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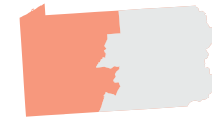
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## AVAILITY BEST PRACTICES:

## 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.

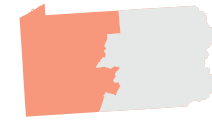
### Step-By-Step Videos

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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# 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.

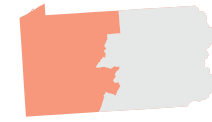
If you have questions about the transition, please contact: [TransitionQuestions@highmark.com](mailto:TransitionQuestions@highmark.com)

## 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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# 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**.



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## 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	Lamzedo

PROCEDURE CODE	DRUG NAME
J3397	Mepsevii
J0219	Nexviazyme
J1576	Panzyga
J1203	Pombiliti
J2327	Skyrizi
J1747	Spevigo
J2779	Susvimo
J2781	Syfovre
J7331	Synjoynnt
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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# 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 reception 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.

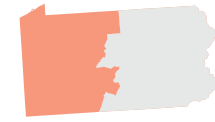
The necessity of HPV vaccinations may be unclear to patients and family. Here are some messages and strategies to overcome vaccine hesitancy:

- 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.



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## 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:
  - A note indicating the date the cervical cytology was performed.
  - 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.
  - 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.
  - 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](#)

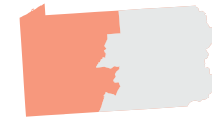
[Community Mobilization, Education, and Counselling – Comprehensive Cervical Cancer Control - NCBI Bookshelf \(nih.gov\)](#)

## Acknowledgement

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

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

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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# HIGHMARK'S Healing at Home Supplemental Benefit



The Healing at Home supplemental benefit allows eligible members to receive non-skilled caregiver services in their home following a hospitalization **at no additional cost** to them or their loved ones. This type of service can be a meaningful relief to patients and caregivers who are navigating the complexities of recovery after an acute episode.

The Healing at Home benefit provides a set number of hours of non-skilled caregiver support. Depending on plan type, members can receive from 28 hours up to 50 hours within a specified window of time following discharge from an inpatient acute episode.

## Patient Eligibility

To be eligible, members must meet several specific criteria:

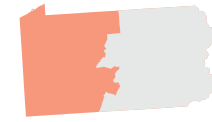
### 1. Highmark Plan Enrollment

Patients must be enrolled in one of several qualifying Highmark plans, including:

- Freedom Blue PPO Classic
- Freedom Blue PPO Select
- Security Blue HMO POS Deluxe
- Security Blue HMO Value RX
- Security Blue HMO POS Standard
- Together Blue HMO Signature
- Community Blue HMO Signature
- Community Blue HMO Prestige.

Verifying plan enrollment is the initial step in determining eligibility.





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[Highmark's Healing at Home Supplemental Benefit \(Continued\)](#)

## 2. Recent Hospital Discharge

Patients must have been discharged to their home from an inpatient hospitalization. The timeframe for this discharge varies depending on the plan type: within 90 days for PPO plans, and within 365 days for HMO plans.

## 3. Qualifying Chronic Condition

Patients must have a diagnosis of a qualifying chronic condition. These include cardiovascular disorders, congestive heart failure (CHF), chronic lung disorders, stroke, cancer, end-stage renal disease (ESRD), and dementia.

## 4. Residence in SWPA Counties

Patients must reside within one of these 11 southwestern Pennsylvania (SWPA) counties: Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Washington, and Westmoreland.

## Holistic Approach to Patient Care

Crucially, the Healing at Home benefit is not exclusive and is designed to work in tandem with other services. Patients can concurrently receive home health nursing, therapies, or other home-based medical services. This integrative model ensures a holistic approach to patient care, streamlining care coordination and improving overall patient outcomes.

## Simplifying Access and Reducing Administrative Burden

One of the key advantages of the Healing at Home supplemental benefit is its straightforward application process. No physician orders are required for accessing the benefit, thereby simplifying both patient and provider involvement. The absence of complicated procedures reduces administrative burdens and streamlines the delivery of services, getting vital support to those who need it quickly and easily.

