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A newsletter for the Highmark Blue Cross Blue Shield Delaware providers

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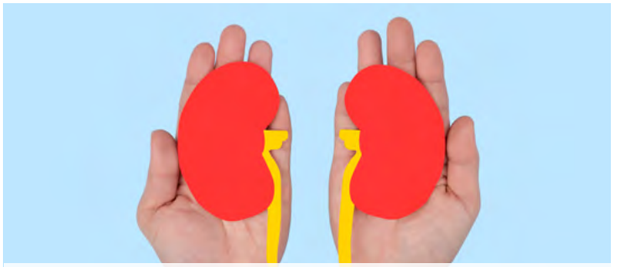
Electronic Claims: *GET PAID FASTER*

TOP STORIES:

Simplifying Prior Authorization with Active Gold Carding and Other Innovations

Short Takes: MA Products in SEPA, MA Out-of-Area Members, and More



Diabetes and Kidney Disease: A Comprehensive Approach to Patient Care

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Electronic claims are the better option for your office or facility.

They're faster to submit for providers, faster to process for Highmark, and result in faster payment than paper claims.

They also require much less administrative work than their paper counterparts. There's no need to print forms, bundle letters, buy postage, and drop in the mail.

Electronic claims can be submitted 24/7 via the Availity® portal or Electronic Data Interchange (EDI).

Paper Claims – A Slower, More Error-Prone Process

Paper claims have a higher error rate because information must be manually inputted, which results in mistakes... which leads to unnecessary denials or rejections... which means claims need to be corrected and resubmitted... before they can eventually be processed and paid.

Using electronic claims avoids this drawn-out scenario. For electronic claims, most errors are flagged during the submission process, allowing administrative personnel to correct the mistake and successfully submit the claim.

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When a real-time electronic claim is submitted successfully, you may receive confirmation — along with a claim number — that enables you to track the claim's progress as it's being processed.

Electronic claims have higher acceptance rates, while reducing staff time needed for claim research and resubmissions.

Submitting Electronic Claims

There are two ways to submit electronic claims:

1. Availity Essentials – a secure, full-service web portal that offers electronic solutions at no charge for providers to perform essential claim processes.

   If your organization is not already registered with Availity, visit the Register and Get Started with Availity Essentials webpage.

   The Electronic Claims page on the Provider Resource Center has valuable guides and helpful links on submitting claims electronically, checking their status, and making claims inquiries.

2. **Electronic Data Interchange (EDI)** – This primary method of electronic connectivity enables claims or electronic inquiries to be submitted through a provider's clearinghouse or directly from their existing practice management software.

For information on how to bill through EDI, providers should contact their clearinghouse or practice management software vendor. To sign up for EDI or for more information, choose the applicable link below:

- **Delaware:** edi.highmark.com/edi-bcbsde/index.shtml
- **New York:** www.ask-edi.com
- **Pennsylvania:** edi.highmark.com/edi/index.shtml
- **West Virginia:** edi.highmark.com/edi-wv/index.shtml

EDI transaction and connectivity specifications are available in the **Resources** section of each *edi.highmark.com* website listed.

The Electronic Advantage

While the majority of offices and facilities submit claims electronically, there are still a surprising number of organizations that rely on paper claims.

If your practice or facility is one of those offices, you have a **tremendous opportunity** to save administrative costs and increase productivity, while at the same time, getting paid faster for the care you provide to patients.

It's easy — simply make the switch to electronic claims.

Additional Resources

- **Availity** – In the Availity Essentials navigation bar, select **Help & Training > Get Trained** and then search for "Claim Submission for Highmark Providers."
- Highmark's ***Provider Manual*** – 6.2 Electronic Claim Submission.

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Simplifying Prior Authorization with Active Gold Carding and Other Innovations

By Catherine Clements

Originally published in the *Highmark Health Digital Magazine*.

Across the industry, the current state of utilization review and management is too often a barrier to good health. While prior authorizations are intended to ensure compliance with evidence-based practices, they can be an obstacle to appropriate care, delaying diagnosis and treatment.

