PROVIDER NEWS

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

HIGHMARK

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Changes to Highmark Insurance Programs in 2026

As we look ahead to 2026, Highmark is making adjustments to our Affordable Care Act (ACA), Commercial, and Medicare Advantage (MA) programs to enhance benefits, improve access to care, and ensure long-term sustainability.

Below are the product changes effective **Jan. 1, 2026**, for the following market segments:

Affordable Care Act (ACA)

Individual Markets Only

- **OOA and OON Changes** – Preferred Provider Organization (PPO) members in Delaware, Pennsylvania, and West Virginia will see changes in coverage for out-of-area (OOA) and out-of-network (OON) providers.
  - **DE and WV** – Providers outside the BlueCard Network — less than 3% of all providers — will no longer be covered in Delaware and West Virginia (except for urgent or emergent care).
  - **PA** – Using OON providers will result in a higher member cost-share.
- **New Name** – Delaware's product will be renamed "My Blue Access Select PPO" due to the change in coverage for out-of-state, out-of-network providers.

Individual and Small Group Markets

- **Pilot Program Ending in Western PA** – The TytoCare pilot will be discontinued for Together Blue products.

(Continued)

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Commercial

The only product change for Commercial is the addition of **CopayGo** for our Administrative Services Only (ASO) large group segment.

CopayGo is a PPO product with two in-network (INN) tiers, enhanced and standard. Professional INN providers within 20 specific specialties are tiered at the practitioner level based on cost, quality, and appropriateness. There is no INN deductible or coinsurance for medical or prescription drugs. All services apply a copay, except for preventive, which pays 100%.

For more on CopayGo, see the article in this month's issue.

Medicare Advantage

Highmark is launching a new product **Complete Blue HMO** in Western Pennsylvania, while also expanding the reach of two existing products:

- **Complete Blue PPO** – currently offered across Pennsylvania will be available in **Delaware and West Virginia**.
- **Community Blue Medicare HMO** – offered in select counties in Pennsylvania's Western, Central, and Northeastern regions will be available in **Western New York**.

There are two related National Association of Insurance Commissioners (NAIC) code changes for Pennsylvania and West Virginia when filing claims for these new offerings:

- **PA** – For Complete Blue HMO, use NAIC Code 54771 with prefix **BMW**.
- **WV** – For Complete Blue PPO, use NAIC Code 15459 with prefix **WBH**.

Stay Informed

To ensure you receive important updates on Highmark policy and program changes, join our mailing list and receive our monthly newsletter in your email inbox.

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Introducing CopayGo: Highmark's New Tiered Copay Plan for ASO Large Group Accounts

Effective Jan. 1, 2026, Highmark is launching CopayGo, an innovative alternative health product designed for our Administrative Services Only (ASO) large group accounts. CopayGo simplifies healthcare costs with a national two-tiered network of "Enhanced" and "Standard" providers.

Understanding CopayGo's Structure

CopayGo is a unique **copay-only plan**. This means members will not face deductibles or coinsurance for covered services. Instead, they will have differentiated copay amounts based on whether they choose an "Enhanced" or "Standard" provider. It's important to note that these tiered copays solely impact the member's out-of-pocket cost at the point of service and **do not affect the total reimbursement providers receive for their services**.

How Providers are Tiered

CopayGo leverages the most current Blue Cross Blue Shield Axis® Provider Insights national dataset to tier selected providers across the nation. This tiering applies to providers in 20 specialties, including essential services like primary care, pediatrics, and OB/GYN.

The analysis for each individual provider is based on three key measures: Quality, Appropriateness of Care, and Cost. To ensure ongoing accuracy, this dataset will be refreshed annually, which may lead to changes in a provider's "Enhanced" or "Standard" designation based on their performance.

Information for Provider Offices

Provider offices can verify a member's CopayGo plan through an eligibility and benefits inquiry in Availity Essentials®. Both Availity and a 270 inquiry will display the member's copay amounts for both "Enhanced" and "Standard" providers within your practice. In addition, member ID cards will clearly indicate enhanced and standard copays for primary care providers (PCPs), specialists, emergency room (ER) visits, and Urgent Care.

For detailed information on which individual providers within your practice are designated as "Enhanced" or "Standard," visit the CopayGo page on the Provider Resource Center, which is located under the **Provider Network** tab.

Empowering Members with Simplicity

CopayGo's streamlined design aims to alleviate common member pain points by offering clear, upfront cost and quality information. Through the digital tools available on the MyHighmark member portal, members can easily reference individual provider designations and check copay amounts *before* their visit.

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Changes to Payment Remittances and Electronic Claims

Highmark is making important changes to how we deliver payments/remittances (835s) and process electronic claims (837s) for our New York providers. These changes are designed to streamline processes and improve efficiency.

