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A newsletter for the Highmark Blue Cross Blue Shield Delaware providers

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IN THIS ISSUE:

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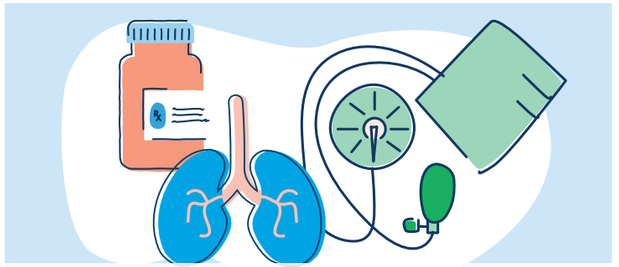
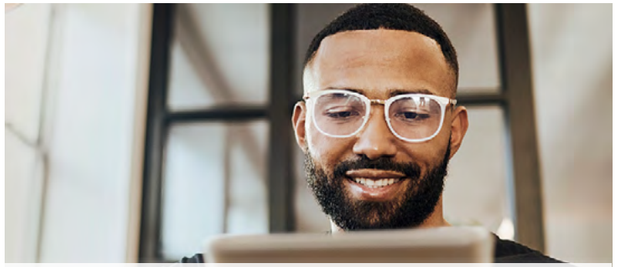
TOP STORIES:

Highmark to Offer Medicare Advantage Products in Southeastern PA Starting in 2025



HEDIS Tips: 5 Ways to Close Gaps in the Next 60 Days



Empowering Your Patients with My Highmark

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Effective Feb. 1, 2025, more than 100 codes will be added to the prior authorization list, including codes related to the following procedures, treatments, and medical devices:

- Arthrodesis
- Cholecystectomy
- Correction, hallux valgus (bunionectomy)
- Extracapsular cataract removal
- Gastrectomy
- Laminectomy
- Laparoscopy
- Segmental pneumatic appliance

To see the codes requiring prior authorization on Feb. 1, click here.

eviCore-Managed Codes Moving to Highmark on Jan. 1

On **Jan. 1, 2025**, the management of more than 80 codes that require prior authorization will move from eviCore to Highmark. The codes represent nuclear medicine and advanced imaging services, including select cardiac imaging procedures. Codes representing the following services are among those covered by this change:

- Adrenal nuclear imaging
- Bone marrow imaging
- Bone or joint imaging
- Brain imaging
- Echocardiography
- Kidney imaging
- Salivary gland imaging
- Thyroid imaging

To see all the affected codes, click here.

Important Information for Acquiring Prior Authorization

The List of Procedures/DME Requiring Authorization for Highmark is subject to change. During the year, Highmark makes several adjustments to its full list of outpatient procedures, services, durable medical equipment, and drugs requiring authorization. For benefits to be paid, the member must be eligible on the date of service and the service must be a covered benefit. Providers should use Availity® or the applicable HIPAA electronic transactions to check member benefits and eligibility, to verify if an authorization is required, and to obtain authorization for services before they are rendered.

