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PROVIDER NEWS

A newsletter for the Highmark Blue Cross Blue Shield Delaware providers

Issue 12, December 2024

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INSTRUCTIONAL VIDEOS, GUIDES, AND MORE

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Cervical Cancer Prevention: Patient Education and HEDIS Documentation

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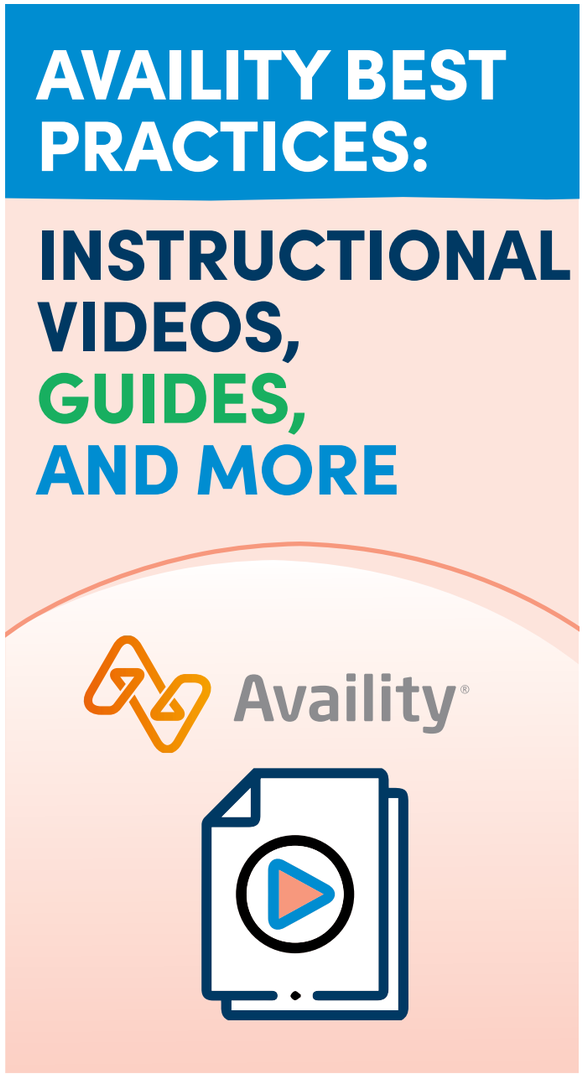

AVAILITY BEST PRACTICES: INSTRUCTIONAL VIDEOS, GUIDES, AND MORE

We heard you. You wanted a **one-stop shop** for all Highmark's authorization-related resources in one place, and now you got it!

In mid-December, we rolled out the new Authorization Training & Resources page on the Provider Resource Center. Here, you will find instructional videos, guides, and additional resources. The primary focus is on how to submit authorization requests for multiple types of services on the Predictal Auth Automation Hub via Availity®.

New Troubleshooting Guide

The Availity Troubleshooting Guide includes helpful, how-to tips on setting up and using the following applications and/or functions in Availity.

- Authorizations
- Eligibility and Benefits (E&B)
- Claims Inquiry
- Credentialing
- Payer Spaces Access
- Reporting Access
  (Provider Facing Analytics and Quality Blue)

Claims Guides

In addition to new authorization resources, the Electronic Claim Submission page features two new guides on submitting claims via Availity:

- Claims in Availity (Including Zero-Dollar Claims)
- Submitting 1500 Quick Claims in Availity (Including Zero-Dollar Claims)

More Availity-Related Resources

The updated Manage My Organization User Guide is now available on the Authorization Training & Resources page and features tips on editing Billing Group information, selecting the Billing Group (Type 2) NPI, and using the full ZIP Code + 4 information when inputting the provider's address.

Other training materials include instructions on making case management referrals and submitting extension requests.

Step-By-Step Videos

The following videos — which walk you through the auth submission process step by step — are listed on Authorization Training & Resources:

- Electronic Authorization Submission Process (General)
- Submitting a Prior Authorization for Outpatient PT, OT, Chiro
- Submitting a Prior Authorization for Home Health
- Submitting a Prior Authorization for Inpatient Hospice
- Submitting a Prior Authorization for Inpatient Rehab Facility Services
- Submitting a Prior Authorization for Outpatient Speech Therapy
- Submitting a Prior Authorization for Skilled Nursing Facility

As more auth-related resources become available, they, too, will find a home here at the Authorization Training & Resources page.