Here's what you need to know:

- **Payment Remittances Moving to ECHO Health:** Effective Jan. 26, 2026, Highmark is expanding its partnership with ECHO Health to manage payments and remittances for Western and Northeastern New York.
- **Transition from ASK Clearinghouse:** As previously communicated, Highmark is requiring New York providers who file electronic claims to transition from the ASK clearinghouse to Highmark-EDI for electronic claim submissions (837s).

Summary of Key Dates:

- **November 2025:** Expect communications from ECHO Health regarding enrollment and payment options.
- **Jan. 12, 2026:** Deadline to select alternative payment method with ECHO Health to avoid receiving payments via Virtual Credit Card.
- **Jan. 26, 2026:** ECHO Health begins managing Highmark New York claim payments.
- **September 2026:** Deadline to transition from ASK clearinghouse to Highmark-EDI.

Take Action Now!

To ensure uninterrupted claim processing and payment, it's crucial that you and your billing/IT departments are aware of these changes and take the necessary steps.

For more information, please refer to last month's Provider News article: *Important Claims Updates for New York Providers*.

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Risk Adjustment Programs: New Compensation Model for 2026

Effective Jan. 1, 2026, Highmark will implement a new prospective risk adjustment program compensation model for all markets and lines of business. This new model will allow for flexible and easier program participation, recognize higher performance, and increase targeted gap opportunity.

What Programs Are Affected

The Unconfirmed Diagnosis Code (UDC) and Risk Score Accuracy (RSA) programs will incorporate this new compensation model. **Important:** No changes to the True Performance Lite and Vatica/eAWV compensation are occurring in 2026.

What Is Changing

To continue our focus on improving member outcomes and that conditions are being addressed appropriately, Highmark is aligning compensation with outcomes for our entire member population.

The new compensation model will be multifaceted to meet providers where they are and incorporate risk adjustment gap closure requirements into their preferred existing workflow.

- **Straightforward Gap Compensation**
  - All Hierarchical Condition Category (HCC) gap types, persistent and suspect, will have the same monetary value at a per-gap base compensation rate.
- **Availability of Additional Gaps**
  - Medicare Part D HCC gaps will now be in scope for risk adjustment programs increasing the opportunity to earn. We are working with our risk adjustment program vendors currently and throughout 2026 to incorporate Part D HCC gaps into their point-of-care tool that presents and manages HCC gaps.

- **Risk Adjustment Enablement (RAE) PMPM**
  - An opportunity to earn a per member per month (PMPM) compensation (in addition to per-gap compensation) for developing a deeper collaboration with the Highmark risk team through point-of-care solution utilization, governance and education, and access to medical records and clinical information.
- **Tiered Threshold Assessment**
  - Providers can further increase their compensation with population-based comprehensive care by addressing a higher percentage of targeted risk conditions. Higher percentage tiers can earn additional compensation per gap.

Where Can I Learn More?

Additional resources will be available on the **Risk Adjustment Programs page** on the Provider Resource Center (PRC) next month.

- Log into Availity Essentials®, select your state, go to **Payer Spaces**, and choose **Provider Resource Center** from the applications.
- Once on the PRC, select **Resources & Education > Clinical Quality & Education > Risk Adjustment Programs**.

If you are already participating in Highmark's UDC or RSA programs, your primary Highmark risk adjustment contact will also be able to assist with any questions and comments.

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Low Acuity Non-Emergent Professional Claim Review

Effective Feb. 2, 2026, Highmark will begin reviewing Emergency Department professional claims submitted with procedure codes 99284 and 99285, which indicate moderate and high complexity levels. These reviews are designed to determine the appropriate and fair level of professional reimbursement for emergency department services based on Centers for Medicare and Medicaid Services (CMS) criteria and Mercer's Low Acuity Non-Emergent (LANE) analysis.

Low-Acuity Visits

If the primary discharge diagnosis is of **low-level** complexity or is deemed as a low acuity, non-emergent visit, the service will be automatically downcoded from a level 4 (99284) or level 5 (99285) to a level 3 (99283). This aligns with CMS' definition of that code level where the presenting problem requires a low level of medical decision making.

For more information about this program, refer to Reimbursement Policy (RP)-037: Emergency Evaluation and Management Coding Guidelines.

Determining How the Claim was Changed

If the review determines that the claim warrants the level of care at which it was billed, the claim will **not** be changed.

If the review — conducted using Highmark's RP-037 — determines the claim warrants a different level of care based on the primary discharge diagnosis, Highmark will deactivate the original line and add a new line with the correct procedure code and reimburse accordingly.

The code originally submitted on the claim and the code Highmark adds to the claim will be stored in Highmark systems for CMS audits. However, the Explanation of Payment (EOP) will only show the procedure code that Highmark applies to the claim.

Questions About Claims or How to Appeal the Updated CPT Code

The notification of payment for the newly updated CPT code will come in the form of an EOP. There will be no denial letters. If there are questions regarding the updated coding of the claim, contact Highmark via **Message this Payer** in Availity Essentials®.

