PROVIDER NEWS

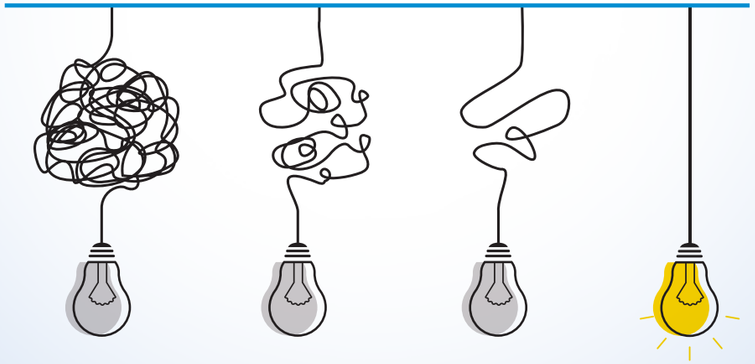
A newsletter for the Highmark Blue Cross Blue Shield providers in western Pennsylvania

HIGHMARK

Issue 6, June 2025

IN THIS ISSUE

Highmark Among Insurers Pledging to Simplify Prior Authorization



FEATURE ARTICLES

Home Health Episodic Program: Enhanced Prior Auth Process

Annual Update to Highmark's Professional Fee Schedule and Pricing Methodology

Short Takes: Claims Guidance, Retro Auth Requests, and More

Building Value for Well-Child Visits: How to Talk to Parents

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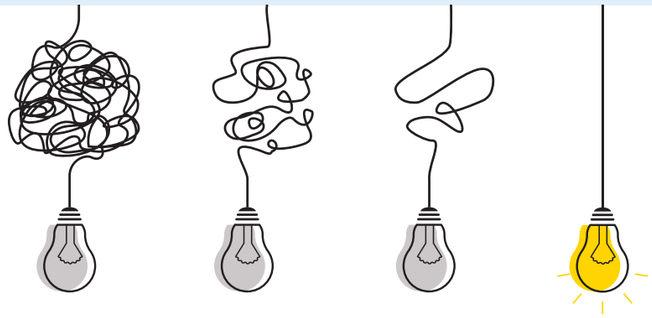


Highmark is committed to improving the prior authorization process, recently joining nearly 50 health plans in a national effort to streamline and simplify requirements.

“My belief is that we should be a conduit to appropriate care between the provider and the patient, not the roadblock that everyone thinks we are,” said Chief Medical Officer Dr. Timothy Law, a practicing physician.

Highmark has been focused on improvements, with recent successes including:

- **Decreasing turnaround** time for urgent and non-urgent case requests from approximately five days to one day, on average.
- **Increasing electronic submission** of prior authorization requests to over 75% in the last two quarters.
- **Increasing automation** of authorizations at the point of submission from 2% to more than 45%.

Technology Enhancements for Providers

Over the past few years, Highmark has invested significantly in technology to reduce administrative burden and simplify workflows for providers.

- **Availity Essentials®**: Transitioned to this multi-payer platform to streamline payer-provider transactions.
- **Electronic Retrospective Review**: Launched an electronic process for retrospective claim review, eliminating mail-in requests.
- **EMR (Electronic Medical Record) Integration**: Implementing technology to deliver information directly within providers' EMR systems, reducing reliance on portals, faxes, and phone calls.
- **Availity Authorizations & Referrals**: Leveraging more of Availity’s streamlined authorization process to enhance the experience.

Gold Card Program

Highmark's Gold Card program expedites prior authorization for over 23,000 clinicians who have a proven record of adhering to clinical criteria. Highmark also offers an "active gold carding" program to help provider groups improve their care practices and qualify for Gold Card status.

Highmark remains committed to improving prior authorization processes and systems to ensure our members get medically necessary and appropriate care quickly and easily.

Stay Informed

Sign up for our mailing list to stay informed on continued enhancements to the prior authorization process.

Home Health Episodic Program: Enhanced Prior Auth Process

Highmark is implementing an enhanced prior authorization process for our Home Health (HH) Episodic program, effective **Aug. 1, 2025**, designed to benefit both your agency and our members.

For eligible Highmark Medicare Advantage members in Pennsylvania, a single approved prior authorization will now cover all six HH disciplines:

- **Skilled Nursing**
- **Physical Therapy**
- **Occupational Therapy**
- **Speech Therapy**
- **Social Work**
- **Home Health Aide**

Important Note: This enhancement applies *only* to providers participating in the Home Health Episodic Value-Based Reimbursement (VBR) program.