Ninety-four percent of physicians report prior authorization has caused delays in accessing necessary care. More than nine in 10 physicians said that prior authorizations can have a negative impact on patient outcomes. These delays and negative impacts directly translate to increased stress and frustration for patients, who often face lengthy wait times and struggle to understand the rationale behind authorization decisions.

"Utilization management in its current form is the antithesis to a remarkable health experience — it's a pain point for patients, doctors, health plans and the government," says Tony Farah, MD, FACC, FSCAI, chief medical and clinical transformation officer. "At Highmark Health, we're on a mission to make the health care experience simple and seamless for providers and customers."

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In this article, Dr. Farah and Tim Law, DO, MBA, chief medical officer and vice president of integrated care delivery at Highmark, share how the health plan takes a fundamentally different approach to utilization management by collaborating with providers on shared goals for improving care and controlling costs. Learn more about how Highmark's Gold Carding and Active Gold Carding programs are improving the prior authorization process for everyone.

Balancing Care and Costs: The Role of Utilization Management

Catherine Clements: We know that prior authorization and other aspects of payer utilization management are pain points for many providers. Can you start by talking about why utilization management is necessary?

Dr. Tim Law: Utilization management is necessary because, as a health plan, we have two responsibilities: a medical responsibility to our members to make sure they get appropriate care at the right time and place, and a fiduciary responsibility to the people that pay premiums, like employers.

Whether the health plan is involved or not, most doctors are prescribing the right things — and for that population of clinicians we want to stay out of their way. On the other side, doctors may need some guidance or support eliminating procedural errors on authorizations. For example, a simple mistake like ordering a cardiac test with contrast when it's not needed can lead to delays and unnecessary costs. Through our health plan data, we've found that a significant percentage of denials are attributed to administrative errors as opposed to poor medical decision making.

Catherine Clements: Dr. Farah, what challenges are top of mind for you?

Dr. Tony Farah: Prior authorizations are costly and are associated with a significant administrative burden. Providers request an average of 45 authorizations per physician per week — that's the equivalent of two days of physician and staff time.

These slow, complex authorization processes allow for tens of millions of dollars of waste in the health care system. It's our responsibility, and it's consistent with our Living Health strategy, to eliminate the barriers that get in the way of having a remarkable health experience for everyone involved.

Dr. Tim Law: The remarkable health experience isn't just for members — it's for providers too. We're trying to make the whole system better for everybody. When providers are supported and satisfied, they can focus on delivering the best care to their patients.

Gold Carding

Catherine Clements: Variation in care still exists, despite widely endorsed evidence-based guidelines. How are we addressing this?

Dr. Tony Farah: Health plans should not be in the business of telling physicians how to practice medicine — we understand that, and I've been a big voice in that. But clinical variation is present across the country, even at the most sophisticated health systems. Most of the clinical variation I would put in the confines of the art of medicine, because we treat every patient that we see based on their individual conditions and attributes. That's not the kind of variation we are trying to reduce — we want to reduce variation that goes beyond what most physicians agree should not be taking place, and that really doesn't adhere to evidence-based guidelines.

Catherine Clements: In recent years, Gold Carding has emerged as a tool to streamline prior authorization. Can you tell me more about Highmark's Gold Card Program?

Dr. Tim Law: Gold Carding is a transformative way to do utilization management. It removes some procedural requirements, allowing for a shorter timeframe between diagnosis and treatment. At Highmark, providers are Gold Carded once they reach

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a high level of adherence (99%+) to evidence-based clinical care guidelines. This eligibility criteria can vary in accordance with state mandates and does take into account certain patient-to-patient variations that arise in many areas of medicine.

Once Gold Carded, providers only submit a prenotification to schedule services — no clinical information is needed, and approval is granted immediately. Providers can expect up to an 85% reduction in administrative processing time. That means less need for peer-to-peer reviews and more time for patient care. By providing instant approval at the point of care, Gold Carding eliminates the need for phone calls, emails, and delays. Patients leave your office knowing their treatment is approved and that the test or procedure can be promptly scheduled. Doctors are eager to participate in this program because they want appropriateness of care to be an outcome for them while simultaneously reducing administrative burdens.

Catherine Clements: How does the adherence rate (99%+) we set as an organization compare to other Gold Card programs?