Providers who do not agree with Highmark's updated CPT Code can request an appeal.

Please submit the appeal request and medical records that substantiate the appeal to:

Attention: Payment Integrity
Highmark Inc.
PO Box 890120
Camp Hill, PA 17089

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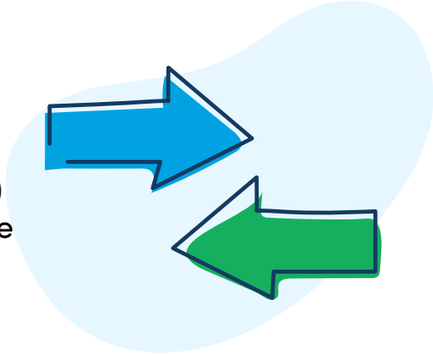
New and Updated Reimbursement Policies



Highmark regularly issues new or updated reimbursement policies. Keep an eye on this newsletter and the Provider Resource Center (PRC) for announcements regarding upcoming policy changes. As specific policy changes go into effect, the updated policies can be found on the Reimbursement Policies page of the PRC. **The following is a list of recent and upcoming updates to reimbursement policies (RPs):**

RECENTLY UPDATED

Oct. 1, 2025

RP-074 Diagnostic Pathology Services

This policy was archived, retroactive to July 1, 2025.

UPCOMING

Dec. 1, 2025

RP-029 Surgical Techniques, Procedures and Related Services

This policy will be made applicable to Medicare Advantage.

RP-033 Anesthesia Services

A section for Epidural Anesthesia Care will be added and direction for modifiers QK and QY reductions will be clarified. Codes 62273, 62281, 62282, and 01967-01969 will be added.

RP-077 Intraoperative Neurophysiological Monitoring

Direction will be added for codes 95941 and G0453. Code 95941 will no longer be separately reimbursed.

Jan. 1, 2026

RP-068 Mid-Level Practitioners and Advanced Practice Providers

This policy will be updated for Commercial and Medicare Advantage to add direction for the pharmacist specialty, which will be reimbursed at 85% of the fee schedule allowance.

NEW: RP-083 Spravato®(esketamine)

This new policy — applicable to Commercial and Medicare Advantage markets — will provide direction on the billing of esketamine (Spravato) services.

Jan. 5, 2026

RP-027 Hemodialysis and Peritoneal Dialysis

This policy will be made applicable to Medicare Advantage. Codes 99242-99245 and 99252-99255 will be removed. Codes 90993, 90999, 99233, 99291, 99292, 99341, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, S9335, and S9339 will be added.

Feb. 2, 2026

RP-037 Emergency Evaluation and Management Coding Guidelines

This policy will be made applicable to professional claims, which will be reviewed by Highmark when submitted for emergency department services, **effective Feb. 2, 2026**. For more information, CLICK HERE.

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Short Takes: RadCard Auths, High-Volume Claim Inquiry, and More

New Availity Functionality: High-Volume Claim Issue Inquiry

Providers have a new tool in Availity Essentials® for streamlining the review of high-volume claim denials for the same issue due to a Highmark error.

When submitting a claim inquiry in Availity via **Message this Payer**, there's a new option on the **Reason for Message** dropdown: **High-Volume Claim Issue (HVCI)**.

To learn more, go **here**.

Help Us Create a Truly Remarkable Health Experience — And Make Your Voice Heard!

We're inviting you to join Highmark Provider Perspectives, our exclusive online insights community where we partner with providers like you as trusted advisors. The community is open to both clinical and non-clinical staff.

To learn more, go **here**.

In Case You Missed Last Month's *Provider News*...

The September issue featured the following articles:

- Upcoming Site of Care Program Impacts Certain Outpatient Surgeries
- Medicare Advantage Network Updates: What Providers Need to Know
- Update to Highmark's Medicare Advantage Professional Physician Office Laboratory Fee Schedule
- Navigating Digital Member ID Cards

You can find back issues of *Provider News* **here** on the Provider Resource Center.

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Prior Authorization Changes Occurring in the New Year

Effective Feb. 1, 2026, 11 codes will be added to the prior authorization list related to intra-operative neuromonitoring, skin substitutes, histotripsy, and one medical injectable drug. Other Feb. 1 changes include the removal of six breast tomography codes and a medical injectable code.

In addition, five codes for osteopathic manipulative treatment (98925–98929) were removed from the prior auth list on Sept. 22, 2025.