Benefits for Your Agency

- **Simplified Authorization Process:** Reduce authorization requests, saving time and resources.
- **Enhanced Care Coordination:** Facilitate timely access to all necessary HH disciplines for patients.
- **Improved Patient Outcomes:** Support comprehensive care delivery to optimize patient health at home.

Impact on Prior Authorizations

When submitting a prior authorization request for HH services, the approved authorization will cover all six disciplines, as medically necessary and appropriate within the member's plan benefits. Extension requests are no longer required for members in the Home Health Episodic program.

This change will streamline HH service delivery and improve the overall experience for providers and members.

For questions, please contact your Network Performance Manager.

Annual Update to Highmark's Professional Fee Schedule and Pricing Methodology

Effective Sept. 1, 2025, Highmark will make its annual update to our standard professional fee and pricing methodology[1], which applies to the following Highmark service areas — Delaware, Pennsylvania, and West Virginia — for Commercial lines of business.

This change does not affect Highmark's Medicare, Medicaid, or any value-based fee schedule adjustments. The annual update is part of Highmark's continued effort to align with industry standard values and remains non-negotiable for contracted providers.

What Is Changing

The Commercial standard professional fee schedule and pricing methodology enables Highmark to:

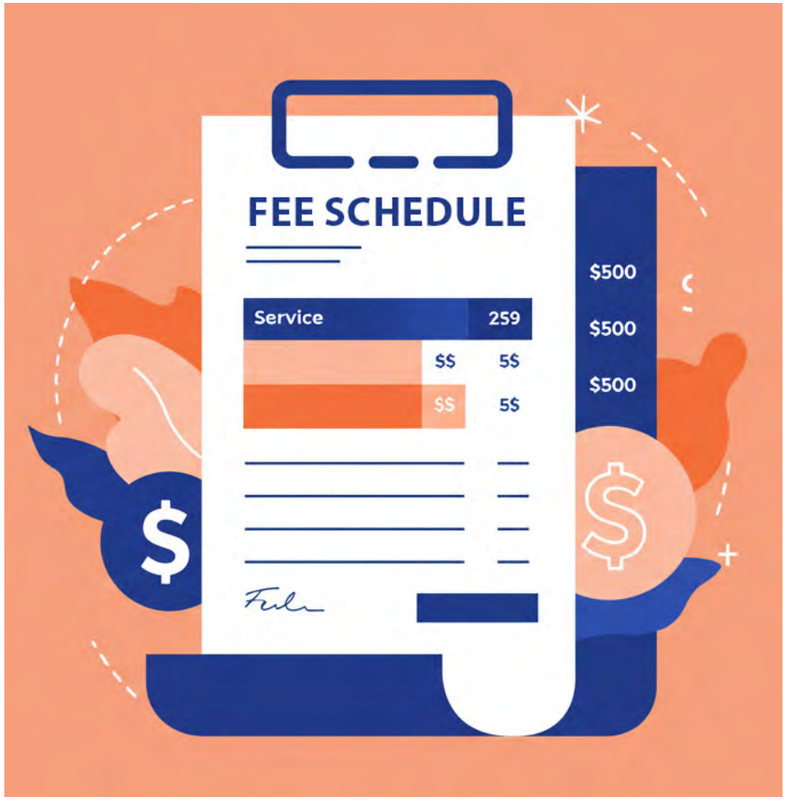
- Update our fee allowances based on industry research by leveraging different sources and data points, including changes the Centers of Medicare and Medicaid Services (CMS) made to the 2025 Medicare Physician Fee Schedule.
- Continue to bring our fee schedules in closer alignment with Highmark's value-based reimbursement strategies through uniform standard fees.

Download and Review the Fee Schedule

You can review the updated standard professional fee schedule within Availity Essentials® beginning **Aug. 1, 2025**. Once you log into Availity, select **Claims & Payments** from the task bar and then **Fee Schedule Listing** from the right side.

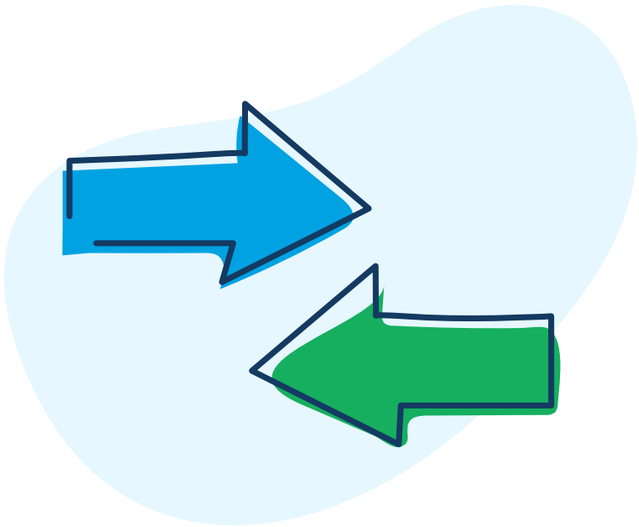
You can also access fee schedules by going to **Highmark's Payer Spaces** in Availity, and then select **Provider Resource Center (PRC)** under **Applications**. Once you arrive at the PRC, select **Claims & Authorization > Reimbursement Programs > Fee Schedule Information**.

