HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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

Issue 5, May 2024

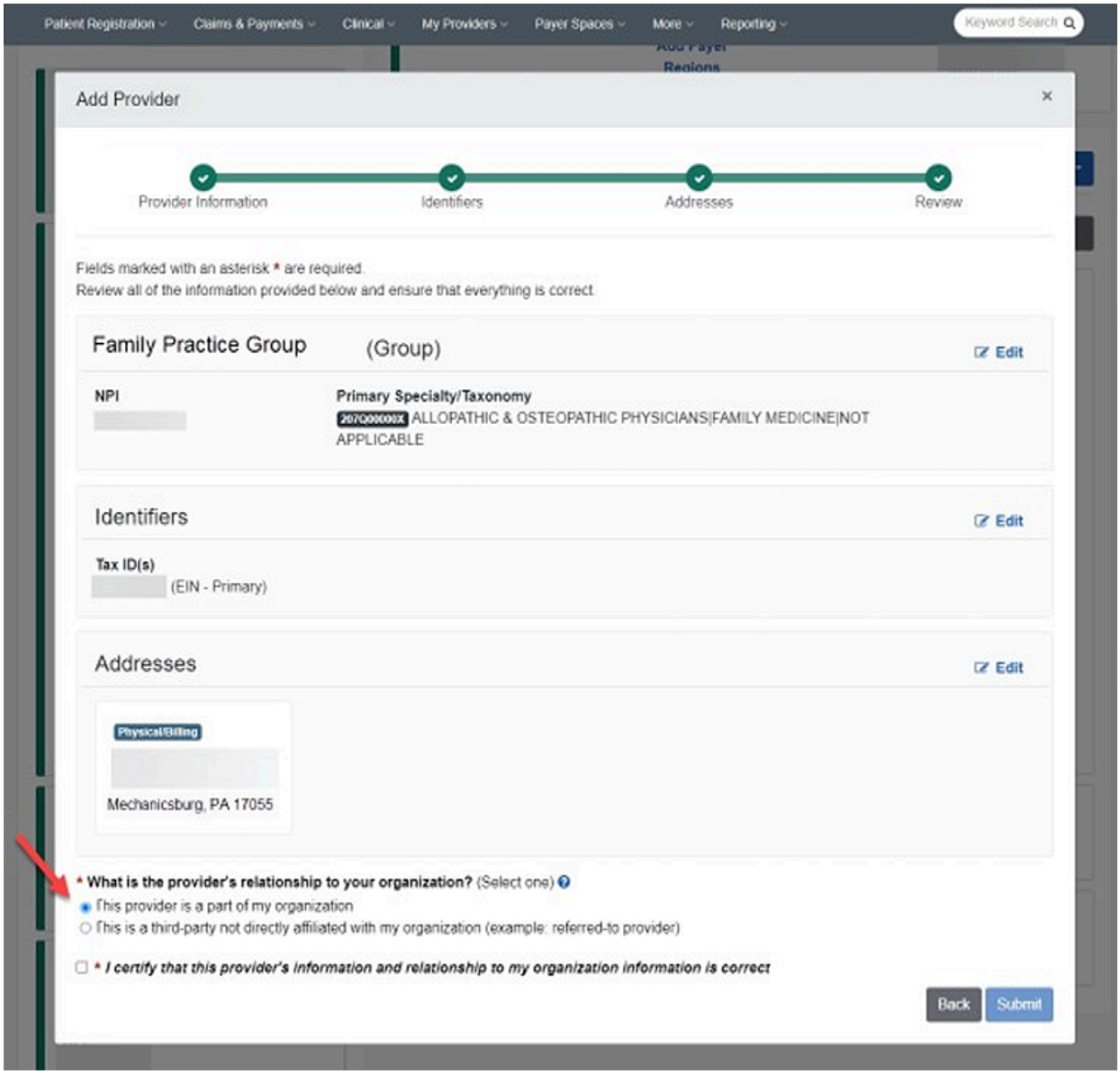
Based on feedback from providers and their teams, we put together these tips to help providers and their teams complete transactions in Availity® easier and faster:

1. Use **Manage My Organization** to List All Billing Groups in Your Practice/Facility
2. Choose Billing Group NPI (National Provider Identifier) for Transactions in Availity
3. Real Time 270/271 and 276/277 Transactions Now Available

1. Use Manage My Organization to List All Billing Groups in Your Practice/Facility

Highmark contracts with providers at the group level, so when adding "Providers" in **Manage My Organization**, be sure to list the Billing Groups — and not individual practitioners. By listing all the Billing Group providers in your organization right from the start, you'll make submitting transactions in Availity easier and faster.

