HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

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

Issue 9, September 2024

Amendment to Health Plan Notices Addresses Under Your Participation Agreement

The New PRC Officially Launches Tomorrow

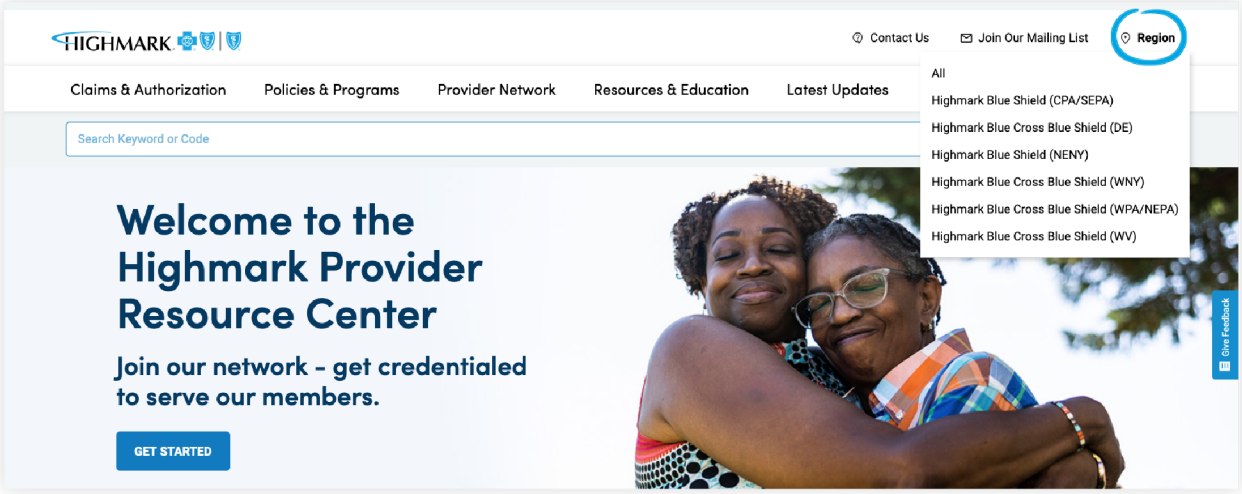
We've heard you. You've been asking for an easier-to-use Provider Resource Center (PRC)... and tomorrow (Oct. 1) is the day the new PRC arrives.

Instead of six regional sites, there will now be a single, centralized PRC for all Highmark's network across our footprint of Delaware, New York, Pennsylvania, and West Virginia. You can access the new site at this URL: https://providers.highmark.com.

What You Will Experience

Starting tomorrow, the regional Provider Resource Center websites that you've been using will no longer be accessible. Instead, you will be redirected to the new PRC site. Please update any bookmarks with the new PRC site URL.

In the upper right-hand corner, you can choose an all-region view, or select your individual region.



The site defaults to an all-region view which gives you access to information for all Highmark service areas. To streamline information for your region, select the appropriate region from the drop-down.

Our top navigation bar has a simplified structure, which can be seen in the above screenshot:

- Claims & Authorization
- Policies & Programs
- Provider Network
- Resources & Education
- Latest Updates

Other differences include:

- **Easier-to-navigate, intuitive design**
- **Prioritized content** – Making it easier for you to find the information you need.
- **Enhanced site search tool** – Get the right answers to your questions faster.

We have a user guide available to help you navigate the new Provider Resource Center.

Better Self-Service Tools

The new PRC is an important part of Highmark's commitment to providing you with improved self-service tools that enable you and your team to successfully complete transactions with Highmark — simpler, easier, and more effectively.

The new consolidated site is the first stage in the evolution of the PRC. We will continue to enhance, refine, and improve the new site. As we continue to evolve the site, your feedback is important. Tell us what you like about the new PRC, what works for you, and how can we make improvements by clicking on the **Give Feedback** icon on the right side of the screen.

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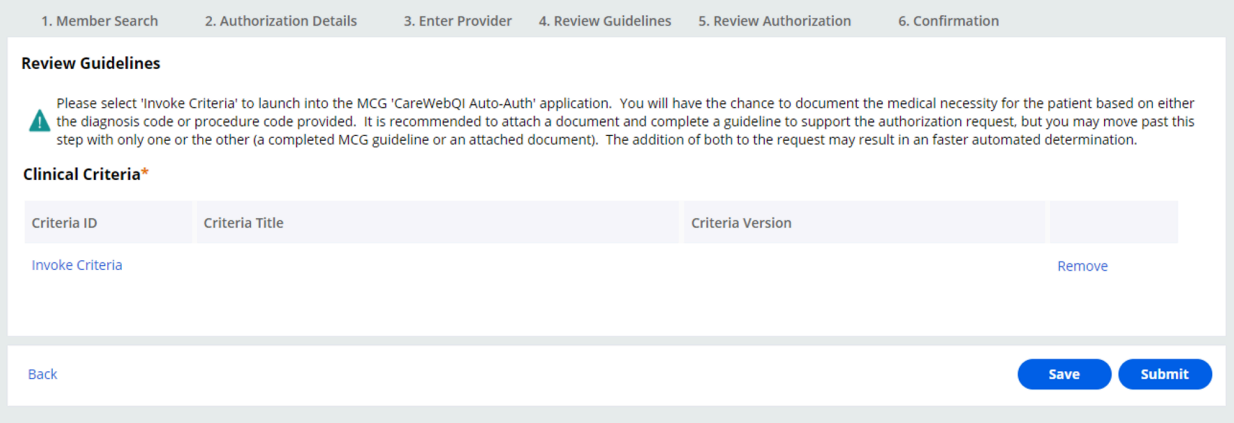
Effective Oct. 14, 2024, Highmark is rolling out a new enhancement to the Predictal Auth Automation Hub that will streamline the authorization review process, saving time and effort for providers and their teams. When submitting a prior authorization request, providers will now be able to invoke MGC's clinical criteria, triggering a faster review of their request.

