

PROVIDER NEWS



A newsletter for the Highmark Blue Cross Blue Shield providers in western New York

Issue 12, December 2024

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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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NEW TRUE PERFORMANCE LITE: Sign Up for Online Training



Register for an upcoming training session to learn about the True Performance Lite application within Value Insight Center. The new app can be used for entering data, tracking and addressing care gaps, and confirming 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.

Background: Transition to True Performance Programs

New York primary care providers who currently participate in the following practice-level incentive programs – Pay for Outcome (P4O), Pay for Performance (P4P), Pediatric Behavioral Health Incentive, and End of Year Stars (EOY Stars) – will transition to Highmark True Performance starting **Jan. 1, 2025**.

Practices with fewer than 250 attributed Highmark members as of June 30, 2024, will move to the **True Performance Lite** value-based incentive program. Offices with more members will transition to the regular **True Performance** program. See [Sept. Provider News](#) for more details.

Upcoming Webinars – True Performance Lite

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

- [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 in the coming weeks.



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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	Nexvazyme
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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THE CARE AT HOME PROGRAM TRANSITION: Training in the New Year



Effective Jan. 1, 2025, Highmark will transition the management of the Care at Home program from Landmark to ConcertoCare in the Northeastern and Western New York regions. This information was previously communicated in last month's issue of *Provider News*.

Introductory Webinars in January 2025

To assist providers with this transition, Highmark will be offering an introductory webinar in collaboration with ConcertoCare at 2 p.m. on the dates and times below. Please click to register for your preferred session:

- [Tuesday, Jan. 14, at 2 p.m.](#)
- [Friday, Jan. 24, at 2 p.m.](#)

Care at Home: New Vendor, Same Commitment

Care at Home is an ongoing, exclusive Highmark Medicare Advantage (MA) program delivering in-home support to qualifying patients with complex

health care needs. The Care at Home umbrella of services includes chronic condition management, urgent care, care transition management, behavioral health care, and advance care planning support.

Just like the current Care at Home program, ConcertoCare will offer the same comprehensive clinical programs and will continue to provide your patients with high-quality, compassionate in-home care, as well as phone-based support from pharmacists, social workers, and other care teams.

Because this program is designed to complement the care you provide, ConcertoCare will establish regular communication with primary care providers to align on treatment and collaborate with you to address the care needs of patients engaged in the program.

Preparing for the Transition

We are dedicated to ensuring a smooth transition for you and your patients and will provide additional information as it becomes available.

If you have any questions, please contact Highmark's Provider Service Center: 800-950-0051 from 8 a.m. to 5 p.m. EST, Monday-Friday.

Review Your Contact Information

To stay informed about the upcoming transition, it's important that your contact information — including mailing and email addresses — with Highmark is correct.

Here's how to review and update your information:

- Log into [Availity Essentials](#)
- Choose New York state.
- Click on **Payer Spaces** and choose your **Highmark** plan.
- Scroll down and select **Provider Data Maintenance** under the **Applications** tab.

Join Our Mailing List

Stay up to date on the latest news and announcements from Highmark, including this transition, by clicking [here](#)





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ESSENTIAL PLAN REMINDER: Highmark to Transition Administration to Wellpoint on Jan. 1, 2025



Highmark Blue Cross Blue Shield in Western New York is transitioning administration of Essential Plan to Wellpoint Partnership Plan, LLC (formerly Amerigroup Partnership Plan, LLC) **effective Jan. 1, 2025**. This transition was approved by the New York State Department of Health on July 31, 2024.

Wellpoint currently manages Highmark's Medicaid Managed Care (MMC), Health and Recovery Plan (HARP), and Child Health Plus (CHP) in Western New York as well. Our collaboration, which started in 2016, has allowed us to work together to provide dedicated, quality service to our MMC, HARP, and CHP members.

The transition to Wellpoint has been previously communicated. See the following:

- [July 2 Special Bulletin](#)
- September [Provider News](#)

What You Should Know

In July, Wellpoint began reaching out to providers currently contracted with Highmark for the Essential Plan to inform them about the upcoming change. If you currently see patients who are members of Highmark's MMC, HARP, or CHP plans, the processes to request authorization, submit claims, and receive reimbursement for Essential Plan members will be familiar to you.