Remember to ensure that the radio button, "*This provider is part of my organization*," is selected.



Inputting all Billing Groups may take some time and effort on the front end — depending on the size of your organization — but it pays off as you go forward.

If you've already done this, congratulations! If you still need to add more providers, use the **Manage My Organization** guide on the Provider Resource Center (PRC).

This guide walks you step-by-step on how to add all the Billing Groups in your organization, as well as making updates in the future.

If you're a solo practice — and there is only one practitioner in the organization — you would still need to add your practice NPI. This may be the same as your individual practitioner NPI... ***unless you have a different NPI for the practice itself***.

Once all the Billing Groups have been added, then you don't have to worry about inputting them later or wondering why a particular Billing Group provider isn't showing up when you're trying to complete a transaction.

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2. Choose Billing Group NPI (National Provider Identifier) for Transactions in Availity

Since Highmark contracts and reimburses at the Group level, always use the appropriate Billing Group NPI — and not the individual practitioner NPI — for all Availity transactions, including Eligibility and Claim Status.

Here's an example of how to properly complete the provider selection for a transaction within Payer Spaces:

1. Sign in to Availity.
2. If appropriate, select your state from the top menu bar.
3. Click **Payer Spaces** on the task bar and choose your Highmark plan.
4. From Highmark Blue Cross Blue Shield **Payer Spaces**, scroll down to **Applications** and click **Cash Management**.
    a. From the **Select an Organization** dropdown, choose your organization with your tax identification number (TIN).
    b. **Skip** the **Select the Provider** dropdown, which is optional, especially if you're with a large organization, and click "**Submit**".
    c. If you decide to use the **Select the Provider** dropdown, it will generate a list of both group and individual practitioner NPIs from your Manage My Organization setup. You should **select the correct Group NPI**. If you're a member of a large facility or multi-doctor practice, this could be an extensive list.

In Payer Spaces, for larger organizations, just use the **Select an Organization** dropdown, choose your TIN, and hit **Submit**. It's the fastest way to generate a list of group NPIs within that TIN for your facility/practice.

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3. Real Time 270/271 and 276/277 Transactions Now Available

Providers now have had the ability to submit real-time batch 270/271 and 276/277 transactions to Highmark via Availity. There are two submission options:

- **File Upload (Manual)**
  - Sign into Availity Essentials, choose **EDI Clearinghouse**, and then **Send and Receive EDI Files**.
- **File Transfer Protocol (FTP) Connection**
  - Register to establish an FTP connection with Availity through your Practice Management System. Instructions begin on page 12 of Availity's Batch Electronic Data Interchange guide.
  - Use the Payer ID for Highmark NY – 55204.

HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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

Issue 5, May 2024

As previously announced, Highmark will require providers in our New York service areas to use our self-service tools for questions related to claim status or claim investigation beginning **Aug. 1, 2024**.

The Highmark Provider Service Center will no longer be able to give information regarding claims status and claims investigation for all lines of business, including the Federal Employee Program (FEP) and BlueCard*. Instead, our representatives will direct providers to our self-service tools — which are available 24/7 — and include the following:

- **Availity Essentials, Highmark's Provider Portal** – the primary method for submitting transactions to Highmark and accessing reports, including:
  - Authorization Submission
  - Claim Submissions / Investigations – *The use of Availity to check claim status and submit a claim investigation is required, effective Aug. 1, 2024*.

    - Credentialing (Initiate Application, Submit Change, Review Status)
    - Eligibility and Benefits Check
    - Value Insights Center (Value-Based Program Reporting Tool)
- **Interactive Voice Response (IVR)** – quickly manage routine inquiries, such as claim status or member benefits, without a live agent via the Provider Service Center.
- **Highmark's Provider Resource Center (PRC)** – the main hub for accessing important information, including policies, procedures, the *Provider Manual*, and *Provider News*.