How It Will Work

All prior authorization requests routed through Predictal will land on the **Review Guidelines** screen. **NOTE:** *This does NOT apply to authorization requests managed by Helion, eviCore, or other third-party administrators.*

Previously, most authorization requests moving through Predictal would bypass this screen. Now, these auth requests will be directed to the **Review Guidelines** screen (step 4), which will have an **Invoke Criteria** option.



IMPORTANT: Prior to reaching this screen, providers should have attached relevant clinical documentation for their authorization during **step 2 – Authorization Details**. Authorization requests cannot be approved without appropriate documentation.

During step 4 (Review Guidelines), providers will now have the opportunity to invoke criteria — in the form of an MCG guideline or custom policy — that may result in a faster approval for their request. Using the **Invoke Criteria** tool can accelerate the review process and lead to faster decisions, including approvals.

Note: Only licensed clinical personnel should use the **Invoke Criteria** tool. Non-clinical personnel can continue to follow the current process for submitting authorization requests.

Current Process – Option to Skip Criteria

For faster approvals, providers and other licensed clinical personnel can leverage our criteria-based system. By following the criteria, your authorization requests will be processed more efficiently.

However, we understand that some situations may require a different approach. Providers have the flexibility to bypass the criteria by clicking “Remove” in the lower right corner of the screen. **Please note:** Choosing to bypass the criteria may result in a longer processing time for your authorization request.

We encourage you to utilize the criteria system whenever possible to expedite your authorizations.

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Primary care providers who currently participate in a practice-level incentive program will transition to Highmark True Performance starting **Jan. 1, 2025**. The transitioning programs include Pay for Outcome (P4O), Pay for Performance (P4P), Pediatric Behavioral Health Incentive, and End of Year Stars (EOY Stars).

Practices with **at least 250 attributed Highmark members** as of June 30, 2024, will transition to the regular True Performance value-based incentive program. Those with fewer members will move to the True Performance Lite value-based incentive program.

For practices that are part of an entity-level incentive program through an Independent Practice Association or Accountable Care Organization, this transition does not impact that program or agreement.

Best Practice to Continue in 2025

The same is true for Best Practice; the program will remain in place for 2025. There are no changes to the program or the agreement. Best Practice PCPs, please watch your email for a direct communication with specific details about the 2025 Best Practice incentive program.

How to Find Program Materials and Your Transition Information

The 2025 True Performance Physician Incentive Plan Terms — along with additional details about the True Performance programs — will be available in the **Value-Based Reimbursement (VBR) Static Reports** on the **Provider Facing Analytics (PFA) Platform** via the Availity® portal. You will be notified via *Provider News* when your program transition information is available in VBR Static Reports on the PFA Platform.

Online training and information sessions also are planned this fall. Watch for details on how to register for and attend these sessions.

For instructions on how to access VBR Static Reports on the PFA Platform, click **here**. If you need additional assistance or have specific questions regarding the tool, call Provider Service at 800-950-0051.

Vatica Enhanced Annual Well Visit (eAWV) 2025 Program Compensation Schedule

Providers who participate in the Highmark Vatica program for Medicare Advantage (MA) and Affordable Care Act (ACA) members will receive program compensation of $100 per completed encounter for visits performed between Jan. 1, 2025, and Dec. 31, 2025.

To receive compensation, providers must fully complete the visit via the approved tool (Vatica Well 365 Plus); submit a claim reflecting the information gathered during the visit including HCPCS/CPT diagnosis code and active Blue Shield ID; and ensure all documentation from each visit is contained in the member's permanent medical record.

The following visit types are approved for a Vatica visit:

- **G0402** – Initial Preventive Physical Examination (IPPE); face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment
- **G0438** – Annual Wellness Visit (AWV) initial visit
- **G0439** – Subsequent Annual Wellness Visit (SWV), subsequent visit
- **99204** – Office Outpatient New 45 Minutes

- **99205** – Office Outpatient New 60 Minutes
- **99213** – Office Outpatient Visit 15 Minutes
- **99214** – Office Outpatient Visit 25 Minutes
- **99215** – Office Outpatient Visit 45 Minutes
- **99385** – Initial Preventive Medicine, New Patient 18-39 Yrs.
- **99386** – Initial Preventative Medicine, New Patient 40-64 Yrs.

- **99387** – Initial Preventative Medicine, New Patient 65 Yrs. & Older
- **99395** – Periodic Preventative Medicine, Established Patient 18-39 Yrs.
- **99396** – Periodic Preventative Medicine, Established Patient 40-64 Yrs.
- **99397** – Preventative medicine visit, established patient

Program manuals will be posted on the Provider Resource Center prior to Jan. 1, 2025.

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APPROVED AUTHORIZATIONS:

Automated Call System

to Notify Members and Providers

Highmark will be moving to an automated call system for **approved** authorization requests requiring a call, **effective Nov. 15, 2024**. Both members and providers will be notified of approved authorization requests from the automated call system rather than a Highmark customer service representative.

