HIGHMARK WESTERN NEW YORK

# PROVIDER NEWS

**A newsletter for Highmark Blue Cross Blue Shield of Western New York (Highmark BCBSWNY) network providers**

**Issue 7, July 2023**


Highmark recommends providers use our self-service tools for questions related to claim status or claim investigations.

Our electronic, self-service tools — **available 24 hours a day** — are the fastest and most effective ways for providers to get answers to routine claim inquiries. Phone calls take more time, are less efficient, and can only be processed during normal business hours.

## Self-Service Tools – NaviNet and IVR

Highmark offers provider self-service tools through NaviNet® and our Interactive Voice Response (IVR) system to quickly manage your routine inquiries. These tools can help providers reduce

administrative costs, improve office workflows, and assist in the collection of claim payments.

## NaviNet

NaviNet's Quick Start Guide — available on the Provider Resource Center — has step-by-step procedures for conducting both claim status inquiries and claim investigations. The guide features easy-to-follow instructions accompanied by screenshots showing users what to do during each step.

The Claim Status Inquiry function allows you to view real-time, detailed claims information for any member, whether claims were submitted electronically or on paper. You can track the status of a claim from the start of the adjudication process until the time of payment.

## IVR

Highmark's IVR system enables providers and their teams to make routine claim inquiries via telephone. To check on the status of a claim, follow these steps:

- **Call the Provider Service Center for your region.**
- **Enter the following information:**
  - Provider's NPI number.
  - Member's Highmark ID or Social Security number.
  - Member's birthdate.
  - Say "Claims" and then enter or say the date of service.

The system will provide a summary of the claim, including service date(s), charges, process date, and member responsibility. If you ask for "More Details," you will also receive information, such as claim number, number of charges on the claim, provider responsibilities, and paid amount.

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As announced in *Provider News* last month, Highmark will be replacing its existing provider portal NaviNet® with Availity® Essentials.

Availity will offer both live and on-demand training to providers. Training dates and information will be posted on the Provider Resource Center when available. You also can ensure you receive information on training updates when you sign up for our eSubscribe list.

The transition to Availity will occur in stages. Here's the scheduled timeline:

1. **August and September 2023:**
   Highmark will engage a pilot group of providers to ensure a seamless transition.

2. **October 22, 2023:**
   Providers who currently use Availity for other payers will see Highmark as an option in the states where they are contracted.

3. **February 5, 2024:**
   Availity will be available for all Highmark providers.

4. **March – June 2024:**
   Highmark will retire its use of NaviNet® and HEALTHeNET (NY).

*(**Note:** Highmark Wholecare and Highmark Health Options will not transition to Availity; providers should continue to use their current portals for transactions related to these plans.)*

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National Immunization Awareness Month — which runs throughout August — is an excellent time to remind your patients that receiving all recommended vaccines protects against serious illness.

In fact, educating patients about the effectiveness of vaccines has never been more important. There's a lot of misinformation regarding vaccines on the internet and social media, and that has resulted in some people refusing to get themselves or their children vaccinated; such a decision can lead to unnecessary and even life-threatening illnesses.

## Drop in Vaccination Rates

Recent data from the Centers for Disease Control and Prevention (CDC) show that vaccination rates for children, teens, and adults dropped in 2020 and 2021 during the COVID-19 pandemic. Other factors related to declining immunization rates include

religious reasons, safety concerns, and personal beliefs or philosophical reasons. Some parents mistakenly believe that preventable diseases — for which there are approved and effective vaccinations — are not very prevalent, so their children are at minimal risk of contracting these illnesses. There's also a false belief that preventable diseases are somehow **not** serious or life-threatening.

## What You Can Do

Patients trust you as their Primary Care Provider and, therefore, listen to your recommendations. We encourage you to educate your patients on the value of immunizations.

