PROVIDER NEWS

A newsletter for the Highmark Blue Cross Blue Shield Delaware providers

HIGHMARK

Issue 2, February 2025

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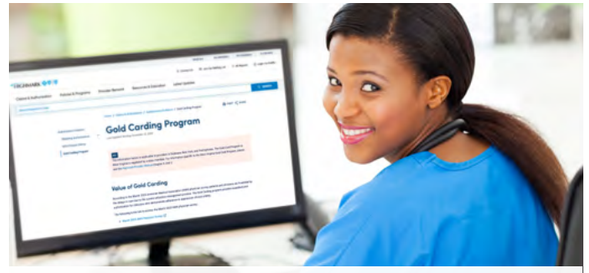

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REMARKABLE LEADERSHIP:

NICK MORIELLO

Highmark Delaware President

by Catherine Clements

Originally published in the Highmark Health Digital Magazine.

President of Highmark Delaware Nick Moriello was recently profiled by Highmark Health Digital Magazine. In a wide-ranging interview with writer Catherine Clements, Nick Moriello discusses the "why" that drives him to improve health care for patients and providers; his extensive background in health care, including his key role in shaping the Affordable Care Act (ACA) in Delaware; and his focus on investing in Delaware's communities and future.

In this excerpt, he talks about the importance of payer-provider collaboration, using the example of Highmark and ChristianaCare.

Payer-Provider Collaboration

Catherine Clements: One of our organization's differentiators is how we work with providers like ChristianaCare. Why is payer-provider collaboration so important?

Nick Moriello: Payer-provider collaboration is fundamentally rooted in shared goals. Highmark and ChristianaCare, for example, are both mission-driven, non-profit organizations serving the same Delaware population. Our visions for improved patient care and experience are aligned.

Historically, the fee-for-service model has fostered an adversarial relationship, creating a win-lose dynamic where the patient ultimately suffers. This distrust undermines our collective ability to improve the health care ecosystem.

(Continued)

Catherine Clements: How did the collaboration between Highmark and ChristianaCare come about?

Nick Moriello: Highmark Delaware and ChristianaCare's overlapping market share presented a unique opportunity. After a thoughtful, three-year exploratory process (2018-2021), we forged a groundbreaking 10-year agreement. This collaboration allows us to explore innovative approaches, learn from each other, and, aspirationally, develop a replicable model for value-based care nationwide.

Medicare Advantage

Catherine Clements: What are some examples of the initiatives we have done with ChristianaCare so far?

Nick Moriello: A key achievement of our collaboration with ChristianaCare is our jointly developed Medicare Advantage product, which also had founding support from Bayhealth, the state's second-largest health system.

Previously unavailable in this market, this product continues to align economics with Highmark and ChristianaCare. The thinking was that if we removed the barriers with the existing economics, we could really do something different with this population and learn a whole lot.

Three years in, this innovative approach has achieved high star ratings and substantial growth, reflecting the improved member experience. The success underscores the potential of payers and providers to align and create a more effective and sustainable health care model.

Another example I'll highlight is our virtual primary care practice. ChristianaCare had this offering prior to the relationship with Highmark, but it was an opportunity to do it together and have shared economics. This offering is making an impact on the people we serve with improved health outcomes and engagement. We've evolved — and continue to evolve — the virtual primary care solution based on customer feedback.

Value-Based Care

Catherine Clements: I want to dig deeper into that idea of shared economics, and specifically value-based care. How is Highmark leading in this area?

Nick Moriello: There's recognition in the industry, and it's really taken to heart at Highmark, that the traditional fee-for-service model is not sustainable. Health care costs continue rising and it's at a breaking point for many of those paying, whether that's the United States paying for government coverage like Medicare and Medicaid, employers, and down to the individual level.

We're trying to shift not just the payment model, but also the mindset, to outcome-based, performance-based arrangements. I have the privilege of working with others around the country on driving value-based care, and every place is at a different readiness state to adopt value-based programs.