This change will help Highmark reduce unnecessary health care expenditures, while delivering more effective member and provider outreach. The move to an automated call system applies to all six Highmark regions for the following lines of business:

- **Commercial**
- **Affordable Care Act (ACA)**
- **Medicare Advantage**
- **Federal Employee Program (FEP)**

What to Expect

Highmark's automated system will use the number **800-452-8507** to reach members and providers regarding the approved authorization request. The message will include the following information:

- Calls to begin with: "Hello, this is Highmark..."
- The authorization number (communicated twice)
- Patient name and date of birth
- Members to receive a confirmation letter
- Providers to receive written confirmation via fax, letter, or status update in the portal. ***Note:*** *This ensures that practitioners have the most current status of the submitted authorization.*

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PREVENTIVE HEALTH: Annual Screening for Breast Cancer

The average risk of a woman in the U.S. developing invasive breast cancer during her lifetime is about 13% or 1 in 8. The chance that a woman will die from breast cancer is about 2.5% or 1 in 39.[1] While breast cancer death rates have come down, they are still much too high!

Due to the rise in breast cancer in women aged 40-49, the U.S. Preventive Services Task Force (USPSTF) final recommendation is that women begin screening for breast cancer at **age 40** instead of the previously recommended age of 50.

Breast Cancer Awareness Month, which occurs every October, represents an excellent opportunity to encourage female patients, 40 and over, to schedule their annual breast cancer screening before the end of the year.

Screening Saves Lives

Mammography is the most effective screening test used today and can detect cancers at an early stage when chances of survival are highest. Mammography has helped reduce breast cancer mortality in the U.S.

Important: Three out of four women diagnosed with breast cancer have no family history of the disease and are not considered high risk.[2]

Physician's Role

The American Society of Breast Surgeons recommends that all women discuss breast cancer risks with a provider when they are between the ages of 25 and 30. This information can be updated by the provider at the patient's health appointments prior to the start of mammography screening.[3]

Providing breast health awareness education and counseling is essential for your patients to :

- Know when they should be screened
- Not ignore a symptom or change, big or small
- Not be afraid to take the necessary steps to get treatment

Signs and symptoms of breast cancer[4] may include:

- Lump in the breast or underarm
- Swelling or thickening of all or part of the breast
- Dimpling or skin irritation of breast skin
- Localized, persistent breast pain
- Redness, scaliness, or thickening of the nipple or breast skin
- Newly inverted nipple or nipple discharge
- Any change in the size or shape of breast.

Overcoming Barriers to Care

Providers can address barriers to screening mammography by advocating for convenient screening locations with accessible transportation. For women who may be uninsured or under-insured, there are programs that offer free or low-cost mammography, including those sponsored by the following organizations:

- The National Breast Cancer Foundation
- The Susan G. Komen Foundation
- The CDC's National Breast and Cervical Cancer Early Detection Program
- American Breast Cancer Foundation

Resources for Members

For members, Highmark has resources available that emphasize the importance of preventive health screenings for female patients. You can order **free copies** of the following materials to share with patients during their visit:

- Breast Cancer Brochure
- Breast Cancer Screening Reminder Card
- Breast Cancer Screening Flyer
- Health Screening and Vaccination Tracker

To access these free resources, go here.

Once on the new Provider Resource Center, select your individual Highmark region from the upper right-hand corner to see the available resources.

References

1. Breast Cancer Statistics | How Common Is Breast Cancer? | American Cancer Society.
2. Mammography Saves Lives | American College of Radiology
3. Consensus Statement on Screening Mammography (breastsurgeons.org)
4. Breast cancer - Symptoms and causes - Mayo Clinic

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For Fully Insured and Affordable Care Act (ACA) Plans Only

Highmark is revising its pharmacy prior authorization policy for certain weight loss medications for fully insured* commercial and Affordable Care Act (ACA) members.

These medications include:

- Contrave (bupropion and naltrexone)
- Qsymia (phentermine and topiramate extended release)
- Saxenda (liraglutide)
- Wegovy (semaglutide)
- Xenical (orlistat)
- Zepbound (tirzepatide)

Prior authorization criteria for weight loss medications for Highmark's commercial self-insured members is not impacted.

When do these changes apply?

Fully Insured Plans Issued in:	Member New to Therapy	Member with Existing Prior Authorization
Delaware or West Virginia	09/01/2024	Upon reauthorization following required notice. Impacted members will receive 60-day advance notice via letter.
Pennsylvania	10/01/2024	
New York	09/01/2024	Upon reauthorization, following 2025 group renewal. Impacted members will receive 90-day advance notice via letter.

Both members and their prescribers will receive this advance notice of the changes and effective date via letter.

What is changing?

The pharmacy policy contains several updates that include*:

Prioritization of use for members most in need, including those with severe obesity and obesity-related health conditions.	→	Higher baseline body mass index (BMI) with at least two weight-related comorbidities.
Use of **medications** that have **demonstrated the highest efficacy and lowest cost.**	→	A documented intolerance/contraindication to certain drugs.
Use of medications in conjunction with **lifestyle modifications**.	→	Documentation of healthy dietary changes and increased physical activity.

*For the full list of updates to the pharmacy policy, click here. Coverage is governed by the terms of the member's health benefits plan. If the terms of the member's health benefits plan change, the member's coverage will also change.

This policy change also does not affect FDA-approved GLP-1s used in the treatment of type 2 diabetes.

Why is Highmark making these changes?

To learn more, click here to read the **Aug. 30 Special Bulletin**.

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

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

The transition to Wellpoint was previously communicated in this July 2 Special Bulletin.

