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Highmark's Preventive Health Guidelines Updated for 2025

The 2025 Preventive Health Guidelines are now available on the Provider Resource Center.

Every year, Highmark reviews and updates the Preventive Health Guidelines, which are made available to the practitioner community as a reference tool to encourage and assist you in planning your patients' care.

What's Changing

For New York, Pennsylvania, and West Virginia, there were minimal changes this year to Highmark's preventive services, which are included in the Preventive Health Guidelines. For Delaware, there were two state-mandated changes for mammogram screening and ovarian cancer screening.

Below is a list of the changes to the Preventive Health Guidelines for this year:

Clarifying Language Added to Pharmacy Benefit

The following sentence was added regarding qualifying purchases at retail pharmacies:

All benefits for over-the-counter drugs and supplies must be purchased through in-network pharmacy providers in order to be covered.

Download the Guidelines

To help make the information more accessible and convenient for you, the complete set of 2025 Preventive Health Guidelines is posted online. Just visit the Provider Resource Center, go to **Resources & Education > Clinical Quality & Education > Preventive Health Guidelines**.

To obtain a copy of the guidelines, please email Clinical Quality at ClinicalQualityOutreach@highmark.com.

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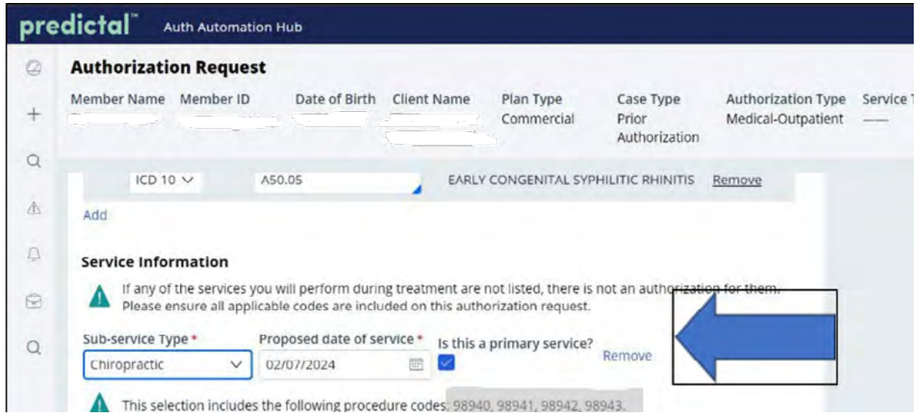
AUTH ENHANCEMENT:

Specific Codes Required for **Physical Medicine, Home Health, and Hospice Requests**

Effective Feb. 22, 2025, providers will be able to enter **specific procedure codes** when requesting authorization for outpatient physical medicine, home health, and hospice services via the Predictal Auth Automation Hub within the Availity®, portal. This upgrade will streamline the authorization process and prevent unnecessary denials.

Currently, when making an authorization request for these services, providers are not allowed to select specific procedure codes — they can only select the **Sub-service Type**, which automatically attaches multiple codes (an umbrella code) to the request. Some of these codes **may not be applicable** to the requested treatment. Extraneous codes can impede the authorization approval process. In addition, the umbrella code in some instances was insufficient and resulted in an inadvertent denial of the authorization request.

(Continued)



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Auth Enhancement: Specific Codes Required for Physical Medicine, Home Health, and Hospice Requests *(Continued)*