What I really appreciate about our approach at Highmark is we have different levels to meet folks where they're at. It's not a one-size-fits-all. We have a lot of strong value-based programs around primary care. In my view, we need to continue to evolve and add these types of arrangements in specialty care, such as behavioral health.

To read the full article in the Highmark Health Digital Magazine, click here.

> **We're trying to shift not just the payment model, but also the mindset, to outcome-based, performance-based arrangements.**
>
> **Nick Moriello**
> Highmark Delaware President

ELECTRONIC CLAIMS UPDATE:

Supporting Documents Can Be Attached When Submitting New Claims in Availity

The claim submission process in Availity® is getting an update, **effective April 18, 2025**. When submitting a new claim via Availity, providers will be able to attach supporting documents — also called 275 transactions — saving practitioners time and effort, while accelerating the claim review and approval process for Highmark.

Currently, providers can only submit an initial claim in Availity **without** any attachments; supporting documents must be sent in a separate and later communication via **Message this Payer** in Availity or via other methods, such as fax or mail.

NOTE: This 275 enhancement does **not** apply to batch submissions or Quick Claims.

How to Submit Attachments with Your NEW Claim

You will follow the same process you do now when submitting a claim via Availity. Under the **Diagnosis Codes** section, go to the **Add Additional Claim Information** dropdown. Click the arrow or caret and select **Attachments**.

Next, you will select the **Report Type Code** that identifies the information being shared. Click **Report Transmission Code of EL – Electronically Only**, and then select **Choose File**, attaching your files from your desktop.

Once you have attached your documents, you will continue through the claim submission process until you click **Submit**. You will receive confirmation of a successful claim submission.

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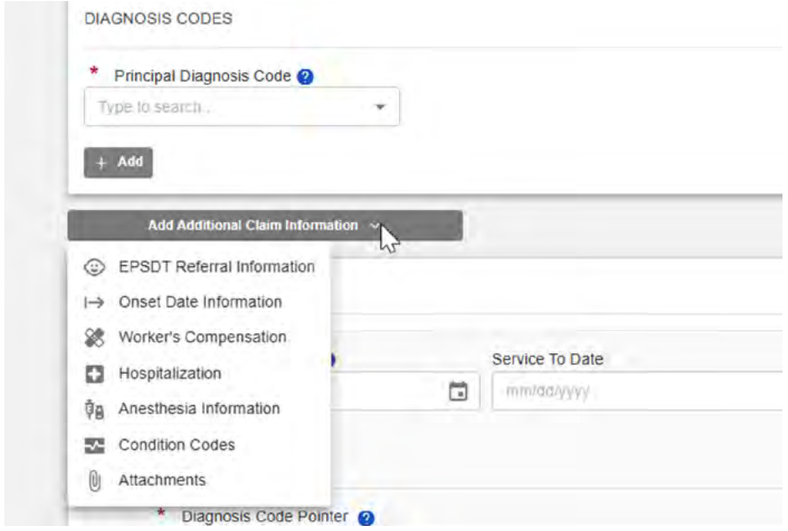


Attachments can also be Added for Pended Claims via Claim Status Inquiry

The Claim Status Inquiry function in Availity enables you to add attachments for pended claims. Click the **Add Attachments** button, choose the appropriate record types, and then add your attachments.

The Attachments Dashboard is accessible under **Claims & Payments** and provides details on all attachments by your organization.

Multiple Documents, Multiple Formats – Applicable to Both Workflows

Using the new feature, providers can attach up to 10 electronic documents per new or pended claim, in a variety of formats, including Word, Excel, PDF, JPG, PNG, GIF, and TIFF. This functionality enables providers to easily send their supporting documents via the Availity portal.

Additional Resources

For more information on electronic claims, visit this page on the Provider Resource Center, where you will find information on the following claims processes:

- Submit a Claim
- Check Claim Status
- Claim Inquiry

...providers will be able to attach supporting documents — also called 275 transactions — saving practitioners time and effort, while accelerating the claim review and approval process for Highmark

Availity®

Annual HEDIS® Medical Record Reviews to Begin in February 2025

Clinical staff from Highmark Blue Shield will conduct the annual Healthcare Effectiveness Data and Information Set (HEDIS) medical record reviews — based on measurement year 2024 data — from February through mid-May 2025.