Prior Authorization List – Codes to be Added on Feb. 1, 2026

Code	Description
0686T	Histotripsy (i.e., non-thermal ablation via acoustic energy delivery) of malignant hepatocellular tissue, including image guidance
95940	Continuous intraoperative neurophysiology monitoring in the operating room, one-on-one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)
95941	Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)
G0453	Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes (list in addition to primary procedure)
J1551	Injection, immune globulin (Cutaquig), 100 mg
Q4100	Skin substitute, not otherwise specified
Q4107	GRAFTJACKET, per sq cm
Q4116	AlloDerm, per sq cm
Q4159	Affinity, per sq cm
Q4187	Epicord, per sq cm
V2790	Amniotic membrane for surgical reconstruction, per procedure

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Prior Authorization List – Codes to be Removed on Feb. 1, 2026

Code	Description
0633T	Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast material
0634T	Computed tomography, breast, including 3D rendering, when performed, unilateral; with contrast material(s)
0635T	Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast, followed by contrast material(s)
0636T	Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast material(s)
0637T	Computed tomography, breast, including 3D rendering, when performed, bilateral; with contrast material(s)
0638T	Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast, followed by contrast material(s)
J0480	Injection, basiliximab, 20 mg (Simulect)

Prior Authorization List – Codes Removed on Sept. 22, 2025

Code	Description
98925	Osteopathic manipulative treatment (OMT); one (1) to two (2) body regions involved
98926	Osteopathic manipulative treatment (OMT); three (3) to four (4) body regions involved
98927	Osteopathic manipulative treatment (OMT); five (5) to six (6) body regions involved
98928	Osteopathic manipulative treatment (OMT); seven (7) to eight (8) body regions involved
98929	Osteopathic manipulative treatment (OMT); nine (9) to ten (10) body regions involved

To view the **List of Procedures/DME Requiring Authorization**, go here and scroll down to the **Prior Authorization Coding List** section for your region.

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Onboarding Webinar for Providers and Staff: Register for Nov. 20 Session

Since August, Highmark has been hosting virtual onboarding webinars for providers and staff on the third Thursday of the month.

By attending, you will learn best practices for navigating Highmark systems, accessing provider manuals and tools, utilizing Availity Essentials®, and more.

Register here for our next onboarding session on **Thursday, Nov. 20, 12–1 p.m.**

Who Is Invited

- Providers new to the Highmark network.
- Providers new to a practice or facility.
- New and existing provider staff seeking updated information or a refresher.

If you know a colleague who would be interested in attending, please share this information with them.

What Will Be Covered

The webinar will cover key topics and best practices, including:

- Locating the provider manual, medical and reimbursement policies, and other tools.
- Accessing Availity for training and transactions, including prior authorizations.
- Online tools for credentialing and updating provider data.
- Understanding the BlueCard program.

There will be the opportunity to ask questions and get live answers throughout the presentation.

Go here to register for the Nov. 20 session.

Stay Informed

Join our mailing list for the latest news and announcements from Highmark by clicking here.

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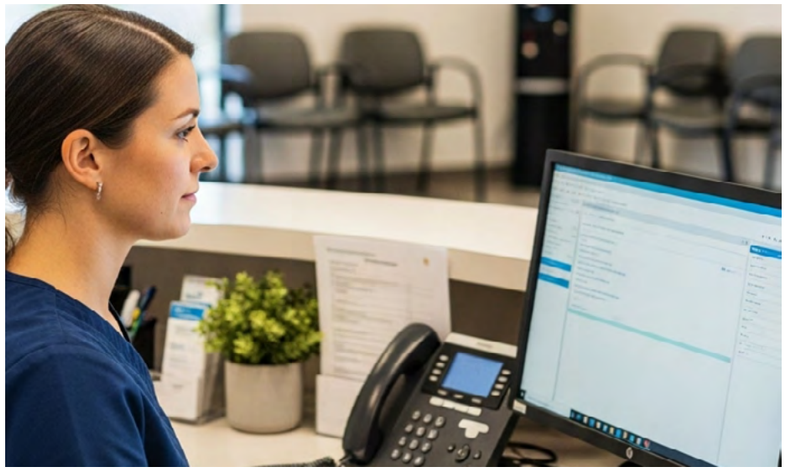
We're Listening: Streamlining Credentialing for a Better Experience

We understand that Highmark's credentialing process has not always been the easiest to navigate. We've heard your valuable feedback and are excited to share how your insights have directly led to recent improvements designed to enhance your experience. We are actively working to create a more efficient and seamless credentialing journey for you and your organization.



Enhancing Our Systems

- **New Credentialing Platform – Launching Nov. 3, 2025:** Based on your feedback seeking quicker turnaround times, we are updating our current credentialing platform, which will now be powered by CertifyOS. This significant upgrade is designed to improve turnaround times for credentialing applications and provide more robust verification of provider qualifications, ultimately making the process faster and more efficient for you.
  - **Organizational Providers** – Our previous forms have been consolidated into a single enrollment form for organizational providers, regardless of specialty — a direct result of requests for simpler processes.