We encourage you to visit the page, bookmark it, and share the URL with others on your team.

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IN THIS ISSUE:

TRUE PERFORMANCE LITE: Enhanced Capabilities in 2025

Highmark is launching a new program application for True Performance Lite, which will be accessible within Value Insight Center.

The new component will replace the Stellar tool, effective Q1 2025, enabling providers to enter data, track and address care gaps, and confirm when care gaps are closed.

The Value Insight Center is part of Highmark's ongoing strategy to build and deliver its own applications for providers who participate in our value-based reimbursement programs.

Transition from Stellar Tool

Prior to the launch of the True Performance Lite application, there will be a brief transition period during which providers will continue to use the Stellar tool to address 2024 care gaps during the 2024 claims runout period.

If you have questions about the transition, please contact: TransitionQuestions@highmark.com.

Register for an Online Training Session

Each session is from 11 a.m. to noon and will provide an overview of new True Performance Lite application and the Diagnosis Gap closures functionality. Select a link to register today!

- Tuesday, Jan. 28
- Wednesday, Jan. 29
- Thursday, Jan. 30
- Tuesday, Feb. 4
- Wednesday, Feb. 5
- Thursday, Feb. 6

Additional sessions are planned for March to provide an overview of the Care Gap closures functionality. Please watch *Provider News* for details and registration instructions for those sessions.

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IN THIS ISSUE:

REIMBURSEMENT CHANGES for Some Medical Injectable Drugs

Effective April 1, 2025, Highmark is changing the reimbursement rates for some Medical Injectable Drugs for all regions in Delaware, New York, Pennsylvania, and West Virginia. Reimbursement rates will increase or decrease to align with the average selling price (ASP); drugs lacking an ASP will use the average wholesale price (AWP). Drugs remain in the program once assigned an HCPC code.

Note: Changes in reimbursement rates do **not** impact the Site of Care rate.

The chart below outlines important information regarding the drugs affected by the reimbursement change. Please use Availity® to access the proposed rate on the effective date, which is different than the Highmark standard, for each drug listed below.

Accessing Fee Schedules via Availity

Once you log into Availity, select **Claims & Payments** from the task bar and then **Fee Schedule Listing** from the right side. You can also access fee schedules by going to **Payer Spaces** in Availity, and then select Provider Resource Center (PRC) under **Applications**. Once you arrive at the PRC, choose **Claims & Authorization > Reimbursement Programs > Fee Schedule Information**.

(Continued)

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IN THIS ISSUE:

Reimbursement Changes for Some Medical Injectable Drugs *(Continued)*

PROCEDURE CODE	DRUG NAME
J3262	Actemra IV
J0801	Acthar
J1931	Aldurazyme
J2793	Arcalyst
Q3027	Avonex
Q5121	Avsola
J0490	Benlysta Iv
J1830	Betaseron/Extavia
J1556	Bivigam
J0585	Botox
J1786	Cerezyme
J0717	Cimzia
J3590*	Cosentyx
J7318	Durolane
J0586	Dysport
J1743	Elaprase
J3380	Entyvio
J7323	Euflexxa
J0177	Eylea HD
J0178	Eylea
J0180	Fabrazyme
J1572	Flebogamma DIF
J3110	Forteo/ Teriparatide
J1569	Gammagard Liquid
J1557	Gammaplex

PROCEDURE CODE	DRUG NAME
J1561	Gamunex-C, Gammaked
J7326	Gel-One
J7328	Gelsyn-3
J7320	Genvisc 850
J1595	Glatopa
J2941	Growth Hormones – Various
J1559	Hizentra
J7321	Hyalgan, Supartz, and Visco-3
J7322	Hymovis
J1575	Hyqvia
J0638	Ilaris
J3245	Ilumya
Q5103	Inflectra
J1566	Gammagard S/D
J1290	Kalbitor
J2840	Kanuma
Q2042	Kymriah
J0202	Lemtrada
J2778	Lucentis
J0221	Lumizyme
J1950	Lupron Depot
J3398	Luxturna
J7327	Monovisc
J0587	Myobloc
J1458	Naglazyme