Get More Done Faster with Our Self-Service Tools

Over the past few years, Highmark has made significant investments in our self-service tools to reduce administrative burden, improve office workflows, and simplify complex transactions — allowing you and your staff to focus on delivering care to our members.

As a result of this evolution, **Highmark requires providers to utilize our enhanced self-service tools** to obtain the fastest resolution to many common issues and tasks. This enables our Provider Service advocates to assist with more complex issues, while allowing your staff to avoid unnecessary hold times on the telephone.

Additional Resources

Highmark just launched a new **Self-Service Tools page** on the PRC to help providers and their teams to maximize these resources. By familiarizing yourself with these tools, you'll be able to increase office efficiencies and get more done faster.

For easy reference, download our Self-Service Support Chart by clicking here.

**Highmark rolled out the same requirement in Delaware, Pennsylvania, and West Virginia last year.*

HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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

Issue 5, May 2024

Highmark is pleased to announce that over 10,900 new clinicians have qualified for our expedited prior authorization program, known as the **Gold Card Program**, which provides streamlined approval for select services. Qualification to the program is a recognition of each provider practice or individual clinician's adherence to evidence-based guidelines and appropriate care.

The Gold Card Program is part of Highmark's efforts to accelerate access to appropriate care, reduce administrative burden, and streamline complex transactions for our providers.

Beginning **May 24, 2024**, those newly gold-carded providers will experience a simplified process for obtaining prior approval for services that typically require a comprehensive prior authorization review.

About the Gold Card Program

Launched in 2022, Highmark's Gold Card Program has experienced considerable growth — with over 17,000 providers currently enrolled. We are committed to further expansion and are exploring the inclusion of additional service types.

For additional details on eligibility criteria and how the program works, please see our **Gold Card Program page** on the Provider Resource Center.

A key driver behind the program's growth is **Active Gold Carding**, a data-driven educational initiative where Highmark and provider groups collaborate to identify and address the root causes of denials. This proactive approach aims to enhance appropriate ordering practices and support more clinicians in achieving gold card status.

Clinicians who qualify for our **Gold Card Program** see the following benefits:

1. **Reduces staff processing time by up to 85%, minimizing administrative burden.**
2. **Eliminates wait time for authorization decisions, enhancing efficiency.**
3. **Provides practitioners with greater flexibility to schedule services, improving patient care coordination.**

Dr. Susan Deakin, an internal medicine physician at Allegheny Health Network, participated in the **Active Gold Carding** pilot program.

"It has been a significant improvement in health care delivery," Dr. Deakin said. "A patient can schedule their test immediately without having to wait for the authorization or worry there will be an issue. My office staff doesn't have to confirm or work on authorizations, freeing them up for other direct patient care activities. Most importantly, it provides a better patient experience."

To qualify for the program, provider practices or individual clinicians must meet specific criteria, including maintaining an historical authorization approval rate of 99% or higher.

*Note: The Gold Card Program, including qualification criteria, varies in the state of West Virginia in accordance with West Virginia Senate Bill 267.

Dr. Deakin is also the Living Health Medical Director for Highmark Health. Highmark's Living Health model puts the patient and clinician at the center of our system — and aligns seamlessly with our **Gold Card Program** which streamlines the authorization

process, empowering clinicians to focus on patient care while guaranteeing members access to the necessary treatments promptly.

For additional questions about Highmark's Gold Card Program, please contact GoldCardInquiries@highmark.com.

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HIGHMARK. WESTERN NEW YORK

PROVIDER NEWS

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

Issue 5, May 2024

Professional Providers Moving to Group Contracts

Highmark Blue Cross Blue Shield is beginning the process of moving professional providers in its New York markets onto Highmark Professional Agreements — which are group contracts that match the structure that is in place in the other Highmark service regions.

For offices with newly contracted individual practitioners, Highmark Professional Agreements(s) were sent out beginning in December 2023. For practices without newly contracted individual practitioners, offices will start seeing new contracts in their email inboxes in the second quarter of this year. For more information, click here.

Latest Edition of MCG Guidelines – Aug. 1, 2024

The 28th edition of MCG's Care Guidelines will be available on Aug. 1, 2024.

After that date, you will be able to submit authorization requests using the 28th edition for any new requests. Any authorization requests with a start of care date prior to Aug. 1, 2024, will be reviewed using the 27th edition.