[1]Any changes to the commercial standard professional fee schedule and pricing methodology will comply with 18 Del. Code §§ 3342B and 3556A.



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

May 30, 2025

For more information about the policy updates (RP-019A, RP-040, and RP-061) and policy addition (RP-080) listed below, CLICK HERE.

RP-019A *(formerly RP-019N)* Drugs and Biologicals

To align with Highmark's reimbursement methodology for outpatient medications, RP-019A (formerly RP-019N) now includes inpatient drugs and biologicals; pricing will be adjusted to the Average Selling Price (ASP) +10% (Commercial) or ASP +6% (Medicare Advantage) and in the absence of ASP, Average Wholesale Price (AWP) will be utilized.

To view this reimbursement policy, access the PRC via the provider portal (Availity Essentials®). Once redirected to the PRC from the provider portal, hover over **Claims & Authorization** in the main menu, then click **Reimbursement Polices** under **Reimbursement Programs**.

RP-040 Facility Routine Supplies and Services

The list of routine supplies, services, and items that are not separately reimbursable were updated.

RP-061 Implants and Implant Components

Following industry best practices, Highmark will apply the invoice cost for implants as the covered charge(s) for that implant. Highmark will determine invoice pricing on each claim based on the national invoice average as codified in RP-061.

NEW: RP-080 Integral or Necessary Services

The intent of this policy is not to develop new guidance, but rather to provide standalone policy language clarifying Highmark's definition of "integral":

- **"Integral" refers to services** that are needed or required during the provision of patient care which are inclusive of another service or component parts of a more comprehensive service.
- **"Integral" refers to supplies, equipment, and certain services** that are inherent, needed, or required for the provision of patient care and are considered by Highmark as part of another service.

(Continued)

June 2, 2025

RP-024 Eye Procedures Done in Stages or Sessions

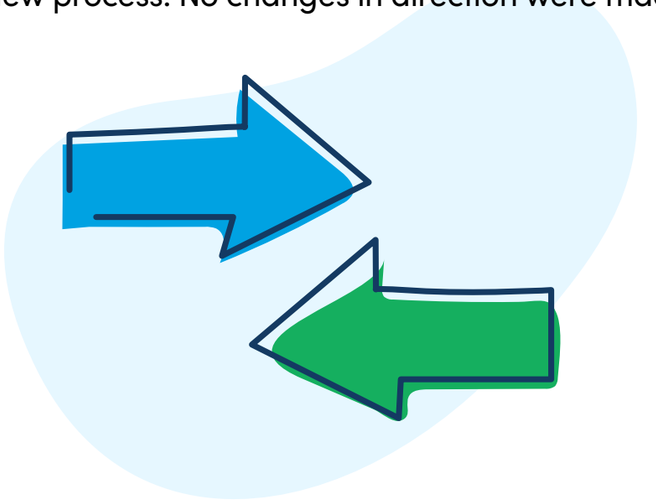
This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-025 Implantation of Subcutaneous Intravascular Catheter

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

RP-026 Portable Radiography and ECG Services – Modifiers UN, UP, UQ, UR, US

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



UPCOMING

July 1, 2025

For more information about the policy updates (RP-039 and RP-050) listed below, CLICK HERE.

RP-039 Outpatient Services Prior To An Inpatient Admission

When a Highmark member is seen for outpatient services within 72 hours prior to an inpatient admission for a related diagnosis at *any* facility within the same health system, those outpatient services will be considered part of the inpatient stay.

RP-050 Inpatient Readmissions

When a Highmark member is readmitted to any inpatient hospital within the same health system for a related diagnosis within 15 days from the initial stay, all services over the two stays will be considered part of the initial stay.

Aug. 4, 2025

RP-047 Venipuncture and Lab Services

This policy will be made applicable to Medicare Advantage professional.