There are also no co-pays or other out-of-pocket expenses for patients who receive this benefit, including a \$0 co-pay for the first \$1000 in Durable Medical Equipment (DME)\*, allowing them to utilize these services without added financial stresses or considerations.

*\*After \$1,000 in DME costs, a co-pay may be applied depending on the member's individual plan.*

## Leveraging the Benefit: How Providers Can Help

Providers who believe that their patients are eligible for the Healing at Home benefit can submit a referral through [Availity](#). These referrals will be routed to Highmark Case Management who will connect patients to the specifically contracted vendor supplying the non-skilled caregiver services.

The Healing at Home benefit provides a set number of hours of non-skilled caregiver support.

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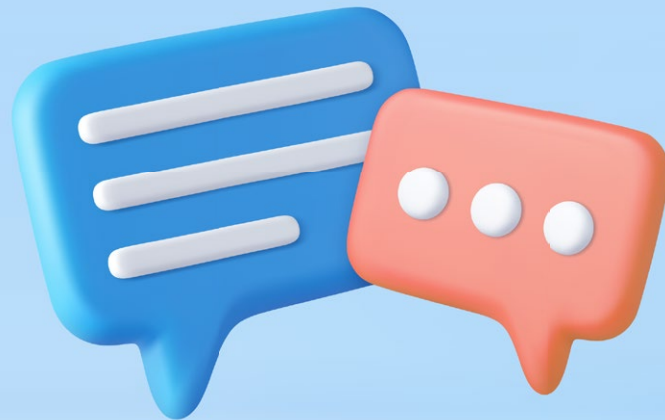
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# LIVE CHAT Pilot for Pennsylvania Providers


## Recently Launched




**On Dec. 16, 2024**, Highmark launched a pilot for a live chat feature which enables providers in our Pennsylvania regions to chat directly with a Highmark representative for questions related to:

- Clinical authorizations including if an authorization is required, authorization status, investigations on an authorization, or questions specific to the authorization process.
  - **Note:** You cannot use live chat to submit an authorization request.
- Member benefit information **not** available via Highmark self-service tools
- Navigation across Highmark [self-service tools](#) 

You can ask questions related to Highmark members in any health plan except for Medicaid.

Claim questions cannot be answered via live chat. Providers need to leverage Highmark's other [self-service tools](#) 


## How to Access Live Chat

Provider live chat will be accessible via Highmark's Payer Spaces in [Availity](#) , making it readily available when you are completing other transactions and Highmark-specific tasks. The live chat feature will be available **Monday – Friday from 8 a.m. to 5 p.m. ET.**

Leveraging provider live chat will eliminate the need for you to wait on the phone for support on some of your most frequently asked questions about our members.

You will receive a link to a survey at the end of each chat session. Since this is a pilot, your feedback is encouraged and will be incorporated as we continue to develop the tool.

## Tips for a Successful Chat Experience

- The chat feature is limited to questions about **one member at a time**. You can ask questions regarding up to eight members back-to-back in a single chat session.
  - You will need to include the member ID (**without** the Alpha Prefix), member name, and member date of birth with your query.
- Currently, only **three topics** can be answered via provider live chat:
  - 1. Clinical authorizations** including if an authorization is required, authorization status, investigations on an authorization, or questions specific to the authorization process.
    - a. Note: You cannot use live chat to submit an authorization request.
  - 2. Member benefit information**
    - a. Live chat should only be used for benefit information beyond what's available via Highmark's self-service tools.
  - 3. Assistance with Highmark's [self-service tools](#)** 
    - a. Availity, Provider Resource Center, Interactive Voice Response

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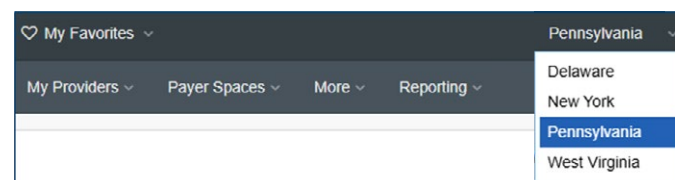
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## Live Chat Pilot for Pennsylvania Providers Recently Launched (Continued)