The HEDIS report includes the medical record review to assess compliance with a set of standardized performance measurements that health plans report to the National Committee for Quality Assurance (NCQA). HEDIS data is collected and reported annually as part of Highmark's accrediting and governmental requirements. The measurements being collected are:

- **Controlling High Blood Pressure**
- **Glycemic Status Assessment for Patients with Diabetes**
- **Blood Pressure Control for Patients with Diabetes**
- **Eye Exam for Patients with Diabetes**
- **Transitions of Care**
- **Cervical Cancer Screening**
- **Childhood Immunization Status**
- **Immunizations for Adolescents**
- **Lead Screening in Children**
- **Prenatal and Postpartum Care**
- **Weight Assessment and Counseling for Nutrition and Counseling for Physical Activity for Children and Adolescents**

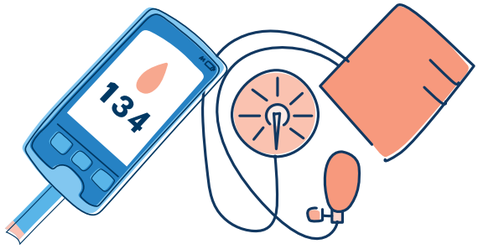
A random sample of members will be identified, and a representative from Blue Shield will notify you either by telephone or fax to discuss the process to submit specific elements of the members' medical records via fax or mail for review.

CHART RETRIEVAL PROCESS: We are encouraging all providers to submit requested HEDIS medical records to Highmark via secure electronic delivery or fax to the designated return fax number identified on the original chart request.

If you have any questions regarding the HEDIS project, please contact the following representative from Highmark's Clinical Service area: Michael Clark-Polner at 412-544-7438.

Please Note: Continuity of Care (CCD) documents are not an acceptable form of medical record documentation.

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



POSTPONED: Authorization Enhancement for Physical Medicine, Home Health, and Hospice Requests

The recently announced authorization enhancement for outpatient physical medicine, home health, and hospice services has been postponed to allow for additional testing.

Originally scheduled to go live on Feb. 22, 2025, the enhancement will be implemented at a later date. Providers should continue to follow the current process for requesting authorization for the following services:

- **Chiropractic**
- **Physical Therapy**
- **Occupational Therapy**
- **Speech Therapy**
- **Home Health, including Behavioral Health**
- **Hospice**

When submitting an authorization request for these services, continue to select the correct **Sub-service Type**. For more information on submitting authorization requests, including videos and guides, visit the Authorization Training & Resources page on the Provider Resource Center.

To stay informed of upcoming changes, sign up for our mailing list by clicking here.

2025 GOLD CARD PROGRAM EXPANSION: Streamlining Prior Authorizations for Providers

Highmark continues to expand its Gold Card Program, which expedites prior authorization for clinicians who have demonstrated historical adherence to clinical criteria. Gold Carded providers are recognized for achieving authorization approval rates of 99% or higher.

Beginning March 1, 2025, Highmark is adding 1,800 new clinicians to the Enterprise Gold Card Program, bringing the total Gold Carded clinicians to over 23,000.

In addition to advanced imaging services such as CT, MRI, and ECHO, this expansion will include new hysterectomy codes, outpatient joint replacements, and pain modalities with additional CPT codes to expedite authorizations for these services.