Aug. 25, 2025

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

This policy will be updated to add additional billing information and guidelines concerning what is included in the various types of Evaluation and Management Services for Commercial and Medicare Advantage. *(**NOTE:** The effective date for this policy update was changed from June 30, 2025, to Aug. 25, 2025.)*

RP-059 Associated Services

Direction in this policy will be updated to include primary procedure medical necessity denials.

SHORT TAKES:

Claims Guidance, Retro Auth Requests, and More

Claims Guidance in May *Provider News*

Did you get a chance to read last month's issue of *Provider News*? If not, you missed several articles focused on claims, including electronic submissions, coding tips, laboratory claims, and a reminder on correcting claims.

Click **here** to read the following articles:

- 4 Ways to Optimize Claims with Electronic Submissions
- Coding Laboratory Claims: Preventive vs. Diagnostic
- Claims Tips: Secondary Breast Screenings, Colonoscopies, and Members with Dual Enrollments
- Reminder: When Correcting a Claim, Changes Go Directly on the Replacement Claim

Retrospective Reviews

Retrospective reviews are requests for post-service authorization. The service has already been performed, but an authorization — which is required — has NOT been requested prior to treatment. Providers can submit retrospective review requests for authorization via the Availity Essentials® portal. To learn more, go **here**.

Latest Edition of MCG Care Guidelines

The 29th edition of MCG's Care Guidelines will be available on June 30, 2025.

As of this date, you will be able to submit authorization requests using the 29th edition for any new requests. Any authorization requests with a start of care date prior to June 30, 2025, will be reviewed using the 28th edition.

To access the current guidelines, visit the MCG Clinical Criteria Page.

Expanding Access to Affordable Oncology Care

Effective Sept. 1, 2025, Highmark is expanding our Site of Care (SOC) drug management program to include select oncology drugs, continuing our ongoing effort to deliver high-quality and cost-effective care in a setting that is medically appropriate for the level of care being delivered.

The expansion will be applicable to our Commercial and Affordable Care Act (ACA) members in Delaware, Pennsylvania, and West Virginia. As always, please review member benefits to verify individual coverage details.

Included Medications

The following Immune Checkpoint Inhibitors (ICIs) will be added to the Site of Care program:

PD-1 Inhibitors	PD-L1 Inhibitors	CTLA-4 Inhibitors	LAG-3 Inhibitors
Keytruda (pembrolizumab)	**Tecentriq (atezolizumab)**	**Yervoy (ipilimumab)**	**Opdualag (nivolumab; relatlimab)**
Opdivo (nivolumab)	**Imfinzi (urvalumab)**	**Imjudo (tremelimumab)**	
Jemperli (dostarlimab)	**Bavencio (avelumab)**		
Libtayo (cemiplimab)			
Zynyz (retifanlimab)			

These therapies were selected due to a generally favorable safety profile, allowing optimization of the treatment locations to clinically appropriate settings, such as ambulatory infusion suites not affiliated with a hospital and physician's offices, when higher-level care and supervision is not clinically required and therefore, not medically necessary

(Continued)

Eligible Settings

Beginning Sept. 1, 2025, the oncology medications added to the program will be outlined in our SOC Medical Policy I-151 and must meet clinical as well as preferred site of service medical necessity criteria for coverage.

If the drug therapy meets clinical medical necessity criteria but the hospital outpatient setting is not medically necessary, Highmark will cover the infusion when administered by a certified infusion specialist at a non-hospital-affiliated ambulatory infusion center, in a qualified provider's office, or in the member's own home, as appropriate.

NOTE: *The policy will not apply to Medicaid members. Medicare Advantage members will continue to be subject to a clinical medical necessity review; however, the site of care requirement does not apply.*

Administration at a hospital outpatient setting or hospital affiliated ambulatory infusion center may be covered when a higher level of clinical care is determined to be medically necessary by meeting the exception criteria outlined in policy I-151.

If the site of service medical necessity exception criteria are not met, administration at the higher level of care setting will be deemed medically necessary if the hospital has agreed to accept reimbursement rates similar to the preferred lower level of care settings as the site is not more costly than the alternative lower level of care settings.

Building on Success

This expansion builds on the demonstrated success of the Site of Care Drug Management program in reducing costs and improving member experience for specialty infused medications. Highmark is confident that this initiative will further improve access to high-quality, affordable oncology care for our members while maintaining the highest standards of patient safety.

Highmark will directly notify the prescribers of impacted members in the coming weeks.

Reminder: *Availity Essentials® can be used for submitting any authorization request. This will not only save time, but you also will be notified if a duplicate request has already been received by Highmark. In addition, using the Availity portal enables providers to ensure that the patient is an active Highmark member.*

2025 Mid-Year Preventive Schedule

The following three updates were made to the 2025 Preventive Schedule:

1. **Pneumonia Vaccine – Recommended Age Lowered**

   The Centers for Disease Control and Prevention (CDC) lowered the age to receive the vaccine from 65 to 50 in the general population.