    IMPORTANT: While the new form will be available on Nov. 3, it won't link to the Certify portal until a later time. Highmark will ensure that Certify receives all credentialing applications.
  - **Professional Providers** – Continue to use the Initial Credentialing Request Form on the Provider Resource Center (PRC). At the end of the form, you will click a link that integrates with the credentialing portal, powered by CertifyOS.
  - For more information on the move to Certify, click **here**.
- **Upgraded Delegated Credentialing Technology – Live!** We recognize the administrative burden faced by our delegated credentialing partners. That's why we've enhanced our automated roster loading. This eliminates manual data entry, reduces errors, and improves overall efficiency in managing your provider networks, saving you valuable time.

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Dedicated Support Channels

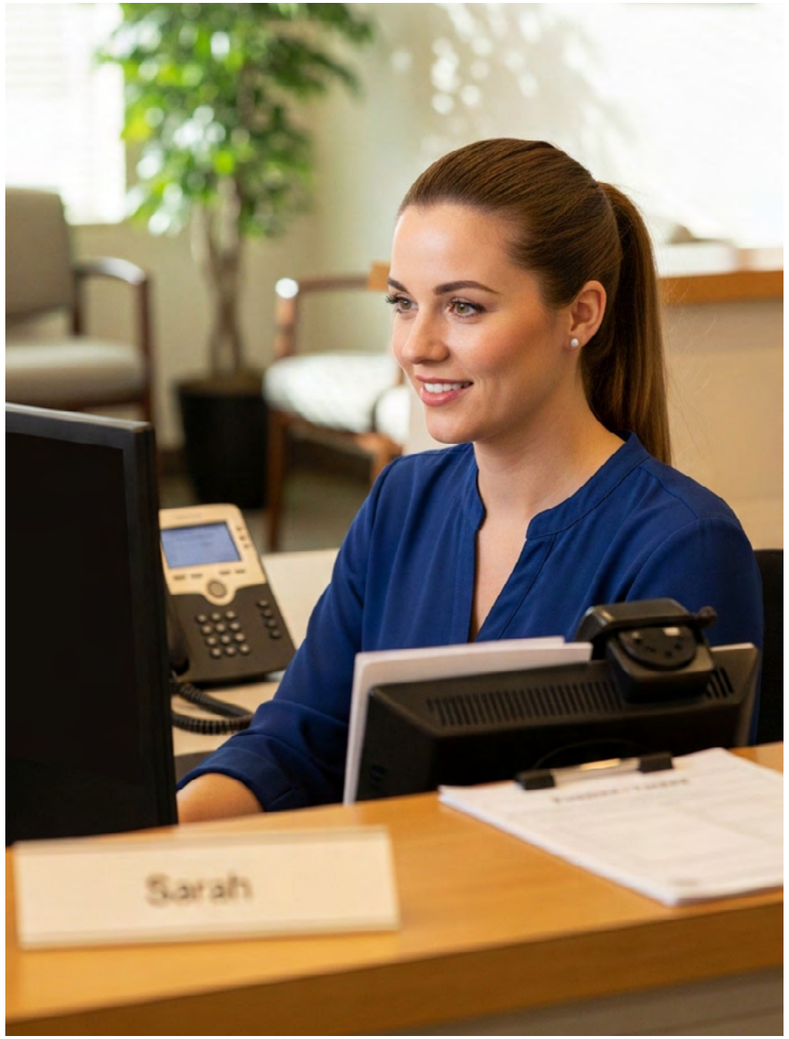
- **New Credentialing Phone Support** – In response to requests for more direct support, we recently launched live phone assistance for providers with questions about credentialing, standard contracts, and the provider file directory. This dedicated line is designed to get you the answers you need quickly.
  - **How to Reach the Team:** Simply call your regional Provider Service Center and select the **Credentialing** option from the Interactive Voice Response (IVR) menu.
- **Credentialing Status Inquiry Form** – Submit credentialing status inquiries directly to Highmark's credentialing team through **this form** on the Provider Resource Center. Our team strives to complete our reviews promptly upon receipt and we're committed to providing updates in a timely manner.

Self-Service Options

We understand the value of quick and convenient access to information. Our online resources remain the fastest way to make updates to your practices information or check network status.

- **The Provider Data Management (PDM) tool** in the Availity Essentials® portal enables professional providers to complete tasks, such as updating practice demographic information or practitioner affiliations.
- **The Provider Resource Center (PRC)** has a variety of credentialing forms for both professional and facility providers, as well as the PDM Guide.

We are committed to continuous improvement. There are many more enhancements we are working on to make the credentialing process truly efficient and seamless. **We encourage you to continue sharing your feedback with us** as we explore new ways of working together and build an even stronger partnership. Thank you for your vital role in caring for our members.



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2026 Medicare Advantage Formulary Updates

Highmark will be updating its Medicare Part D formularies on **Jan. 1, 2026**. These changes are designed to ensure our members have access to affordable and effective prescription medications.

Key Updates

Some medications may be removed from the formulary or have new restrictions. To identify if a drug status or restriction has been updated, review the 2026 formulary.

Accessing the Medicare Formularies

Go to the Provider Resource Center (PRC) at providers.highmark.com.