How the Gold Carding Program Works

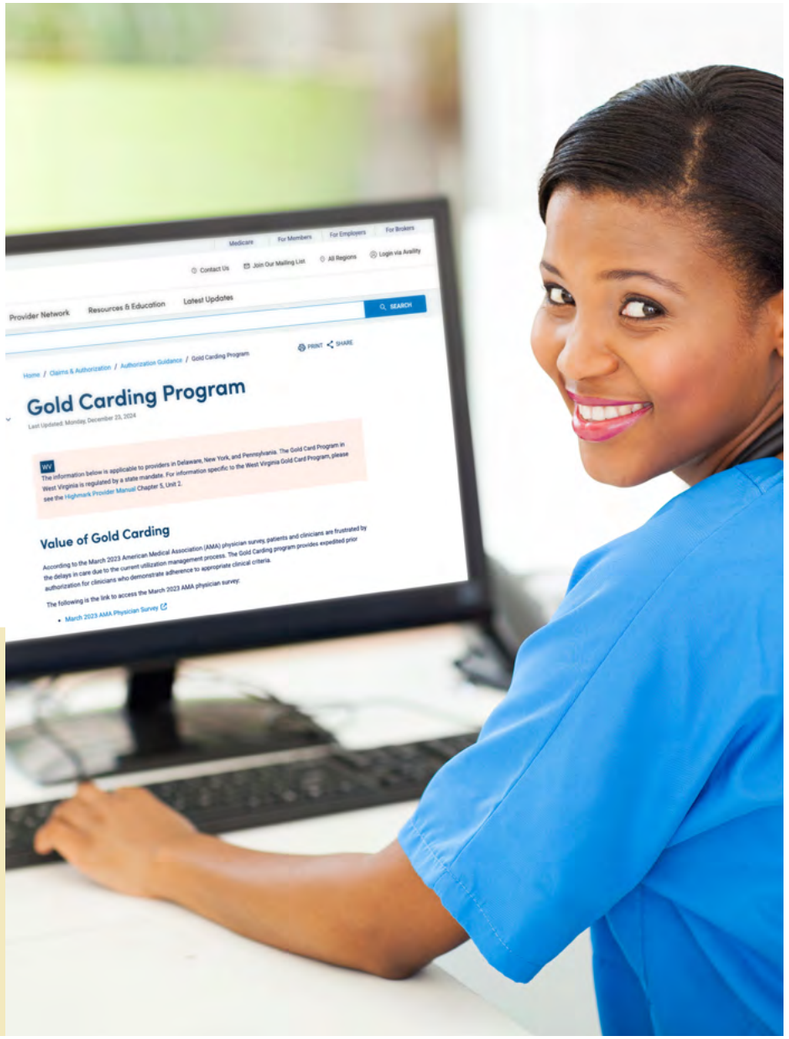
Highmark automatically enrolls clinicians, twice annually, when eligibility criteria are met. Once Gold Carded, clinicians will enter the appropriate information for the Highmark member and upon submission will receive an immediate authorization number to attach to any subsequent claims. In locations that can accommodate, this will enable clinicians to schedule patients' follow-up services before they leave the office, avoiding delays in care.

You can view the current list of Gold Carded clinicians on the Provider Resource Center. Go to **Claims & Authorization > Authorization Guidance > Gold Carding Program** to verify if you or your practice are Gold Carded. You can also review the Gold Card Prenotification Process for authorizations and eligibility criteria.

For questions about the Gold Card program, please email goldcardinquiries@highmark.com.

Gold Carded providers are recognized for achieving authorization

approval rates of 99% or higher.



Collaborating to Improve Your Patients' Health and Experience

The 2025 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey period is coming soon. Highmark Medicare Advantage members who are selected for the survey will receive it in March.

The survey asks members about their experiences with their health plan and providers as well as their perception of the care they receive from you within the past six months. Any patient interaction can impact CAHPS scores.

The CAHPS survey presents a critical opportunity for Highmark and providers to collaborate to achieve an optimal patient experience. Members are asked several questions about the following topics that relate to their experience with their overall health care and/or their health care providers:

- **How quickly** they are able to get appointments and care – for both urgent and routine care.
- **How easy** it is for them to get the care they need from their primary provider and/or specialists.
- **How well** their care is coordinated between different providers and services.
- **The overall quality** of the health care they receive.

Collaboration Is Key

Collaboration between health plans and providers is key to ensuring that members/patients have positive health care experiences.