2. **Inactivated Poliovirus Vaccine (IPV) – Recommendation**

   The CDC is recommending that adults, who either were never vaccinated or didn't complete their vaccination, receive the IPV.

3. **Lung Cancer Screening – Clarification**

   The screening does not require prior authorization; the language for the procedure has been updated. There is no change to the benefit.

Coding Laboratory Claims: Preventive vs. Diagnostic

Highmark has been experiencing an uptick in improperly coded claims for laboratory services. Understanding which labs are on the Standard Preventive Schedule *and when they qualify as preventive or diagnostic* are key to successful claim submission and acceptance:

- **Preventive** – As part of the member's Annual Preventive Office Visit, screening tests on the Standard Preventive Schedule are covered.
- **Diagnostic** – For members with chronic disease or symptoms, claims will have a medical diagnosis and apply cost share.

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

Download the 2025 Preventive Guidelines

To help make the information more accessible and convenient for you, the complete set of 2025 Preventive Health Guidelines is posted online. Just visit the Provider Resource Center, go to **Resources & Education > Clinical Quality & Education > Preventive Health Guidelines**.

Building Value for Well-Child Visits: How to Talk to Parents

Well-child visits declined during the COVID-19 pandemic, according to the National Institutes of Health. While visits are beginning to return to pre-pandemic levels, challenges remain, including:

- Medical disinformation, especially regarding vaccines, on social media.
- Parents experiencing social determinants of health (SDOH), such as food insecurity and transportation issues.
- The general busy-ness of parenthood, which can lead to missed or canceled appointments.

Points of Emphasis

The following talking points are helpful reminders when speaking with parents about the importance of maintaining regular well-child visits:

- **Early Detection and Prevention:** Well-child visits are vital for identifying potential health issues. Early detection allows us to intervene quickly and prevent more serious complications. We'll also ensure your child receives all necessary vaccinations to protect them from preventable diseases.
- **Tracking Growth and Development:** We'll closely monitor your child's physical and developmental milestones at each visit. This allows us to identify any potential delays or concerns early and address them proactively.
- **Open Communication and Support:** These visits are a dedicated time for you to ask questions, voice any concerns, and receive guidance on all aspects of childcare, from infant care to managing common childhood illnesses. No question is too small!
- **Building a Strong Partnership:** Regular well-child visits help us build a trusting relationship with both you and your child. This partnership is essential to ensuring the best possible health and well-being for your child throughout their development.

(Continued)

- **Age-Specific Guidance:** At each visit, we'll provide anticipatory guidance tailored to your child's current age and stage. This will cover important topics like nutrition, safety, and age-appropriate behavior.

HEDIS® Measures

The National Committee for Quality Assurance (NCQA) recognizes the importance of well-child visits and has created the following HEDIS measures to track these appointments:

- Well-Child Visits in the First 30 Months of Life (W30)
- Child and Adolescent Well-Care Visits (WCV)

Meeting these HEDIS measures is crucial for demonstrating high-quality patient care and aligns with Highmark's True Performance Program (TPP).

A related HEDIS benchmark — Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) — encourages healthy habits in young patients by documenting BMI percentile, discussing nutrition and physical activity, as well as providing counseling or referrals. For more information on documentation and codes needed to close care gaps, click here.

Children's Health Insurance Program (CHIP) – Lead Screenings

Highmark Healthy Kids (CHIP) requires all children to have at least one lead blood test as early as nine months but prior to their second birthday, as recommended by the American Academy of Pediatrics and Bright Futures periodocity schedule. This screening is also part of Highmark's True Performance program. **NOTE:** A risk assessment questionnaire alone does not meet the requirement for True Performance. Testing is required at ages 12 and 24 months for children covered by Medicaid.

Additional Resources

For more information on HEDIS measures for Highmark providers, log into Availity Essentials®, and then click here.

**HEDIS® — an acronym for Healthcare Effectiveness Data and Information Set — is a registered trademark of the 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.

Meeting these HEDIS measures is crucial for demonstrating high-quality patient care and aligns with Highmark's True Performance Program (TPP).

Virtual Joint Health: Relieving Pain, Restoring Life

By Catherine Clements and Tanner Rose

Originally published in Highmark Health Digital Magazine.

Virtual care is a key part of Highmark's Living Health strategy, which integrates health coverage and care to deliver a simpler more personalized and proactive health experience for our members and clinicians.