Availity®

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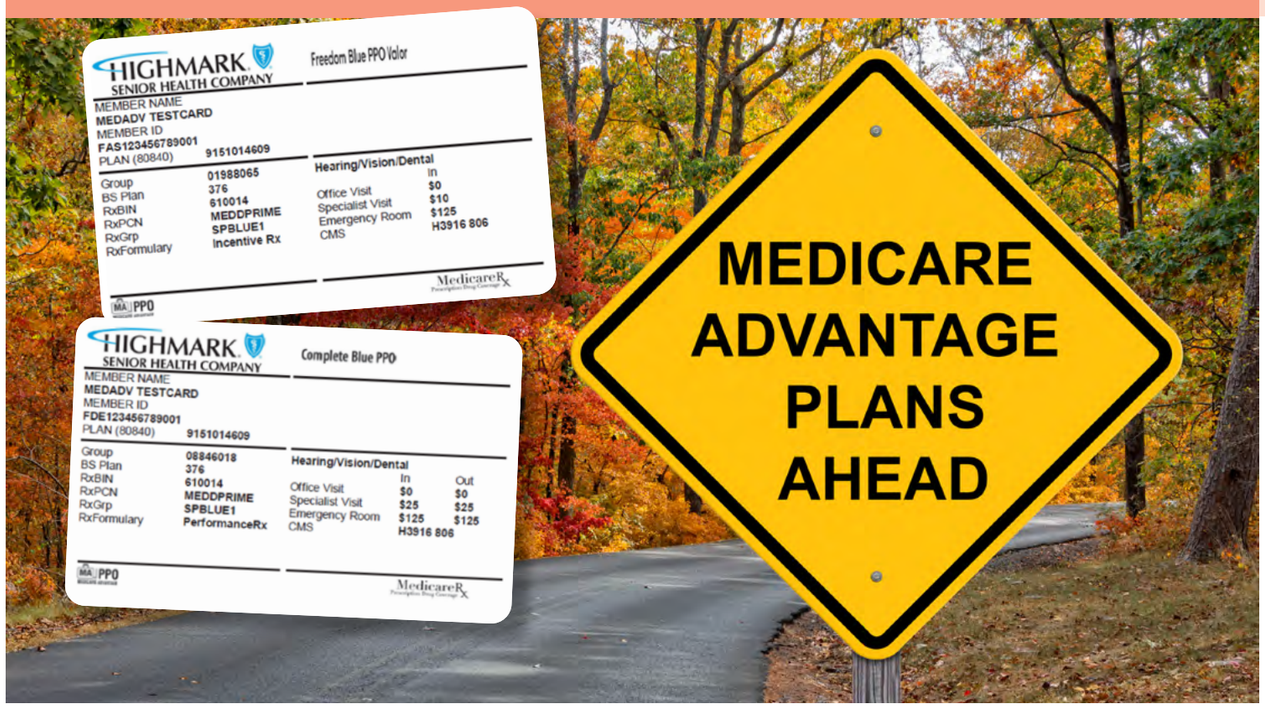
Highmark to Offer MEDICARE ADVANTAGE Products in Southeastern PA **Starting in 2025**



Effective Jan. 1, 2025, Highmark will offer Medicare Advantage (MA) plans in Southeastern Pennsylvania (SEPA), which encompasses the counties of Bucks, Chester, Delaware, Montgomery, and Philadelphia. The following MA products will be available to members in the SEPA region:

- **Freedom Blue PPO Valor**
- **Complete Blue PPO Choice Deluxe**
- **Complete Blue PPO Premier**

Background

In 2024, Highmark Blue Shield expanded into the SEPA region and began offering Commercial, Affordable Care Act (ACA), and self-insured plans to members who live in the region.

In 2025, Highmark Blue Shield will build on that initial expansion by offering MA plans to members in the SEPA region.

NAIC Information

When billing for members covered by MA plans in the SEPA region, providers should use NAIC Code **15460**.

The following alpha prefixes should be included with claims for these SEPA MA products:

- Freedom Blue PPO – **FAS**
- Complete Blue PPO Choice Deluxe – **FDE**
- Complete Blue PPO Premier – **FDE**

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Highmark to Offer Medicare Advantage Products in Southeastern PA Starting in 2025 *(Continued)*

Two MA PPO Network Sharing Local Plans

Effective Jan. 1, 2025, there will be two MA PPO Network Sharing Local Plans for Medicare Advantage in the five-county region of Southeastern Pennsylvania (SEPA): Highmark Blue Shield and Independence Blue Cross (IBC). If providers have a contract with both plans, they can choose which plan to send the out of area member claims to. If they see a Highmark member, the claims must be filed to Highmark. If they see an IBC member. the claim must be filed to IBC. When they see another Blue Plan member, they can choose which plan to file claims to.

