members *who work or reside in the Highmark service area.*

If a provider — located in a county contiguous to a Highmark plan service area — contracts with that Highmark plan ("Contiguous County Contracting Highmark Plan") and renders services to any Highmark plan member who works or resides in any Highmark plan service area, the provider must file the claim to the Contiguous County Contracting Highmark Plan. See below the response to the question, **"How Contiguous Claims Filing Rules Apply for Highmark Service Areas"**.

If the Highmark member does **not** work or reside in the Highmark service area, the provider must file the claim for the Highmark member to the local Blue Plan where the provider is located and regular BlueCard claim filing rules apply.

Claims filing rules for contiguous area providers are based on the following:

- Provider's physical location (the Blue Plan service area where the provider's office is located).
- Provider's contract status with the two Blue Plans (Is the provider contracted with only one or both service areas?).
- Member's Home Plan and where the member works and resides.
- Location where the member received services.

Criteria for Submitting to the Member's Home Plan

Contiguous county claims filing rules allow claims to be filed directly to the member's Home Plan when each of the following criteria are met:

- The Home Plan's member lives or works in the Home Plan's service area, and
- The Home Plan contracts with a provider located in its contiguous county, and
- Service is provided in the provider's office located in a contiguous county.

If each of the criteria is not met, the claim must be filed to the Blue Plan in whose service area the provider is located.

IMPORTANT: The contiguous county claims filing rules **don't** apply to ancillary claims filings (independent labs, durable/home medical equipment and supplies, and specialty pharmacy) or in overlapping service areas, where multiple Blue Plans share the same service area.

For claim submission guidelines for ancillary claims and overlapping service areas, please see the "Overlapping Service Areas" and "Ancillary Claims Filing Rules" sections in the *Highmark Provider Manual's* **Chapter 2.6: The BlueCard Program**.

How Contiguous Claims Filing Rules Apply for Highmark Service Areas

Blue Cross Blue Shield Association contiguous county claims filing rules consider all Plans operating in multiple service areas as one service area. Therefore, Highmark plans in all of our service areas in Delaware, New York, Pennsylvania, and West Virginia are viewed as one service area for claims filing.

What You Can Do to Avoid Claim Denials

To help avoid unnecessary claim denials, it is recommended that contracted contiguous county providers have a process in place to assure you request and document a Highmark member's home and work addresses accurately. If it is determined that the member does not live or work in the Highmark service area where you have a contiguous county contract, it should be documented that claims are to be filed to your local Blue Plan as BlueCard claims.

Dually Contracted

Providers in contiguous counties to Highmark Plan areas should be dually contracted so that they can bill claims for non-Highmark members to the appropriate Plan. By participating with BOTH plans, providers can facilitate appropriate claims submission for Highmark members and non-Highmark members.

 

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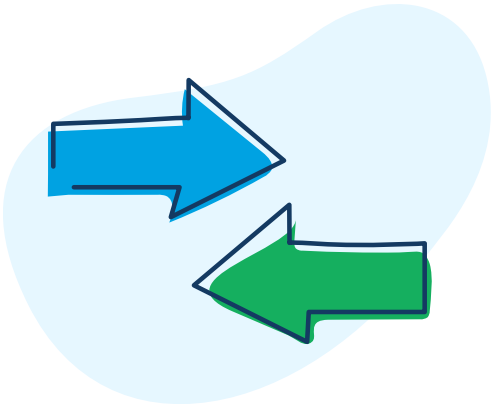
New and Updated Reimbursement Policies



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

August 8, 2024

RP-053 Advanced Gene and Cellular Therapies
This policy was updated with new drugs and therapies, as well as cross-references to medical policies. The name of RP-053 changed from "Gene and Cellular Therapy" to "Advanced Gene and Cellular Therapies."

UPCOMING

October 28, 2024

RP-054 Ambulance Services

Direction from Medicare Advantage (MA) Medical Policy T-2 (Ground Ambulance) will be transferred to RP-054, which will become applicable to MA effective **Oct. 28, 2024**. There will be no changes to the MA direction.