**The National Foundation for Infectious Diseases® shares 10 reasons to get vaccinated:**

1. Vaccine-preventable diseases have not gone away
2. Vaccines help keep you healthy
3. Vaccines are as important to your overall health as diet and exercise
4. Vaccination can mean the difference between life and death
5. Vaccines are safe
6. Vaccines cannot give you the diseases they are designed to prevent
7. Young and healthy people can get very sick, too
8. Vaccine-preventable diseases are expensive
9. When you get sick, your children, grandchildren, and parents are at risk, too
10. Everyone deserves the chance to stay healthy

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**Immunization schedules by age can be downloaded from the CDC website:**

- Infants and Child (through 6 years) Immunization Schedule
- Preteens and Teens (ages 7 through 18) Immunization Schedule
- Adult (ages 19 years or older) Immunization Schedule

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**The Provider Resource Center (PRC) has the following educational materials available for download:**

- Childhood Immunization Brochure & Schedule
- Childhood Immunization Flyer
- Preventive Health Reminder Poster
- Flu Flyer
- Health Screening and Vaccination Tracker

To access them, go to the **PRC**, select **EDUCATION/MANUALS** from the left menu and then click **Educational Resources – Member And Provider**. Highmark's Preventive Health Guidelines are also available from the drop-down menu under **EDUCATION/MANUALS**.

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## Diversity Business Classification Survey – Deadline This Friday

Highmark's Provider Supplier Diversity Initiative is conducting a survey to gather demographic data on providers in our network to ensure that our overall network re ects the diversity of the members and patients we serve. Interested in participating? Hurry, survey closes this **Friday, August 4**. Click here to get started.

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## "Stabilize and Transfer" OON Protocol Will Not Be Reinstated

The "Stabilize and Transfer" out-of-network (OON) protocol was not reinstated for all narrow network products on **July 6, 2023**, as had been previously announced. In accordance with the **No Surprises Act** (NSA), Highmark will continue to pay out-of-network providers directly when they render emergency services to members who are receiving

care in a hospital or freestanding emergency department. For more information on the NSA, visit the Provider Resource Center and select **No Surprises Act** from the left menu.

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## New Capabilities Added to Provider Data Maintenance Tool

Highmark continues to make enhancements to its new Provider Data Maintenance (PDM) tool. Professional providers are now able to use PDM to view the following credentialing process information:

- Insights into where credentialing applications are in the process
- Open and closed cases

Click here to read the **Special Bulletin**.

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## Medical Policy Update Newsletter

The July newsletter is available here.

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## Submission of Claims Older than January 1, 2023

As Highmark Blue Cross Blue Shield of Western New York (BCBSWNY) completes its transition to Highmark systems, we will be retiring the use of our existing internal claim adjudication system. This will not affect how you submit claims to us.

Highmark BCBSWNY asks that providers submit all outstanding claims and claim adjustments with dates of service **prior to January 1, 2023, to us by October 1, 2023**. While most claims may be submitted within 365 days from the date of service, this will help us process claims older than January 1, 2023, more quickly during this transition period. For more information, read the recent Special Bulletin.

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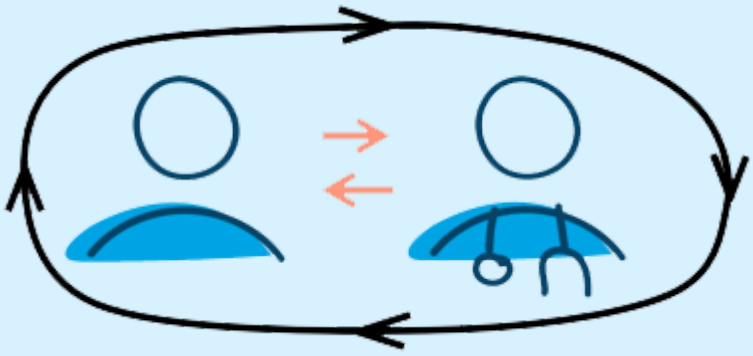
## New Clinical Support Program Resource Page

To help you get more information about some of our patient clinical support programs, we've added a new page on the Provider Resource Center (PRC). These programs support our Living Health strategy to improve the patient and provider experience and reduce administrative burden for you.