Dr. Tim Law: Our standard is above that of the industry. The 99th percentile gets us to the point where the doctor is truly performing — providing the right care for their patients nearly all the time. We believe every clinician can and should be Gold Carded — and we're going to help them get there. That's why we're collaborating directly with clinicians to provide a pathway to get them to 99% through our Active Gold Carding Program.

Some states mandate Gold Card approval based on a threshold of 80-90% appropriate care. That means you're willing to accept suboptimal care, whether it's clerical or bad medicine, for up to 20 out of every 100 people. Simply setting a minimum threshold for specific modalities is not enough.

Dr. Tony Farah: That low of a threshold won't move the needle on improving health outcomes, and it doesn't alleviate the burdens that we're talking about.

Dr. Tim Law: Right, to create a remarkable health experience means improving the health of the community that you're serving from both the provider and health plan side. If you get too low approval rates, you're propagating suboptimal care, and that's not what we want to do.

Expanding Gold Carded Modalities

Catherine Clements: How has Highmark grown and scaled its Gold Card Program?

Dr. Tim Law: We initially launched Gold Carding in January 2022, expanding in May 2023 for a total of 400 providers. As of September 2024, we've grown the program to more than 21,000 Gold Carded providers. More than half of those providers are Gold Carded for two or more modalities. This is important, because if you're only Gold Carded for one modality, that's not going to reduce the administrative burden of the practice.

In the last 12 months, we've had over 400,000 authorizations submitted by our Gold Carded clinicians. We've also reduced our cost to process an authorization significantly, allowing us to manage more and pass savings to members.

Catherine Clements: What sets Highmark's Gold Card Program apart from the industry?

Dr. Tim Law: Where Highmark is differentiating is by constantly evaluating modalities to add to the Gold Card Program. Other organizations set their top codes and stop there. Instead, we're continuously refreshing codes based on our data and direct clinician input. We're also leading the industry through our Active Gold Carding Program.

Catherine Clements: Direct clinician input — that is a significant differentiator from other health plans. We have clinician leaders at the table to help shape these decisions. We'll dive deeper into Active Gold Carding next. But first, tell me more about where we're at with automation and electronic submissions?

Dr. Tim Law: For modalities clinicians prescribe correctly 100% of the time, we're automating it. Before electronic submission of authorizations, there were a lot

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of phone calls and faxes. We're aiming to get to 70% of authorizations submitted electronically by 2025. Once we get practices to adopt the portal, we can move forward quickly, positively impacting the bottom line and providing quicker care. We're trying to think outside the box to get as much off the doctor's plate as we can so that they can focus on taking care of patients.

Dr. Tony Farah: Automation for authorizations and Gold Carding go hand in hand. You can automate the existing process and not Gold Card a single physician — if we don't actively Gold Card physicians, we won't address the appropriateness. It's just not enough.

Catherine Clements: What modalities are included in Highmark's Gold Carding Program?

Dr. Tim Law: We're expanding the program to include additional modalities, and it's good to check our Provider Resource Center for up-to-date information. As we speak, physicians are eligible to be Gold Carded for 14 different modalities, including CT, ECHO, MRI, pain injection, nuclear medicine, PET/PET CT, diagnostic heart cath and more. We believe we'll soon be the first health plan in the country to actively Gold Card for neuro spine surgery, laminotomy, laminectomy and single level fusions. Expanding Gold Carding for inpatient care, post-acute care, behavioral health, and pharmacy are also on our roadmap.

Catherine Clements: Can you give me an example of how the streamlined authorization process makes a difference for patients and clinicians?

Dr. Tim Law: Absolutely. One of the first codes we added to the Gold Carding Program was pain injections. Streamlining this approval process helps prevent patients from resorting to opioids because they can't get timely pain injections. By removing unnecessary barriers for appropriate pain management, we can reduce avoidable opioid prescriptions.

Additionally, the way we manage cancer tracking and diagnosis is positively impacting the experience for patients and clinicians. For instance, we know that in the post treatment of lung cancer, a patient needs to have six PET scans over a course of two years. Instead of requiring authorization for each scan, we'll say, when you ask for this PET scan for this lung cancer, you get approved for six PET scans over the next 24 months. We've granted authorization for all six, do them when you need them. Let's leave medicine in the hands of the doctors.

