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Stay informed and never miss out on what matters!



# ELECTRONIC CLAIMS UPDATE:

## Supporting Documents Can Be Attached When Submitting New Claims in Availity




The claim submission process in [Availity](#)®  is getting an update, **effective April 18, 2025**. When submitting a new claim via Availity, providers will be able to attach supporting documents – also called 275 transactions – saving practitioners time and effort, while accelerating the claim review and approval process for Highmark.

Currently, providers can only submit an initial claim in Availity **without** any attachments; supporting documents must be sent in a separate and later communication via **Message this Payer** in Availity or via other methods, such as fax or mail.

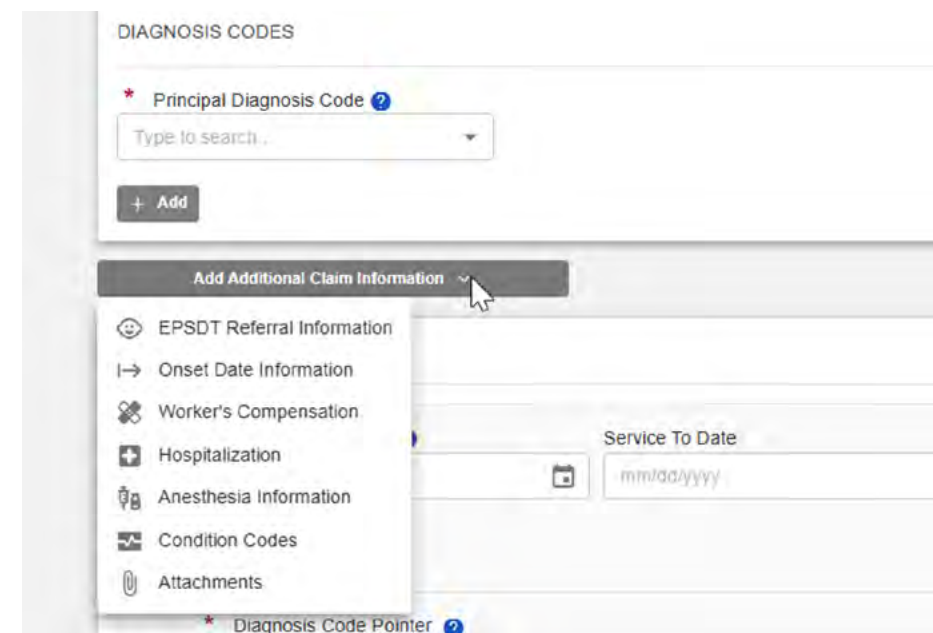
**NOTE:** This 275 enhancement does **not** apply to batch submissions or Quick Claims.

### How to Submit Attachments with Your **NEW** Claim

You will follow the same process you do now when submitting a claim via [Availity](#) . Under the **Diagnosis Codes** section, go to the **Add Additional Claim Information** dropdown. Click the arrow or caret and select **Attachments**.

Next, you will select the **Report Type Code** that identifies the information being shared. Click **Report Transmission Code of EL – Electronically Only**, and then select **Choose File**, attaching your files from your desktop.

Once you have attached your documents, you will continue through the claim submission process until you click **Submit**. You will receive confirmation of a successful claim submission.



## Attachments can also be Added for Pended Claims via Claim Status Inquiry


The **Claim Status Inquiry** function in Availity enables you to add attachments for pended claims. Click the **Add Attachments** button, choose the appropriate record types, and then add your attachments.

The **Attachments Dashboard** is accessible under **Claims & Payments** and provides details on all attachments by your organization.

## Multiple Documents, Multiple Formats – Applicable to Both Workflows

Using the new feature, providers can attach up to 10 electronic documents per new or pended claim, in a variety of formats, including Word, Excel, PDF, JPG, PNG, GIF, and TIFF. This functionality enables providers to easily send their supporting documents via the Availity portal.

## Additional Resources

For more information on electronic claims, visit [this page](#)  on the Provider Resource Center, where you will find information on the following claims processes:

- [Submit a Claim](#) 
- [Check Claim Status](#) 
- [Claim Inquiry](#) 

...providers will be able to attach supporting documents – also called 275 transactions – saving practitioners time and effort, while accelerating the claim review and approval process for Highmark



# Annual HEDIS® Medical Record Reviews to Begin in February 2025

Clinical staff from Highmark Blue Shield will conduct the annual Healthcare Effectiveness Data and Information Set (HEDIS) medical record reviews – based on measurement year 2024 data – from February through mid-May 2025.

