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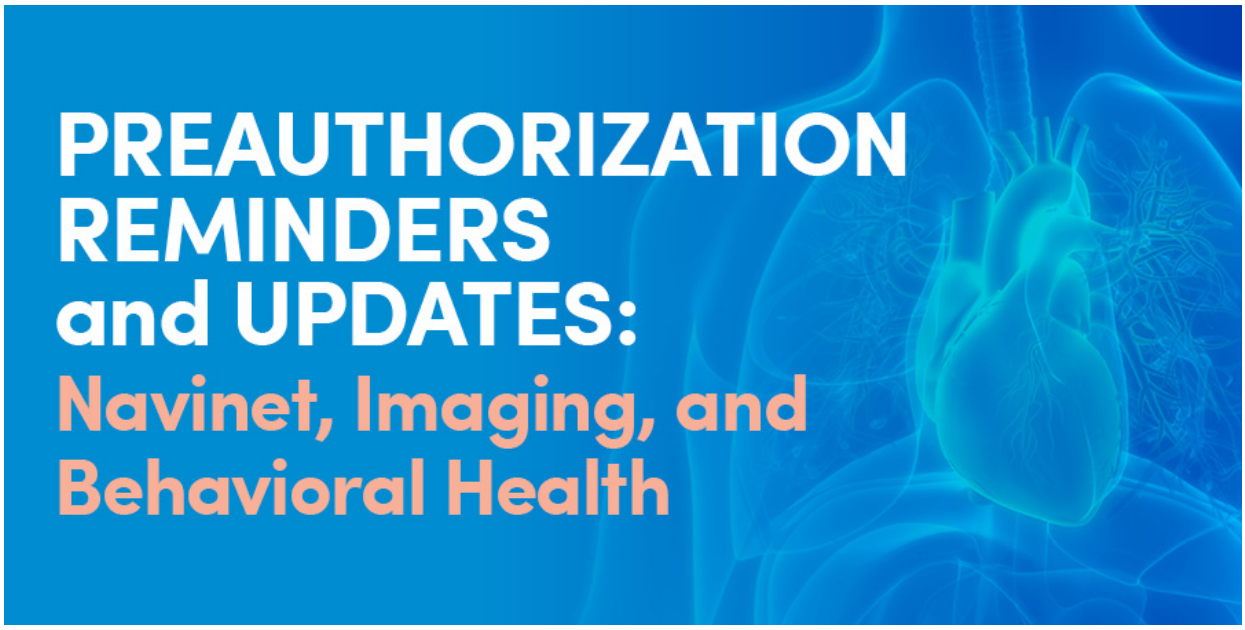

As more of your patients move onto the Highmark system, understanding key preauthorization differences for your Legacy and Highmark system patients will help ensure faster processing times while reducing administrative burdens.

Using NaviNet® for Preauthorization Requests

For patients on Highmark's system, preauthorization requests must be submitted through NaviNet. We will be following Highmark's list of procedures/DME requiring authorization.

You can access this list any time by going to the Provider Resource Center and clicking the "Requiring Authorization" tab at the top of the PRC homepage.

Imaging Info

High-end imaging, cardiac imaging, and cardiac implantable devices will need to be submitted to NaviNet for Highmark system patients.

Requests for high-end imaging and **radiation therapy services** will continue to be sent to NIA Magellan for your **Legacy system patients through the remainder of 2022**.

You can submit preauthorization requests and view pending requests by logging into your NaviNet account and clicking "Authorization Submission" or "Auth Inquiry and Reports" on the side menu of Plan Central under "Workflows for This Plan."

For additional guidance on how to navigate through NaviNet, please review the user guide here.

New Behavioral Health Criteria

Beginning September 1, 2022, the New York State Office of Mental Health will implement new preauthorization criteria for inpatient behavioral health services for adults and children. This change will be effective for **BOTH** your Highmark system and Legacy system patients.