Active Gold Carding

Catherine Clements: Gold Carding is a step forward in utilization management, but it doesn't solve the root problem of why authorizations get denied. Dr. Farah, how is Highmark addressing this?

Dr. Tony Farah: We're focused on educating and empowering providers to get prior authorizations right through what we call Active Gold Carding. This approach actively engages providers to ensure they are submitting accurate and clinically appropriate requests, thereby reducing denials and streamlining the process. The process involves providing them with actionable information, enabling them to improve their ability to achieve this level of performance.

Dr. Tim Law: Active Gold Carding is where we look at not only those providers that meet the metrics for instant prior authorizations, but those that are getting close. We leverage a concierge nurse to provide real-time feedback and live in-person or virtual coaching to help practices avoid denials and improve authorizations.

Dr. Tony Farah: Highmark is the only payer in the industry that grows its Gold Carding program through direct engagement with providers. Fostering close collaboration with providers is key to our success. Our unique structure as a blended payer-provider health organization allows us to provide valuable insights for our providers to maximize positive health outcomes.

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Simplifying Prior Authorization with Active Gold Carding and Other Innovations *(Continued)*

From our perspective, there should be no reason why all physicians aren't Gold Carded. By creating a pathway to Gold Carding, Highmark helps to improve patient and clinician experience and access to care while reducing avoidable costs.

Catherine Clements: How have we deployed the Active Gold Carding Program?

Dr. Tony Farah: Last year, we piloted the program with 250 Allegheny Health Network (AHN) providers, simply explaining our Active Gold Carding concept and tracking performance based on claims, volume, and appropriateness data. In just a few months, request volume decreased. This demonstrated that providers are motivated to proactively engage in solving the prior authorization problem.

Dr. Tim Law: As of September 2024, we have more than 1,200 clinicians in the Active Gold Carding Program. Some have already graduated into the Gold Card Program. We're getting ready to expand even farther across our footprint.

Dr. Tony Farah: We're initiating Active Gold Carding first with our strategic provider partners such as Allegheny Health Network, Christiana Care, Penn State Health, Lehigh Valley Health Network and the Great Lakes Integrated Network.

Evolving Utilization Management

Catherine Clements: What's on the roadmap for further innovation and improvement in utilization management?

Dr. Tony Farah: We're exploring a partnership with an organization specializing in cancer care to establish value-based, standardized protocols, in collaboration with doctors, for cancer treatment. This partnership represents a significant advancement in the utilization management process for cancer, offering a more efficient and patient-centered approach.

Dr. Tim Law: We are working to expedite and automate prior authorization processes to the point that they are seamless and occur behind the scenes for a provider. We have a robust roadmap for further scaling our automation authorization capabilities using AI and machine learning, while integrating the authorization experience within the electronic medical record.

Dr. Tony Farah: We're really excited about the direction we're headed. We have the vision, the team, and the roadmap in place to create a differentiated experience for patients and clinicians. While we're just one payer, we're committed to making our interactions with providers stand out. We believe that by focusing on a truly exceptional experience, we can contribute to a better health care system for everyone.

To learn more about the backgrounds of Dr. Tony Farah and Dr. Tim Law, click here.

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SHORT TAKES:

MA Products in SEPA, MA Out-of-Area Members, and More

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**

For more information, see the article in last month's *Provider News*.

Medicare Advantage: How to Bill for Out-of-Area Members

All Blue Medicare Advantage (MA) PPO Plans participate in reciprocal network sharing. Under this Inter-Plan arrangement, Blue Medicare Advantage PPO members will receive in-network benefits when traveling or living in the service area of any other participating Blue MA PPO Plan.

As long as covered services are provided by participating MA PPO providers, the member's in-network benefit level will apply.

To read more about MA billing information, click here.

Reminder: For Drug Wastage Claims, Use Modifiers: JW And JZ — It's Required!

Highmark follows industry standards — consistent with the Centers for Medicare and Medicaid Services (CMS) approach — requiring the use of the drug wastage modifiers JW and JZ.