Please continue to use the Predictal Auth Automation Hub application in Availity® to submit authorization requests with clinical information included.

Medical Policy S-249 Update: Missing Line of Procedure Codes Added

Medical Policy (MP) S-249 Amniotic Membrane and Amniotic Fluid Typing was recently published with a line of experimental and investigational procedure codes omitted. This error has been corrected and the policy was updated on **May 17, 2024**.

To view **MP S-249** policy, go to the Provider Resource Center. On the top task bar, click the drop-down arrow for **MEDICAL POLICY SEARCH**, select **MEDICAL POLICIES**, and then type "S-249" into the search bar.

Additional Documentation Required for Quality Improvement Organization Audits

The Centers for Medicare and Medicaid Services (CMS) is requiring that insurers, including Highmark, collect additional documentation from facilities for Quality Improvement Organization (QIO) program audits, effective January 1, 2024.

For these audits, facilities will now be required to submit the following documents:

- Notice of Medicare Non-Coverage (NOMNC)
- Detailed Explanation of Non-Coverage (DENC)

For more, see the recent Special Bulletin.

Quick Claims Functionality in Availity Now Available for Highmark Providers

Professional providers who use Availity® for claim submission now have access to the Quick Claims functionality for Highmark members. Quick Claims allows providers to create templates that pre-populate certain fields when submitting a CMS-1500 claim. This will save time for providers who routinely submit claims for the same patient or same service each week or each month. To learn more, go here.

New Inpatient Facility Diagnosis Guidelines Available on PRC via Availity

To assist providers with claims submission for highly complex medical conditions, Highmark has created the Inpatient Facility Diagnosis Guidelines page on the Provider Resource Center (PRC) via Payer Spaces in Availity®.

Providers will find detailed information, including diagnostic thresholds and accurate coding guidance, on a variety of conditions, including Acute Respiratory Failure, Malnutrition, and Sepsis and Septic Shock. To view the **Special Bulletin**, click here.

Removal of PCP Change Form from PRC

As we continue to align with Highmark processes, the Primary Care Physician (PCP) Change form — which allows you to remove/add a member to your practice with the member's consent — is being discontinued. Members are responsible for selecting their own Primary Care Physician, and they can do so in two easy ways by:

- Calling Member Service with the phone number on the back of their insurance card.
- Using the Member Portal to electronically change their PCP designation.

How to Bill for Cosmetic Procedures Without a Valid CPT Code

Effective immediately, providers who bill for cosmetic procedures — that do not have a valid CPT code and/or who submit claims for dermal fillers — must follow the process outlined in this Special Bulletin.

HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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

Issue 5, May 2024

A wellness visit is an important time to discuss healthy choices that may prevent future chronic conditions including diabetes, cardiovascular diseases, and some cancers.

The Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) — which is an important part of the annual well visit — can provide parents and young people guidance on maintaining or moving toward a healthier lifestyle.

However, there are several misconceptions related to annual well visits and the WCC that need to be addressed:

Misconception #1:

"Well child visits are only covered every 365+1 days."

FACT: Providers don't have to wait a year plus a day to schedule their patient's next wellness visit. The Highmark Preventative Schedule is based on the calendar year and resets Jan. 1 of each year. Completing annual visits and recommended screenings before the child's birthday provides the greatest compliance with multiple quality metrics.

Misconception #2:

"Only children evaluated in the office for a well-child visit are included in the metric."

FACT: Patients 3-17 years of age who have had at least one visit during the calendar year with a Primary Care Physician (PCP) or Obstetrician-Gynecologist (OBGYN) are included. Well visits are part of the metric, but so are sick visits, telephone / virtual visits, and other in-person visits.

Misconception #3:

"I have to include multiple and specific screening forms in my notes to meet the requirements."

FACT: Documentation to support the completion of activities and corresponding codes is required, but the method of completion may vary. The three measures, along with documentation examples, can be found below.

Body Mass Index (BMI) Percentile

- Include height, weight, and BMI percentile. Specific percentiles, such as 54% or >95th%, ARE acceptable. Ranges are **NOT** acceptable, such as 50-75th percentile.