Under the new criteria, only your adult and pediatric patients with the **following complexity triggers** will require preauthorization for behavioral health admissions:

- High utilization of psychiatric inpatient or emergency department (ED) services in the past year which includes:
  - Three or more psychiatric inpatient hospitalizations over the past 12 months
  - Four or more psychiatric ED visits in the past 12 months
    - **OR** any combination of four or more psychiatric inpatient and/or psychiatric ED visits in the past 12 months
  - Three or more medical inpatient admissions within the past 12 months
- Inpatient psychiatric readmission within 30 days of discharge from a psychiatric inpatient unit with a length of stay exceeding 30 days

For additional information about preauthorization, please go here.

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4 Tips on Helping Older Teenagers Graduate from Pediatric to Adult Care

Choosing a new primary care physician (PCP) is a big decision for anyone. But it's especially true for young men and women (and their families) as they enter adulthood. It is estimated that more than 4 million Americans will turn 18 in 2023.[1]

The following steps can help pediatric doctors and their teams facilitate the transition to a new PCP for their "older" patients:

1. Create a Transition Policy

Make sure it's readily available to practitioners, parents/guardians, and adolescents. According to gottransition.org, this policy and process should be a part of planning for all adolescents, including those with special needs. In addition, the Got Transition website has other valuable recommendations on helping pediatric patients graduate to adult care.

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2. Educate Families

Family members usually need guidance about the transition process and their role in it. Inform parents and guardians of the legal changes that occur once a child reaches age 18 and emphasize how pediatric and adult care are delivered differently. Be prepared to address any questions regarding this transition.

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3. Empower Adolescent Patients

Teenage patients should be viewed as key participants in the process. Discussions about the transition should begin in early adolescence, with the goal of members completing the process between the ages of 18 and 21. To assess patient readiness, physicians can download and administer the ADAPT Survey.[2]

A focus of these practice-patient conversations should include plans after high school graduation, such as attending college or vocational school, joining the military, or entering the workforce. These decisions will often affect the selection of an adult care provider.

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4. Access Key Resources

The American College of Physicians has created a Pediatric to Adult Care Transitions Toolkit that has valuable information for helping pediatric practices, patients, and parents prepare for this change. Some of the subjects covered include implementing a transition plan, establishing timelines, measuring progress, and maintaining up-to-date medical records and documentation to help ensure a seamless transition to an adult care provider.

As with any big life change, preparation is key. These four tips can assist pediatric practices in facilitating the transition of members to an adult care provider.

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[1]According to the National Vital Statistics Report published by the Centers for Disease Control and Prevention in 2007, there were 4.13 million babies born in the United States during 2005. In 2023, they will be turning 18 years of age.

[2]ADAPT is an acronym for Adolescent Assessment of Preparation for Transition.

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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Patient Satisfaction: Use Survey Ratings to Spur Improvements

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Medicare Health Outcomes Survey (HOS) are patient surveys that affect Centers for Medicare & Medicaid Services (CMS) star ratings—for you and for Highmark.

Improving the patient experience leads to better health outcomes for your patients and helps support gap closure programs.

Survey responses are confidential and may be completed by your Medicare Advantage patients or their designated representatives. Improving the patient experience leads to better health outcomes for your patients and helps support gap closure programs.

CAHPS Survey

The CAHPS survey, administered annually from March through June, asks your Medicare Advantage patients about their experience with—and to rate—their health plan and network providers. Providers and practices that have seen high patient satisfaction results generally do the following:

- Follow up with patients when they have seen another provider or specialist
- Ask about prescription drugs they may now be taking
- Share pertinent clinical information with your patient's other providers through a HIPAA-compliant health information exchange, such as NaviNet®
- Assist patients with scheduling tests and referral appointments
- Let patients know when to expect test results and who will provide them

Your staff can also improve patient satisfaction by:

- Leaving some open appointment slots each day for urgent and post-inpatient visits
- Shortening perceived wait times by assigning staff to perform preliminary work-up activities, such as blood pressure and temperature checks
- Providing brief and frequent updates for appointment schedule delays and offering options to reschedule or be seen by another provider
- Encouraging patients to make routine checkup or follow-up appointments in advance
- Proactively calling patients months in advance to schedule tests, screenings, or physicals

To view CAHPS survey questions, click here.