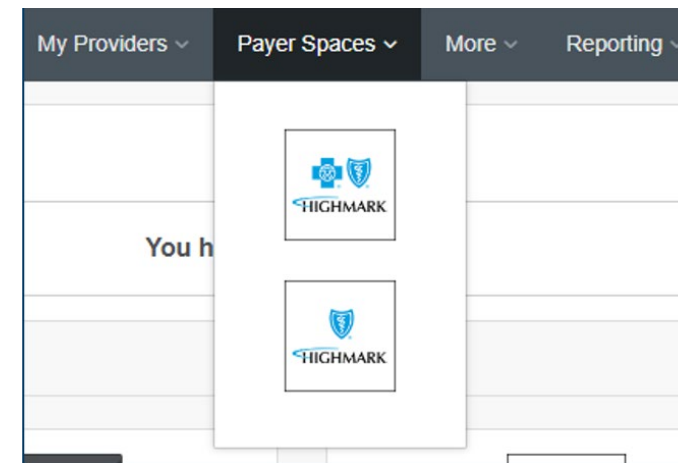
- Each message you enter in the chat is limited to 256 characters.
- If your question cannot be answered via Live Chat, you may be redirected to [Availity](#) self-service or asked to call [Highmark Provider Service](#).
- Claim questions cannot be answered via live chat. Providers need to leverage Highmark's other [self-service tools](#) to obtain answers to their claim questions.
- You will receive a reference number for each individual member query via chat. For example, if you discuss three different Highmark members during a chat session, you will receive three reference numbers, one for each member. Maintain that number(s) for your records in the event that you need to follow up with Highmark.

## How to Access Provider Live Chat

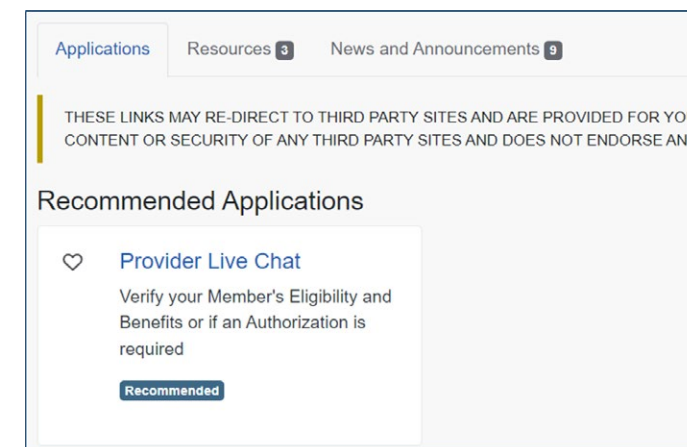
- From the [Availity](#) home screen, choose Pennsylvania as your state.
- If you are not contracted in one of Highmark's Pennsylvania regions, you do not have access to provider live chat at this time.



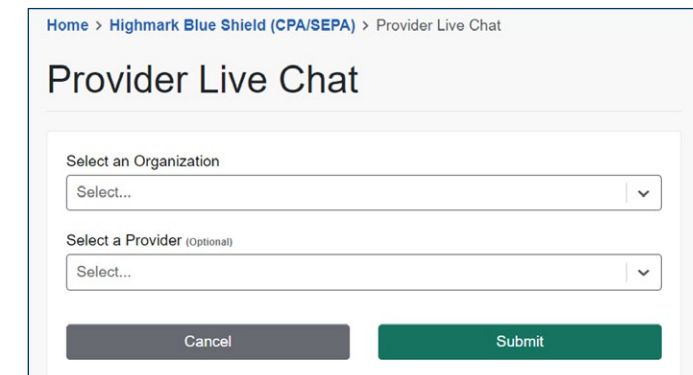
- Navigate to Highmark's **Payer Spaces** for your region.