Eligible members may enroll directly in these programs as part of their benefits, and we want to make sure you can find out more about the programs your patients are enrolled in or interested in using. We hope having access to this information will help you recommend enrollment to your eligible patients.

**Currently, the available programs focus on:**

- Diabetes Management
- Musculoskeletal Care
- Kidney Care Management
- Telemedicine
- Behavioral Health



New programs will continue to be added to this page as they become available. Overviews, eligibility/exclusion criteria, health outcomes and more are included for each

program.

Please check member benefits to confirm eligibility in your region. To visit this new page and learn more about these programs, click here.

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## PHARMACY & MEDICAL INJECTABLE AUTHORIZATION SUBMISSIONS

## Moving to Auth Automation Hub

Effective **August 11, 2023**, electronic authorization requests for Pharmacy and Medical Injectables will be automatically routed to our Auth Automation Hub.

The Auth Automation Hub enables offices to submit, update, and query medical authorization requests. It features an easy-to-use interface that allows for faster reviews and greater transparency around the status of authorization requests.

As of **August 11, 2023**, the following authorization request types can be completed using the Auth Automation Hub, which is accessible via NaviNet®:

| Inpatient Urgent | Inpatient Non-Urgent | Outpatient |
|---|---|---|
| • Urgent Admission | • Planned Medical<br>• Planned Surgical | • Planned Medical<br>• Planned Surgical<br>• Speech Therapy |

| | | |
|---|---|---|
| | • Large Joint Procedures*<br>• Spine Surgery Procedures*<br>• Chemotherapy<br><br>**Highmark managed only.* | • Advanced & Cardiac Imaging – Request<br>• Medical Drug and Chemotherapy<br>• Pharmacy |

Please note the following differences in the Medical Injectable Drug authorization workflow:

- For Medical Injectable Drug requests, you no longer need to select the Site of Care in the Service Field. It will default to "Request."
- Outpatient Chemotherapy requests should now be built under the "Chemotherapy" Service. Previously, providers were instructed to build those authorization requests under the "Medicare Care" Service.

The preferred method for requesting a pharmacy authorization electronically is through CoverMyMeds. The new Auth Automation Hub is another electronic option available for providers.

## Reference Guides

We have a number of step-by-step reference guides available on the Provider Resource Center (PRC) to assist you with the authorization process:

### Pharmacy/Formulary

- Understanding Formulary Restrictions and Requesting an Authorization

### Authorizations

- Auth Automation Hub Frequently Asked Questions
- Inpatient Authorization Guides:
  - Non-Urgent Inpatient Authorization Submission
  - Urgent Inpatient Authorization Submission

- Outpatient Authorization Guide

## Resources

For additional resources on the Provider Resource Center, go to **AUTHORIZATIONS** on the left menu, and click on **Procedures/Service Requiring Prior Authorization**. If you need assistance regarding electronic authorization workflows, you can email us at ElecAuthSubmit@highmark.com.

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The Medicare Health Outcomes Survey (HOS) is an annual survey — administered from July through November by the Centers for Medicare and Medicaid Services (CMS) — to a random sample of Medicare Advantage (MA) members.

Every year, a new cohort of MA patients receives a baseline survey; then two years later, those same respondents are surveyed again. HOS measures members' perceptions of their physical and mental health, and how their health has changed over time.

HOS includes three Healthcare Effectiveness Data and Information Set (HEDIS®) measures that contribute to the health plan's Medicare Star Rating:

- **Monitoring physical activity**
- **Reducing the risk of falling**
- **Improving bladder control**

Survey responses are confidential and may be completed by MA patients or their designated representatives. Initiating discussions about the HOS topics may lead to better health outcomes for your patients. Such conversations also help support gap closure programs.