COMING SOON

Effective Date to Be Determined

NEW: RP-076 Medical Nutrition Therapy

This new policy will direct the plan's reimbursement for Medical Nutrition Therapy (MNT) codes 97802, 97803, 97804, G0270, and G0271 for Commercial and Medicare Advantage plans. MNT services will only be reimbursed when billed by a registered dietician or nutritional professional, or by a facility that accepts or received assignment from a registered dietician or nutritional professional. *(NOTE: This policy is not yet available on the PRC.)*

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Authorization Updates: Out-of-Area Exceptions, MSK Bilateral Reminder, and Sept. 30 Changes

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®
- 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:

Out-of-Area Gap Exceptions

There's a new tip sheet posted on the Provider Resource Center that explains how the out-of-area gap exception process works, including the following information:

- An out-of-network gap exception is a formal request for Highmark to cover care from an out-of-network provider/facility at the in-network rate.
- These requests must be made before care is provided and **determined to be medically necessary by Highmark**.

- Failure to submit a gap exception request prior to care will result in higher costs for the patient/member.

Bilateral MSK Requests Should Be for Two Units

Highmark is experiencing an increased volume of incorrect authorization requests for bilateral musculoskeletal (MSK) procedures. For bilateral procedures, requested units should be in multiples of 2 (e.g., 2, 4, 6, etc.).

To ensure efficient processing of your authorization request for this type of treatment, providers need to include the correct code(s) for bilateral MSK procedures and request units in multiples of 2. This will result in faster approvals for appropriate treatment.

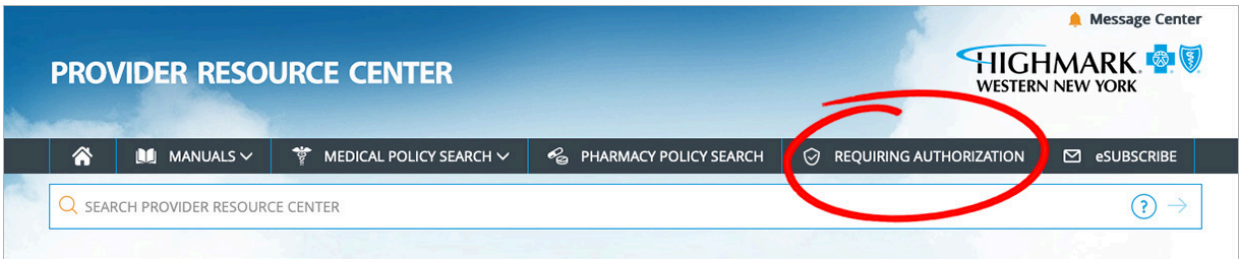
Prior Authorization Changes Occurring on Sept. 30, 2024

Effective Sept. 30, 2024, nearly 100 codes will be added to the prior authorization list, including codes related to the following procedures and/or treatments:

- Implantable defibrillator
- Insertion of new or replacement pacemaker; Removal of permanent pacemaker
- Mastectomy
- Nasal/sinus endoscopy

The codes below will not appear on the Prior Authorization list until the effective date of **Sept. 30, 2024**. To view the codes now, click here.

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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HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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

Issue 8, August 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 listed** 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.

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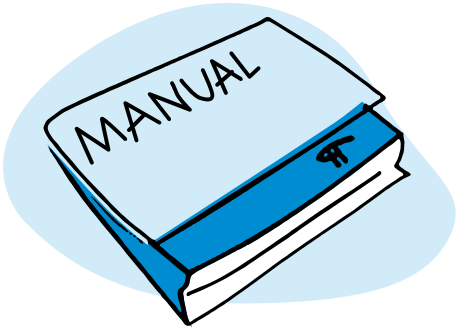
Staying Up to Date with the *Highmark Provider Manual*

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 occurred in the following chapters and units:

- **Chapter 1, Unit 4: Highmark Member Information**
- **Chapter 2, Unit 6: The BlueCard Program**
- **Chapter 3, Unit 2: Professional Provider Credentialing**
- **Chapter 4, Unit 1: PCPs and Specialists**
- **Chapter 4, Unit 2: Behavioral Health Providers**
- **Chapter 4, Unit 7: Durable Medical Equipment and Prosthetics**
- **Chapter 5, Unit 1: Care Management Overview**
- **Chapter 5, Unit 3: Medicare Advantage Procedures**
- **Chapter 5, Unit 7: Value-Based Reimbursement Programs**
- **Chapter 5, Unit 6: Quality Management**
- **Chapter 6, Unit 8: Payment Review**

To see the full list of recent changes, visit the Highmark Provider Manual Changes page.

HIGHMARK WESTERN NEW YORK

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Issue 8, August 2024

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.