Here's how to improve your CAHPS results

FOCUS AREAS

These are key areas where even small improvements make a big difference!

- **Access to Care (Improve Timeliness)** – Patients value quick appointments and easy specialist referrals. Faster access leads to better health outcomes and increased patient satisfaction.
- **Empathetic Communication (Enhance Patient Experience)** – Active listening, clear explanations, and respect build trust. Positive interactions improve patient adherence to treatment plans and overall well-being. This is crucial for Medicare members who may require additional patience and personalized communication.
- **Proactive Health (Promote Wellness)** – Encourage preventive care, screenings, and address tobacco use. Preventive care reduces long-term health issues, improving patient health and lowering healthcare costs.

ACTIONABLE TIPS

- **Schedule Smart** – Proactive appointment reminders and streamlined scheduling improve timeliness.
- **Clear Communication** – Running late can sometimes be unavoidable in a busy office; when it happens, provide a brief explanation for the delay.
- **Care Coordination** – Before the visit begins, review your patient's medical history, prescriptions, and any other providers or specialists they've seen recently.
- **Referral Efficiency** – Implement a system for quick and efficient referrals to specialist and follow up with members about their specialist visit.
- **Technology Use** – Leverage telehealth and virtual visits for convenient follow-ups and instruct your team on how to provide support to patients when accessing virtual care.

Thank you for your partnership and your commitment to your patients and their health. For more information about Medicare Advantage Stars and the importance of high-quality performance, click here. For additional tips on how you can approve patient experience in your office, review **our provider CAHPS flyer**.

COLORECTAL CANCER AWARENESS MONTH

Enhance Patient Care and Close HEDIS Gaps

Colorectal Cancer Awareness Month, which occurs in March, is an excellent time for reiterating the importance of colorectal cancer screening. By highlighting the resources available, you and your team can improve patient outcomes, while also meeting the Healthcare Effectiveness Data and Information Set (HEDIS®) Colorectal Cancer Screening (COL) measure. Colorectal cancer is the leading cancer diagnosed in both men and women in the United States, resulting in a significant number of preventable deaths each year.

Screening Recommendations and HEDIS Compliance

The United States Preventive Services Task Force (USPSTF) recommends screening for all adults starting at age 45. Individuals with family history or other risk factors may need earlier or more frequent screening. Meeting the HEDIS COL measure is crucial for demonstrating high-quality patient care and aligns with Highmark's True Performance Program (TPP). In addition, colorectal cancer screening is now an Electronic Clinical Data Services (ECDS) measure.

Accurate coding leads to greater gap closure.

Screening Methods and CPT Codes

Screening Method	Timing	CPT Codes	Notes
Colonoscopy	Measurement year or within preceding 9 years	44388-44392, 44394, 44401-44408, 45378-45382, 45384-45386, 45388-45393, 45398	Clear documentation required showing scope reached the cecum.
Fecal Occult Blood Test (FOBT)	Annually during measurement year	82270, 82274	Includes Guaiac (gFOBT) and Immunochemical (FIT) FIT-DNA is separate.
Stool DNA Test (sDNA FIT)	Measurement year or within preceding 2 years	81528	e.g., Cologuard
CT Colonography	Measurement year or within preceding 4 years	74261-74263	
Flexible Sigmoidoscopy	Measurement year or within preceding 4 years	45330-45335, 45337, 45338, 45340-45342, 45346, 45347, 45349, 45350	

NOTE: Samples collected via digital rectal exam (DRE) or FOBT tests performed in an office setting do not count toward compliance.

(Continued)

HEDIS Exclusions

Exclusion Reason	CPT Codes	ICD-10 Codes
Total Colectomy	44150-44153, 44155-44158, 44210-44212	
Colorectal Cancer Diagnosis		C18.0-C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048

Patient refusal is not an exclusion. Accurate documentation of screening dates, results, and exclusion reasons is essential.