Drug wastage modifiers should be present on all applicable claims, as this policy noted. These modifiers are as follows:

- **JW –** Drug / biological amount discarded / not administered to any patient.
- **JZ –** Zero drug amount discarded / not administered to any patient.

To learn more, go here.

The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a new payment option for Medicare members that works with Highmark's Part D drug coverage to help members manage out-of-pocket costs. While this option may help members manage their monthly expenses, it does not save members money or lower their drug costs. To learn more about the Medicare Prescription Payment Plan, go here.

Express Scripts Will Continue to Stock Freestyle Libre, Rhopressa, and Rocklatan

Express Scripts Pharmacy previously announced that it will no longer stock and dispense 32 medications, effective Oct. 1. However, since the list was shared, the decision has been reversed for the following drugs:

Drug Name	NDC	Common Indication for Use
Freestyle Libre 14 Day	57599000101	Single Source Brand
Freestyle Libre 2 Sens	57599080000	Single Source Brand
Freestyle Libre 3 Sens	57599081800	Single Source Brand
Rhopressa	70727049725	Single Source Brand
Rocklatan	70727052925	Single Source Brand

To read the **Special Bulletin**, click here.

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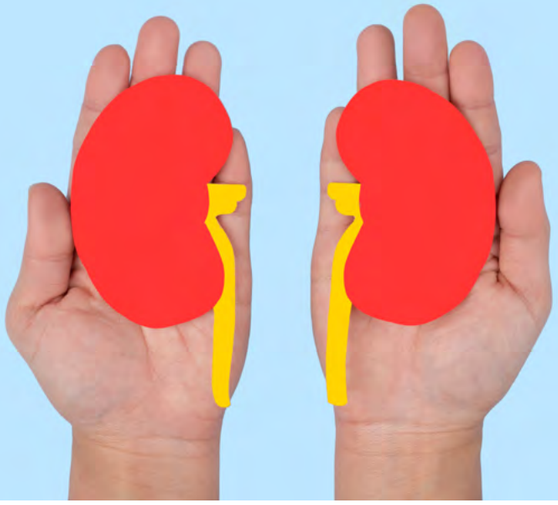
Diabetes and Kidney Disease: A Comprehensive Approach to Patient Care

Diabetes is the leading cause of kidney disease, and many individuals with diabetes may be unaware they have developed kidney complications. Early detection and management are crucial to slowing or preventing the progression of diabetes-related kidney disease (DKD).



Understanding and Combatting the Silent Threat

DKD often progresses silently, with symptoms only appearing after significant kidney function loss. This makes regular screening and proactive management essential.

Key Screening Recommendations

- **Annual Screening:** For individuals with type 1 diabetes for 5 years or more, and all individuals with type 2 diabetes, annual checks for urinary albumin (UACR) and estimated glomerular filtration rate (eGFR) are recommended.
- **Established Chronic Kidney Disease (CKD):** Patients with established CKD should undergo more frequent testing (1-4 times yearly) for UACR and eGFR, depending on the stage of kidney failure.

Treatment Strategies for DKD

A multidisciplinary approach is essential, focusing on the following factors:

- **Enhanced Glucose Management:** Tight blood glucose control is crucial to slowing the progression of DKD.
- **Blood Pressure Control:** Maintaining optimal blood pressure levels helps reduce the risk of both DKD and cardiovascular disease.
- **Medications:** ACE inhibitors, ARBs, mineralocorticoid receptor antagonists, and SGLT2 inhibitors may be prescribed to slow the progression of DKD and reduce cardiovascular risk.
- **Nephrologist Evaluation:** Referral to a nephrologist is recommended for patients with:
  - o Steadily increasing urinary albumin levels or decreasing eGFR.
  - o Uncertainty about the cause of kidney disease.
  - o Difficulty managing DKD (anemia, metabolic bone disease, resistant hypertension, electrolyte disturbances, etc.).
  - o Advanced kidney disease requiring renal replacement therapy.

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Empowering Patients Through Shared Decision-Making

A comprehensive care plan should be developed collaboratively with patients, addressing their individual needs and preferences. Encourage patients to actively participate in their care, asking questions, understanding their medications, and tracking their progress.