What You Should Know

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

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

- Network Participation
- Precertification (Prior Authorization)
- Claims
- Reimbursement
- Training
- Provider manuals and guides
- Forms

Ease of Use – Just One Provider Portal

Availity Essentials is the provider portal for both Highmark and Wellpoint. To register, visit the Register and Get Started with Availity Essentials webpage. If you are already registered for the portal, there is no need to re-register.

Pharmacy Network Change

The pharmacy network for Essential Plan members will be changing from Express Scripts to CarelonRx, **effective Jan. 1, 2025**. Some current pharmacies may be out-of-network on Jan. 1. Letters sent in mid-September encouraged members to check to see if their pharmacy was in network. As part of the transition, members will receive new ID cards in December via postal mail.

Prepare for the Transition

To ensure a smooth transition for our valued providers, both Highmark and Wellpoint will communicate with you regularly as we near the Jan. 1 transition. There are also a few things that you can do now to prepare:

1. **Make Sure Your Contact Information Is Correct**

   Double-check your contact information with Highmark is correct, including mailing and email addresses. Here's how to review and update your information:

   - Log into Availity Essentials.
   - Choose New York state.
   - Click on **Payer Spaces** and choose the **Highmark Blue Cross Blue Shield (WNY)** plan.
   - Scroll down and select **Provider Data Maintenance** under the Applications tab.

2. **Join Our Mailing List**

   Stay up to date on the latest news and announcements from Highmark, including this transition, by clicking here.

Additional Resources

- Essential Plan Implementation – Frequently Asked Questions

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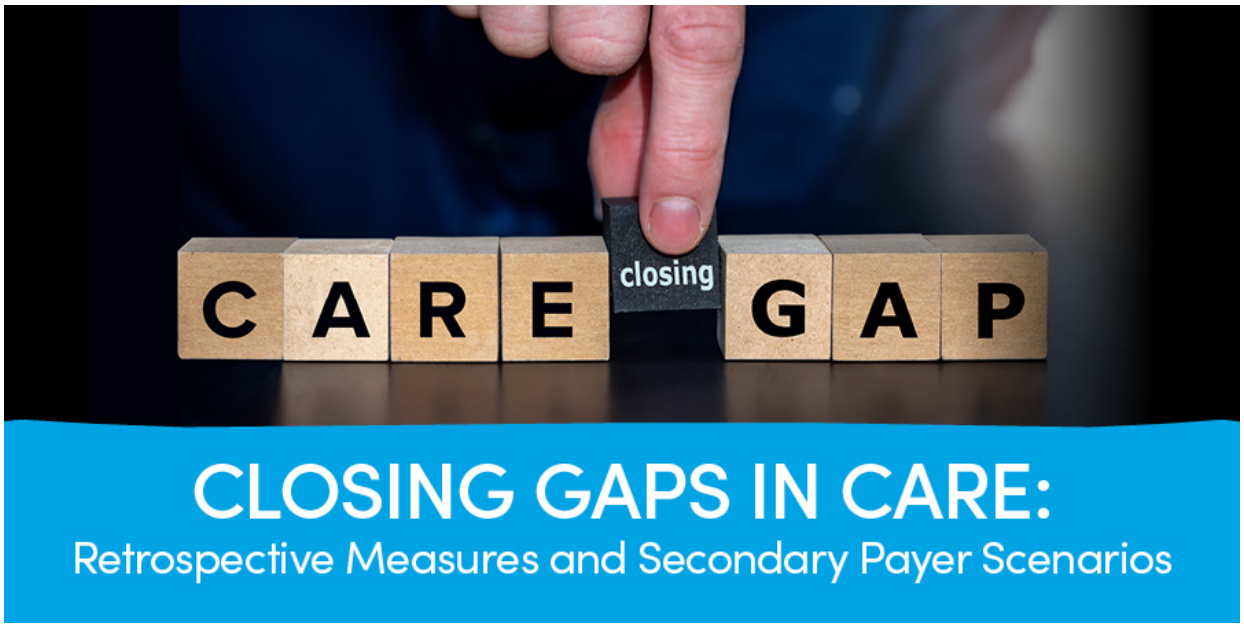

Highmark is committed to collaborating with providers to improve health outcomes for patients. Accomplishing this goal includes providing incentive programs that recognize and reward primary care providers who improve quality and close patients' gaps in care.

How do I close a gap in care?

The standard way to close a patient gap in care is to make sure that claim(s) have been submitted with the appropriate CPT, CPT II, and/or ICD-10 code. All claims must be submitted in a timely manner. In order to reflect accurate risk scores for your patients, please be sure that all diagnoses affecting treatment and care are thoroughly documented and coded to the highest specificity.

However, there are instances where it is not possible to submit a claim (e.g., for a retrospective measure or for services where we are a secondary payer). Medical record submission for patients who had services rendered within a retrospective time period (per HEDIS® technical specifications) will be accepted from **July 1, 2024, through Jan. 15, 2025**.

Retrospective measures include Childhood Immunization Status, Immunizations for Adolescents, Breast Cancer Screening, Colorectal Cancer Screening, Cervical Cancer Screening, Diabetes Care Eye Exam and Osteoporosis Management in Women with a Fracture.

Accepted medical records will be entered and captured in the reporting software. Please allow up to 60 days for these updates to appear in the gap in care reports.

How do I assess if my patients have an open gap in care?