The HEDIS report includes the medical record review to assess compliance with a set of standardized performance measurements that health plans report to the National Committee for Quality Assurance (NCQA). HEDIS data is collected and reported annually as part of Highmark’s accrediting and governmental requirements. The measurements being collected are:

- Controlling High Blood Pressure
- Glycemic Status Assessment for Patients with Diabetes
- Blood Pressure Control for Patients with Diabetes
- Eye Exam for Patients with Diabetes
- Transitions of Care
- Cervical Cancer Screening
- Childhood Immunization Status
- Immunizations for Adolescents
- Lead Screening in Children
- Prenatal and Postpartum Care
- Weight Assessment and Counseling for Nutrition and Counseling for Physical Activity for Children and Adolescents

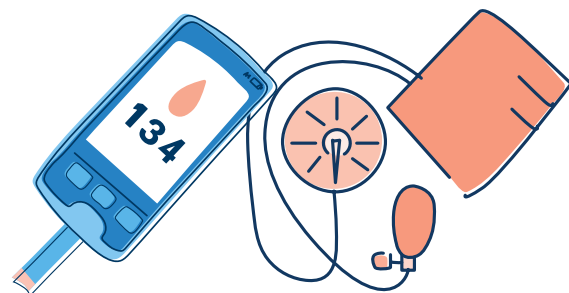
A random sample of members will be identified, and a representative from Blue Shield will notify you either by telephone or fax to discuss the process to submit specific elements of the members’ medical records via fax or mail for review.

**CHART RETRIEVAL PROCESS:** We are encouraging all providers to submit requested HEDIS medical records to Highmark via secure electronic delivery or fax to the designated return fax number identified on the original chart request.

If you have any questions regarding the HEDIS project, please contact the following representative from Highmark’s Clinical Service area: Michael Clark-Polner at 412-544-7438.

***\*Please Note: Continuity of Care (CCD) documents are not an acceptable form of medical record documentation.***

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



**POSTPONED**

# Authorization Enhancement for Physical Medicine, Home Health, and Hospice Requests

The recently announced authorization enhancement for outpatient physical medicine, home health, and hospice services has been postponed to allow for additional testing.

Originally scheduled to go live on Feb. 22, 2025, the enhancement will be implemented at a later date. Providers should continue to follow the current process for requesting authorization for the following services:

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

When submitting an authorization request for these services, continue to select the correct **Sub-service Type**. For more information on submitting authorization requests, including videos and guides, visit the [Authorization Training & Resources page](#) on the Provider Resource Center.

To stay informed of upcoming changes, sign up for our mailing list by clicking [here](#).



# Collaborating to Improve Your Patients' Health and Experience

The 2025 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey period is coming soon. Highmark Medicare Advantage members who are selected for the survey will receive it in March.

The survey asks members about their experiences with their health plan and providers as well as their perception of the care they receive from you within the past six months. Any patient interaction can impact CAHPS scores.

The CAHPS survey presents a critical opportunity for Highmark and providers to collaborate to achieve an optimal patient experience. Members are asked several questions about the following topics that relate to their experience with their overall health care and/or their health care providers:

- **How quickly** they are able to get appointments and care – for both urgent and routine care.
- **How easy** it is for them to get the care they need from their primary provider and/or specialists.
- **How well** their care is coordinated between different providers and services.
- **The overall quality** of the health care they receive.



## Collaboration Is Key

Collaboration between health plans and providers is key to ensuring that members/patients have positive health care experiences.

### Here's how to improve your CAHPS results

#### FOCUS AREAS

These are key areas where even small improvements make a big difference!

- **Access to Care (Improve Timeliness)** – Patients value quick appointments and easy specialist referrals. Faster access leads to better health outcomes and increased patient satisfaction.
- **Empathetic Communication (Enhance Patient Experience)** – Active listening, clear explanations, and respect build trust. Positive interactions improve patient adherence to treatment plans and overall well-being. This is crucial for Medicare members who may require additional patience and personalized communication.
- **Proactive Health (Promote Wellness)** – Encourage preventive care, screenings, and address tobacco use. Preventive care reduces long-term health issues, improving patient health and lowering healthcare costs.