## Discussing HOS topics with Your Patients

To improve patients' well-being and encourage continued open discussion about their health status, we recommend focusing on the following items:

- Conducting annual wellness visits with your patients, especially those who are MA members
- Screening patients for fall risk, and developing a fall risk reduction plan for patients who screen positive
- Documenting the screening (and fall 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
- Encouraging patients to stay up to date on health care visits and screening opportunities, and notifying their care team regarding any changes in their patients' health status

## Additional Resources

Highmark has created the Care Conversation videos series to encourage members to discuss fall risk and bladder control with their health care providers. If you'd like to view these videos and share them with your patients, click the links below:

- Care Conversations: Bladder Control
- Care Conversations: Fall Risk

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## Diabetes Prevention Program for Medicare Advantage Patients

Western New York Integrated Care Collaborative (WNYICC) offers the **Medicare Diabetes Prevention Program** (M-DPP) to help your Highmark Blue Cross Blue Shield of Western New York (BCBSWNY) Medicare Advantage patients with prediabetes manage their condition.

This evidence-based program — recognized by the Centers for Disease Control and Prevention — helps educate and offer support for older adults diagnosed with prediabetes or who are at high risk for developing type 2 diabetes.

The program offers in-person or virtual sessions. In-person sessions are held at local community centers, including YMCAs, in groups of 10 to 15.

The M-DPP program educates patients on healthy eating and exercise habits to reach the goal of 5% weight loss — decreasing the risk of type 2 diabetes by more than 70%. Losing

weight may also help manage other conditions with fewer medications, including those that treat high blood pressure and high cholesterol.

The program is facilitated by a certified life coach, and helps participants set and achieve personalized goals in weight loss, physical activity, healthy eating, and lifestyle changes. M-DPP is a covered benefit for your Highmark BCBSWNY Medicare Advantage patients and is free to participating members.

To refer your patients, click this link.

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## We appreciate and support your efforts to manage your Highmark Blue Cross Blue Shield of Western New York Medicare Advantage patients' care in a prudent, cost-effective manner.

The Centers for Medicare and Medicaid Services (CMS) requires that members who perceive denial of treatment or care are entitled to certain appeal rights under federal law. This includes situations in which the member's request is made directly to the provider and one of the following conditions exists:

- The member disagrees with the prescribed course/type of treatment.
- The provider declines to render a course/type of treatment that the member is requesting.
- The member does not agree with the provider's decision to discontinue or reduce a course of treatment.

**Examples of Perceived Denials**

- A patient asks to be referred to a radiologist for an MRI, but the provider does not believe that an MRI is necessary.

- A patient asks to be referred to a dermatologist for the treatment of a rash, but the provider declines to refer the patient because the practitioner believes he or she can effectively treat the patient.
- A patient is receiving physical therapy services and the provider determines that physical therapy is no longer necessary.

## Your Responsibility

When a perceived denial occurs, you must:

- **Contact our Utilization Management Department the day the denial occurs to inform us. See phone numbers below.**
- **Ensure our members are informed of their right to appeal.**

## Our Responsibility

We will issue a letter with details of the denial, including description and reason for the denial. A copy of the letter will be sent to you as well. The letter will inform members of the following:

- **Clinical rationale**
- **Their right to obtain reconsideration**
- **Procedure for requesting reconsideration**

Members will be advised that they can appeal if they do not agree with our decision.

If you have questions about perceived denials, please contact Utilization Management at **844-946-6263**. Faxes can be sent to the following numbers:

- **833-581-1868 (inpatient)**
- **833-619-5745 (outpatient)**

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## Correction: Reimbursement Changes to Incident To Services

Last month's *Provider News* article about **Reimbursement Policy (RP)–010**: **Incident To Billing Services and Advanced Practice Provider Reductions** contained incorrect information.