1. Retrieve your report in Provider Facing Analytics (PFA) in Availity®.
2. For each patient and measure, determine the following:
    - If the service required by the quality measure was NOT rendered, the provider office may reach out to the patient to coordinate scheduling the service.
    - If the service WAS rendered, determine if a claim has been submitted to us.
    - If a claim was submitted in the past 60 days, allow time for the claim to process. **Do not submit any medical record documentation at this time**.
    - If a claim was not submitted, do so now: Use the appropriate CPT, CPT II and/or ICD-10 code.
    - If the service was rendered prior to the current year, such as for a *retrospective* P4P measure, or if we are the secondary payer, submit the medical record documentation via secure file transfer through Axway or by fax, using the appropriate Quality Compliance Form (QCF). Once on the new Provider Resource Center, select your individual Highmark region from the upper right-hand corner. Medical records received by fax will not be accepted unless accompanied by the appropriate QCF. A QCF must be filled out for each measure for each individual member's medical record. The documentation should be faxed to the Clinical Team for review at **888-297-0771**.
    - For SFTP password resets, contact our FTP administrators at ftpadmin@nyhplans.org or the 7.1 PASSWORD CHANGES section of your WEBTRADER USER GUIDE.

What records will NOT be accepted?

- Records for measures that are not included in our incentive programs
- Records for services performed in 2024 (except for secondary insurance)
- Records that are submitted after Jan. 15, 2025

- Records submitted without the appropriate QCF
- Records for inactive members
- Continuity and Coordination of Care (CCD) documents that include HEALTHeLINK documents

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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.

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.


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Facility Providers: Highmark to Align HCRA Processes with NY State Recommendations

To align with New York (NY) State Department of Health's recommendations and to reduce unnecessary health care expenditures, Highmark is making changes to its Health Care Reform Act (HCRA) processes, **effective Nov. 15, 2024**. Highmark notified facility providers on Aug. 12 of this upcoming change via an email that linked to this Special Bulletin.

Reimbursement Update: Daily Maximum to Increase for Most Therapy Services

Effective Nov. 1, 2024, Highmark is increasing the Daily Dollar Maximum (DDM) for most therapy services in the Western New York and Northeastern New York regions.

For physical therapy (PT) and occupational therapy (OT) services, the DDM rate is increasing for both Commercial and Medicare Advantage lines of business. For Chiropractic Services, the DDM is increasing for Commercial and remaining the same for Medicare Advantage. To see the rates, click here.

Medicare Advantage Medical Policies are Once Again Accessible from the PRC

To facilitate provider ease of use, the Highmark Medicare Advantage (MA) Medical Policy search site is again accessible from the Provider Resource Center (PRC). To search for MA medical policies, go to the PRC, select **Policies & Programs** from the top task bar, and then click **Medical Policies**. Scroll down to **Medicare Advantage Policy Search**. For more information, go here.

Express Scripts Pharmacy to No Longer Stock 32 Medications

Effective Oct. 1, 2024, Express Scripts Pharmacy will no longer stock 32 medications — including Arnuity, Ellipta, Entresto, Savella, and Trintellix — across all lines of business. To see the list of medications, click **here**.

Annual Fee Schedule Update Will Occur on Nov. 1, 2024

Our annual fee schedule update for commercial and Medicare Advantage products in our New York regions will take effect on Nov. 1, 2024. Updates include some incremental increases and decreases throughout the fee schedule to align with Highmark's fee schedules. Learn more here.

Case Management Referrals via Availity

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 learn more, watch **this video**.

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The requirement for non-participating (non-par) providers to check claim status or submit a claim inquiry for a Highmark member — using Availity® or our Interactive Voice Response (IVR) system — has moved to February 2025. The original implementation date was Sept. 30, 2024.

This change will apply to all non-par providers in Delaware, Pennsylvania, New York, and West Virginia who are not currently contracted with Highmark.

For more details, see **the article** in August *Provider News*.

Signing Up for the Provider Portal

Availity Essentials, Highmark's Provider Portal, is the primary method for submitting transactions to Highmark.

Because Availity is a multi-payer platform, **even if you are not contracted with Highmark**, you can register your organization to transact with Highmark and other payers across the country.

Once you register with Availity, you can start using Highmark's provider portal right away to check claim status or submit a claim inquiry.

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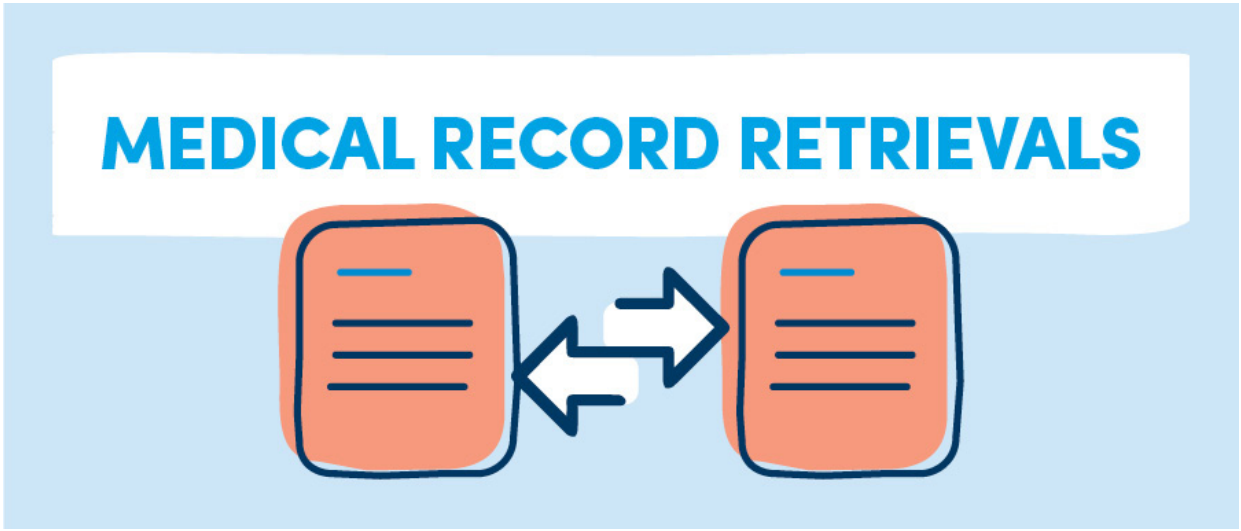