#### ACTIONABLE TIPS

- **Schedule Smart** – Proactive appointment reminders and streamlined scheduling improve timeliness.
- **Clear Communication** – Running late can sometimes be unavoidable in a busy office; when it happens, provide a brief explanation for the delay.
- **Care Coordination** – Before the visit begins, review your patient's medical history, prescriptions, and any other providers or specialists they've seen recently.
- **Referral Efficiency** – Implement a system for quick and efficient referrals to specialist and follow up with members about their specialist visit.
- **Technology Use** – Leverage telehealth and virtual visits for convenient follow-ups and instruct your team on how to provide support to patients when accessing virtual care.

Thank you for your partnership and your commitment to your patients and their health. For more information about Medicare Advantage Stars and the importance of high-quality performance, [click here](#). For additional tips on how you can approve patient experience in your office, review [our provider CAHPS flyer](#).

# COLORECTAL CANCER AWARENESS MONTH

Enhance  
Patient Care  
and Close  
HEDIS Gaps



Colorectal Cancer Awareness Month, which occurs in March, is an excellent time for reiterating the importance of colorectal cancer screening. By highlighting the resources available, you and your team can improve patient outcomes, while also meeting the Healthcare Effectiveness Data and Information Set (HEDIS®) Colorectal Cancer Screening (COL) measure. Colorectal cancer is the leading cancer diagnosed in both men and women in the United States, resulting in a significant number of preventable deaths each year.

### Screening Recommendations and HEDIS Compliance

The United States Preventive Services Task Force (USPSTF) recommends screening for all adults starting at age 45. Individuals with family history or other risk factors may need earlier or more frequent screening. Meeting the HEDIS COL measure is crucial for demonstrating high-quality patient care and aligns with Highmark’s True Performance Program (TPP). In addition, colorectal cancer screening is now an Electronic Clinical Data Services (ECDS) measure.

Accurate coding leads to greater gap closure.

### Screening Methods and CPT Codes

Screening Method	Timing	CPT Codes	Notes
<b>Colonoscopy</b>	Measurement year or within preceding 9 years	44388-44392, 44394, 44401-44408, 45378-45382, 45384-45386, 45388-45393, 45398	Clear documentation required showing scope reached the cecum.
<b>Fecal Occult Blood Test (FOBT)</b>	Annually during measurement year	82270, 82274	Includes Guaiac (gFOBT) and Immunochemical (FIT). FIT-DNA is separate.
<b>Stool DNA Test (sDNA FIT)</b>	Measurement year or within preceding 2 years	81528	e.g., Cologuard
<b>CT Colonography</b>	Measurement year or within preceding 4 years	74261-74263	
<b>Flexible Sigmoidoscopy</b>	Measurement year or within preceding 4 years	45330-45335, 45337, 45338, 45340-45342, 45346, 45347, 45349, 45350	

**NOTE:** Samples collected via digital rectal exam (DRE) or FOBT tests performed in an office setting do not count toward compliance.







## HEDIS Exclusions

Exclusion Reason	CPT Codes	ICD-10 Codes
<b>Total Colectomy</b>	44150-44153, 44155-44158, 44210-44212	
<b>Colorectal Cancer Diagnosis</b>		C18.0-C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048

Patient refusal is not an exclusion. Accurate documentation of screening dates, results, and exclusion reasons is essential.

## Patient Education and Resources

Highmark has a variety of free resources on the Provider Resource Center that can help educate patients on the importance of colorectal cancer screening, including:

- [Colorectal Cancer Screening Brochure](#) 
- [Colorectal Cancer Screening Flyer](#)  (Spanish version available)
- [Colorectal Cancer Screening Reminder Card](#) 
- [Health Screening and Vaccination Tracker](#)  (Spanish version available)

To order for your office, go to **Provider Resource Center (PRC) > Resources & Education > Educational Resources – Member & Provider > Inventory Request Form**. Select your region then the item and quantity you wish to order. Click **ADD TO CART** and fill in the shipping details.

Proactive patient education is key to increasing screening rates. By implementing these strategies, you can improve patient outcomes, meet HEDIS goals, and contribute to reducing the colorectal cancer burden.