Patient Education and Resources

Highmark has a variety of free resources on the Provider Resource Center that can help educate patients on the importance of colorectal cancer screening, including:

- Colorectal Cancer Screening Brochure
- Colorectal Cancer Screening Flyer (Spanish version available)
- Colorectal Cancer Screening Reminder Card
- Health Screening and Vaccination Tracker (Spanish version available)

To order for your office, go to **Provider Resource Center (PRC) > Resources & Education > Educational Resources – Member & Provider > Inventory Request Form**. Select your region then the item and quantity you wish to order. Click **ADD TO CART** and fill in the shipping details.

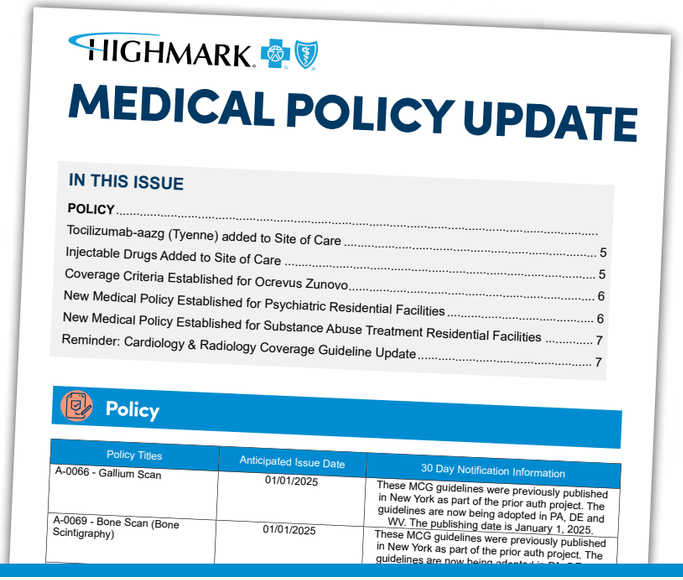
Proactive patient education is key to increasing screening rates. By implementing these strategies, you can improve patient outcomes, meet HEDIS goals, and contribute to reducing the colorectal cancer burden.

References

Information taken from HEDIS MY 2025 Volume 2: Technical Specifications

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.

Have You Seen This Month's **Medical Policy Update Newsletter?**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MEDICAL POLICY UPDATE

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POLICY

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Injectable Drugs Added to Site of Care 5
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New Medical Policy Established for Psychiatric Residential Facilities 6
New Medical Policy Established for Substance Abuse Treatment Residential Facilities 7
Reminder: Cardiology & Radiology Coverage Guideline Update 7

Policy

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

SHORT TAKES:

Fee Schedules, Psychologist Credentialing, and More

Quarterly Fee Schedules

The standard professional quarterly fee schedules were published the week of Feb. 16.

To view the fee schedules on the Provider Resource Center (PRC), log into Availity®. Click **Payer Spaces > Your Highmark Plan > Provider Resource Center**.

Once you arrive at the PRC, choose **Claims & Authorization > Reimbursement Programs > Fee Schedule Information**.

Credentialing Update: Psychologists and BH Organizational Providers

Effective May 19, 2025, Highmark is updating and clarifying the credentialing for the following types of practitioners:

- Licensed Psychologists
- Behavioral Health (BH) Organizational Providers

To learn more, click **here**.

CVS Health to Join Hemophilia and Bleeding Disorder Drug Program

Effective March 1, 2025, CVS Health will be joining the Hemophilia and Bleeding Disorder Drug Program as an exclusive specialty provider, while Soleo Health will no longer be participating in the program.

For more information, go **here**.

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).

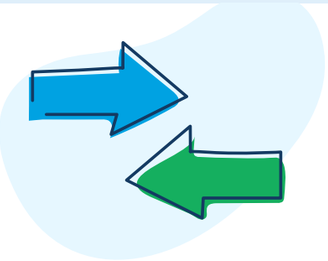
For the full list of injectables, see the article in December *Provider News*.