Highmark does its best to minimize the disruption of medical record requests to your practice as we work to meet continued documentation requirements. Whenever possible, we streamline our outreach to help manage multiple requests.

Coordinating Medical Record Retrieval for Other Blue Plans

Highmark Blue Cross Blue Shield will be requesting medical records from you on behalf of other Blue Cross Blue Shield and/or Blue Shield Plans when necessary. These requests are generally made for Medicare Advantage patients who are covered by out-of-area Blue Plans but receive care in New York state.

You may also receive medical record requests from Datavant formerly known as CIOX Health. The company is authorized to retrieve medical records for out-of-area Blue Plan patients who are covered under Affordable Care Act (ACA) programs and Medicare.

Records are requested in support of Healthcare Effectiveness Data and Information Set (HEDIS®); risk adjustment; government-required programs, including the Affordable Care Act (ACA); Health and Human Services; or Centers for Medicare and Medicaid Services (CMS) star-measure reviews. We ask that you respond to all requests from us and Datavant.

Medical Record Retrieval – A Year-Round Process

Timely and effective medical record retrieval is important to ensuring optimal quality reporting and complete and accurate risk scores. Blue Plans participate in medical record retrieval projects year-round. Earlier in the year, you may have received medical record requests regarding these programs:

- **Commercial Risk Adjustment (CRA) (2024 Benefit Year)**
- **Medicare Advantage Risk Adjustment Data Validation (RADV)**
- **HEDIS**

Currently, the following programs are (or will soon be) requesting medical records:

Program	Start Date	End Date
Medicare Advantage Risk Adjustment (MRA)	April 2024	December 2024
Commercial Risk Adjustment Data Validation Audit (HRADV)	June 2024	December 2024
Commercial Risk Adjustment (CRA) (2024 Benefit Year)	October 2024	April 2025

Working with Datavant

Our vendor Datavant is contractually bound to follow HIPAA (Health Insurance Portability and Accountability Act) regulations and preserve all patient-protected health information (PHI).

Medical records may be submitted to Datavant in the following ways:

- **Mail:** Mark Confidential on the envelope and mail the medical records to:
    - Datavant
      2222 W. Dunlap Ave.
      Phoenix, AZ 85021
- **Fax:** 972-957-2210 or 972-957-2168
- Secure email to ChartReview@datavant.com

If you have questions about delivery options, please call Datavant at **877-445-9293**.

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October Coding Webinar: Depression

"Depression" will be the topic for the Coding and Quality Knowledge College webinar on **Wednesday Oct. 9, 2024, at 12:15** p.m.

Throughout the year, the college presents monthly webinars aimed at providing education on the proper coding of medical diagnoses, along with the associated quality measurements that impact documentation.

Here's the topic schedule for the rest of the year:

- Nov. 13 – BMI, Morbid Obesity, and Malnutrition
- Dec. 11 – Cardiac Conditions

All webinars are held **12:15 – 12:45 p.m. EST** on the second Wednesday of the month.

Continuing Medical Education (CME) Credits

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 learn more about the Coding and Quality Knowledge College on the Provider Resource Center by clicking here.

Once there, you can find instructions to create an AHN CME account, register for the next class, or view past coding webinars. To register for the October webinar on **Depression**, go here.

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Authorization Updates: Injectable Drug to Be Added to PA List, and More

During the year, Highmark adjusts the List of Procedures and Durable Medical Equipment (DME) Requiring Authorization. For information regarding authorizations required for a member's specific benefit plan, providers may:

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

These changes are announced in the form of Special Bulletins and other communications posted on Highmark's Provider Resource Center (PRC). The most recent updates regarding prior authorization (PA) are below:

Medical Injectable Drug to Require Prior Authorization Beginning Jan. 1, 2025

Effective Jan.1, 2025, the medical injectable drug noted below will require prior authorization before the medicine can be administered to Highmark members.

Highmark will revise its **List of Procedures/DME Requiring Authorization** by adding the following procedure code on Jan. 1, 2025:

Procedure Code	Generic	Brand
J3245	Tildrakizumab-asmn	Ilumya

Note: This drug will not require authorization and will not appear on the all-inclusive authorization list on the Provider Resource Center **until the effective date**, Jan. 1, 2025. Plan-preferred product considerations may apply in line with member benefits. Please confirm the most up-to-date coverage criteria outlined in Highmark's applicable Medical Policies, available on the Provider Resource Center.

Prior Authorization Changes Occurring on Sept. 30, 2024

Effective Sept. 30, 2024, nearly 100 codes will be added to the prior authorization list, including codes related to the following procedures and/or treatments:

- Implantable defibrillator
- Insertion of new or replacement pacemaker; Removal of permanent pacemaker
- Mastectomy
- Nasal/sinus endoscopy

To view the codes, click here.