For providers new to Wellpoint-managed plans, including Essential Plan, you are encouraged to visit this Highmark website: bcbswny.com/stateplans

Ease of Use – Just One Provider Portal

[Availity Essentials](#) is the provider portal for both Highmark and Wellpoint. To register, visit the [Register and Get Started with Availity Essentials webpage](#).

If you are already registered for the portal, there is no need to re-register.

Pharmacy Network Change

As part of the transition, the pharmacy network and formulary for Essential Plan members have changed from Express Scripts to CarelonRx. Letters sent in mid-September encouraged members to check to see if their pharmacy would remain in-network and their prescription drugs are included in the new formulary for 2025.

As part of the transition, members will receive new ID cards in December via postal mail.





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SHORT TAKES:

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Accessibility Expectations: Changes for Professional Providers in All Regions

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

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

To learn more, click [here](#).

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

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

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

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

Physical Medicine Programs for 2025: High Performing Provider Program Update

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

Click [here](#) for more information.



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New York State's End the Epidemic – HIV/AIDS Plan



The *End the Epidemic* program seeks to reduce the number of new HIV diagnoses by 55% to 1,515 and increase the number of individuals filling prescriptions for PrEP to 65,000.

***End the Epidemic's* three-point plan includes:**

1. **Identifying persons with HIV** who remain undiagnosed and link them to health care.
2. **Link and retain** persons diagnosed with HIV in health care to maximize virus suppression, so they remain healthy and prevent further transmission.
3. **Facilitate access** to Pre-Exposure Prophylaxis (PrEP) for high-risk persons to keep them HIV-negative.

About PrEP

PrEP is for people who **do not** have HIV. Individuals at risk for HIV infection take a daily pill that contains HIV antiretroviral medication to reduce their risk of becoming infected. Studies show significant reduction in HIV acquisition among HIV-negative persons who use PrEP and are offered a package of prevention, care, and support services.

For more information about PrEP and *End the Epidemic*, visit the [New York State's End The Epidemic – HIV/AIDS Plan](#) on the Provider Resource Center.



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New York Behavioral Health Mandate: Part AA of Chapter 57

Highmark is aware of the New York State Behavioral Health mandate and is in the process of conducting a thorough assessment of the impact on multiple Highmark systems and processes, including billing, credentialing, and reimbursement, to ensure a correct application of the mandate.

Important: Providers should continue to follow their current billing procedures.

We will provide advance notification to affected practitioners and organizations prior to implementing changes to our behavioral health policies and procedures based on the Chapter 57 mandate.

Thank you for your patience and understanding during this time of transition.

Additional Resource

- [Chapter 57 FAQ from New York State](#)





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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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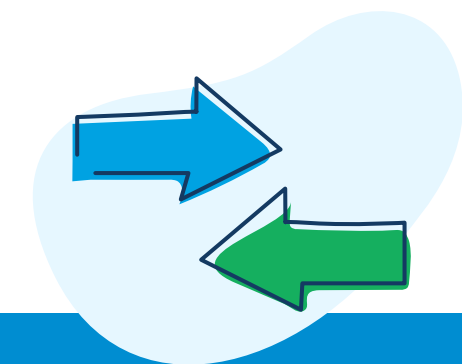
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New and Updated Reimbursement Policies

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)*

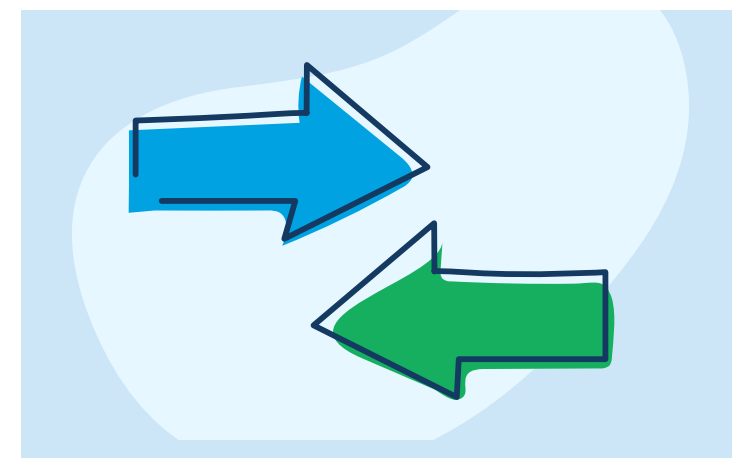
RP-073 [Performance Measurement](#)