Community support is a powerful resource. Connect patients with support groups and resources to foster a sense of community and shared experience.

By working together, healthcare professionals and patients can effectively manage DKD, preserve kidney function, and improve overall health outcomes.

Closing Gaps

This is accomplished through the Kidney Health Evaluation (KED) measure, a HEDIS® metric supported by the NCQA (National Committee for Quality Assurance). The KED measure assesses the percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) ***and*** a urine albumin-creatinine ratio (UACR), during the measurement year. This includes:

- At least one eGFR

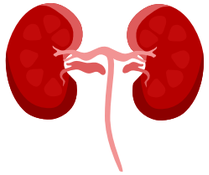
  AND

- At least one UACR identified by either of the following:
  - ***Both*** a quantitative urine albumin test ***and*** a urine creatinine test ***with*** service dates four days or less apart.

The following CPT II codes will meet measure compliance and close the member's gap:

- **eGFR:** 80047, 80048, 80050, 80053, 80069, 82565
- ***Urine*** **Albumin:** 82043
- ***Urine*** **Creatinine:** 82570

Members will be excluded from the measure for either of the following any time during their history:



- **Diagnosis of End Stage Renal Disease (ESRD)**
  - **ICD-10 codes:** N18.5 (Stage 5), N18.6 (Stage 6), Z99.2 (Dialysis)
- **Dialysis**
  - **CPT II codes:** 90935, 90937, 90945, 90947, 90997, 90999, 99512

HEDIS® — an acronym for Healthcare Effectiveness Data and Information Set — is a registered trademark of the National Committee for Quality Assurance

Additional Resources

Chronic Kidney Disease and Risk Management: Standards of Care in Diabetes—2024 | Diabetes Care | American Diabetes Association (diabetesjournals.org)

Chronic Kidney Disease in Diabetes: Guidelines from KDIGO | AAFP

Chronic Kidney Disease | Diabetes | CDC

Diabetes Management in Chronic Kidney Disease: A Consensus Report by the American Diabetes Association (ADA) and Kidney Disease: Improving Global Outcomes (KDIGO) | Diabetes Care | American Diabetes Association (diabetesjournals.org)

Why Is Chronic Kidney Disease (CKD) on the Rise? 6 Things to Know > News > Yale Medicine

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.

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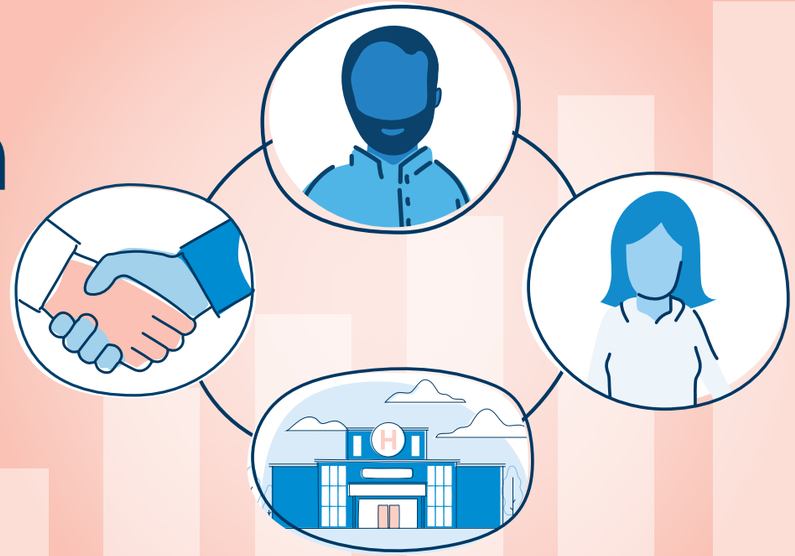
Care Coordination Leads to Better Patient Outcomes



The Highmark Quality Program focuses on the continuity and coordination of patient medical care with behavioral health and primary care providers (PCPs). Working with Highmark on the coordination of care enables practitioners to share educational resources that promote patient self-care and/or connect patients to other community support.