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Effective Jan. 1, 2025, 14 laboratory management tests related to biomarkers will be added to the List of Procedures and Durable Medical Equipment (DME) Requiring Authorization. Here are the codes that will be added:

Code	Test	Description
81383	HLA-DQB1*06:02 Testing for Narcolepsy	HLA Class II typing, high resolution (i.e., alleles or allele groups); one allele or allele group (e.g., HLA-DQB1*06:02P), each
81479	Percepta© Bronchial Genomic Classifier, ProMark® Risk Score, OncotypeDx AR-V7 Nucleus defect	Unlisted molecular pathology procedure

81529	DecisionDx Diff Melanoma	Oncology (cutaneous melanoma), mRNA, gene expression profiling by real-time RT-PCR of 31 genes (28 content and 3 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence risk, including likelihood of sentinel lymph node metastasis
81554	Envisia	Pulmonary disease (idiopathic pulmonary fibrosis [IPF]), mRNA, gene expression analysis of 190 genes, utilizing transbronchial biopsies, diagnostic algorithm reported as categorical result (e.g., positive or negative for high probability of usual interstitial pneumonia [UIP])
81599	Razor RiskReveal	Unlisted multianalyte assay with algorithmic analysis
88120	Urovysion	Cytopathology, in situ hybridization (e.g., FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual
88121	Urovysion	Cytopathology, in situ hybridization (e.g., FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology
0080U	Nodify XL2	Oncology (lung), mass spectrometric analysis of galectin-3-binding protein and scavenger receptor cysteine-rich type 1 protein M130, with five clinical risk factors (age, smoking status, nodule diameter, nodule-spiculation status and nodule location), utilizing plasma, algorithm reported as a categorical probability of malignancy
0089U	DecisionDxMelanoma	Oncology (melanoma), gene expression profiling by RTqPCR, PRAME and LINC00518, superficial collection using adhesive patch(es)
0090U	Mypath	Oncology (cutaneous melanoma), mRNA gene expression profiling by RT-PCR of 23 genes (14 content and 9 housekeeping), utilizing formalin-fixed paraffin-embedded (FFPE)

		tissue, algorithm reported as a categorical result (i.e., benign, intermediate, malignant)
0179U	CtDx	Oncology (non-small cell lung cancer), cell-free DNA, targeted sequence analysis of 23 genes (single nucleotide variations, insertions and deletions, fusions without prior knowledge of partner/breakpoint, copy number variations), with report of significant mutation(s)
0314U	DecisionDx Diff Melanoma	Oncology (cutaneous melanoma), mRNA gene expression profiling by RT-PCR of 35 genes (32 content and 3 housekeeping), utilizing formalin-fixed paraffin-embedded (FFPE) tissue, algorithm reported as a categorical result (ie, benign, intermediate, malignant)
0340U	signatera	Oncology (pan-cancer), analysis of minimal residual disease (MRD) from plasma, with assays personalized to each patient based on prior next-generation sequencing of the patient's tumor and germline DNA, reported as absence or presence of MRD, with disease-burden correlation, if appropriate
0388U	Inivata	Oncology (non-small cell lung cancer), next-generation sequencing with identification of single nucleotide variants, copy number variants, insertions and deletions, and structural variants in 37 cancer-related genes, plasma, with report for alteration detection

Effective Jan.1, 2025, prior authorization will be required for these biomarker tests. Authorization requests should be submitted via the Availity® portal.

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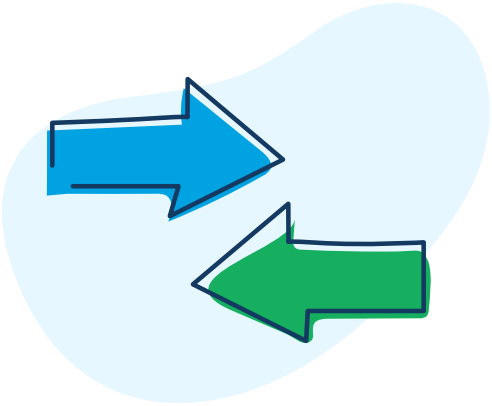
New and Updated Reimbursement Policies



Highmark regularly issues new or updated reimbursement policies. Keep an eye on this newsletter and the Provider Resource Center (PRC) 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

August 30, 2024

RP-057 Evaluation & Management Services

A "Definitions" section was added to this policy. In addition, the total time requirements for codes 99202-99205 (new patient services) and the total minutes requirements for codes 99212-99215 (established patient services) and codes 99306-99308 (nursing facility services) were updated.

Sept. 23, 2024

RP-066 Sleep Study Supplies and Services
This policy was made applicable to Medicare Advantage.

UPCOMING

October 28, 2024

RP-054 Ambulance Services
Direction from Medicare Advantage (MA) Medical Policy T-2 (Ground Ambulance) will be transferred to RP-054, which will become applicable to MA effective **Oct. 28, 2024**. There will be no changes to the MA direction.

COMING SOON

Effective Date to Be Determined

RP-068 Mid-Level Practitioners and Advanced Practice Providers
This policy is being updated for New York Commercial to add direction for the new Psychoanalyst specialty. Psychoanalysts will be reimbursed for procedure code 90845 only.

NEW: RP-076 Medical Nutrition Therapy
This new policy will direct the plan's reimbursement for Medical Nutrition Therapy (MNT) codes 97802, 97803, 97804, G0270, and G0271 for Commercial and Medicare Advantage plans. MNT services will only be reimbursed when billed by a registered dietician or nutritional professional, or by a facility that accepts or received assignment from a registered dietician or nutritional professional. *(NOTE: This policy is not yet available on the PRC.)*

Jan. 1, 2025

NEW: RP-078 Postoperative Sinus Debridement
This is a new reimbursement policy addressing postoperative sinus debridement and service related to sinus surgery. It is applicable to Commercial and Medicare Advantage.