Health Outcomes Survey

HOS—administered annually from July through November—is the first patient-reported outcome survey used in Medicare-managed care to measure how patients' perception of their physical and mental health has changed over time. These perceptions can be improved by:

- Conducting annual wellness visits
- Screening patients for falls risk and developing a falls risk reduction plan for patients who screen positive
- Documenting the screening (and falls risk reduction plan if applicable) and including the appropriate CPT II code on your claim
- Asking patients if they have experienced urinary incontinence
- Conducting medication reconciliation for appropriate usage with patients

You can view HOS questions here.

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Since the onset of the COVID-19 pandemic, virtual health has gained in popularity, offering accessibility, convenience, and enhanced safety during the public health emergency.

According to a survey conducted by the marketing firm SYKES in 2021, nearly 88% of those surveyed want to continue using virtual health for non-urgent consultations after COVID-19 has passed.

What Virtual Health Resources Are Available to Providers?

The Virtual Health page on the Provider Resource Center has valuable information, including links to:

- Virtual Health Playbook
- Virtual Health Podcast
- Provider Manual Chapter on Telemedicine
- Reimbursement Policy RP-046 Telemedicine and Telehealth Services

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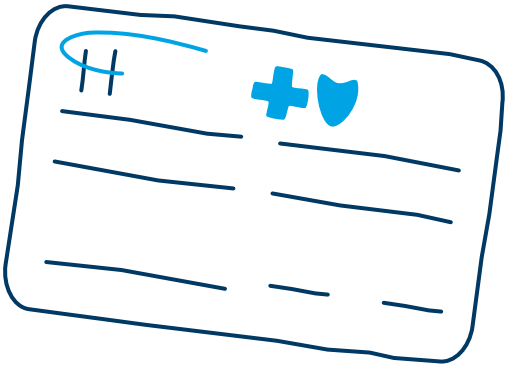
Short Takes: Member ID Cards, Billing, and Claims Adjustments



Missing Letters on Patient ID Cards

If a patient's last name is missing a letter on his or her member ID card, claims should still be submitted with the patient's **complete first and last name**.

New Member IDs

As a reminder, to ensure your claims are processed correctly, you must bill using your patient's **NEW** member ID and include the full number. If you are submitting paper claims, please make sure that you are mailing them to the correct PO Boxes.

Paper claims for your patients on **Highmark's system** can be mailed to:

PO Box 4208
Buffalo, NY 14240

Paper claims for patients still on our **Legacy system** should be sent to:

PO Box 80
Buffalo, NY 14240-0080

In addition, with Highmark contracting at the group level, the claims system requires that the billing provider be submitted as a **group provider** and not as an individual one.

Claims Adjustment Reminder

Providers have **365 days from the date of service** or date of discharge (for inpatient claims) to request an adjustment on a claim or to submit any corrections for both Legacy and Highmark system patients.

For example, if a claim has a date of service August 1, 2022, you will have until July 31, 2023, to submit an adjustment request on that claim.

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Free Coding Webinar on Diabetic Complications

The Coding and Quality Knowledge College is a quarterly webinar aimed at providing education on the proper coding of medical diagnoses, along with the associated quality measurements that impact documentation.

The next webinar "Diabetic Complications" will occur on Wednesday, October 12, at 12:15 p.m.

Attendees are eligible to receive 0.5 CME credit. Preregistration is required and an Allegheny Health Network (AHN) CME account is needed to receive credit. You can visit Coding Knowledge College via NaviNet® by:

- Choosing **Resource Center** from the left-hand menu
- Selecting **EDUCATION/MANUALS** from the left sidebar of the Provider Resource Center homepage
- Clicking **Coding Education/HCC University**

Once there, you can sign up for an AHN account, register for the next class or view past coding webinars. Topics include autoimmune diseases, diabetes, and pediatrics.

To register for the October 12 webinar on diabetic complications, go here.

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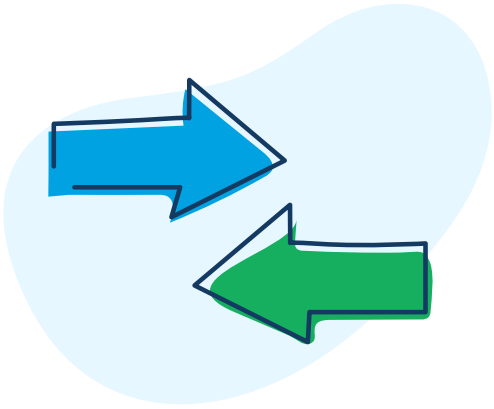
New and Updated Reimbursement Policies



Highmark regularly issues new or updated reimbursement policies. Keep an eye on the Provider Resource Center homepage for eBulletins announcing upcoming policy changes and the Reimbursement Policy page for updates.