- Select your region from the dropdown menu in the upper right corner.
- Navigate to **Policies & Programs > Formulary > Medicare Formulary**.

Member and Provider Communication

Starting in mid-November, Highmark will send letters to both prescribing providers and members outlining the specific changes to the Medicare Part D formularies.

If your patients are taking medications affected by these changes, please consider the following options:

- Prescribe a covered formulary alternative.
- Submit a coverage determination request.

Submitting Coverage Determination Requests

Coverage determination requests for the 2026 plan year can be submitted beginning **Nov. 17, 2025**. Highmark will review all requests and notify both you and the member of the decision.

CoverMyMeds

You can initiate a coverage determination through CoverMyMeds, which is available via Availity Essentials®, Highmark's provider portal. Once you log in, select your state, click **Payer Spaces**, choose your Highmark plan, and then find **CoverMyMeds** under **Applications**.

Request Form on the PRC

You can also use the **Prescription Drug Medication Request form**, which is available on the PRC. Go to **Resources and Education > Forms > Pharmacy Prior Authorization Forms**.

On the form, under the box for Medicare, select the applicable review type. Complete the form and then follow the instructions for submitting it for review.

To ensure you receive important updates on Highmark policy and program changes, join our mailing list and receive our monthly newsletter in your email inbox.

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Some Preferred Diabetic Suppliers are Changing for MA Members in 2026

Effective Jan. 1, 2026, Abbott (Freestyle) and Trividia (True Metrix) will be the preferred suppliers for glucometers, test strips, and lancets for Medicare Advantage (MA) members in all Highmark regions. This represents a change from 2025, as Lifescan (OneTouch) and Roche (Accu-Chek) will no longer be preferred suppliers of diabetic products.

Abbott, a preferred supplier in 2025, will be joined by Trividia in 2026. If members are unable to use the preferred brands of diabetic supplies for any reason, there are still two ways for them to continue to receive their diabetic supplies at no cost:

- Obtain their diabetic supplies through a participating durable medical equipment (DME) supplier.
- Have their provider submit a coverage determination for the non-preferred brand.

What Isn't Changing

There are **no changes** for Continuous Glucose Monitoring (CGM) devices, sensors, and transmitters for MA members, as Abbott and Dexcom will continue to be preferred suppliers for those products.

See the chart below for regional information.

Glucometers/Test Strips/Lancets			
Region	2026 Preferred Brands	2025 Preferred Brands	Change
Highmark MA – DE/PA/WV	Abbott & Trividia	Abbott & Lifescan	Yes - 1 Manufacturer
Highmark MA – NY	Abbott & Trividia	Lifescan & Roche	Yes - 2 Manufacturers
CGMs/Sensors/Transmitters			
Highmark MA – DE/PA/WV	Abbott & Dexcom	Abbott & Dexcom	No Change
Highmark MA – NY	Abbott & Dexcom	Abbott & Dexcom	No Change

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MA Prescription Coverage Update: Humira and Stelara Will Not Be Preferred in 2026

Starting Jan. 1, 2026, Highmark will transition coverage of high-cost, brand-name drugs Humira and Stelara, along with related biosimilars, to lower-cost, **equivalent medications** for Medicare Advantage (MA) members.

This transition enables Highmark to provide members with effective alternatives that can lower their out-of-pocket costs. In most cases, pharmacies can dispense the biosimilar version without needing a new prescription.

With Highmark changing its formulary to prefer the biosimilars listed in the chart below for 2026, all existing authorizations for Humira, Cyltezo, Hyrimoz, Adalimumab, Stelara, Selarsdi, and Ustekinumab will be terminated **effective Dec. 31, 2025**. To make this transition easier, Highmark has already approved an authorization for all 2026 covered preferred biosimilar(s), which is effective immediately.

If there is a medical reason for a member to continue to receive their current prescription instead of switching to a covered biosimilar, a provider must submit a request for a new coverage determination.

2026 MA Prescription Coverage Update for Humira and Stelara

2025 Preferred Brand-Name and Biosimilar Drugs	2026 Preferred Biosimilar Drugs
• **Humira** • Cyltezo • Hyrimoz • Adalimumab	• Simlandi • Yuflyma • Hadlima
• **Stelara** • Selarsdi • Ustekinumab	• Yesintek • Steqeyma

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HEDIS Help: Detailed Information on 47 Measures

To assist providers in closing care gaps, Highmark has created a document with 47 HEDIS® measures that features descriptions, exclusions, and coding information.