NEW: RP-079 Multiple Ultrasounds

This is a new reimbursement policy applicable to Medicare Advantage and Commercial. This policy addresses circumstances surrounding the appropriate reporting of non-obstetrical and obstetrical transabdominal and transvaginal ultrasounds. Reimbursement for multiple procedure payment reductions may be applicable when multiple services are provided during a patient encounter by the same physician or same group physician/other health care professional.

(NOTE: These two new polices are not yet available on the PRC.)

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

This policy is being updated for Medicare Advantage markets in Delaware, Pennsylvania, and West Virginia, to apply a reduction for multiple evaluation and management services done on the same day. When an Annual Wellness Visit (AWV) or Initial Preventive Physical Examination (IPPE) is performed on the same date of service as a routine physical exam by the same physician/provider or physician/provider group, the Plan will reimburse the AWV or IPPE at 100% and the routine physical at 50% of the approved allowed amount.

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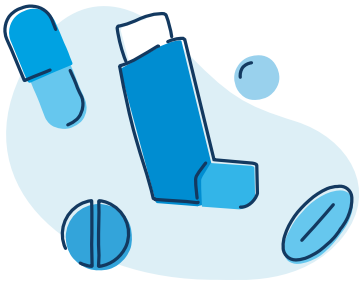
Quarterly Formulary Updates



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

Pharmaceutical Management Procedures

To learn more about how to use these procedures, click on **Polices & Programs** from the top menu on the PRC. Select **Pharmacy Programs** and then **Pharmaceutical Management**.

This section includes information on:

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

Federal Employee Program (FEP) Drug Formularies and Pharmaceutical Management Procedures

The FEP specific drug formularies are available online. Providers also may obtain formulary information by calling **866-763-3608** and following the prompts for *Pharmacy*.

To learn more about the FEP exception request processes for non-formulary drugs, click here.

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Directory Information – Here's How to Attest

When Highmark members are looking for a primary care physician (PCP) or specialist, they expect that our online provider directory presents information that is accurate and current.

That's why it is essential to ensure that your practice information on file with Highmark remains up to date.

Please be aware that providers who don't validate their data quarterly may be removed from the directory and their status within Highmark's networks may be impacted.

Reviewing Data Is Vital for You

The Centers for Medicare and Medicaid Services (CMS) requires Highmark to reach out to you every quarter and ask you to validate your provider directory information. We use this information to populate our online provider directory and to help ensure correct claims processing.

Your thorough review of your directory information confirms:

- **Each practitioner's name** is correct and matches the name on his/her medical license.
- **Each practitioner's National Provider Identifier (NPI) is correct.**
- **The practice name is correct** and matches the name used when you answer the phone.
- **All specialties are correctly listed** and are currently being practiced.
- **Practitioners listed at a location** currently see members and schedule appointments at that office on a regular basis.
    - All practitioners listed must be affiliated with the group. Practitioners who cover, read test results, or are hospitalists should not be listed in the provider directory.
- **The practitioner is accepting new patients** — or not accepting new patients — at the location.
- **The practitioner's address**, suite number (if any), and phone number are correct.

Professional Providers – Use the PDM Tool

Professional providers are now required to validate their Highmark Provider Directory information within the Provider Data Maintenance (PDM) tool every 90 days.

To access PDM, sign in to Availity®, choose the state you practice in, click **Payer Spaces** from the task bar, and then select the Highmark plan you participate in. Once you arrive at the **Payer Spaces** page, scroll down, and select **Provider Data Maintenance** under **Applications**.

Facility, Ancillary, and Medicaid Providers – Use Atlas

The attestation process through Atlas is quick and easy. Just follow these steps...

1. **Go to hub.primeatlas.com.**
2. **Log in.**
3. **Review your information.**
4. **If no changes, confirm.**

5. If there are changes, update your information.

If you haven't attested your provider directory information this quarter, you will receive a letter from Atlas to review your provider information. Some providers may also receive emails from Highmark about validating their directory information through the Atlas website. To ensure delivery of emails from Highmark, please add the following email address, resourcecenter@highmark.com, to your address book.

During the attestation process, always double-check your current email address(es) to ensure that you can receive electronic communications from Highmark without delay.

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

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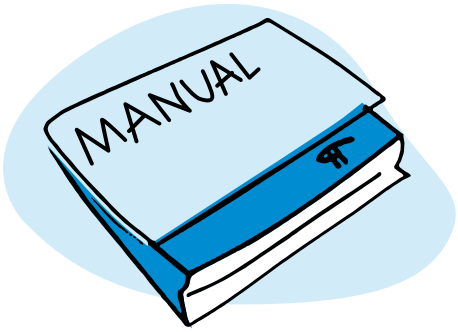
Staying Up to Date with the *Highmark Provider Manual*

Ensure you are regularly reviewing the *Highmark Provider Manual* for our most recent guidance on:

- Participation Rules
- Credentialing/Recredentialing Criteria and Procedures
- Medical Record Criteria
- Requirements for 24/7 Coverage



Some recent noteworthy changes occurred in the following chapters and units:

- **Chapter 3, Unit 2: Professional Provider Credentialing**
- **Chapter 4, Unit 7: Medical Records Documentation Requirements**
- **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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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.


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.