Below is a list of upcoming and recently updated Reimbursement Policies (RP) and Medicare Advantage Reimbursement Policies (MRP):

Upcoming

- **RP-040** List Of Routine Supplies And Services To Be Updated eBulletin: Effective November 1, 2022, more than 30 items will be added to the list of routine supplies and services.

New RPs

- **RP-073** Performance Measurement: New policy based on the performance measurement codes formerly in RP-011.

COVID-Related

- **RP-064** Government Supplied Vaccinations and Antibody Treatments: New COVID vaccination added.

Coding Changes

- **RP-007** Multiple Procedure Payment Reduction (MPPR) for Certain Diagnostic Imaging Procedures: Added codes 0398T, 0716T, 0723T, 0721T.
- **RP-011** Procedure Codes Not Applicable to Commercial Products: Removed performance measurement codes, which were used to create new RP-073.

- **RP-042** Global Surgery and Subsequent Services: Added codes 0643T, 0714T, 0719T, 0725T, 0726T, 0727T, 0730T, 0737T.
- **RP-053** Gene and Cellular Therapy: Added codes J3590, J9999, C9399.

Administrative Updates

An Administrative Update is considered a minor change regarding the policy cross-reference section, reference section, header, or wording (e.g., correction of grammar).

- **RP-021** Annual Gynecological and Rectal Exams
- **RP-023** Newborn Care, Obstetrical Delivery, Antepartum and Postpartum Care and Associated Services
- **RP-025** Implantation of Subcutaneous Intravascular Catheter
- **RP-030** Insertion of Tissue Expanders
- **RP-032** Pain Management
- **RP-033** Anesthesia Services
- **RP-034** Prolonged Detention or Critical Care
- **RP-036** Preventable Serious Adverse Events
- **RP-043** Care Management
- **RP-060** Genetic Testing Ordering Requirements
- **RP-063** Consultation Services
- **RP-066** Sleep Study Supplies and Services
- **RP-069** DME Maintenance, Repair and Replacement
- **RP-070** Continuous Rental of Life Sustaining DME

To access Highmark reimbursement policy bulletins, select **CLAIMS, PAYMENT & REIMBURSEMENT** from the Provider Resource Center left-hand menu, and then click on Reimbursement Policy.

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Quarterly Formulary Updates

View the June updates to Highmark's prescription drug formularies and related pharmaceutical management procedures by clicking here.

Pharmaceutical Management Procedures

To learn more about how to use pharmaceutical management procedures, refer to the **PHARMACY PROGRAM/FORMULARIES** pages, accessible from the left-hand menu. Click on the **Pharmacy Information** from the sidebar and then Pharmaceutical Management from the list on the right.

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.

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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 include:

- Western New York and Northeastern New York regions added to the credentialing sections in Chapter 3.
- New York has been added to the Legal Information appendix.

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About This Newsletter

Provider News is a valuable resource for health care providers who participate in our networks. The publication 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.

Currently, *Provider News* is published six times a year—in February, April, June, August, October, and December. We are happy to announce that *Provider News* will move to a monthly publishing schedule in 2023. We look forward to sharing even more stories and timely content with you in the coming year.

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***.

You can access both Provider News and the Medical Policy Update Newsletter on the Provider Resource Center from the **NEWSLETTERS/NOTICES** link on the sidebar. Email subscriptions are available via the **eSubscribe** button on the PRC taskbar.

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.

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Legal Information

Highmark Blue Cross Blue Shield of Western New York (Highmark BCBSWNY) is a trade name of Highmark Western and Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield Association. Blue Shield and the Shield symbol are registered marks, and BlueCard and Blue Distinction are registered trademarks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield companies. BlueCard, Blue Distinction, Blue Distinction Center, and the Federal Employee Program are registered marks and Blues On Call is a service mark of the Blue Cross and Blue Shield Association.