New York exceptions for the following codes will no longer be applicable, **effective Jan. 1, 2025**, and will be removed from this policy:

- 1111F, 3044F, 3051F, and 3052F
(Commercial and Medicare Advantage plans)
- 3074F, 3075F, 3078F, and 3079F
(Medicare Advantage plans)

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

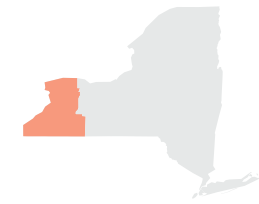
Effective Date to Be Determined

RP-068 [Mid-Level Practitioners and Advanced Practice Providers](#)

This policy will be updated for New York Commercial to add direction for the psychoanalyst specialty. Psychoanalysts will be reimbursed for procedure code 90845 only.

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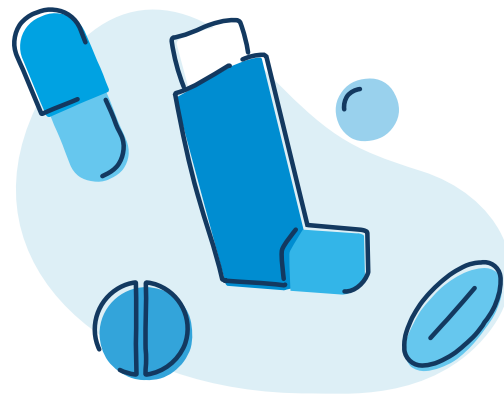
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View the [October 2024 updates](#) to Highmark's prescription drug formularies and related pharmaceutical management procedures at the Formulary Updates page on the **Provider Resource Center (PRC)**.



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:

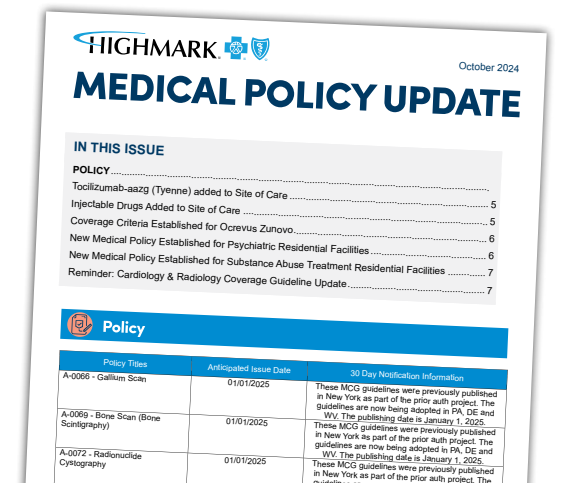
- Exception requests
- The process for generic substitutions
- Explanations of limits/quotas, therapeutic interchange, and step-therapy protocols.

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?



HIGHMARK MEDICAL POLICY UPDATE

October 2024

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- Injectable Drugs Added to Site of Care 5
- Coverage Criteria Established for Ocrevus Zunovo 6
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- New Medical Policy Established for Psychiatric Residential Facilities 6
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- Reminder: Cardiology & Radiology Coverage Guideline Update 7

Policy Title	Anticipated Issue Date	30 Day Notification Information
A-0066 - Gallium Scan	01/01/2025	These MCG guidelines were previously published in New York as part of the prior auth project. The guidelines are now being adopted in PA, DE and WV. The publishing date is January 1, 2025.
A-0069 - Bone Scan (Bone Scintigraphy)	01/01/2025	These MCG guidelines were previously published in New York as part of the prior auth project. The guidelines are now being adopted in PA, DE and WV. The publishing date is January 1, 2025.
A-0072 - Radionuclide Cystography	01/01/2025	These MCG guidelines were previously published in New York as part of the prior auth project. The guidelines are now being adopted in PA, DE and WV. The publishing date is January 1, 2025.