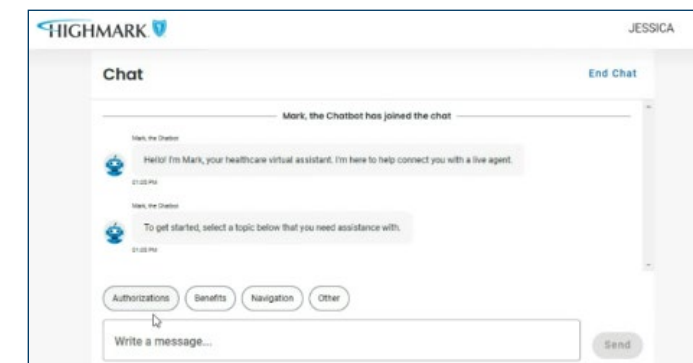
- Choose **Provider Live Chat**



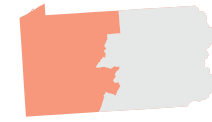
- Select an Organization.
  - Select a Provider.
    - i. While not required, selecting the provider will enable the Highmark representative to handle your request more quickly.



- When you hit **Submit**, a new window will open and connect you with the chat platform.



You will answer a few initial questions and then be connected with the appropriate team to answer your inquiry.



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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.

These changes also apply to providers who participate in Highmark Healthy Kids (CHIP\*) program. 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 Network and High Performing Provider

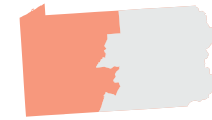
#### 1. High Performing Network (HPN) Program

Highmark will use the 2024 and 2025 benefit years as a transition period for providers to adjust to using the Helion Arc platform. As such, Highmark will not make any changes to the HPN status of our providers during both 2024 and 2025.

#### 2. High Performing Provider (HPP) Program

The 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 about both programs.



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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.

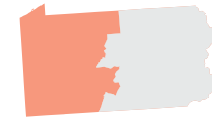
#### Devices\* impacted by the changes:

- 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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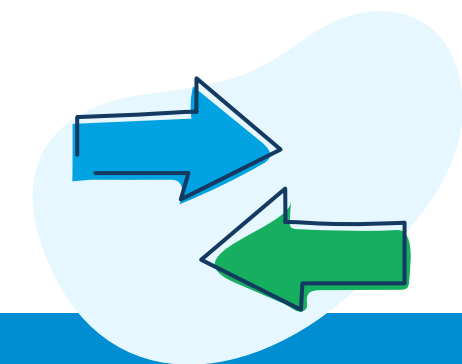
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## New and Updated Reimbursement Policies

Highmark regularly issues new or updated reimbursement policies. Keep an eye on this newsletter and the Provider Resource Center (PRC) for announcements regarding upcoming policy changes. As specific policy changes go into effect, the updated policies can be found on the [Reimbursement Policies](#) page of the PRC.



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

### RECENTLY UPDATED

#### 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.

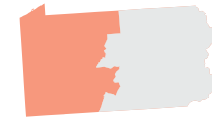
##### RP-020 [Preventive Medicine and Office/ Outpatient Evaluation and Management Services](#)

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.





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## New and Updated Reimbursement Policies (Continued)