Highmark Blue Shield Claim Process

Even if you are **not** contracted with Highmark, all claims for **Highmark Medicare Advantage** members with dates of service **Jan. 1, 2025, or later**, must be sent to **Highmark Blue Shield**.

Claims for your patients covered by Highmark MA plans with dates of service **prior to Jan. 1, 2025**, should still be sent to Independence Blue Cross.

Guidance on how to submit out of area Blue Plan members claims to Highmark Blue Shield can be found in the *Highmark Provider Manual:* 2.2 Medicare Advantage PPO Network Sharing.

Independence Blue Cross Claim Process

All claims for Independence Blue Cross members for dates of service Jan. 1, 2025, or later should be sent exclusively to Independence Blue Cross, even if you are not a contracted provider with them.

QUESTION:

How should MA member inpatient claims spanning from Dec. 31, 2024, to Jan. 2025, be billed? Should the claims be split by date of service?

No, the claims should not be split by date of service. The member's previous MA insurance carrier will provide coverage through the date of discharge, per CMS regulation 422.318, which states:

(1) Payment for inpatient services until the date of the beneficiary's discharge is made by the previous MA organization or original Medicare, as appropriate;

(2) The MA organization offering the newly elected MA plan is not responsible for the inpatient services until the date after the beneficiary's discharge.

Other Blue Plan Member Claims

Member claims — for any other Blue Plan that you are **not** contracted with — can be sent to either Highmark Blue Shield or Independence Blue Cross for processing; however, you will only be able to submit these claims to one of these plans. If you submit a claim to one of the two local Southeastern PA Blue plans, you will not be able to resubmit to the other. (**Example:** Claims sent to Highmark Blue Shield that are denied/rejected, may **not** be sent to Independence Blue Cross for reprocessing).

Claims originally submitted to Highmark Blue Shield must be completed with Highmark and claims originally submitted to Independence Blue Cross must be completed with Independence Blue Cross, including any follow-up actions on the claims.

For more information on filing MA PPO Network Sharing claims with Highmark, please visit the *Highmark Provider Manual*: 2.2 Medicare Advantage PPO Network Sharing on the Provider Resource Center.

CMS is the acronym for the Centers for Medicare and Medicaid Services.

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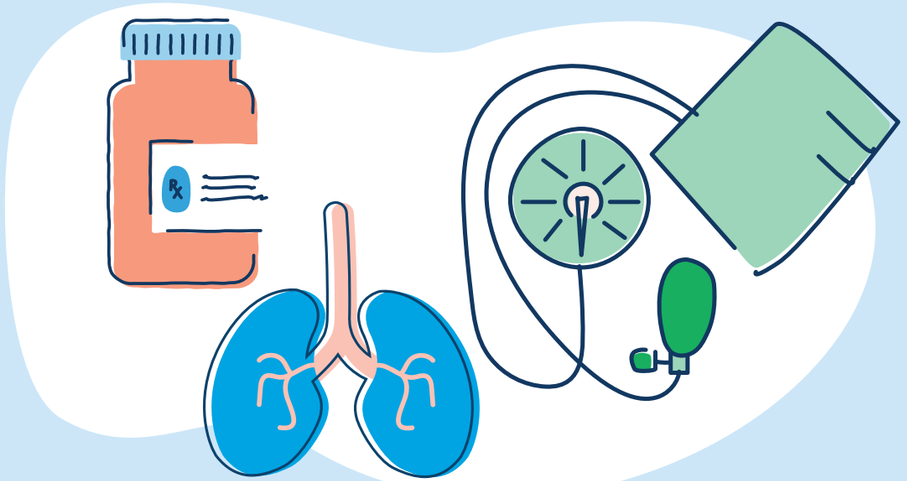
HEDIS Tips:
5 Ways to Close Gaps in the Next 60 Days



With the end of the year fast approaching, there's still time to close Healthcare Effectiveness Data and Information Set (HEDIS®) gaps. By doing so, you will improve patient care while also boosting your practice's quality scores.