PROCEDURE CODE	DRUG NAME
J3590*	Natpara
J2796	Nplate
J2182	Nucala
J2350	Ocrevus
J1568	Octagam
J0129	Orencia IV
J7324	Orthovisc
J3590*	Plegridy
J3590*	Praluent
J1459	Privigen
Q3028	Rebif
J1745	Remicade
Q5104	Renflexis
J2794	Risperdal Consta
J0596	Ruconest
J3590*	Simponi
J1602	Simponi Aria
J1300	Soliris
J2326	Spinraza
J3358	Stelara IV
J3357	Stelara SC
J2860	Sylvant
90378	Synagis
J7325	Synvisc/ Synvisc-One
Q2053	Tecartus
J3241	Tepezza
J3240	Thyrogen

PROCEDURE CODE	DRUG NAME
J2323	Tysabri
J1322	Vimizim
J3396	Visudyne
J3385	Vpriv
J1558	Xembify
J0588	Xeomin
J2357	Xolair
Q2041	Yescarta
J3399	Zolgensma
J0225	Amvuttra
J1554	Asceniv
J0179	Beovu
J0597	Berinert
J2329	Briumvi
Q5124	Byooviz
Q5128	Cimerli
J2786	Cinqair
J0598	Cinryze
J1551	Cutaquig
J1555	Cuvitru
J0589	Daxxify
J2508	Elfabrio
J0177	Eylea HD
J0517	Fasenra
J1744	Various
J0599	Haegarda
J2782	Izervay
J0217	Lamzede

PROCEDURE CODE	DRUG NAME
J3397	Mepsevii
J0219	Nexviazyme
J1576	Panzyga
J1203	Pombiliti
J2327	Skyrizi
J1747	Spevigo
J2779	Susvimo
J2781	Syfovre
J7331	Synojoynt
J2356	Tezspire
Q5133	Tofidence
J7332	Triluron
J7329	Trivisc
Q5134	Tyruko
J1303	Ultomiris
J2777	Vabysmo
J0218	Xenpozyme

1. *Not Otherwise Classified (NOC) code note – only applicable when NOC codes are included:*

   ***Note:** When drugs with NOC or temporary codes are assigned a specific HCPCS code, they will remain part of the Highmark Medical Injectable Drug Program.*

2. *All reimbursement rates subject to change based on quarterly changes to the average wholesale price (AWP) or average sales price (ASP) when applicable.*

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IN THIS ISSUE:

Cervical Cancer Prevention:

Patient Education and HEDIS Documentation

In 2024,the American Cancer Society estimates nearly 14,000 cervical cancer cases will be diagnosed in the United States, and more than 4,000 deaths will occur in the U.S. from this disease.

For women, it is the sixth most common cancer. Fortunately, it can be prevented by human papillomavirus (HPV) vaccination, routine cervical cancer screening, and follow-up treatment.

Cervical Cancer Awareness Month, which occurs during January, is an excellent opportunity to further educate patients about what can be done to fight this preventable and curable disease if caught early.

1. Patient Education Strategies

Health care providers can educate patients using the following approaches:

- **One-On-One Education** – Emphasize the reason for screening, benefits of prevention and early detection, and overcoming barriers.
- **Group Education** – Use your receptions areas to present posters, play videos, and provide written materials.
- **Integrated Education** – Include cervical cancer prevention when talking to patients on other health-related topics.
- **Community Education** – Speak to community groups about maintaining good health, including the importance of screenings for cervical cancer and other diseases.

The necessity of HPV vaccinations may be unclear to patients and family. Here are some messages and strategies to overcome vaccine hesitancy:

- Keep your information short and simple for people to understand the importance of HPV vaccination
- HPV vaccination is safe and protects against cervical cancer
- HPV vaccine is effective before exposure to HPV
- The HPV vaccine can be given to girls as early as 9 years old with 2 doses suggested to be completed by age 13.
- HPV vaccine will not treat or rid the existing HPV infections but will prevent new HPV infections.

Cervical cancer screening rates declined during the COVID-19 pandemic and now are experiencing an upward trend but have not attained pre-pandemic levels.

2. HEDIS® Measures

The Healthcare Effectiveness Data and Information Set (HEDIS®) measures healthcare performance for a variety of clinical procedures, including cervical cancer screenings. HEDIS criteria promote excellent patient care, especially in the critical area of disease prevention.