Counseling for Nutrition

- Include documentation of eating habits, dieting behavior, well-rounded diet, and snacking habits. Types of food eaten or meal frequency. May also include copies of nutrition checklists or provided education with noted discussions on content. Counseling is not required to be completed by a dietician. Documentation related to the child's appetite **DOES NOT** meet the criteria.

Counseling for Physical Activity

- Include documentation of current physical activity behaviors such as exercise or sports participation. May include copies of a checklist indicating physical activity or educational materials provided with noted discussion on content. Documentation of

members' screen time as the only support for physical activity **DOES NOT** meet criteria.

Include the appropriate codes for each of the three components above for full measure compliance.

One coding example:

VISIT DIAGNOSIS:

Encounter for routine child health examination without abnormal findings (primary) [Z00.129]		
Nutrition Counseling	Z71.3	Dietary counseling and surveillance
Physical Activity Counseling	Z02.5	Encounter for examination for participation in sport
Physical Activity Counseling	Z71.82	Exercise counseling
BMI Percentile	Z68.52	BMI pediatric, 5th percentile to less than 85th percentile for age

Additional Information

Log into Availity®, select the state where you practice, choose **Payer Spaces**, and then, under **Applications**, select the **Provider Resource Center**. Once there, select **EDUCATION/MANUALS** from the left menu, choose **HEDIS®**, and then click **Overview of the 2024 NCQA HEDIS measures**. You can find more information on page 92 regarding the measure for Weight Assessment & Counseling for Children/Adolescents.

***HEDIS®** — which is an acronym for Healthcare Effectiveness Data and Information Set — is a registered trademark of the National Committee for Quality Assurance (NCQA).*

HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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

Issue 5, May 2024

Case Management Referrals: Caring for Members with Complex Conditions

Highmark encourages providers to identify members who could benefit from coordinated case management services. You can submit referrals for Clinical Care and Wellness (CC&W) case management programs from Availity®.

This feature will help connect Highmark members who have chronic conditions and complex medical needs to the right clinical support.

To access this feature:

- Log into Availity.
- Select the state where you practice.
- Click **Payer Spaces** on the task bar and choose your Highmark plan.
- From **Payer Spaces**, scroll down to **Applications** and click **Predictal**.
- From the **Predictal™ Auth Automation Hub**, hover over the **left navigational panel** and select **Case Management Referral**.
- Acknowledge the information needed to submit the form and **Continue**. This will take you to the **Program Referral Submission** for member selection.

- Follow the remaining steps to create and submit the referral.

Using this feature in Availity also simplifies and expedites the overall case management referral process, while reducing the administrative burden for providers.

Additional Resource

To learn more about making case management referrals, watch the Case Management Referral Process (Predictal via Availity), which is available on the Provider Resource Center (PRC).

Once on the PRC, choose **PRIOR AUTHORIZATION** from the left menu, click **Procedures/Service Requiring Prior Authorization**, and then scroll down to the **Videos** section.

HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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

Issue 5, May 2024

REMINDER: Maintaining Accurate Directory Information and Accessibility Standards

Highmark Blue Cross Blue Shield requires that all credentialed network providers, per their contractual obligations, maintain accurate directory information and adhere to accessibility standards as detailed in the *Highmark Provider Manual*.

We are committed to ensuring that the information in the Highmark Provider Directory meets Centers for Medicare & Medicaid Services (CMS) regulations, New York State Department of Health (NYS DOH) regulations, and National Committee for Quality Assurance (NCQA) standards, as well as our own standards of quality.

In addition, members use the Highmark Provider Directory to make informed decisions when selecting a provider; therefore, it is also crucial to your organization to ensure your information is always accurate and up-to-date.

Accurate Directory Information

CMS requires Highmark Blue Cross Blue Shield to reach out to you every quarter and ask you to validate your provider directory information. See the article in this month's *Provider News* on "How to Attest" your directory information.

Accessibility Expectations for Professional Providers

To stay healthy, members must be able to see their physicians when needed. In support of this goal, Highmark Blue Cross Blue Shield has implemented accessibility standards that set forth specific time frames in which network providers should respond to member needs based on symptoms.

For example, when a member requires emergency care, the performance standard is an immediate response from the provider. For urgent care appointments, the standard of care is an office visit within 24 hours.