Below is the corrected update for RP-010:

### Correction: RP-010 Update

**RP-010** Incident To Billing Services and Advanced Practice Provider Reductions

***For West Virginia:*** West Virginia was inadvertently checked as an applicable Commercial market in the current version of RP-010. This will be corrected in the updated policy. Highmark will continue to reimburse for these services for Medicare Advantage products, as well as for Mid-Level Practitioners and Advanced Practice Providers who have been enumerated and bill using their own provider ID.*

***For Pennsylvania:*** Incident To services for Commercial products will no longer be recognized, effective **January 1, 2024**. Highmark will continue to reimburse

for these services for Medicare Advantage products, as well as for Mid-Level Practitioners and Advanced Practice Providers.*

***For Delaware:*** Only non-Primary Care Physician (PCP) Incident To services will no longer be applicable to the policy, effective **January 1, 2024**. PCP Incident To services will still be covered. Highmark will also continue to reimburse for these services for Medicare Advantage products, as well as for Mid-Level Practitioners and Advanced Practice Providers who have been enumerated and bill using their own provider ID.*

***For New York:*** New York was inadvertently checked as an applicable Commercial market in the current version of RP-010. This will be corrected in the updated policy. Highmark will continue to reimburse for these services for Medicare Advantage products, as well as for Mid-Level Practitioners and Advanced Practice Providers.*

**Direction for continued reimbursement for Mid-Level Practitioners and Advanced Practice Providers will be published in a new policy, RP-068 (see* **NEW: RP-068** *further down in this article), effective on* ***September 25, 2023****.*

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## September 25

**NEW: RP-068** Mid-Level Practitioners and Advanced Practice Providers
Highmark has created RP-068 to provide direction on reimbursement for Mid-Level Practitioners and Advanced Practice Providers. *(NOTE: This policy will be available on the PRC on September 25.)*

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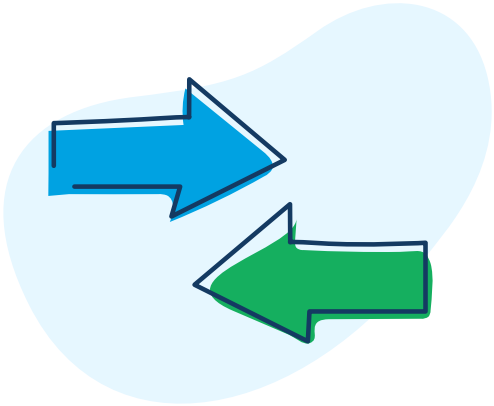
## Reimbursement Updates, Including Changes to RP-026



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.

### ATTENTION!

### October 30

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

This policy will be made applicable to Medicare Advantage. Additional direction will be added for modifiers UN, UP, UQ, UR, and US when submitted with code R0075 (a transportation service code). These modifiers are also required to be included on all related claims, and the Commercial section will be updated with direction to reflect this requirement..

### Correction: RP-010 Update

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**Direction for continued reimbursement for Mid-Level Practitioners and Advanced Practice Providers will be published in a new policy, RP-068 (see* **NEW: RP-068** *further down in this article), effective on* ***September 25, 2023****.*

**Below is a list of recently updated and upcoming Reimbursement Policies (RPs):**

## RECENTLY UPDATED

### July 3

**RP-007** Multiple Procedure Payment Reduction for Certain Diagnostic Imaging Procedures

Codes 0807T and 0808T were added to the APPENDIX A – Procedure Codes Applicable To Professional And Technical Component Reduction section. Code 0804T was added to the APPENDIX B – Applicable Cardiovascular Procedure Codes section.

**RP-042** Global Surgery and Subsequent Services
Codes 0793T, 0795T, 0796T, 0797T, 0798T, 0799T, 0800T, 0801T, 0802T, 0803T, 0805T, 0809T, and 0810T were added to the global YYY codes sections for Medicare Advantage and Commercial.

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## July 10

**RP-015** Professional and Technical Components for Applicable Services
The Public Health Emergency (PHE) exception note was removed. Codes 99000 and 99001 returned to pre-PHE policy direction.

**RP-016** Physician Laboratory and Pathology Services
The PHE exception note was removed. Codes 99000 and 99001 returned to pre-PHE policy direction.

**RP-027** Hemodialysis and Peritoneal Dialysis
Policy exception notes pertaining to the PHE were removed. A definitions section was added.