(Continued)

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IN THIS ISSUE:

Cervical Cancer Prevention: Patient Education and HEDIS Documentation *(Continued)*

The Cervical Cancer Screening (CCS) measure evaluates females, 21–64 years of age, who were screened for routine cervical cancer using any of the following criteria:

- 21–64 years who had routine cervical cytology performed within the last three years
- 30–64 years who had routine cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last five years
- 30–64 years who had routine cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years.

HEDIS Exclusions for the CCS Measure

- Members with a history of a hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix.
- Members currently in hospice and/or have received hospice services during the measurement year.
- Members currently receiving palliative care any time during the measurement year.
- Members who died any time during the measurement year.
- Members who are sex assigned at birth as male.

Tips

- **Documentation** – The medical record must include the following:
  - o A note indicating the date the cervical cytology was performed.
  - o The result or finding. Documenting "Unknown" is not considered a result/finding.
- **Hysterectomies** – Documenting that a member had a hysterectomy does not exclude the member unless the cervix is totally removed.
  - o If a member had their cervix removed, please indicate with the appropriate ICD-10 codes.
- **Biopsies** – Do not count biopsies as they are diagnostic and therapeutic only and not valid for primary cervical cancer screening.
- **Labs** – Lab results that indicate the sample contained "No Endocervical Cells" may be acceptable if a valid result is reported for the test.
- **Closing Gaps** – Be proactive by evaluating practice processes for opportunities to close care gaps every time a patient is seen.
  - o Always document the date and result of the most recent exam.
- **Exclusions** – Look back as far as possible in the member's history for exclusions.

Note: *CPT S0612 is not a valid code for closing the gap. This code is global and does not indicate that a PAP smear was actually completed. For complete HEDIS gap closure, cervical cytology results must be submitted*

Annual gynecological exams can be a life-saving appointment. Detection of cervical cancer at an early stage can help decrease mortality and incidence of invasive cervical cancer. We appreciate your efforts to educate patients about the importance of cervical cancer screening and HPV vaccination.

Resources

Cervical Cancer is Preventable | Johns Hopkins | Bloomberg School of Public Health

Cervical Cancer Causes, Risk Factors, and Prevention – NCI

The HPV Vaccine: Access and Use in the U.S. | KFF

Cervical Cancer Statistics | Key Facts About Cervical Cancer | American Cancer Society

Community Mobilization, Education, and Counselling – Comprehensive Cervical Cancer Control - NCBI Bookshelf (nih.gov)

Acknowledgement

This article is based in part on information from HEDIS MY 2024 Volume 2: Technical Specifications.

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REMINDER:
Highmark to Offer Medicare Advantage Products in SEPA 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**

This information has been previously communicated in the October and November issues of *Provider News*.

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**

In addition, there's a new onboarding guide for facility and professional providers on the Provider Resource Center that features helpful information related to serving members in SEPA region, including:

- SEPA Region Facility Claims NAIC Codes
- Highmark Plan Codes for SEPA
- An overview of new provider training resources

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 SEPA region: 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

For detailed information on submitting claims for Highmark MA members in the SEPA region, see October *Provider News*.

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SHORT TAKES:

Provider Accessibility, Helion Prior Auth End Dates, and More

Accessibility Expectations: Changes for Professional Providers in All Regions

Highmark recently updated its accessibility expectations for professional providers to align across all markets. Key changes include:

- **Faster access** to urgent care (immediate response)
- **Shorter wait times** for non-urgent appointments (48–72 hours) for both primary care physicians (PCPs) and behavioral health providers
- **Routine care appointments** within three weeks (with subsequent appointments within seven days)
- **A new requirement for follow-up visits** within five days of discharge or as clinically indicated.

To learn more, click here.

Helion Update: Prior Auth End Dates Moving to a Fixed 180-Day Period

A change has been made to how prior authorization end dates are handled in Helion Arc to better align with the Predictal Auth Automation Hub in Availity®. This change will shift the authorization end date from the last day of the calendar year to a fixed 180-day period.

This means providers will no longer need to resubmit authorizations on Jan. 1, 2025.

Instead, providers will need to resubmit authorizations after the 180-day period should there be a need for additional therapy.

Physical Medicine Programs for 2025: High Performing Provider Program Update

The High Performing Provider (HPP) designation for physical medicine providers will be posted to Helion Arc via the HPP scorecard in Q4 and will denote if the provider is designated as a High Performing Provider for the upcoming year. Scorecards will be posted quarterly, allowing providers to see how they rank each quarter.

Click here for more information.