The HEDIS Measures Provider Information Document is available on the private Provider Resource Center (PRC). Here are some of the measures featured:

- Blood Pressure Control for Patients with Hypertension **(BPC-E)**
- Breast Cancer Screening **(BCS-E)**
- Cervical Cancer Screening **(CCS-E)**
- Child and Adolescent Well-Care Visits **(WCV)**
- Kidney Health Evaluation for Patients with Diabetes **(KED)**
- Lead Screening in Children **(LSC)**
- Transitions of Care: Patient Engagement After Inpatient Discharge Total **(TRC)**
- Use of Imaging Studies for Low Back Pain **(LBP)**
- Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents **(WCC)**
- Well-Child Visits in the First 30 Months of Life **(W30)**

Accessing This Resource

- Log into Availity Essentials®, select your state, go to **Payer Spaces**, and choose **Provider Resource Center** from the applications.
- Once on the PRC, select **Resources & Education > Clinical Quality & Education > HEDIS**.

We recommend downloading this document — which is updated every January — and saving it on your desktop for easy access.

**HEDIS® — an acronym for Healthcare Effectiveness Data and Information Set — is a registered trademark of NCQA.*

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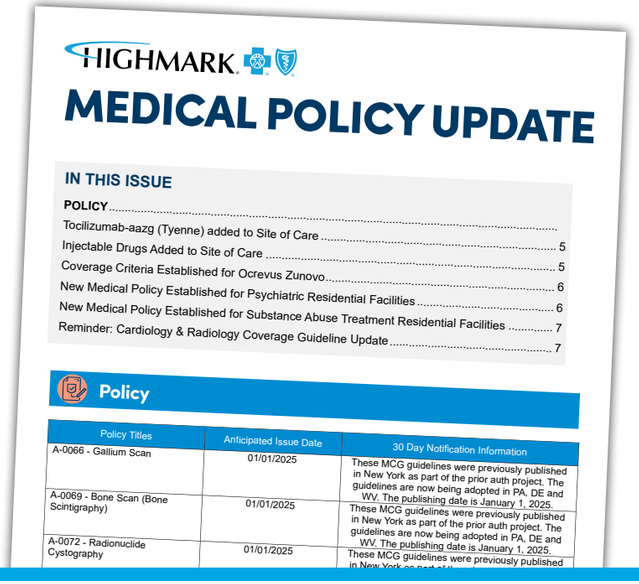
New Fertility and Family Building Benefit

Highmark is offering our Administrative Services Only (ASO) clients a **new Fertility and Family Building solution** for 2026. In partnership with WIN Fertility, the program provides members with access to resources, guidance, and assistance with family building and navigating fertility treatment options. For members of clients who opt into this benefit, WIN Fertility's network of fertility clinics and providers **must** be used.

Eligible members will see the **Fertility and Family Building solution** as an option in their Highmark member portal. The Availity Essentials® provider portal will show the member has an Assisted Fertility benefit.

Providers in the WIN network will need to work through WIN to request prior authorizations for any applicable CPT codes. Providers interested in joining WIN's network can reach out to their team at providerrelations@winfertility.com.

Have You Seen This Month's Medical Policy Update Newsletter?



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MEDICAL POLICY UPDATE

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POLICY

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Reminder: Cardiology & Radiology Coverage Guideline Update 7

Policy

Policy Titles	Anticipated Issue Date	30 Day Notification Information
A-0066 - Gallium Scan	01/01/2025	These MCG guidelines were previously published in New York as part of the prior auth project. The guidelines are now being adopted in PA, DE and WV. The publishing date is January 1, 2025.
A-0069 - Bone Scan (Bone Scintigraphy)	01/01/2025	These MCG guidelines were previously published in New York as part of the prior auth project. The guidelines are now being adopted in PA, DE and WV. The publishing date is January 1, 2025.
A-0072 - Radionuclide Cystography	01/01/2025	These MCG guidelines were previously published

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SURVEY SAYS: How CAHPS Can Help Improve the Patient Experience

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is an annual survey that asks a random sample of Medicare Advantage members about their experiences with their health plan and providers in the past six months.

- CAHPS questions are based on members' **experience and perception** — meaning that any patient interaction can impact CAHPS scores.
- The Centers for Medicare and Medicaid Services (CMS) considers CAHPS and the member experience to be so important that approximately **25% of a health plan's Medicare Star Rating** is based on the survey scores.

The Medicare CAHPS Survey typically starts in late February and goes until the beginning of June.

CAHPS Measures

There are nine CAHPS measures that are incorporated into a plan's Star Rating, with four presenting a strong opportunity for providers to positively impact the patient experience:

- Getting Appointments and Care Quickly
- Getting Needed Care
- Care Coordination
- Rating of Health Care Quality

Collaboration Is Key

Collaboration between health plans and providers is key to ensuring that members/patients have positive health care experiences. **Providers and practices that have seen high patient satisfaction results generally do the following:**

- Follow up with patients after they have seen another provider or specialist.
- Ask about prescription drugs patients may now be taking.
- Share pertinent clinical information with your patient's other providers through a HIPAA-compliant health information exchange, such as Availity Essentials®.
- Assist patients with scheduling tests and referral appointments.
- Let patients know when to expect test results, and how they can access them.

For more information about the Medicare CAHPS Survey, click here.