In addition, Highmark works with network organizational providers — **hospitals, emergency facilities, ambulatory surgery centers, home health agencies, and skilled nursing facilities** — to promote continuity and coordination of care by encouraging communication with PCPs when care is delivered to their patients.

PCPs should expect a written description of the care given to their patients any time services have been rendered by organizational providers.

Additional information is available in the *Highmark Provider Manual*, Chapter 5 Unit 6: Quality Management.

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Cultural and Language Resources on the PRC

Providing quality care requires not only excellent medical skills and training but also the ability to communicate effectively with patients. That can be especially challenging when caring for patients who are non-native speakers of English.

The Provider Resource Center (PRC) features a variety of cultural and language resources for providers and their teams, including:

- Centers for Disease Control and Prevention Languages
- Cultural & Health Literacy Training
- Integrating Cultural Information into Clinical Practice
- The Office of Minority Health
- National Institutes of Health – U.S. National Library of Medicine MedlinePlus

To access these resources on the PRC, go here.

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Authorization Updates: Changes in the New Year

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:

JAN. 1 CHANGES

Some eviCore-Managed Services Moving to Highmark

Effective Jan. 1, 2025, the management of more than 80 codes that require prior authorization will move from eviCore to Highmark. The codes represent some 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**

IMPORTANT: *For providers who submit authorization requests directly to eviCore, they will need to submit the codes listed below directly to Highmark via the Availity portal, effective Jan. 1, 2025.*

To learn more, go here.

Medical Injectable Drug Ilumya

Effective Jan.1, 2025, the medical injectable drug noted below will require prior authorization before the medicine can be administered to Highmark members. Highmark will revise its **List of Procedures/DME Requiring Authorization by adding the following procedure code on Jan. 1, 2025:**

Procedure Code	Generic	Brand
J3245	Tildrakizumab-asmn	Ilumya

NOTE: This drug will not require authorization and will not appear on the all-inclusive authorization list on the Provider Resource Center **until the effective date**, Jan. 1, 2025. Plan-preferred product considerations may apply in line with member benefits. Please confirm the most up-to-date coverage criteria outlined in Highmark's applicable Medical Policies, available on the Provider Resource Center.

FEB. 1 CHANGES

100+ Codes to Be Added to Prior Auth List

Effective Feb. 1, 2025, more than 100 codes will be added to the prior authorization list, including those 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 view the codes, click here.

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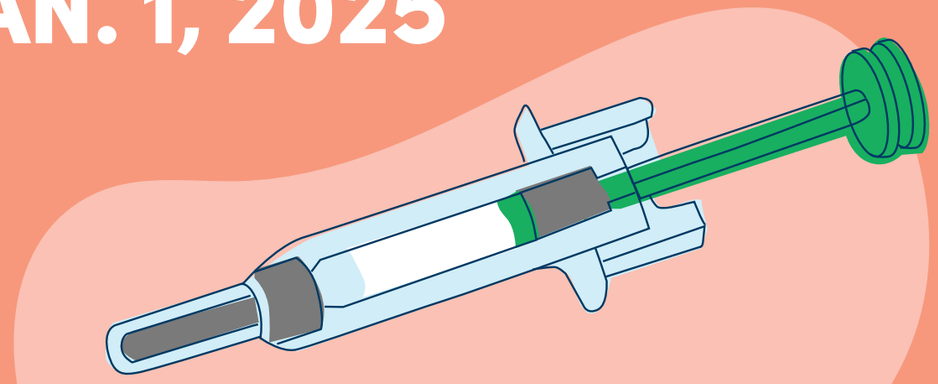
IN THIS ISSUE:

MEDICAL INJECTABLE DRUG to REQUIRE Prior Authorization on JAN. 1, 2025



Effective Jan.1, 2025, the medical injectable drug listed below will require prior authorization before the medicine can be administered to Highmark members. Highmark will revise its List of Procedures/DME Requiring Authorization by adding the following procedure code on Jan. 1, 2025:

Procedure Code	Generic	Brand
J1628	guselkumab	Tremfya (intravenous)

Intravenous guselkumab (Tremfya) will not require authorization and will not appear on the all-inclusive Medical authorization list on the Provider Resource Center **until the effective date, Jan. 1, 2025**. Plan-preferred product considerations may apply in line with member benefits. Please confirm the most up-to-date coverage criteria outlined in Highmark's applicable Medical Policies, available on the Provider Resource Center.