These five HEDIS measures present an excellent opportunity for gap closure within the next two months:

1. Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis (AAB)

- **Measure:** AAB
- **Documentation:** Avoid prescribing antibiotics for acute bronchitis/ bronchiolitis day of visit or three days following unless patients have co-morbid diagnoses, such as pneumonia or COPD.
- **Exclusionary Codes:** Submit on claim any ICD-10 codes to exclude members with competing diagnoses (e.g., pneumonia, sinusitis).
- **Patient Education:** Inform patients about the potential side effects of antibiotics and recommend supportive care measures.
- **Resource:** See the article in July *Provider News*.

2. Diabetes – Glycemic Status Assessment Diabetes (GSD)

- **Measure:** GSD
- **Documentation:** Document HbA1c, point-of-care test, or average glucose results and date in the member's chart. Use the lowest result if multiple assessments are recorded on the same date.
- **CGM Data:** Remind members with continuous glucose monitor (CGM) devices to bring in their most recent average glucose results. Self-reported results are eligible if documented.

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HEDIS Tips: 5 Ways to Close Gaps in the Next 60 Days *(Continued)*

- **CPT II Codes:** Submit the appropriate CPT II code based on the HbA1c or average glucose value.
- **Resource:** See the recent Special Bulletin.

3. Hypertension – Controlling High Blood Pressure (CBP)

- **Measure:** CBP
- **Documentation:** Document multiple BP readings if elevated. Use the lowest systolic and diastolic readings if taken on the same day.
- **Home Monitoring:** Encourage home BP monitoring and document self-reported readings.
- **CPT II Codes:** Submit both a systolic and diastolic code to capture the completed BP reading.
- **Resource:** See the recent Special Bulletin.

4. Prenatal and Postpartum Care

- **Measure:** Prenatal/Postpartum Care
- **Coding:** Use CPT II codes for prenatal and postpartum visits.
- **Timing:** Prenatal care begins in the first trimester. Postpartum care occurs 7-84 days post-delivery.
- **Live Births:** Live births must be delivered between Oct. 8, 2023, and Oct. 7, 2024.
- **Resource:** See the recent Special Bulletin.

5. Statin Therapy

- **Measure:** Statin Therapy for Cardiovascular Disease
- **Exclusionary Codes:** Use the following ICD-10 codes to exclude members intolerant to statins due to myopathy, myositis, or myalgia:

ICD-10 EXCLUSION CODES	DEFINITION
G72.0	Drug-induced myopathy
G72.2	Myopathy due to other toxic agents
G72.9	Myopathy, unspecified
M60.80	Other Myositis, unspecified
M60.9	Myositis, unspecified
M62.82	Rhabdomyolysis
M79.10	Myalgia, unspecified site
M79.18	Myalgia, other site

- **Resource:** ICD-10 Exclusionary Codes For Members Intolerant To Statin Therapy

Key Takeaways

Coding and documentation are crucial for closing HEDIS gaps. Using the correct CPT II and ICD-10 codes — along with thoroughly documenting assessments, readings, and visits — allows for accurate HEDIS reporting.

Patient engagement matters. Encourage members to participate in self-monitoring and bring relevant data to appointments.

By following these tips, providers can ensure accurate HEDIS reporting and contribute to better patient care.

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

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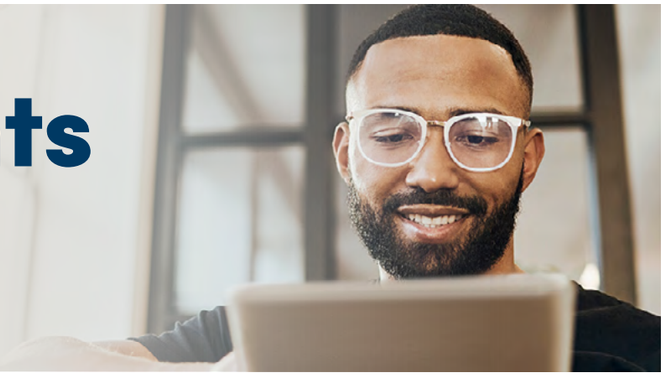

Highmark strives to deliver the best possible care outcomes for our members. One powerful tool that helps us achieve this is My Highmark, our secure online member portal and mobile app.