### 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

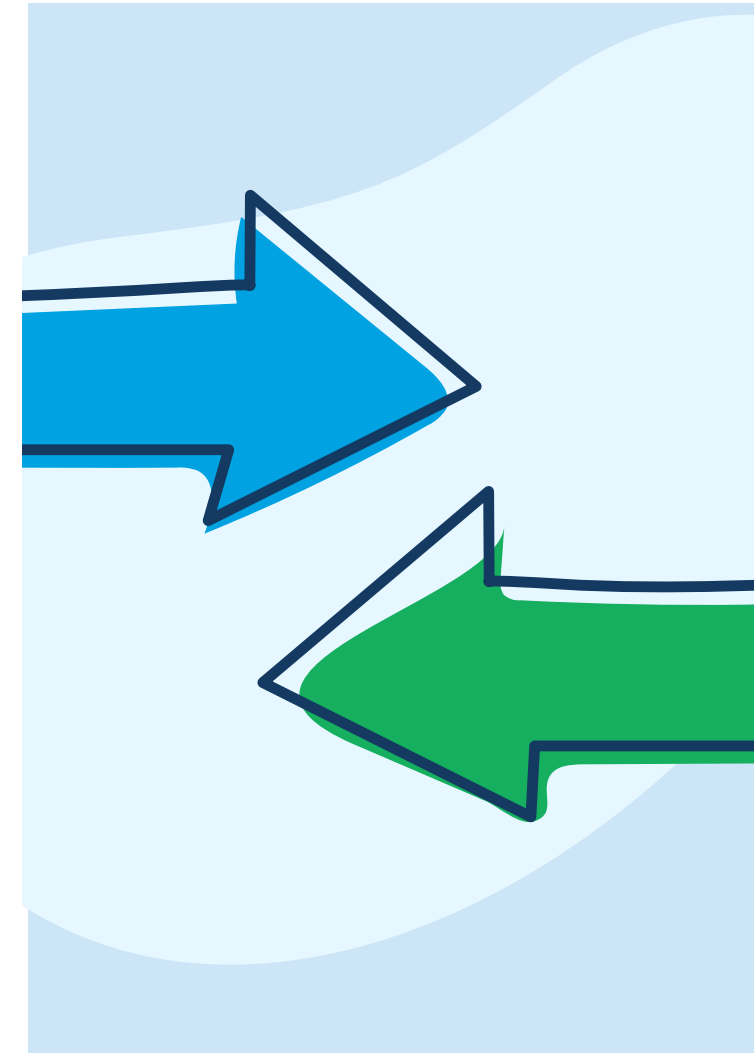
This new policy will direct the plan's reimbursement for Medical Nutrition Therapy (MNT) codes 97802, 97803, 97804, G0270, and G0271 for Commercial and Medicare Advantage plans. MNT services will only be reimbursed when billed by a registered dietician or nutritional professional, or by a facility that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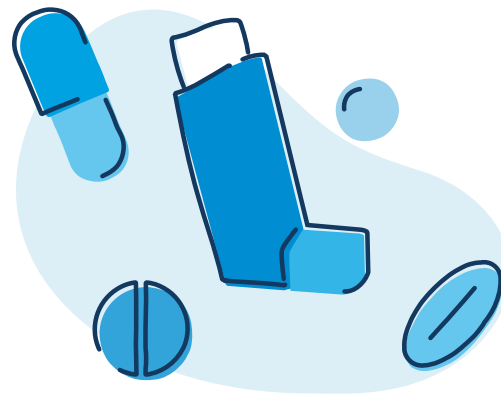
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## Quarterly Formulary Updates

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:

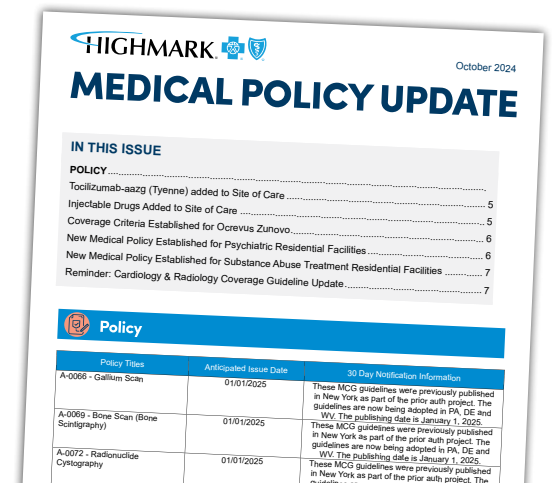
- Exception requests
- The process for generic substitutions
- Explanations of limits/quotas, therapeutic interchange, and step-therapy protocols.

### 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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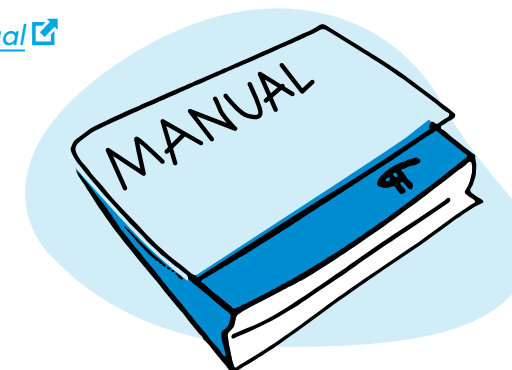
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## Staying Up to Date with the *Highmark Provider Manual*

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:

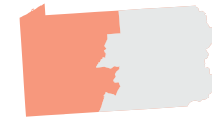
- [Chapter 2, Unit 3: Other Government Programs](#)
- [Chapter 5, Unit 6: Quality Management](#)

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



## Are You Using [Availity](#) for Your Highmark Transactions?

**LEGACY PORTALS NOW  
DEACTIVATED**



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## Directory Information – Here's How to Attest

When Highmark members are looking for a primary care physician (PCP) or specialist, they expect that our online provider directory presents information that is accurate and current.