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

NaviNet is a registered trademark of NaviNet, Inc., which is an independent company that provides a secure, web-based portal between providers and health care insurance companies.

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.

Current Procedural Terminology (CPT) is a registered trademark of the American Medical Association. HEDIS and Quality Compass are registered trademarks of the National

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.

View the BCBSWNY Privacy Policy.

QUICK REFERENCE

HIGHMARK PROVIDER SERVICE CENTERS

Please use NaviNet® for all of your routine eligibility, benefit, and claim inquiries.
For non-routine inquiries that require analysis and/or research, contact Highmark's Provider Services.

What Is My Service Area?

PENNSYLVANIA:

- Western Region: Professional Providers **1-800-547-3627**; Facilities **1-800-242-0514**
  Hours of Availability: 8 a.m. to 5 p.m. EST, Monday through Friday
- Central & Northeastern Regions: Professional Providers **1-866-731-8080**; Facilities **1-866-803-3708**
  Hours of Availability: 8 a.m. to 5 p.m. EST, Monday through Friday
- Eastern Region **1-800-975-7290**
  Hours of Availability: 9 a.m. to 12 noon, 1 p.m. to 4:30 p.m. EST, Monday through Friday.
- Medicare Advantage:
  - Freedom Blue PPO: **1-866-588-6967**
  - Community Blue Medicare HMO: **1-888-234-5374**
  - Community Blue Medicare PPO: **1-866-588-6967**
  - Security Blue HMO (Western Region only): **1-866-517-8585**
- Behavioral Health:
  - Western & Northeastern Regions: **1-800-258-9808**
  - Central & Eastern Regions: **1-800-628-0816**

DELAWARE:

- Highmark Delaware Provider Services: **1-800-346-6262**
  Hours of Availability: 8:30 a.m. to 5 p.m. EST, Monday through Friday
- Behavioral Health: **1-800-421-4577**

WEST VIRGINIA:

- Highmark West Virginia Medical: **1-800-543-7822**
- Highmark Senior Solutions Medicare Advantage Freedom Blue PPO: **1-888-459-4020**
  Hours of Availability: 8 a.m. to 8 p.m. EST, Monday through Sunday
- Behavioral Health: **1-800-344-5245**

NEW YORK:

- Highmark Blue Cross Blue Shield of Western New York: **1-800-950-0051 or (716) 884-3461**
- Highmark Blue Shield of Northeastern New York: **1-800-444-4552 or (518) 220-5620**
  Hours of Availability: 8 a.m. to 8 p.m. EST, Monday through Sunday
- Behavioral Health: **1-844-946-6264**
  - Fax: Behavioral Health Outpatient: **1-822-581-1867;** Behavioral Health Inpatient **1-833-581-1866**

Please listen carefully to the available options to reach the appropriate area for your inquiry.

HIGHMARK CLINICAL SERVICES

NaviNet® is the preferred for authorization requests. Contact Clinical Services for inquiries that cannot be handled via NaviNet.® **Hours of Availability:** Monday-Friday 8:30 a.m.-7 p.m.; Saturday & Sunday 8:30 a.m.-4:30 p.m. for urgent issues.

PENNSYLVANIA:

- Western Region:
  - Medical Services: Professional Providers **1-800-547-3627**; Facilities **1-800-242-0514**
  - Behavioral Health: **1-800-258-9808**

- Central Region:
  - Medical Services: Professional Providers **1-866-731-8080**; Facilities **1-866-803-3708**
  - Behavioral Health: **1-800-628-0816**
- Northeastern Region: Medical Services **1-800-452-8507**; Behavioral Health **1-800-258-9808**
- Eastern Region: Call Independence Blue Cross at **1-800-862-3648**

DELAWARE:

- Medical Services **1-800-572-2872**; Behavioral Health **1-800-421-4577**

WEST VIRGINIA:

- Highmark West Virginia Products for Medical and Behavioral Health Services: **1-800-344-5245**
- Medicare Advantage Freedom Blue PPO: **1-800-269-6389**

NEW YORK:

- Medical Services: **1-844-946-6263**
  - Fax: Medical Outpatient **1-833-619-5745**; Medical Inpatient **1-833-581-1868**

Please see the *Highmark Provider Manual's* Chapter 1.2 for additional contact information.