My Highmark brings together everything our members need to manage their benefits and reach their health goals, including:

- **Easy Access to Health Information** – Members can view their virtual member ID card, claims, benefits, and medical records.
- **Personalized Support** – Members can personalize their digital experience with a Health Assessment, creating a unique member journey to track health goals, screenings, and activities, such as chronic condition management, sleep improvement, and exercise.
- **Increased Engagement** – My Highmark helps to ensure that our members are more actively involved in their health care, so they can better adhere to treatment plans and make healthier choices.

In addition, your patients can gain access to clinical support programs that help them reach their goals and manage their health conditions between office visits, including:

- **Mental Well-Being powered by Spring Health** – Offers personalized care through self-guided tools and wellness coaching, and virtual care with a therapist or psychiatrist.
- **CHF and COPD Management powered by Vida** – For eligible patients with congestive heart failure (CHF) and/or chronic obstructive pulmonary disorder (COPD), this program supports patients between office visits through self-management and virtual one-on-one health coaching, to prioritize medication adherence and improve outcomes.
- **Virtual Physical Care Program** – With patient care provided by licensed physical therapists, members receive a "Digital Therapist" kit including a secure tablet, which provides access to their personalized Sword therapy program to help manage musculoskeletal pain.

My Highmark can be a valuable tool for both you and your patients. Highmark members can go to myhighmark.com or download the My Highmark app to create a new account with a username and password. Please encourage your patients to enroll in My Highmark and to regularly check into the portal/app.

Resources

- My Highmark
- Condition Management Programs

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SHORT TAKES:

U.S. Digestive Health, ED Claim Audits Reminder, and More

U.S. Digestive Health Returns to Highmark Network Effective September 20, 2024

On July 1, 2024, U.S. Digestive Health's (USDH) provider agreements with Highmark in Delaware and Pennsylvania expired.. We have spent the past several months negotiating to ensure we reached an agreement that is acceptable to the provider(s) and limits cost increases to the members and employers we serve.

U.S. Digestive Health and Highmark have now come to terms on an agreement that will allow our members to again have in-network access to USDH practices, **effective Sept. 20, 2024**. Members who were previously notified of USDH's out of network status will receive a letter now that a new agreement is finalized.

For more information, please read our press release.

Reminder: Emergency Department Claim Audits Using CMS Criteria

Effective Sept. 1, 2023, Highmark began auditing all outpatient Emergency Department facility claims to ensure the correct procedure codes are being billed. These audits are designed to determine the appropriate and fair level of facility reimbursement for emergency department services based on the Centers for Medicare and Medicaid Services (CMS) criteria for the appropriate procedure code. For more information, see the recent Special Bulletin.

Medicare Update: No Cost-Sharing for Pre-Exposure Prophylaxis for HIV Prevention

Effective Sept. 30, 2024, Pre-Exposure Prophylaxis (PrEP) to prevent HIV is now covered without cost-sharing by the Centers for Medicare and Medicaid Services (CMS) under Medicare Part B.

HIV PrEP for prevention drugs were previously covered under Medicare Part D and were typically subject to a deductible and coinsurance or co-pay. CMS transitioned coverage of PrEP for HIV prevention to Medicare Part B, and beneficiaries have no Part B cost-sharing obligations (i.e., deductibles or co-pays).

Antiretroviral drugs used for the treatment of HIV continue to be covered under Medicare Part D, even though these may be the same drugs that are used for HIV PrEP. To learn more, go here.