**RP-041** Services Not Separately Reimbursed
PHE exception notes and end-dated codes G2023, G2024, and U0005 were removed. Codes 99000, 99001, 90887, 99024, 99374, 99377, 99378, 99379, 99380, and 99483 returned to pre-PHE direction.

**RP-046** Telemedicine and Telehealth Services
This policy was updated with post-PHE direction.

**RP-054** Ambulance Services
The PHE exception note for destination requirements was removed.

**RP-064** Government Supplied Vaccinations and Antibody Treatments
Direction was updated for codes 91303, 0031A, and 0034A.

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## July 24

**RP-002** Co-Surgery
This policy was reviewed as part of our standard review process. No changes in direction were made.

**RP-014** Bilateral and Multiple Surgical Procedures
This policy was reviewed as part of our standard review process. No changes in direction were made.

**RP-017** Evocative or Suppression Testing Panels
This policy was reviewed as part of our standard review process. No changes in direction were made.

**RP-018** Myocardial Perfusion SPECT Imaging
This policy was reviewed as part of our standard review process. No changes in direction were made.

**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-023** Newborn Care, Obstetrical Delivery, Antepartum and Postpartum Care and Associated Services
This policy was reviewed as part of our standard review process. No changes in direction were made.

**RP-025** Implantation of Subcutaneous Intravascular Catheter
This policy was reviewed as part of our standard review process. No changes in direction were made.

**RP-030** Insertion of Tissue Expanders
This policy was reviewed as part of our standard review process. No changes in direction were made.

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## UPCOMING

### August 7

**RP-032** Pain Management
This policy was reviewed as part of our standard review process. No changes in direction were made.

**RP-034** Prolonged Detention or Critical Care
This policy was reviewed as part of our standard review process. No changes in direction were made.

**RP-041** Services Not Separately Reimbursed
This policy will be made applicable to facility (UB) claims.

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## August 31 (Effective September 1):

**RP-019N** Drugs and Biologicals
An updated version of this policy will be available for review on the PRC on August 31, 2023, and will be effective beginning **September 1, 2023**. Drug tiering is being eliminated for Delaware, Pennsylvania, and West Virginia. To access this reimbursement policy, log into NaviNet® and select Resource Center from the left menu. Once redirected to the PRC, select **CLAIMS, PAYMENT & REIMBURSEMENT** in the left menu and then click **Reimbursement Policy**.

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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:

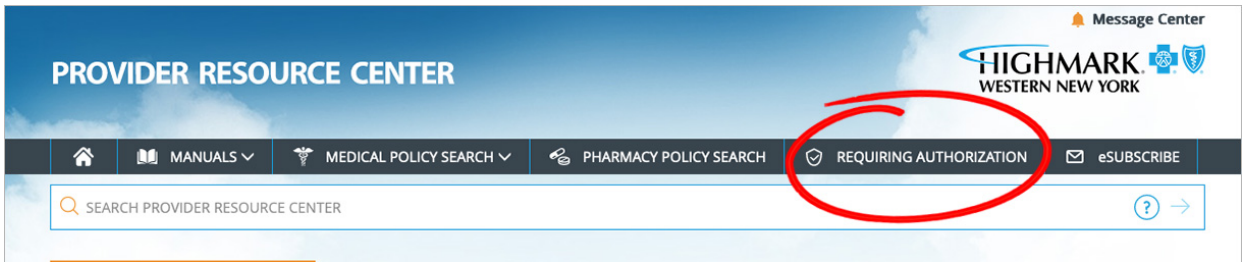
- Call the number on the back of the member's card,
- Check the member's eligibility and benefits via NaviNet®, or
- Search BlueExchange through the provider's local provider portal.