One Living Health solution — Virtual Joint Health powered by Sword Health — offers our members personalized musculoskeletal care from home. Whether experiencing acute pain, chronic discomfort, or a desire to improve mobility, Virtual Joint Health is available to eligible members 13 or older experiencing pain in their back, shoulder, hip, knee, ankle, neck, or elbow.

The program uses a tablet with advanced computer vision technology to guide members through customized exercises, providing real-time feedback to ensure proper form and maximize effectiveness. This tailored approach helps members heal and strengthen.

One Member's Journey

Kathy Kennedy-Ratajack, DBA, assistant vice president of Academic Affairs and Partnerships at Wilmington University and a fitness instructor in Kent County, Delaware, knows firsthand the demands of a busy schedule.

When a torn meniscus — sustained during a rigorous fitness class and exacerbated by a hiking trip in Iceland — threatened her active lifestyle, she initially sought traditional physical therapy. However, fitting in-person sessions into her schedule proved challenging.

From the start, Kathy found Virtual Joint Health easy to integrate into her life. Her virtual physical care specialist customized her exercises, and even accommodated her travel schedule with flexible, text-based consultations.

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After six months of using the computer vision technology and completing her customized program, Kathy experienced significant pain reduction, enabling her to resume her yoga and fitness classes, long walks with her dog, and an active life — all without cortisone injections, painkillers, or surgery.

Sword encounters do **not** count against your patients' allowed number of physical therapy visits in their benefits. Virtual Physical Care (Sword) may be considered a part of preoperative, pre-procedure, or pre-advanced imaging conservative therapy if clinicians document the use of Sword in a patient's chart. Please refer to the relevant medical policy, which may require that Sword use, as conservative therapy, meets a required time frame.

By the Numbers: Impact of Virtual Joint Health

These positive member experiences are backed by data. By the end of 2024, over 36,000 Highmark members enrolled in Virtual Joint Health. High member engagement (92%) and a 72% completion rate demonstrate the program's effectiveness and ease of use. Most importantly, for those suffering from moderate to severe pain, 69% found relief.

Compared to non-participants, Virtual Joint Health users showed a statistically significant reduction in emergency department visits, hospital admissions, and the need for imaging, surgery, and joint replacements. This benefits both members and the long-term sustainability of the health care system.

This is an excerpt of the full article that recently appeared in the Highmark Health Digital Magazine.

Key FAQs: Medicare Compliance Training

If your practice or facility cares for Medicare-eligible patients, read this important notice and share it with your colleagues.

Q What kind of training is required annually by Highmark?

A Highmark requires Medicare first-tier, downstream and related (FDR) entities to complete annual compliance training.

Q Who must complete these trainings?

A Every individual who is associated with your practice or facility and works with Highmark's Medicare Advantage and/or Medicare Part D Prescription Drug Plan (PDP) members and who fall into one of these categories:

- Employee
- Governing-body member
- Temporary worker
- Contractor
- Subcontractor
- Volunteer

Q Why does Highmark require these trainings to be completed by employees, vendors, and others?

A Highmark requires compliance training to ensure that all practices and facilities receiving Medicare dollars understand how to comply with the laws, regulations, guidelines, and policies for the Medicare program and how to prevent, detect, and correct Medicare fraud, waste, and abuse (FWA).

Q When does Highmark require these individuals to complete these trainings?

A Compliance training must be completed:

- At the beginning of the individual's employment, contract, or appointment: **Within 90 days**.
- During employment, contract, or appointment: **Between Jan. 1 and Dec. 31 every year**.

Q Where can individuals go to access these trainings?

A Individuals have several options for completing these training requirements. They can:

- Complete compliance trainings online via the CMS Medicare Learning Network
- Complete the compliance and FWA training offered by your practice or facility

Q What proof must be provided that the trainings were completed?

A Individuals must review the training programs in their entirety and present one of the following acceptable forms of evidence:

- Sign-in sheets
- Individual employee attestations
- Electronic certifications

The records must include:

- Time
- Attendance
- Topic
- Certificates of completion (if applicable)
- Test scores (if applicable)

Proof of training completion must be provided to Highmark upon request. Training records must be maintained for the period of the provider's contract with Highmark, plus an additional 10 years.

Q Are there any exceptions to these guidelines?

A Yes. FDRs who have met the FWA training and education certification requirements through enrollment into Parts A or B of the Medicare program or through accreditation as a supplier of durable medical equipment, prosthetics, orthotics, and supplies are deemed to have met Highmark's annual compliance training requirements.