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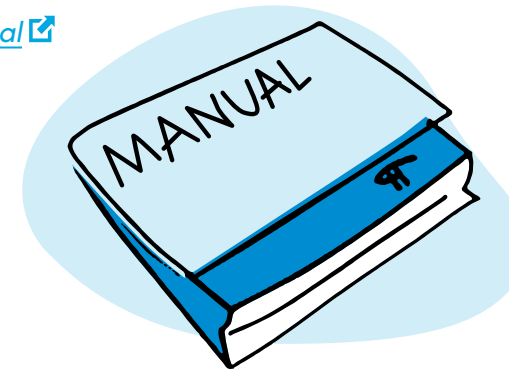
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Staying Up to Date with the Highmark Provider Manual

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
- 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.





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About This Newsletter

Provider News is a valuable resource for health care providers who participate in our networks. Published monthly on the last Monday of the month*, *Provider News* conveys important product, policy, and administrative information, including billing, claims, and program updates.

The publication also features the latest news, information, tips, and reminders about our products and services, as well as relevant interviews, articles, and stories, for health care professionals who serve Highmark members.

Regular topics include:

- New and Updated Reimbursement Policies
- Authorization Updates
- Staying Up to Date with the *Highmark Provider Manual*

*When a holiday falls on the last Monday of the month, *Provider News* will be published on the preceding Friday.

Another Valuable Resource

For medical policy and claims administration updates, including coding guidelines and procedure code revisions, please refer to the Medical Policy Update Newsletter, which is available on the **Provider Resource Center > Latest Updates > Medical Policy Update**.

To subscribe to our newsletters, click [Join Our Mailing List](#)

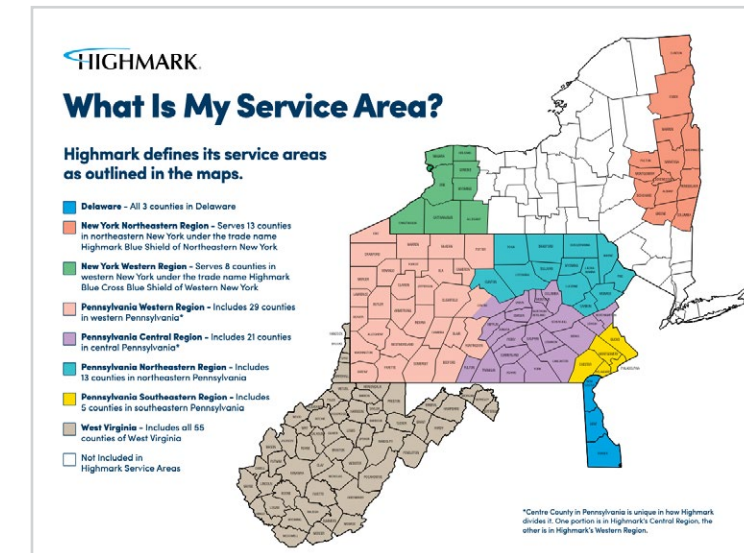
Comments/Suggestions Welcome

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

Highmark Quick Reference

To contact Highmark, click [here](#)

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Information on this website is issued by Highmark BCBSWNY, which serves the 8 counties in western New York.

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

Highmark BCBSWNY has adopted Highmark Inc. medical policies as its own policies applicable to Highmark BCBSWNY members who have moved to the "Highmark System" (i.e., *information systems of Highmark Health and/or its subsidiaries/affiliates*). Please note that for providers with Highmark BCBSWNY members who remain on the BCBSWNY Legacy System (i.e., have not yet moved to the Highmark System), certain BCBSWNY Legacy System medical protocols (found at bcbswny.com) shall apply and control until the earlier of such time as such member is no longer on the BCBSWNY Legacy System or Highmark BCBSWNY communicates otherwise to you.

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Committee for Quality Assurance (NCQA). Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a registered trademark of the Agency for Healthcare Research and Quality. CORE is a registered trademark of CAQH. InterQual is a registered trademark of McKesson Health Solutions, LLC.

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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.