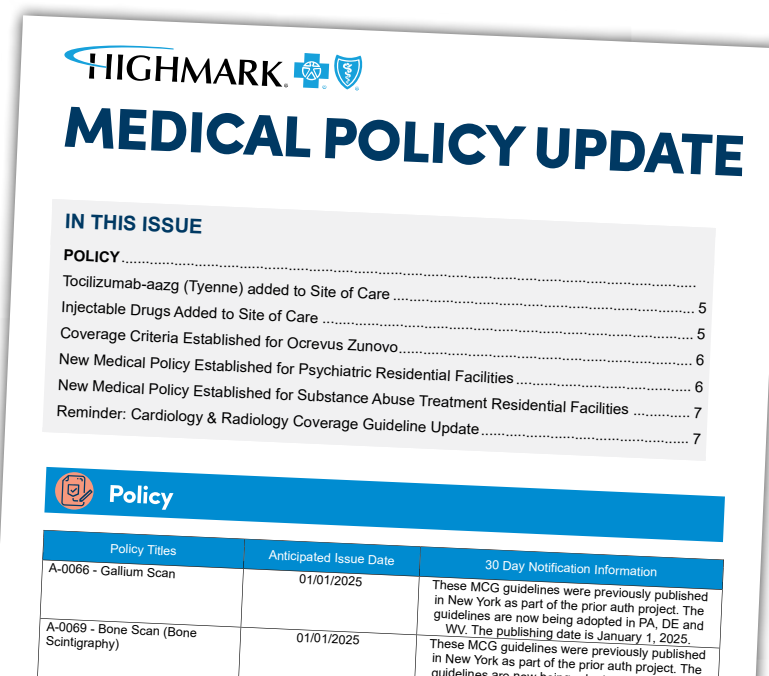
## References

Information taken from HEDIS MY 2025 Volume 2: Technical Specifications

*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.*

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

# Have You Seen This Month's Medical Policy Update Newsletter?



# SHORT TAKES:

## Fee Schedules, Psychologist Credentialing, and More



### Quarterly Fee Schedules

The standard professional quarterly fee schedules were published the week of Feb. 16.

To view the fee schedules on the Provider Resource Center (PRC), log into [Availity](#)<sup>®</sup>. Click **Payer Spaces > Your Highmark Plan > Provider Resource Center**.

Once you arrive at the PRC, choose **Claims & Authorization > Reimbursement Programs > Fee Schedule Information**.

### Credentialing Update: Psychologists and BH Organizational Providers

Effective **May 19, 2025**, Highmark is updating and clarifying the credentialing for the following types of practitioners:

- Licensed Psychologists
- Behavioral Health (BH) Organizational Providers

To learn more, click [here](#).

### CVS Health to Join Hemophilia and Bleeding Disorder Drug Program

Effective **March 1, 2025**, CVS Health will be joining the Hemophilia and Bleeding Disorder Drug Program as an exclusive specialty provider, while Soleo Health will no longer be participating in the program.

For more information, go [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).

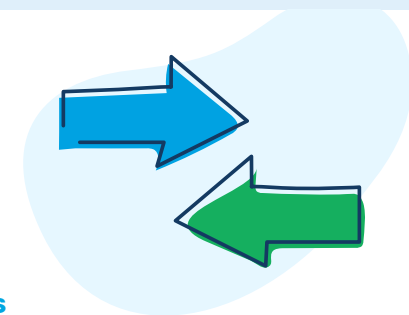
For the full list of injectables, see the article in December [Provider News](#).

### Accessibility Expectations – Updated for Professional Providers

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

# 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

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

## UPCOMING

April 14, 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.)*

# 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.

- **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.

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.**

## 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](https://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](mailto:resourcecenter@highmark.com), to your address book.

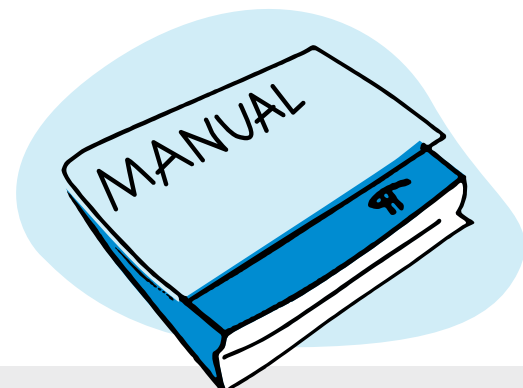
During the attestation process, always double-check your current email address(es) to ensure that you can receive electronic communications from Highmark without delay.

If you need additional information regarding the attestation process, [Atlas’ step-by-step guide](#) is available on the Provider Resource Center.