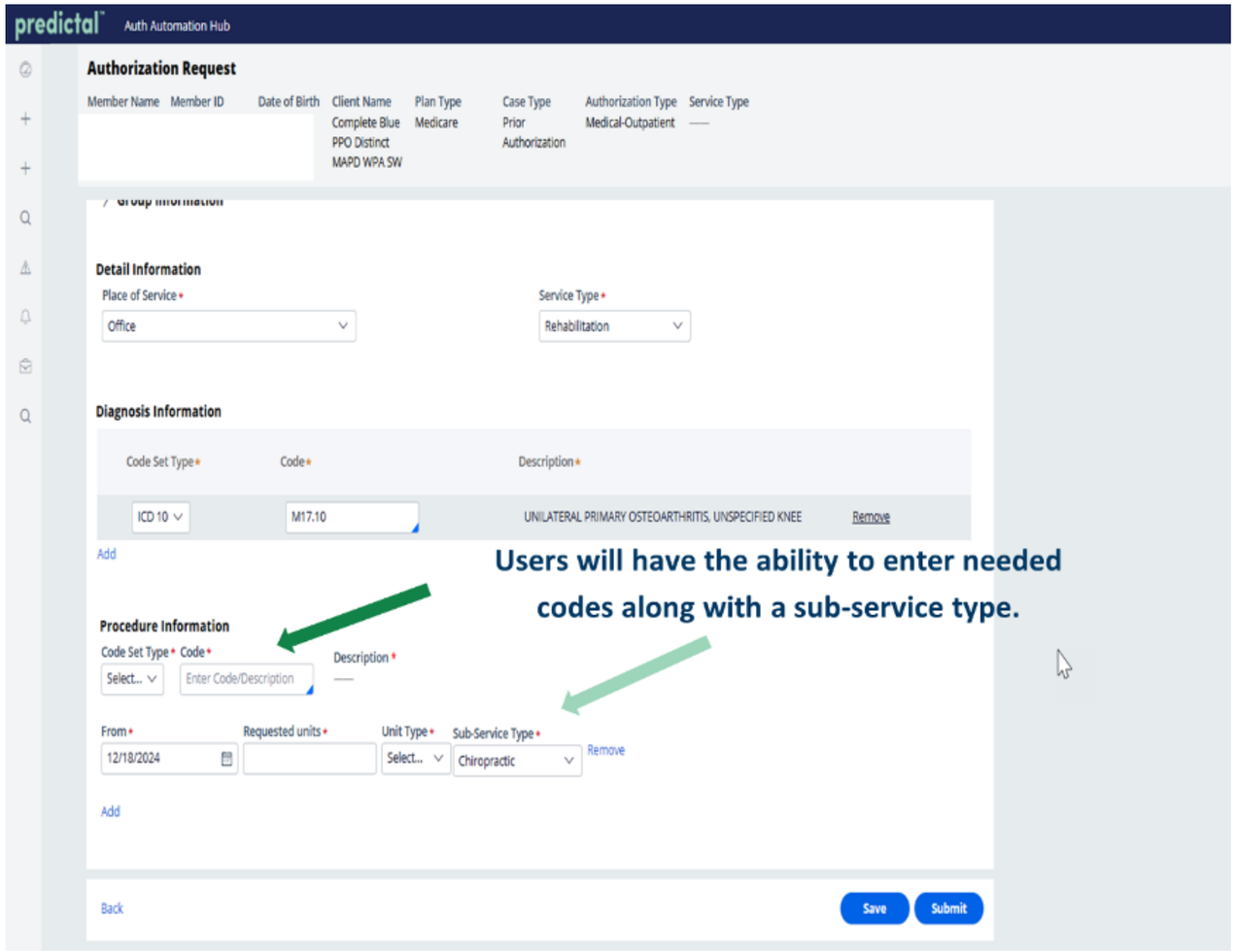
The following services will be affected by this change:

- **Chiropractic**
- **Physical Therapy**
- **Occupational Therapy**
- **Speech Therapy**
- **Home Health, including Behavioral Health**
- **Hospice**

The use of specific procedure codes will facilitate both efficient authorization and claims processing, with the goal of reducing denials due to lack of authorization. While this is a change for these services, it is similar to how all other medical services are requested, creating consistency across authorization requests and allowing for tracking in our claims processing systems.

Starting on Feb. 22, 2025, providers will have the ability to select the specific procedure code related to each Sub-Service Type when requesting authorization for treatment.

As with all submissions, without any procedure code, the authorization request will not move forward. For more information on submitting authorization requests, visit the Authorization Training & Resources page on the Provider Resource Center.



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SHORT TAKES:

HEDIS Changes, MID Reimbursement, and More

HEDIS Changes for 2025:
Mammogram Assessments, Blood Pressure Control, and More

The Healthcare Effectiveness Data and Information Set (HEDIS®) is constantly evolving to ensure measures are relevant and represent clinical best practices. For Measurement Year (MY) 2025, the National Committee for Quality Assurance (NCQA) added three HEDIS measures, retired four measures, and made smaller changes across multiple measures. NCQA also continues the transition to Electronic Clinical Data Systems (ECDS) reporting. To see all the changes, click here.

Reimbursement Changes for Some Medical Injectable Drugs

Effective April 1, 2025, Highmark is changing the reimbursement rates for some Medical Injectable Drugs for all regions in Delaware, New York, Pennsylvania, and West Virginia. Reimbursement rates will increase or decrease to align with the average selling price (ASP); drugs lacking an ASP will use the average wholesale price (AWP).

For the full list of injectables, see the article in December *Provider News*.