Accessibility Expectations – Updated for Professional Providers

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

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

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

UPCOMING

April 14, 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

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

This policy will be updated to apply a reduction to Office/Outpatient E/M codes appended with modifier 25 when reported in the same visit as a preventive medicine service. The preventive medicine service will continue to be fully reimbursed at 100% of the allowable contracted rate. The Office/Outpatient E/M component, when appropriately billed with modifier 25 to signify a separately identifiable service, will be subject to 50% of the allowable contracted rate.

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.)*

NEW: RP-081 Critical Care with Home Discharge

If a critical care service is submitted with revenue code 045X and a discharge status code of 01 (to home or self-care) on the same day, then the critical care services will not be reimbursable. The provider may appeal the denial by submitting clinical documentation supporting the level of care. *(NOTE: This policy is not yet available on the PRC.)*

NEW: RP-082 Lab Panel Testing

This new policy will provide the plan's direction for lab testing CPT codes 87661, 87491, and 87591. When more than one of these codes are billed, regardless of number of units, by the same provider on the same date of service, they will be reimbursed under the comprehensive panel code 87801. *(NOTE: This policy is not yet available on the PRC.)*

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.

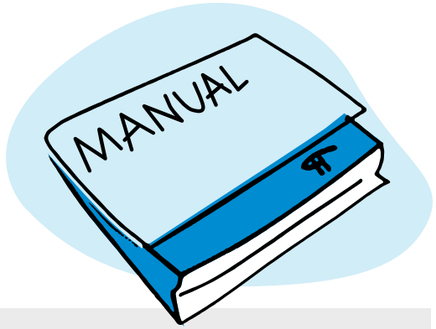
During the attestation process, always double-check your current email address(es) to ensure that you can receive electronic communications from Highmark without delay.

If you need additional information regarding the attestation process, Atlas' step-by-step guide is available on the Provider Resource Center.

Staying Up to Date with the *Highmark Provider Manual*

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

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



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

- **Chapter 1, Unit 4: Highmark Member Information**
- **Chapter 2, Unit 2: Medicare Advantage Products & Programs**
- **Chapter 3, Unit 3: Professional Provider Guidelines**
- **Chapter 4, Unit 3: Facility-Specific Guidelines**
- **Chapter 5, Unit 1: Care Management Overview**
- **Chapter 5, Unit 2: Authorizations**
- **Chapter 6, Unit 7: Payment/EOBs/Remittances**
- **Chapter 7, Unit 5: Third Party Code of Conduct**

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

Availity®

Are You Using Availity for Your Highmark Transactions?

LEGACY PORTALS NOW DEACTIVATED

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.

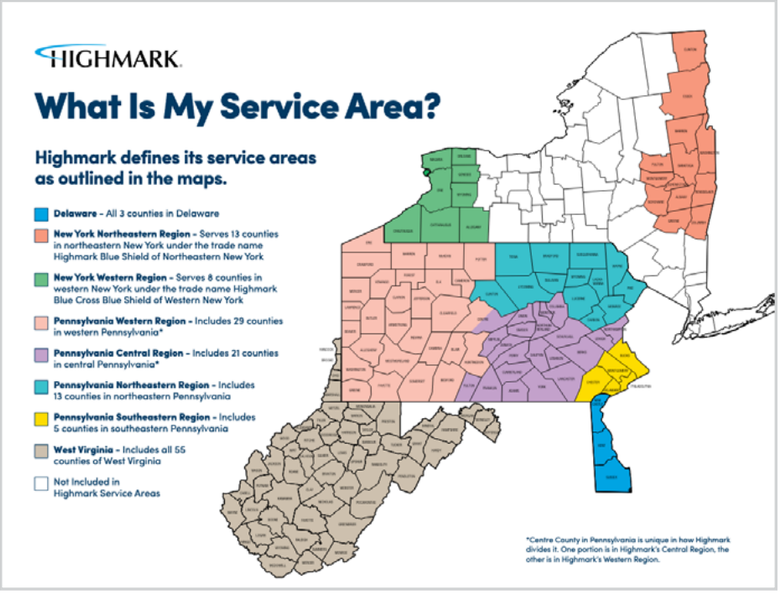
Comments/Suggestions Welcome

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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