IMPORTANT: *For members to schedule an appointment, the provider's phone number needs to be correctly listed in the Provider Directory. In addition, the phone must be answered in a timely manner.*

No Preconditions on Scheduling an Appointment

Pre-appointment scheduling conditions must not be imposed on members requesting an appointment, such as completing forms or access to previous medical records, prior to the provider scheduling the appointment.

The scheduling of the appointment must always be completed at the time the member calls the practice for an appointment. Appointments must be scheduled in compliance with the PCP and Medical Specialist/Behavioral Health Accessibility Expectations referenced below — not contingent on the member's ability or inability to complete paperwork.

To review the full list of accessibility standards for professional providers, visit the following sections in the *Highmark Provider Manual*:

- **Chapter 4, Unit 1: Provider Responsibilities & Guidelines** > *4.1 PCP and Medical Specialist Accessibility Expectations > Accessibility Expectations for Providers.*
- **Chapter 4, Unit 2: Behavioral Health Providers >** *4.2 Accessibility Expectations for Behavioral Health > Accessibility Expectations.*

Availability of Facility Services

Facility services need to be available to Highmark members on a 24/7 basis when medically appropriate and in accordance with industry standards. Physician services are provided by

either hospital-based physicians or physicians employed by a facility. If physician services are provided to Highmark members on behalf of a facility, the facility must verify that physician has the appropriate training, education, and licensure to provide such services.

To review the full list of accessibility standards for facilities and facility providers, visit the following section in the *Highmark Provider Manual*:

- **Chapter 1, Unit 4: Highmark Member Information >** *1.4 Member Access To Physicians and Facilities > Accessibility Expectations for Providers.*

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HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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

Issue 5, May 2024

Policy Reminders: Transitions of Care, Qualified Medicare Beneficiaries, and More

For planned and unplanned transitions between care settings

— for example, home to hospital, or hospital to skilled nursing care — the referring provider is expected to:

- Share the care plan with the receiving setting within one business day of notification of the transition
- Inform the member (or the member's responsible party) of the care transition process, and about changes to the member's health status and plan of care

Qualified Medicare Beneficiaries Program

Federal law bars Medicare providers from collecting Medicare Part A and Medicare Part B beneficiary deductibles, coinsurance, or copayments from those enrolled in the Qualified

Medicare Beneficiaries (QMB) Program. QMB is a dual-eligible program that exempts individuals from Medicare cost-sharing liability (see Section 1902(n)(3)(B) of the Social Security Act, as modified by 4714 of the Balanced Budget Act of 1997).

Balance billing prohibitions also may apply to other dual-eligible beneficiaries in Medicare Advantage (MA) plans if the state Medicaid program holds these individuals harmless for Part A and Part B cost-sharing.

Non-Discrimination Policies

In addition, MA enrollees cannot be discriminated against in the delivery of health care services consistent with the benefits covered in their policy based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

Discrimination based on "source of payment" means, for example, that MA providers cannot refuse to serve enrollees because they receive assistance with Medicare cost-sharing from a state Medicaid program.

Dual Eligibility

Members who are eligible for both Medicare and Medicaid (dually eligible) may have certain services covered by the Medicaid programs. To find out which benefits are covered by the member's Medicaid benefit, please call Provider Service at **800-329-2792**.

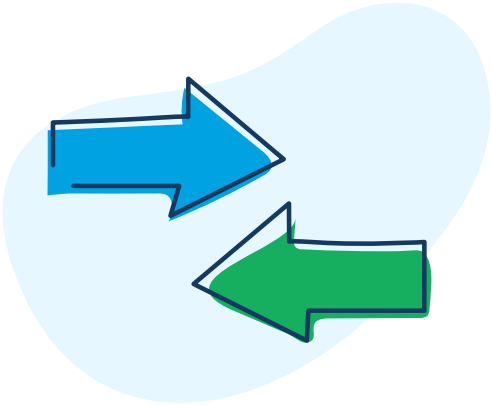
HIGHMARK. WESTERN NEW YORK

PROVIDER NEWS

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

Issue 5, May 2024

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) homepage for announcements regarding upcoming policy changes. As specific policy changes go into effect, the updated policies can be found on the Reimbursement Policy page of the PRC.

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

RECENTLY UPDATED

May 1, 2024

RP-006 Multiple Endoscopy Procedures
New York Medicare Advantage products are being applied to this policy direction effective **May 1, 2024**.