Changing: The Process for Appealing Credentialing Decisions for Professional Providers in DE and WV

Effective Nov. 15, 2024, all appeals of Credentials Committee decisions for Delaware (DE) and West Virginia (WV) professional providers will be presented to the Highmark Network Quality and Credentials Committee (NQCC). Appeals will no longer be presented to the Appeals Review Committee (ARC). The reconsideration step is being removed. To learn more, click here.

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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 30% of a health plan's Medicare Star Rating is based on the survey scores.

The CAHPS survey is scheduled to take place during the second quarter of 2025.

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**

These measures contain questions that ask members if they found it easy to get the care, tests, and treatment they needed; if they were able to get appointments for routine and specialist care when needed; if their doctor was informed about their care and helped to manage it and they received test results when they needed them; and the overall rating of the quality of their health care.

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

Your staff can also improve patient satisfaction by:

- Leaving some open appointment slots each day for urgent and post-inpatient visits.
- Reducing perceived wait times by assigning staff to perform preliminary work-up activities, such as blood pressure and temperature checks.
- Providing brief and frequent updates for appointment schedule delays and offering options to reschedule or be seen by another provider.
- Encouraging patients to make routine checkup or follow-up appointments in advance.
- Proactively scheduling patients — by phone, text, or email — months in advance for tests, screenings, or physicals.

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

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MENTAL WELL-BEING SOLUTION for LOW-ACUITY NEEDS

Highmark's Mental Well-Being powered by Spring Health can help your Highmark commercial, Affordable Care Act (ACA), self-funded Administrative Services Only (ASO), and Medicare Advantage patients with low-acuity needs like stress and burnout. Your patients do not need to have a diagnosed mental health condition to enroll in the Mental Well-Being solution.

Major news events, financial worries, occupational stress/work-life balance struggles, childcare concerns, and an upcoming election can all add to the daily stresses and pressures of life for some of your patients.

Self-Guided Tools

Mental Well-Being offers resources from self-guided tools for meditation and mindfulness exercises to wellness coaching **at no cost to your patients**. These tools may be beneficial for patients whose needs do not meet a diagnosed mental health condition or who may not be interested in therapy or medication for their mental health needs.

Once your patients are enrolled with Mental Well-Being through the My Highmark member portal, they have complete access to the solution and can use it for every level of need. If your patient's condition changes over time to a higher level of care, they will have access to additional tools and can schedule appointments with a therapist at a time that works best for their busy schedule.

We encourage you to speak with your eligible Highmark patients about enrolling in Mental Well-Being to receive individuated support for their unique needs.

For additional information about this solution, you can watch the Mental Well-Being provider webinar on the Provider Resource Center (PRC). More resources are available at the Behavioral Health Telemedicine and Virtual Visits page.

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Authorization Updates

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

- **Call the number on the back of the member's card**
- **Check the member's eligibility and benefits via Availity®**
- **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:

Prior Authorization Changes in the New Year

Click here to read this month's top story. To learn more about the changes that occurred on Sept. 30, go here.

Approved Authorizations to be Conveyed via Highmark's Automated Call System

Highmark will be moving to an automated call system for **approved** authorization requests requiring a call, **effective Nov. 15, 2024**. Both members and providers will be notified of approved authorization requests from the automated call system rather than a Highmark customer service representative.

This change will help Highmark reduce unnecessary health care expenditures, while delivering more effective member and provider outreach. For more information, see September *Provider News*.

Eight Breast MRI Codes to be Removed from Prior Authorization List

Effective Nov. 1, 2024, the following eight breast MRI codes will be removed from the prior authorization list:

Procedure Code	Description
C8903	MRI breast with contrast, unilateral
C8905	MRI breast with and without contrast, unilateral
C8906	MRI breast bilateral with contrast
C8908	MRI breast bilateral with and without contrast
77046	Magnetic resonance imaging, breast, without contrast material; unilateral
77047	Magnetic resonance imaging, breast, without contrast material; bilateral
77048	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral
77049	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; bilateral

Beginning Nov. 1, 2024, these eight procedures will no longer require prior authorization.