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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:

JAN. 1 CHANGES

Medical Injectable Drugs Ilumya and Tremfya

Effective Jan.1, 2025, the medical injectable drugs 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
J1628	guselkumab	Tremfya (intravenous)

***Note:** These drugs 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.*

Continuous Glucose Monitors: Prior Authorization to Be Required in 2025

Highmark is implementing prior authorization for continuous glucose monitors (CGMs) for Commercial and Affordable Care Act (ACA) members. This change will take effect on Jan. 1, 2025, for members initiating therapy. For members currently using a CGM, the effective date of the change is dependent on their individual plan and the state where their Highmark plan is issued.

Devices* impacted by the changes:	• **Dexcom** • **Eversense** • **Freestyle Libre** • **Guardian**

**Includes all applicable components such as transmitters, sensors, and receivers.*

Click here to read the **Special Bulletin**.

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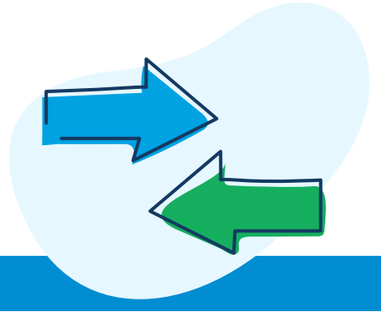
IN THIS ISSUE:

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

Dec. 2, 2024

RP-021 Annual Gynecological and Rectal Exams

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

RP-022 Repeat Surgical Procedures

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

Dec. 30, 2024

RP-064 Government Supplied Vaccinations and Antibody Treatments

Codes M0224 and Q0224 were added for Pemivibart, effective March 22, 2024.

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-006 Multiple Endoscopy Procedures

Codes 53865, 0935T, 0941T, 0942T, and 0943T will be added to endo base procedure 52000 (Group 31: Cystourethroscopy).

RP-007 Multiple Procedure Payment Reduction for Certain Diagnostic Imaging Procedures

Codes 76016-76019, 0944T, 0946T, 0947T, 0902T-0904T, 0926T, 0927T, 0938T, 0939T, and 92137 will be added to this policy. Codes 0398T and 93890 will be removed.

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. *(NOTE: This direction has been in place for Medicare Advantage markets in New York since January 2023.)*

RP-042 Global Surgery and Subsequent Services

Codes 0901T and 0908T-0910T will be added to the "Services Assigned CMS Global Days Indicator YYY" sections of this policy for Medicare Advantage and Commercial. Codes 0553T, 0567T, 0568T, and 0616T-0618T will be removed from this policy.

(Continued)

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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

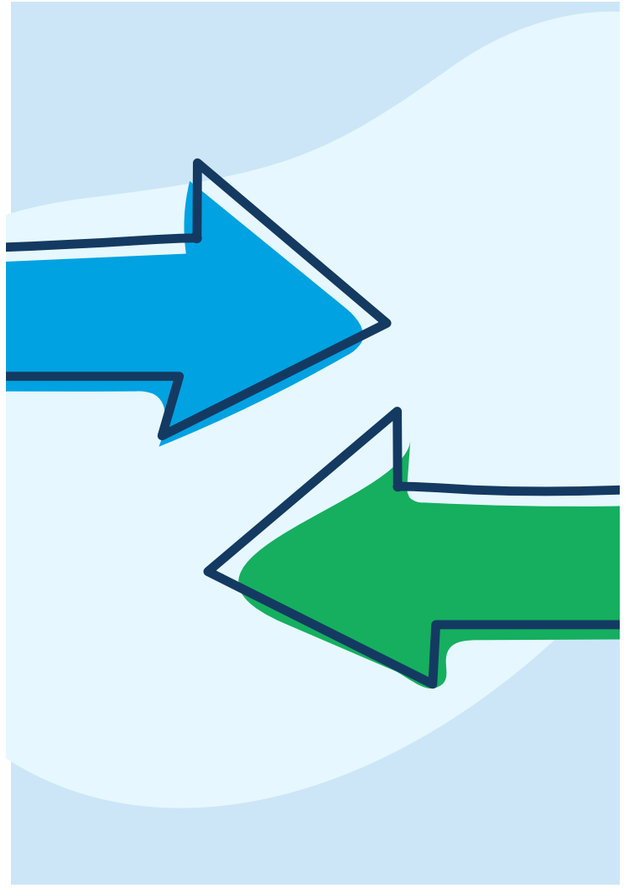
This new policy will direct the plan's reimbursement for Medical Nutrition Therapy (MNT) codes 97802, 97803, 97804, G0270, and G0271 for Commercial and Medicare Advantage plans. MNT services will only be reimbursed when billed by a registered dietician or nutritional professional, or by a facility that 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.)*