RP-026 Portable Radiography and ECG Services – Modifiers UN, UP, UQ, UR, US
Direction for "U" modifier reductions reported with code R0075 will be made applicable for Commercial.

UPCOMING

June 1, 2024 (publishing to PRC on May 31)

RP-068 Mid-Level Practitioners and Advanced Practice Providers
This policy will be updated to include the new licensed associate marriage and family therapist (LAMFT) and licensed associate professional counselor (LAPC) specialties for Delaware and Pennsylvania. It will also be restructured for clarity purposes.

June 24, 2024

NEW: RP-077 Intraoperative Neurophysiological Monitoring
Highmark has created RP-077 to provide direction on reimbursement for Intraoperative Neurophysiological Monitoring (IONM) services. *(NOTE: This policy will be available on the PRC on the effective date of June 24, 2024.)*

August 8, 2024

RP-053 Gene and Cellular Therapy
This policy will be updated with new drugs and therapies, as well as cross-references to medical policies. The name of RP-053 will change from "Gene and Cellular Therapy" to "Advanced Gene and Cellular Therapies."

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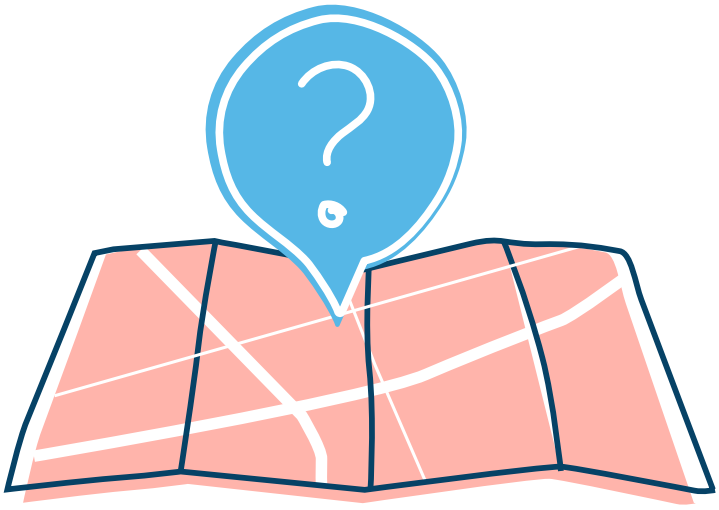
HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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

Issue 5, May 2024

Claims Reminder: Service Facility Location Must Be Filled Out Correctly



Highmark has recently experienced an uptick in claim submissions with the Service Facility Location information either **missing or incorrectly filled out**, leading to claim denials or processing delays. The Service Facility Location field is used to report the physical location where the services were actually performed.

If the services are rendered at a location that ***differs*** from either the billing address or the main facility location (e.g., hospital's off-site outpatient surgery center), then the Service Facility Location field must be filled out completely and accurately on the submitted 837P, 837I and 1500 Health Insurance Claim Form.

HEDIS® Medical Record Retrievals

It is also important to complete the Service Facility Location field to easily locate your patients' medical records when necessary. Highmark requests records for Healthcare Effectiveness Data and Information Set (HEDIS®) and other quality improvement activities.

Identifying the place where services are rendered — by accurately filling out the Service Facility Location field — eliminates unnecessary calls to provider offices to locate medical records, saving administrative teams valuable time.

Important: A physical street address must be reported for the Service Facility Location — a P.O. Box or lock box will not be accepted.

Provider Directory Information

If your organization has multiple locations where members are treated, all these locations should be listed as part of your provider directory information with Highmark. Every quarter, you are required to review and validate your provider directory information on file with Highmark.

Please be aware that providers who don't attest to their data quarterly may be removed from the directory and their status within Highmark's networks may be impacted. To learn more about validating your directory information, see this article in the current issue of *Provider News*.

Additional Resource

For more information on using the Service Facility Location field on claims, see the *Highmark Provider Manual:* **Chapter 6, Unit 1: General Claim Submission Guidelines** > *Service Field Location*.

To access the *Provider Manual*, go to the Provider Resource Center, select **MANUALS** from the taskbar, and click **HIGHMARK PROVIDER MANUAL** from the dropdown.

HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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

Issue 5, May 2024

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®, or
- 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:

Faxes Being Phased Out: Use the Availity Portal for ALL Authorization Requests

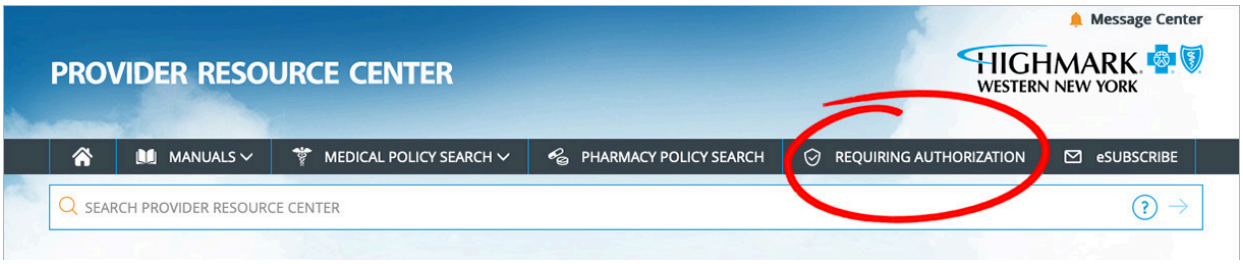
Clinical Services is phasing out fax prior authorization submissions. Providers are required to use the Availity® portal to electronically submit authorization requests, attach documentation, respond to inquiries, and check status. Click here to read last month's article in *Provider News*.

MSK Procedures to Require Prior Authorization Starting Aug. 1

Effective Aug. 1, 2024, Highmark Blue Cross Blue Shield is requiring prior authorization for inpatient and outpatient musculoskeletal (MSK) procedures. New and continuing authorization requirements for inpatient and outpatient MSK services will be managed directly by Highmark Blue Cross Blue Shield.

These changes apply to Highmark Blue Cross Blue Shield members enrolled in our fully insured Commercial, Medicare Advantage, Affordable Care Act (ACA) plans, and members of select self-insured (Administrative Services Only) groups. For more information, click here.

To view the full List of Procedures/DME Requiring Authorization, click **REQUIRING AUTHORIZATION** in the gray bar near the top of the PRC homepage.



Once redirected to the **Procedures/Service Requiring Authorization** page, click **View the List of Procedures/DME Requiring Authorization** under **PRIOR AUTHORIZATION CODE LISTS**.

Please note that the Highmark member must be eligible on the date of service and the service must be a covered benefit for Highmark to pay the claim.

Availity® is the preferred method for:

- Checking member benefits and eligibility
- Verifying whether an authorization is needed
- Obtaining authorization for services

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HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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

Issue 5, May 2024

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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HIGHMARK WESTERN NEW YORK

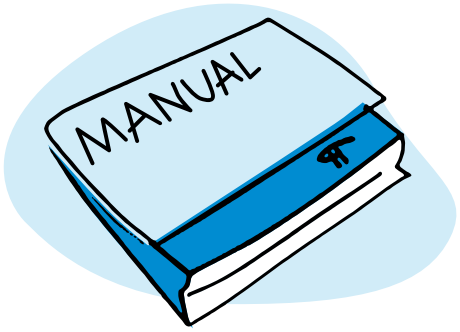
PROVIDER NEWS

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

Issue 5, May 2024

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:

Removal of NaviNet

Highmark finalized changes to the *Provider Manual* related to the provider portal transition from NaviNet and HEALTHeNET (NY) to Availity. NaviNet and HEALTHeNET (NY) access for providers ended on **April 26, 2024**.

Vendor Update

All references to naviHealth in the *Provider Manual* have been changed to Home & Community Care Transitions to reflect the company's name change. Home & Community Care Transitions is a third-party vendor used by Highmark for post-acute care services for Highmark's Medicare Advantage members in Pennsylvania and West Virginia.

Additional changes occurred in the following chapters and units:

- Chapter 3, Unit 2: **Professional Provider Credentialing**

- **Chapter 5, Unit 5: Denials, Adverse Benefit Determinations, Grievances, and Appeals**
- **Chapter 6, Unit 4: Professional (1500/837P) Reporting Tips**

To see the full list of recent changes, visit the Highmark Provider Manual Changes page.

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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***.

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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HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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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.