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Staying Up to Date with the *Highmark Provider Manual*

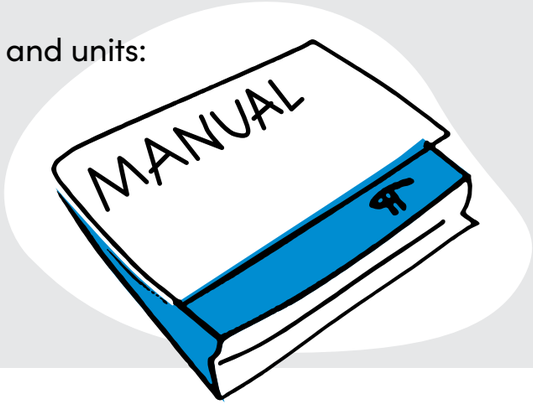
Ensure you are regularly reviewing the *Highmark Provider Manual* for our most recent guidance on:

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

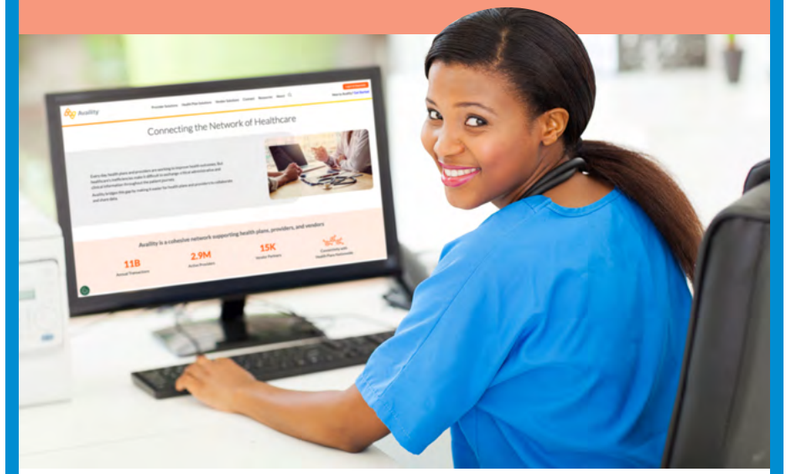
Some recent noteworthy changes occurred in the following chapters and units:

- **Chapter 2, Unit 2: Medicare Advantage Products & Programs**
- **Chapter 2, Unit 6: The BlueCard® Program**
- **Chapter 6, Unit 2: Electronic Claim Submission**

To see the full list of recent changes, visit the *What's New in the Highmark Provider Manual* page.



FREE. FAST. SIMPLE.



Are You Using Availity Essentials® for Your Highmark Transactions?

Availity®

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About This Newsletter

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

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

Regular topics include:

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

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

Another Valuable Resource

For medical policy and claims administration updates, including coding guidelines and procedure code revisions, please refer to the Medical Policy Update Newsletter, which is available on the **Provider Resource Center > Latest Updates > Medical Policy Update**.

To subscribe to our newsletters, click Join Our Mailing List.

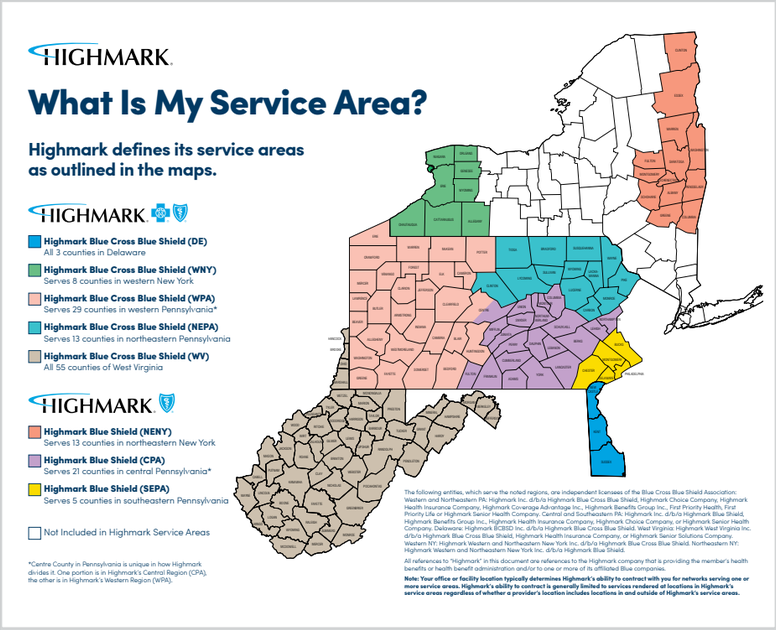
Comments/Suggestions Welcome

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.

Highmark Quick Reference

To contact Highmark, click here.

Service Areas



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Availity is an independent company that contracts with Highmark to offer provider portal services. Highmark Health is the parent company of Highmark Inc.

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.

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View the BCBSWNY Privacy Policy.

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