Accessibility Standards:
Ease of Scheduling an Appointment at Your Practice

As a participating Highmark Blue Cross Shield provider, you must adhere to specific in-person/telehealth appointment scheduling standards, including:

- **Urgent care:** Immediate appointment.
- **Non-urgent, regular care:** Within 48-72 hours.
- **Initial routine (PCPs, OBGYNs, Specialists):** Within 3 weeks.
- **Initial Behavioral Health (BH) assessment:** Within 7 days.
- **Subsequent routine:** Within 10 days.
- **Non-life-threatening Behavioral Health:** Within 6 hours.
- **Follow-up after hospital discharge:** Within 5 days.
- **Facility Services:** Must be available 24/7 when medically appropriate. Verify physician qualifications if services are provided on behalf of the facility.

These appointment expectations are set forth by the health plan, at the direction of the state and federal regulatory bodies, including, but not limited to:

- Centers for Medicare & Medicaid Services (CMS)
- National Committee for Quality Assurance (NCQA)

No Preconditions on Scheduling an Appointment

Conditions must **not** be imposed on members when requesting an appointment.

- **Members cannot be asked to complete forms,** provide identification documentation, or share medical records prior to the provider scheduling the appointment.
- **An appointment must always be scheduled** at the time the member calls the practice and must be scheduled in compliance with the PCP and Medical Specialist, and BH accessibility expectations referenced below.
- **An appointment must not be contingent** on the member's ability or inability to complete paperwork prior to the telehealth or in-person office visit.

(Continued)

Directory Accuracy

Highmark requires all credentialed providers to maintain accurate directory information which enables members to make informed decisions about their care.

Accurate Directory Information

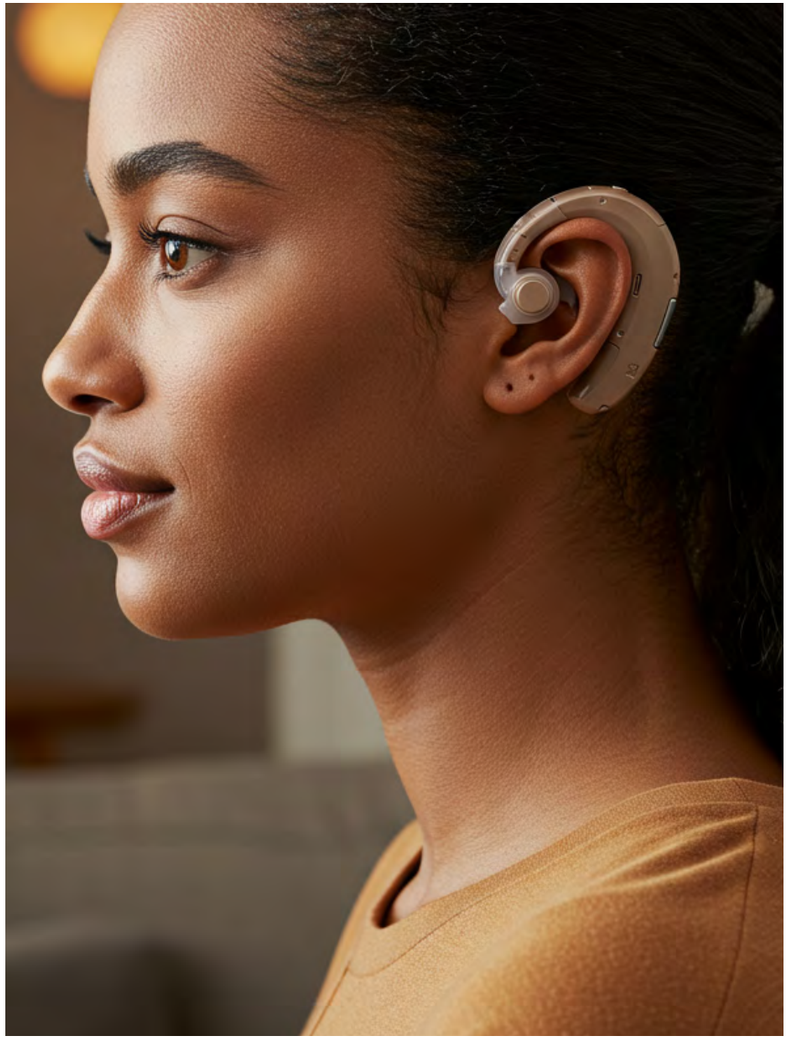
CMS requires Highmark to reach out to you every quarter and ask you to validate your provider directory information, including the following:

- Each practitioner's name is correct and matches the name on his/her medical license.
- Each provider'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 providers 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 provider 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.