Accessibility Expectations:
Changes for Professional Providers in All Regions

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

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

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HEART HEALTH MONTH:
Preventing Cardiovascular Complications for People with Diabetes

February is American Heart Health Month, and for your patients with diabetes, we know they are at a higher risk for heart failure, ischemic heart disease, peripheral artery disease, and stroke.

Patients with diabetes should be assessed for cardiovascular risk yearly, according to the American Diabetes Association.

One assessment tool that may be helpful to physicians is a risk calculator, which estimates the 10-year risk of a first atherosclerotic cardiovascular disease (ASCVD) event for people with diabetes. Developed by the American College of Cardiology and American Heart Association, the calculator provides risk assessments that can inform treatment decisions and guide therapy recommendations.

Diabetes Management Solution for Patients

Empowering patients to better manage their diabetes is also critical for avoiding cardiovascular complications, as well as other issues. Highmark's Diabetes Management Solution — a digital self-management program — helps patients stay on track with their health goals and medication adherence, leading to better health outcomes and lower emergency department (ED) utilization.

The solution provides access to certified diabetes care and education specialists (CDCES), health coaches, dietitians, and endocrinologists who provide education and support to your patients in between office visits.

Your patients will also have access to coaching and remote monitoring to help manage their diabetes. For patients with type 1, they can choose to use their own, compatible device and sync it to the corresponding Tidepool App for easier remote monitoring of their A1c.

Our Diabetes Management Solution is available for your Highmark fully insured commercial, Affordable Care Act (ACA), Administrative Services Only (opt-in), and Medicare Advantage patients with types 1 or 2 diabetes. Eligible patients can enroll through their Highmark member portal.

HEDIS® – Diabetes-Related Measures

From a Healthcare Effectiveness Data and Information Set (HEDIS) standpoint, there are four diabetes-related measures that are connected — directly or indirectly — to cardiovascular complications. Closing any gaps related to these measures helps your patients with diabetes reach better health outcomes:

- **Blood Pressure Control for Patients With Diabetes (BPD)** – Members 18-75 years of age with diabetes (types 1 and 2) whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.
- **Eye Exam for Patients With Diabetes (EED)** – Members 18-75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.
- **Hemoglobin A1c Control for Patients with Diabetes (HBD)** – Members 18-75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year:
  - HbA1c control (<8.0%) FEP-only scores <8.0%
  - HbA1c poor control (>9.0%)
- **Kidney Health Evaluation for Patients with Diabetes (KED)** – Members 18-85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ration (uACR), during the measurement year.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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Authorization Updates

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

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

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

JAN. 1 CHANGES

UPDATE: Two Additional eviCore-Managed Codes Moving to Highmark

On Oct. 22, 2024, Highmark announced in a Special Bulletin that more than 80 codes requiring prior authorization will move from eviCore to Highmark, effective Jan. 1, 2025. The two codes listed below were inadvertently omitted from the original list. They also moved from eviCore to Highmark, **effective Jan. 1, 2025**.

Procedure Code	Description
78803	Radiopharm Localization of Tumor Tomographic (SPECT)
78830	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, single area (e.g., head, neck, chest, pelvis), single-day imaging

No Need to Resubmit Authorization Requests

For authorization requests submitted to eviCore for these two codes on or after Jan. 1, 2025, these submissions are being captured and directed to Highmark for processing. There is **no need to resubmit authorization requests submitted on or after Jan. 1 to eviCore** for codes 78803 and 78830.

Submit Requests via the Availity Portal

Authorization requests for these codes, along with the other codes listed in the Oct. 22 Special Bulletin, must be submitted to Highmark via the Availity portal.

FEB. 22 CHANGES

Auth Enhancement: Specific Codes Required for Physical Medicine, Home Health, and Hospice Requests

Effective Feb. 22, 2025, providers will be able to enter **specific procedure codes** when requesting authorization for outpatient physical medicine, home health, and hospice services via the Predictal Auth Automation Hub within the Availity portal. This upgrade will streamline the authorization process and prevent unnecessary denials.

Click here to read the article in this month's *Provider News*.

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New and Updated Reimbursement Policies

Highmark regularly issues new or updated reimbursement policies. Keep an eye on this newsletter and the Provider Resource Center (PRC) for announcements regarding upcoming policy changes. As specific policy changes go into effect, the updated policies can be found on the Reimbursement Policies page of the PRC.

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

RECENTLY UPDATED

Jan. 1, 2025

RP-006 Multiple Endoscopy Procedures

Codes 53865, 0935T, 0941T, 0942T, and 0943T will be added to endo base procedure 52000 (Group 31: Cystourethroscopy).