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:

**Reminder: Submitting Auth Requests for Medical Injectables in NaviNet**

**Pharmacy & Medical Injectable Authorization Submissions Moving to Auth Automation Hub**

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.*

NaviNet® is the preferred method for:

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

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## Quarterly Formulary Updates

View the June 2023 updates to Highmark's prescription drug formularies and related pharmaceutical management procedures at the Formulary Updates page on the **Provider Resource Center (PRC)**. From the left menu, select **PHARMACY PROGRAM/FORMULARIES** and then **Formulary Updates**.

### Pharmaceutical Management Procedures

To learn more about how to use these procedures, go to the **PHARMACY PROGRAM/FORMULARIES** section on the PRC. Click on **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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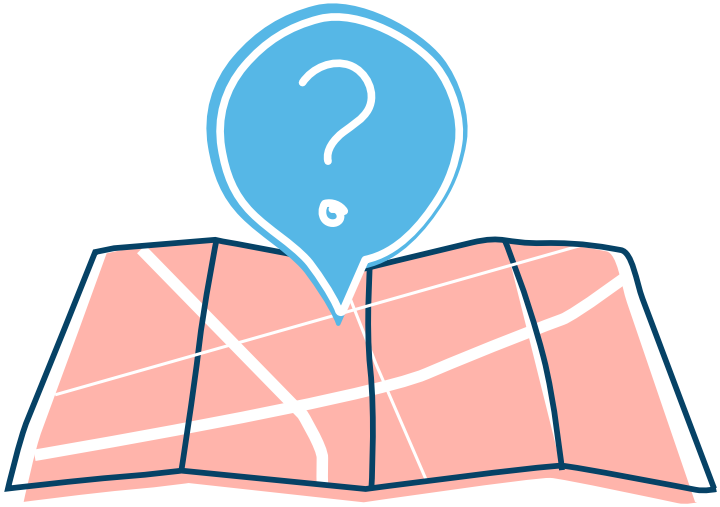
## Ensure Your Directory Information Stays Current

The Centers for Medicare and Medicaid Services (CMS) and the No Surprises Act require Highmark to conduct an outreach to providers at a minimum of every 90 days to validate their provider directory information. Verifying your data consistently ensures accurate claims processing and allows members to make informed decisions regarding their health care needs based on the information in the provider directory.



### Professional Providers – New PDM Tool

Professional providers are now required to validate their Highmark Provider Directory information within the new Provider Data Maintenance (PDM) tool in NaviNet® every 90 days. They also can use the **forms** available on the Provider Resource Center.

**Reminder:** Practitioners will no longer receive calls from Atlas or use PrimeHub, Atlas' provider data management software, to update information.

***Please be aware that providers who don't validate their data quarterly may be removed from the Highmark online directory.***

### Your thorough review of your directory information confirms:

- Each practitioner's name is correct and matches the name on his/her medical license.
- The practice name is correct and matches the name used when you or team members answer the phone.
- All specialties are correctly listed and are currently being practiced.
- The practitioner's address, suite number (if any), and phone number are correct.
- Practitioners listed at a location currently see members and schedule appointments at that office on a regular basis.
    - Practitioners who cover on an occasional basis should not be listed.
- The practitioner is accepting new patients — or not accepting new patients — at the location.

To learn more about the new PDM tool, click here.

## Facility, Ancillary, and Medicaid Providers – 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 this quarter. To ensure delivery of emails from Highmark, please add the following email address, resourcecenter@highmark.com, to your address book.

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

HIGHMARK WESTERN NEW YORK

# PROVIDER NEWS

A newsletter for Highmark Blue Cross Blue Shield of Western New York (Highmark BCBSWNY) network providers

Issue 7, July 2023

## 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:**

### Chapter 4, Unit 1: PCPs and Specialists

- The **4.1 PCP And Medical Specialist Accessibility Expectations** section was updated under **ACCESSIBILITY EXPECTATIONS FOR PROVIDERS**. For Urgent Care Appointments, the Performance Standard was changed from "Office visit within 1 day (24 hours)" to "Immediate response" in the **PCP AND MEDICAL SPECIALIST ACCESSIBILITY EXPECTATIONS** table.