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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.

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

RECENTLY UPDATED

Oct. 28, 2024

RP-054 Ambulance Services

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

UPCOMING

Nov. 4, 2024

RP-008 X-rays Using Film, Computed Radiography and Computed Tomography: Modifiers FX, FY, CT

This policy was reviewed as part of our standard review process. No changes in direction will be made.

Jan. 1, 2025

(RP updates effective Jan. 1, 2025, will be available for review on the PRC on Dec. 31, 2024, due to the New Year's Day holiday.)

RP-020 Preventive Medicine and Office/Outpatient Evaluation and Management Services

This policy will be updated for Medicare Advantage markets in Delaware, Pennsylvania, and West Virginia to apply a reduction for multiple evaluation and management services done on the same day. When an Annual Wellness Visit (AWV) or Initial Preventive Physical Examination (IPPE) is performed on the same date of service as a routine physical exam by the same physician/provider or physician/provider group, the plan will reimburse the AWV or IPPE at 100% and the routine physical at 50% of the approved allowed amount.

NEW: RP-078 Postoperative Sinus Debridement

This new policy — applicable to Commercial and Medicare Advantage markets — will address postoperative sinus debridement and service related to sinus surgery. *(NOTE: This policy is not yet available on the PRC.)*

NEW: RP-079 Multiple Ultrasounds

This new policy — applicable to Commercial and Medicare Advantage markets — will address circumstances surrounding the appropriate reporting of non-obstetrical and obstetrical transabdominal and transvaginal ultrasounds. Reimbursement for multiple procedure payment reductions may be applicable when multiple services are provided during a patient encounter by the same physician or same group physician/other health care professional. *(NOTE: This policy is not yet available on the PRC.)*

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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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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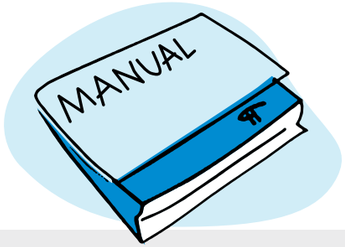
Staying Up to Date with the *Provider Manual*

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 6: The BlueCard Program**
- **Chapter 3, Unit 1: Network Participation Overview**
- **Chapter 4, Unit 1: PCPs and Specialists**
- **Chapter 5, Unit 3: Medicare Advantage Procedures**
- **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.

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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.

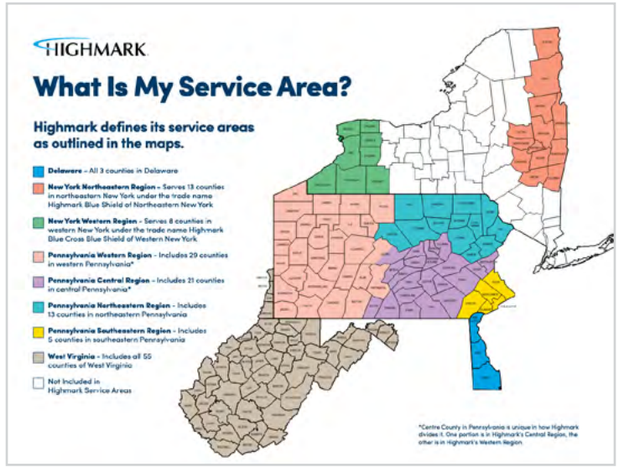
Comments/Suggestions Welcome

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



PROVIDER NEWS

A newsletter for the Highmark Blue Cross Blue Shield Delaware providers

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The Blue Cross Blue Shield Association is an association of independent, locally operated Blue Cross and Blue Shield companies.

Atlas Systems, Inc. is a separate and independent company that conducts physician outreach for Highmark.

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