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

Codes 76016-76019, 0944T, 0946T, 0947T, 0902T-0904T, 0926T, 0927T, 0938T, 0939T, and 92137 will be added to this policy. Codes 0398T and 93890 will be removed.

RP-011 Procedure Codes Not Applicable to Commercial Products

Codes G0532-G0536 were added to this policy. Codes G1012-G1024 and G2070-G2072 were removed.

RP-016 Physician Laboratory and Pathology Services

Codes 88388 and 86327 were removed from this policy.

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

This policy will be updated for Medicare Advantage markets in Delaware, Pennsylvania, and West Virginia to apply a reduction for multiple evaluation and management services done on the same day. When an Annual Wellness Visit (AWV) or Initial Preventive Physical Examination (IPPE) is performed on the same date of service as a routine physical exam by the same physician/provider or physician/provider group, the plan will reimburse the AWV or IPPE at 100% and the routine physical at 50% of the approved allowed amount. *(NOTE: This direction has been in place for Medicare Advantage markets in New York since January 2023.)*

RP-022 Repeat Surgical Procedures

Code 33471 was removed from this policy.

RP-041 Services Not Separately Reimbursed

Code 96041 was added to this policy.

RP-042 Global Surgery and Subsequent Services

Codes 0901T and 0908T-0910T will be added to the "Services Assigned CMS Global Days Indicator YYY" sections of this policy for Medicare Advantage and Commercial. Codes 0553T, 0567T, 0568T, and 0616T-0618T will be removed from this policy.

NEW: RP-078 Postoperative Sinus Debridement

This new policy – applicable to Commercial and Medicare Advantage markets – will address postoperative sinus debridement and service related to sinus surgery.

Jan. 20, 2025

RP-021 Annual Gynecological and Rectal Exams

Verbiage in the "Gynecological Examinations" section of this policy was updated. No changes in direction were made.

(Continued)

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RP-054 Ambulance Services

In the "Medicare Advantage Reimbursement Guidelines" section of this policy, a note about codes A0380 and A0390 was added under "Supplies and Miscellaneous Services" to indicate they will be rejected as non-billable to the member.

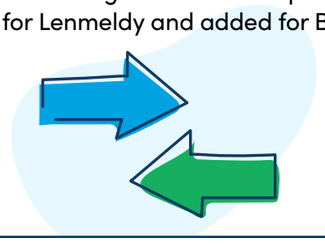
UPCOMING

Feb. 24, 2025

RP-053 Advanced Gene and Cellular Therapies

The following updates will be made to this policy:

- Cellular therapy Tecelra and gene therapy Beqvez will be added
- Not Otherwise Classified (NOC) will be replaced with Healthcare Common Procedure Coding System (HCPCS) code J3393 for Zynteglo and code J3394 for Lyfgenia
- References to related Highmark medical policies were updated for Lenmeldy and added for Beqvez



April 11, 2025

NEW: RP-076 Medical Nutrition Therapy

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

COMING SOON

Effective Date to Be Determined

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

This policy will be updated to apply a reduction to Office/Outpatient E/M codes appended with modifier 25 when reported in the same visit as a preventive medicine service. The preventive medicine service will continue to be fully reimbursed at 100% of the allowable contracted rate. The Office/Outpatient E/M component, when appropriately billed with modifier 25 to signify a separately identifiable service, will be subject to 50% of the allowable contracted rate.

NEW: RP-079 Multiple Ultrasounds

This new policy — applicable to Commercial and Medicare Advantage markets — will address circumstances surrounding the appropriate reporting of non-obstetrical and obstetrical transabdominal and transvaginal ultrasounds. Reimbursement for multiple procedure payment reductions may be applicable when multiple services are provided during a patient encounter by the same physician or same group physician/other health care professional. *(NOTE: This policy is not yet available on the PRC.)*

NEW: RP-081 Critical Care with Home Discharge

If a critical care service is submitted with revenue code 045X and a discharge status code of 01 (to home or self-care) on the same day, then the critical care services will not be reimbursable. The provider may appeal the denial by submitting clinical documentation supporting the level of care. *(NOTE: This policy is not yet available on the PRC.)*

NEW: RP-082 Lab Panel Testing

This new policy will provide the plan's direction for lab testing CPT codes 87661, 87491, and 87591. When more than one of these codes are billed, regardless of number of units, by the same provider on the same date of service, they will be reimbursed under the comprehensive panel code 87801. *(NOTE: This policy is not yet available on the PRC.)*