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### Chapter 5, Unit 1: Care Management Overview

- In the **5.1 Introduction to Care Management** section, "Wellness" replaced "Health Promotion (except in New York)" in a bulleted list of core services.
- In the **5.1 High-Risk Maternity (NY Only)** section:
  - Under **BENEFITS FOR PHYSICIANS, MOTHERS, AND THEIR BABIES**, a link to the Preventive Health Guidelines page of the Provider Resource Center

was added. There, the High-Risk Maternity clinical practice guidelines are included in the Prenatal/Perinatal Care Preventive Health Guidelines.
    - Under **POSTPARTUM VISIT COMPONENTS**, links for supporting documentation were updated.
- In the **5.1 Practice Guidelines and Standards of Care for HIV (NY Only)** section:
    - Under **AIDS INSTITUTE NYSDOH COUNSELING AND TESTING RESOURCES**, the phone number for HIV Counseling was updated.
    - Under **PREGNANT WOMEN AND EXPOSED INFANTS LOST-TO-CARE REQUIRE IMMEDIATE ACTION FOR RE-ENGAGEMENT**, the phone number for the New York State Department of Health Perinatal HIV Prevention Program was updated.

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### Chapter 5, Unit 2: Authorizations

- In the **5.2 Authorization Request Process** section:
    - Under **HOME HEALTH AUTHORIZATION REQUESTS**, the language was updated to reflect that authorization procedures for Delaware, Pennsylvania, and West Virginia are the same for each region. Previous language gave the appearance that there were different regional procedures.
    - Under **TELEPHONE REQUESTS**, the contact information was updated. Professional providers should use the phone numbers for the appropriate Medicare Advantage program.

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### Chapter 5, Unit 6: Quality Management

- In the **5.6 Functional Areas and Their Responsibilities** section, the committee list under **QI Committee Structure** (for providers in New York) was updated to include Highmark Inc./Highmark NY Utilization Management Master Service Agreement (MSA) Joint Oversight, and Network Quality and Credentials Committee.
- In the **5.6 Case Review Process for Quality Concerns** section, language under **IMPORTANT!** (for providers in New York) was updated to: "Members are able to make clinical quality of care complaints to the health plan."
- In the **5.6 Clinical Quality** section under **CONDITION MANAGEMENT PROGRAM, HIV/AIDS** was added to the list of chronic conditions for which members are eligible to receive health coaching.

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

HIGHMARK WESTERN NEW YORK

# PROVIDER NEWS

**A newsletter for Highmark Blue Cross Blue Shield of Western New York (Highmark BCBSWNY) network providers**

**Issue 7, July 2023**

# 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

**A newsletter for Highmark Blue Cross Blue Shield of Western New York (Highmark BCBSWNY) network providers**

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

### DELAWARE:

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

### WEST VIRGINIA:

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

### NEW YORK:

- Highmark BCBSWNY and Highmark BSNENY: **800-950-0051**
- Medicare Advantage: **800-329-2792**

  **Hours of Availability:** 8 a.m. to 8 p.m. EST, Monday through Sunday

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

## HIGHMARK CLINICAL SERVICES

NaviNet® is the preferred method for authorization requests. Contact Clinical Services for inquiries that cannot be handled via NaviNet.®

**Hours of Availability:**

**Delaware, Pennsylvania, and West Virginia:** Monday-Friday 8:30 a.m.-7 p.m.; Saturday & Sunday 8:30 a.m.-4:30 p.m. for urgent issues.

**New York:** Monday-Friday 8:15 a.m.-5:00 p.m.

### PENNSYLVANIA:

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

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

**DELAWARE:**

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

**WEST VIRGINIA:**

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

**NEW YORK:**

- Medical Services: **844-946-6263**
  - Fax: Medical Outpatient **833-619-5745**; Medical Inpatient **833-581-1868**
- Behavioral Health: **844-946-6264**
  - Fax: Behavioral Health Outpatient: **833-581-1867;** Behavioral Health Inpatient **833-581-1866**

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