Note: *Guselkumab (Tremfya) is also available as a subcutaneous injection which can be self-administered and managed under the* ***Pharmacy benefit****.*

Directory Information—
Here's How to Attest

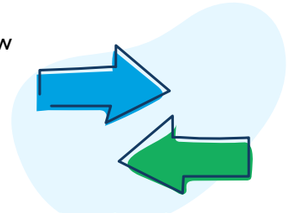
PROVIDER NEWS

A newsletter for the Highmark Blue Cross Blue Shield Delaware providers

Issue 11, November 2024

IN THIS ISSUE:

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

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.

Nov. 18, 2024

RP-072 Injection and Infusion Services

Effective Nov. 18, 2024, this policy is no longer in use and was archived.

UPCOMING

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.)*

Feb. 24, 2025

RP-053 Advanced Gene and Cellular Therapies

The following updates will be made to this policy:

- Cellular therapy Tecelra and gene therapy Beqvez will be added
- Not Otherwise Classified (NOC) will be replaced with Healthcare Common Procedure Coding System (HCPCS) code J3393 for Zynteglo and code J3394 for Lyfgenia
- References to related Highmark medical policies were updated for Lenmeldy and added for Beqvez

March 31, 2025

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.)*

COMING SOON

Effective Date to Be Determined

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.)*

PROVIDER NEWS

A newsletter for the Highmark Blue Cross Blue Shield Delaware providers

HIGHMARK

Issue 11, November 2024

IN THIS ISSUE:

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.

Directory Information—
Here's How to Attest

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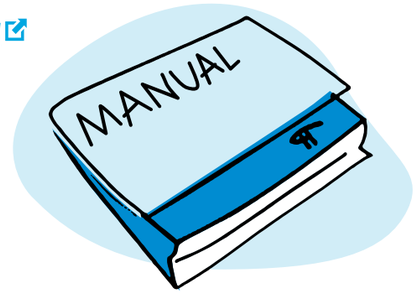
IN THIS ISSUE:

Join Our Mailing List
Stay informed and never miss out on what matters!

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 2: Online Resources & Contact Information**
- **Chapter 2, Unit 2: Medicare Advantage Products & Programs**
- **Chapter 3, Unit 2: Professional Provider Credentialing**

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

Directory Information—
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PROVIDER NEWS

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IN THIS ISSUE:

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.

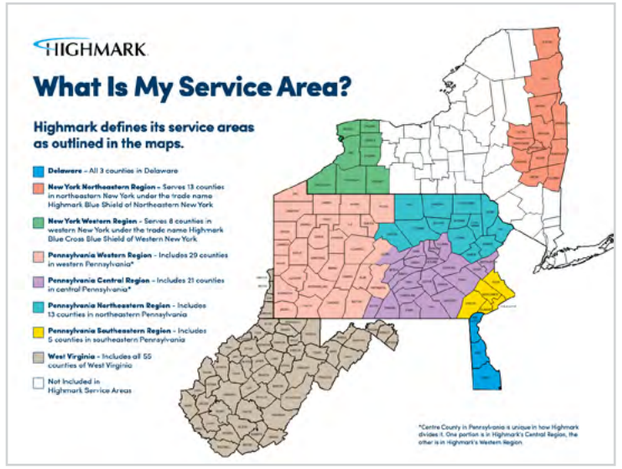
Comments/Suggestions Welcome

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

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IN THIS ISSUE:

Legal Information

Highmark Blue Cross Blue Shield Delaware is an independent licensee of the Blue Cross and Blue Shield Association. BlueCard is a registered trademark of the Blue Cross and Blue Shield Association.

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

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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Note: This publication may contain certain administrative requirements, policies, procedures, or other similar requirements of Highmark Delaware (or changes thereto) which are binding upon Highmark Delaware and its contracted providers. Pursuant to their contract, Highmark Delaware and such providers must comply with any requirements included herein unless and until such item(s) are subsequently modified in whole or in part.