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Quarterly Formulary Updates

View the October 2024 updates to Highmark's prescription drug formularies and related pharmaceutical management procedures at the Formulary Updates page on the **Provider Resource Center (PRC).**

Pharmaceutical Management Procedures

To learn more about how to use these procedures, click on **Polices & Programs** from the top menu on the PRC. Select **Pharmacy Programs** and then **Pharmaceutical Management**.

This section includes information on:

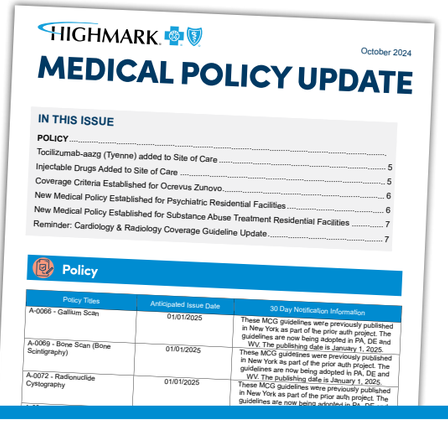
- Exception requests
- The process for generic substitutions
- Explanations of limits/quotas, therapeutic interchange, and step-therapy protocols.

Federal Employee Program (FEP) Drug Formularies and Pharmaceutical Management Procedures

The FEP specific drug formularies are available online. Providers also may obtain formulary information by calling **866-763-3608** and following the prompts for Pharmacy.

To learn more about the FEP exception request processes for non-formulary drugs, click here.

Have You Seen This Month's **Medical Policy Update Newsletter?**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October 2024
MEDICAL POLICY UPDATE
IN THIS ISSUE
POLICY
Tocilizumab-aazg (Tyenne) added to Site of Care
Injectable Drugs Added to Site of Care
Coverage Criteria Established for Ocrevus Zunovo
New Medical Policy Established for Psychiatric Residential Facilities
New Medical Policy Established for Substance Abuse Treatment Residential Facilities
Reminder: Cardiology & Radiology Coverage Guideline Update
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 in New York as part of the prior auth project. The guidelines are now being adopted in PA, DE and

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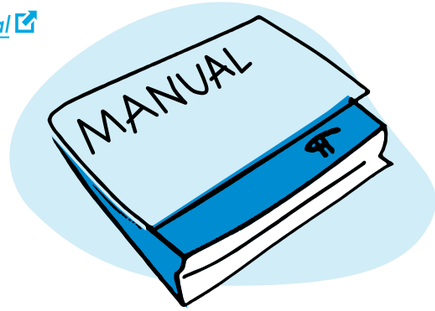
Staying Up to Date with the *Highmark Provider Manual*

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 3: **Other Government Programs**
- Chapter 5, Unit 6: **Quality Management**

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

PROVIDER NEWS

A newsletter for the Highmark Blue Cross Blue Shield Delaware providers

HIGHMARK

Issue 12, December 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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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.

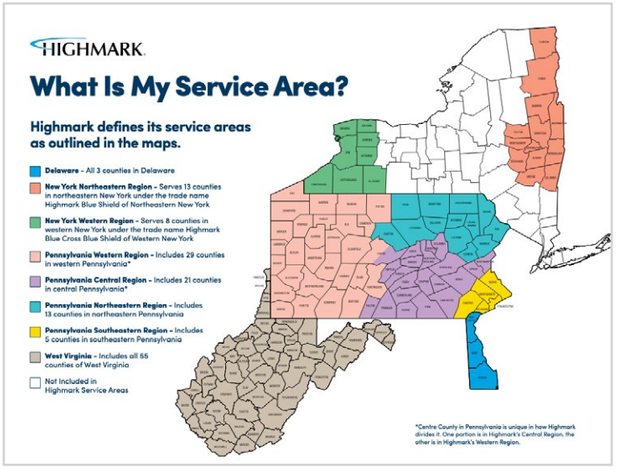
Comments/Suggestions Welcome

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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Legal Information

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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.

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.