That's why it is essential to ensure that your practice information on file with Highmark remains up to date.

Please be aware that providers who don't validate their data quarterly may be removed from the directory and their status within Highmark's networks may be impacted.

### Reviewing Data Is Vital for You

The Centers for Medicare and Medicaid Services (CMS) requires Highmark to reach out to you every quarter and ask you to validate your provider directory information. We use this information to populate our online provider directory and to help ensure correct claims processing.

Your thorough review of your directory information confirms:

- Each practitioner's name is correct and matches the name on his/her medical license.
- Each practitioner's National Provider Identifier (NPI) is correct.

- The practice name is correct and matches the name used when you answer the phone.
- All specialties are correctly listed and are currently being practiced.
- Practitioners listed at a location currently see members and schedule appointments at that office on a regular basis.
  - All practitioners listed must be affiliated with the group. Practitioners who cover, read test results, or are hospitalists should not be listed in the provider directory.
- The practitioner is accepting new patients – or not accepting new patients – at the location.
- The practitioner's address, suite number (if any), and phone number are correct.

### Professional Providers – Use the PDM Tool

Professional providers are now required to validate their Highmark Provider Directory information within the Provider Data Maintenance (PDM) tool every 90 days.

To access PDM, sign in to [Availity](#), choose the state you practice in, click **Payer Spaces** from the task bar, and then select the Highmark plan you participate in. Once you arrive at the **Payer Spaces** page, scroll down, and select **Provider Data Maintenance** under **Applications**.

### Facility, Ancillary, and Medicaid Providers – Use Atlas

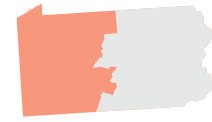
The attestation process through Atlas is quick and easy. Just follow these steps...

- 1 Go to [hub.primeatlas.com](https://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](mailto:resourcecenter@highmark.com), to your address book.

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

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



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## 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](#).

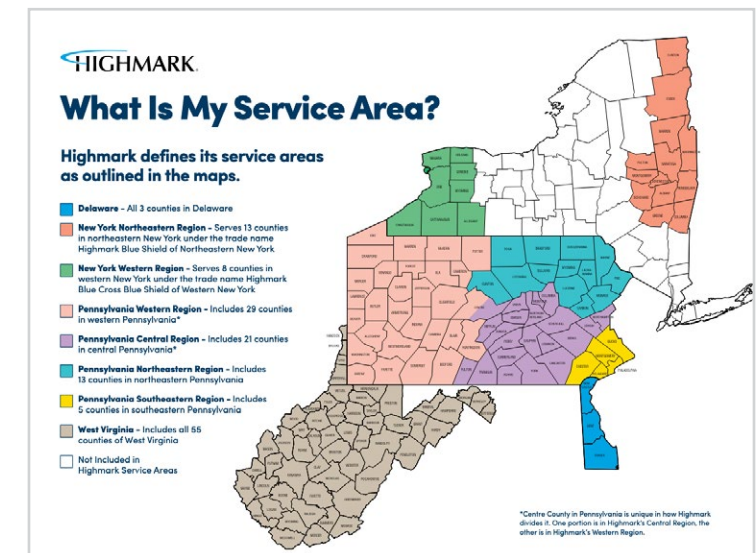
### Comments/Suggestions Welcome

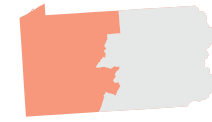
We want *Provider News* to meet your needs for timely, effective communication. If you have any suggestions, comments, or ideas for articles in future issues, please email the *Provider News* team at [ResourceCenter@Highmark.com](mailto:ResourceCenter@Highmark.com).

### Highmark Quick Reference

To contact Highmark, click [here](#).

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## Legal Information

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Highmark Senior Health Company and Highmark Coverage Advantage are service marks of Highmark Inc. 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.

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

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All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