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Quarterly Formulary Updates

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

Pharmaceutical Management Procedures

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

This section includes information on:

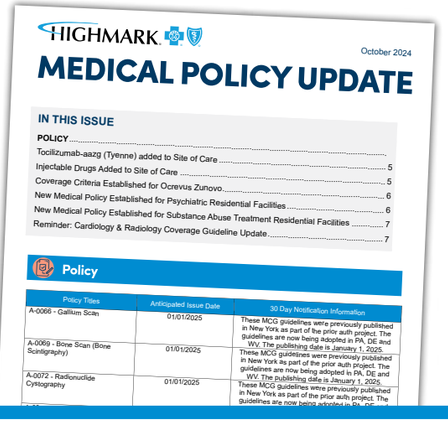
- Exception requests
- The process for generic substitutions
- Explanations of limits/quotas, therapeutic interchange, and step-therapy protocols.

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

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

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

Have You Seen This Month's **Medical Policy Update Newsletter?**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October 2024
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A-0066 - Gallium Scan | 01/01/2025 | These MCG guidelines were previously published in New York as part of the prior auth project. The guidelines are now being adopted in PA, DE and WV. The publishing date is January 1, 2025.
A-0069 - Bone Scan (Bone Scintigraphy) | 01/01/2025 | These MCG guidelines were previously published in New York as part of the prior auth project. The guidelines are now being adopted in PA, DE and WV. The publishing date is January 1, 2025.
A-0072 - Radionuclide Cystography | 01/01/2025 | These MCG guidelines were previously published in New York as part of the prior auth project. The guidelines are now being adopted in PA, DE

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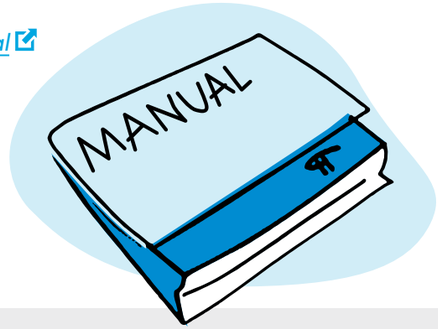
Staying Up to Date with the *Highmark Provider Manual*

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 1: **Network Participation Overview**
- Chapter 3, Unit 2: **Professional Provider Credentialing**
- Chapter 3, Unit 3: **Professional Provider Guidelines**
- Chapter 6, Unit 1: **General Claim Submission Guidelines**
- Chapter 6, Unit 2: **Electronic Claim Submission**
- Chapter 6, Unit 4: **Professional (1500/837P) Reporting Tips**
- Chapter 6, Unit 6: **Coordination of Benefits**
- Chapter 6, Unit 7: **Payment/EOBs/Remittances**

To see the full list of recent changes, visit the *What's New in the Highmark Provider Manual* page.

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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.

Directory Information—
Here's How to Attest

PROVIDER NEWS

A newsletter for the Highmark Blue Cross Blue Shield West Virginia providers

HIGHMARK

Issue 1, January 2025

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About This Newsletter

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

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

Regular topics include:

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

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

Another Valuable Resource

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

To subscribe to our newsletters, click Join Our Mailing List.

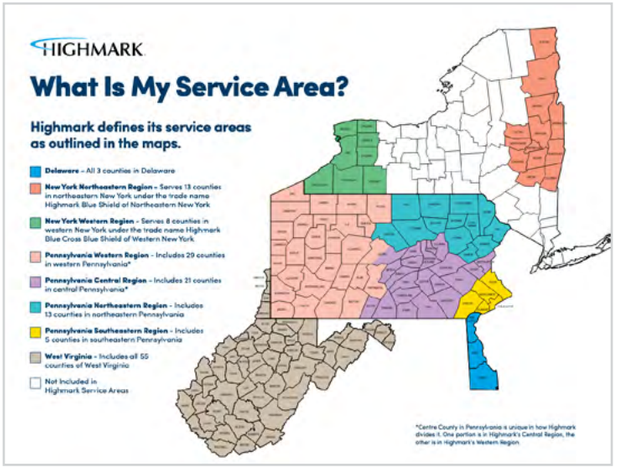
Comments/Suggestions Welcome

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

Highmark Quick Reference

To contact Highmark, click here.

Service Areas



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The Blue Cross Blue Shield Association is an association of independent, locally operated Blue Cross and Blue Shield companies.

Atlas Systems, Inc. is a separate and independent company that conducts physician outreach for Highmark.

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

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