Validate your directory information (practitioner name, NPI, practice name, specialties, location details, and acceptance of new patients) every 90 days to avoid removal from the directory, as required by the No Surprises Act. For more information on how to attest, click here.

Resources

- **Chapter 4: Provider Responsibilities & Guidelines > Unit 1: PCPs and Specialists >** 4.1 PCP and Medical Specialist Accessibility Expectations > Accessibility Expectations for Providers.
- **Chapter 4: Provider Responsibilities & Guidelines > Unit 2: Behavioral Health Providers >** 4.2 Accessibility Expectations for Behavioral Health > Accessibility Expectations.
- **Chapter 4: Provider Responsibilities & Guidelines > Unit 3: Facility-Specific Guidelines >** 4.3 Member Access to Facilities.



Is Your Provider Directory Information Still Accurate?

An accurate and up-to-date online provider directory is essential for Highmark members seeking care. To maintain the accuracy of our provider directory, we ask that you verify your information every 90 days.

Why Is This Important?

- **Compliance** – The Centers for Medicare and Medicaid Services (CMS) mandates quarterly validation of provider directory data.
- **Accuracy** – Validated data ensures correct claims processing and helps members find the right care.
- **Network Status** – Failure to validate data quarterly may result in removal from the directory and impact network status.

What to Review

Please verify the following information for each practitioner:

- Full name (matches medical license)
- National Provider Identifier (NPI)
- Practice name (matches phone greeting)
- Accurate list of current specialties
- Confirmation that practitioners see members and schedule appointments regularly at listed locations and are affiliated with the group.
  - **Exclusion:** Do not include covering physicians, those reading test results, or hospitalists.
- New patient acceptance status (accepting or not accepting)
- Correct address, suite number (if applicable), phone number, and email address

How to Attest

- **Professional Providers:** Use the Provider Data Maintenance (PDM) tool within the Availity Essentials® provider portal every 90 days.
- **Facility and Ancillary Providers:** Use the Highmark Facility/Ancillary Change form on the Provider Resource Center every 90 days.

Important Reminders

- Add resourcecenter@highmark.com to your address book to ensure you receive important emails from Highmark.
- Double-check your email address(es) during the attestation process to guarantee uninterrupted communication.

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 3, Unit 2: Professional Provider Credentialing**
- **Chapter 3, Unit 3: Professional Provider Guidelines**
- **Chapter 4, Unit 7: Medical Records Documentation Requirements**
- **Chapter 5, Unit 2: Authorizations**
- **Chapter 5, Unit 3: Medicare Advantage Procedures**
- **Chapter 6, Unit 1: General Claim Submission Guidelines**
- **Chapter 6, Unit 3: Facility (UB-04/8371) Billing**
- **Chapter 6, Unit 5: 1500 Claim Form Guidelines**

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

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.

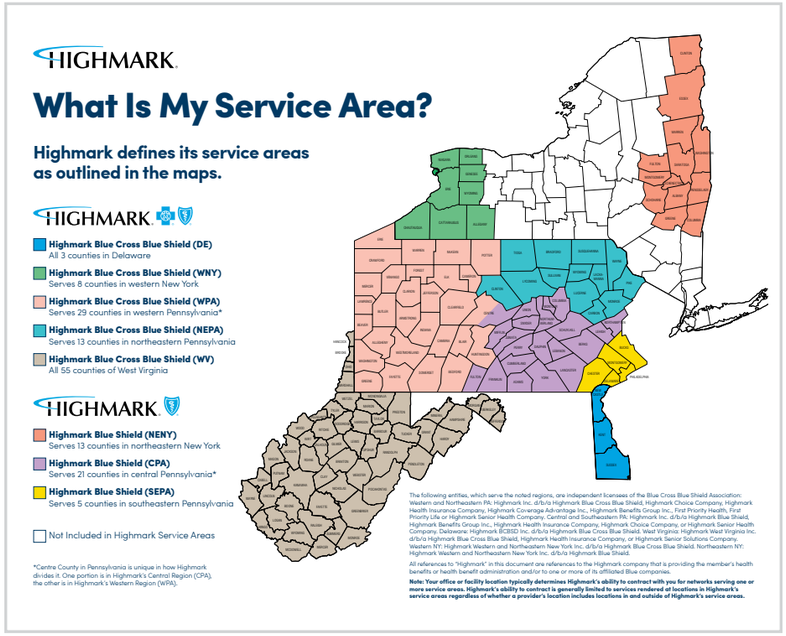
Comments/Suggestions Welcome

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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