## 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 1, Unit 4: Highmark Member Information**
- **Chapter 2, Unit 2: Medicare Advantage Products & Programs**
- **Chapter 3, Unit 3: Professional Provider Guidelines**
- **Chapter 4, Unit 3: Facility-Specific Guidelines**
- **Chapter 5, Unit 1: Care Management Overview**
- **Chapter 5, Unit 2: Authorizations**
- **Chapter 6, Unit 7: Payment/EOBs/Remittances**
- **Chapter 7, Unit 5: Third Party Code of Conduct**

To see the full list of recent changes, visit the [What's New in the Highmark Provider Manual](#) page.



### Are You Using [Availity](#) for Your Highmark Transactions?

**LEGACY PORTALS NOW  
DEACTIVATED**

## 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](#).

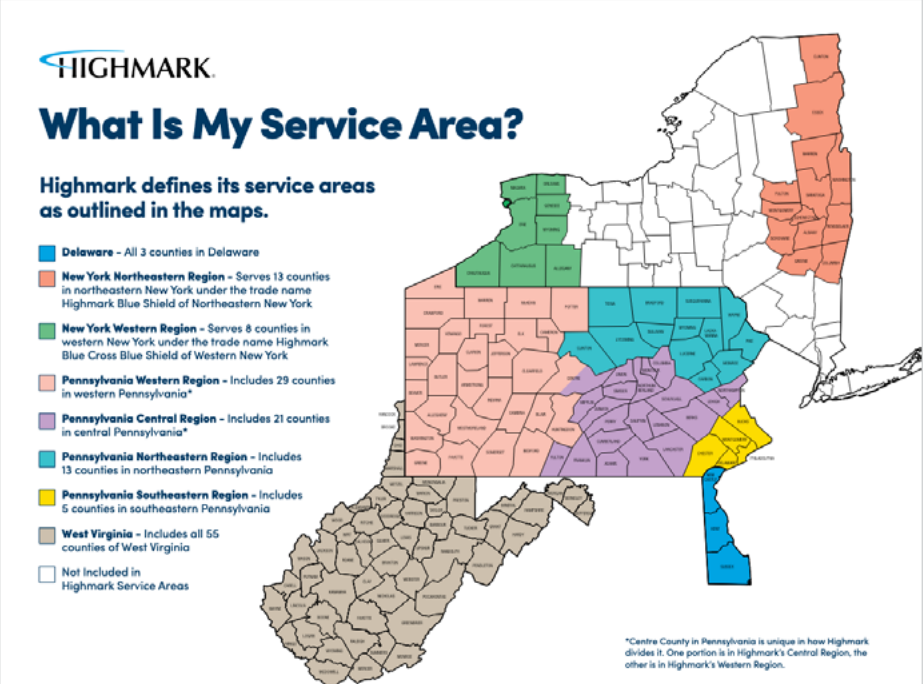
### Comments/Suggestions Welcome

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](mailto:ResourceCenter@Highmark.com).

### Highmark Quick Reference

To contact Highmark, click [here](#).

### Service Areas [↗](#)



**HIGHMARK.**

## What Is My Service Area?

Highmark defines its service areas as outlined in the maps.

- Delaware** - All 3 counties in Delaware
- New York Northeastern Region** - Serves 13 counties in northeastern New York under the trade name Highmark Blue Shield of Northeastern New York
- New York Western Region** - Serves 8 counties in western New York under the trade name Highmark Blue Cross Blue Shield of Western New York
- Pennsylvania Western Region** - Includes 29 counties in western Pennsylvania\*
- Pennsylvania Central Region** - Includes 21 counties in central Pennsylvania\*
- Pennsylvania Northeastern Region** - Includes 13 counties in northeastern Pennsylvania
- Pennsylvania Southeastern Region** - Includes 5 counties in southeastern Pennsylvania
- West Virginia** - Includes all 55 counties of West Virginia
- Not Included** in Highmark Service Areas

\*Centre County in Pennsylvania is unique in how Highmark divides it. One portion is in Highmark's Central Region, the other is in Highmark's Western Region.

## Legal Information

Highmark Blue Cross Blue Shield Delaware is an independent licensee of the Blue Cross and Blue Shield Association. BlueCard is a registered trademark of the Blue Cross and Blue Shield Association.

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

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.

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All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.