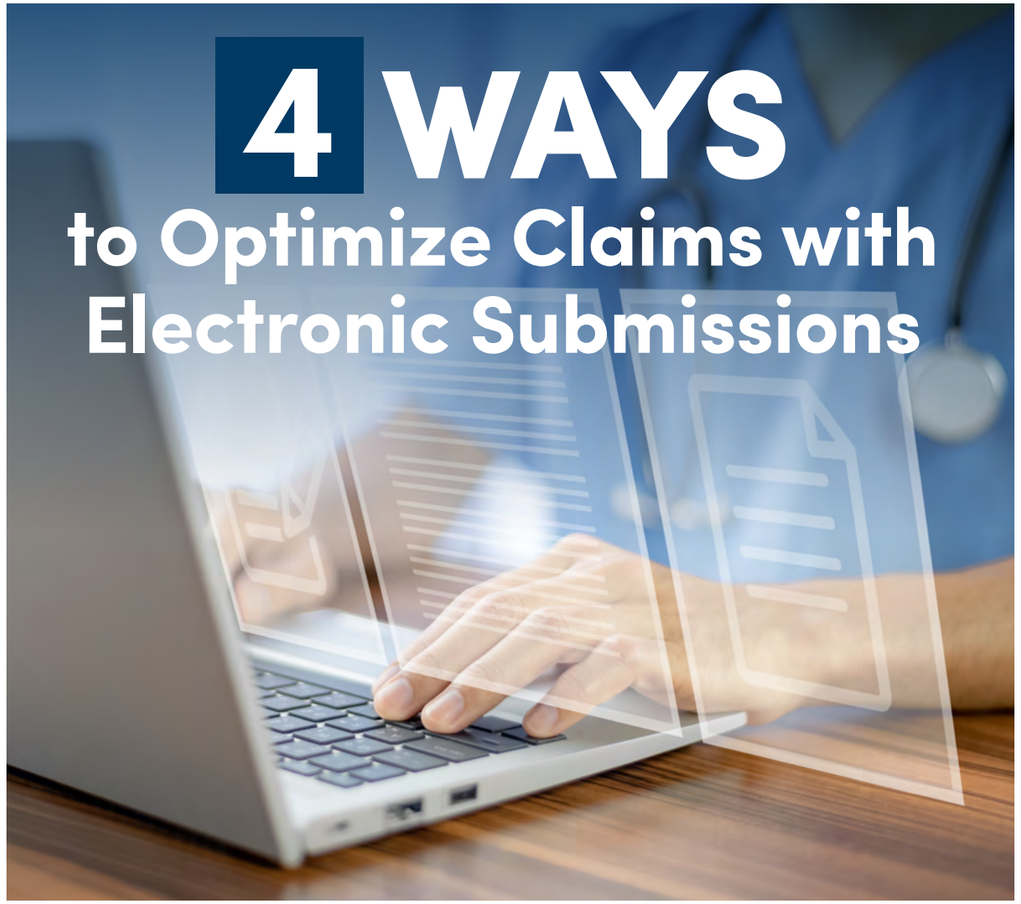
PROVIDER NEWS

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

HIGHMARK

Issue 5, May 2025

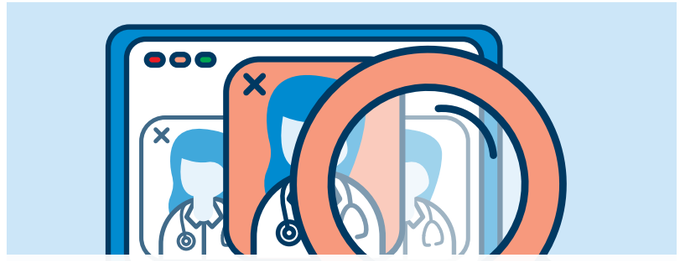
IN THIS ISSUE



FEATURE ARTICLES

Coding Laboratory Claims: Preventive vs. Diagnostic

Short Takes: Initial Medical Auth Requests, Fee Schedules, and More



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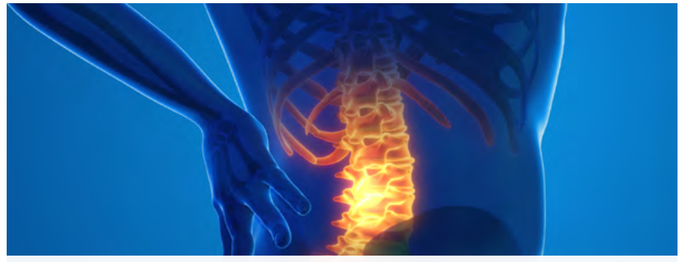
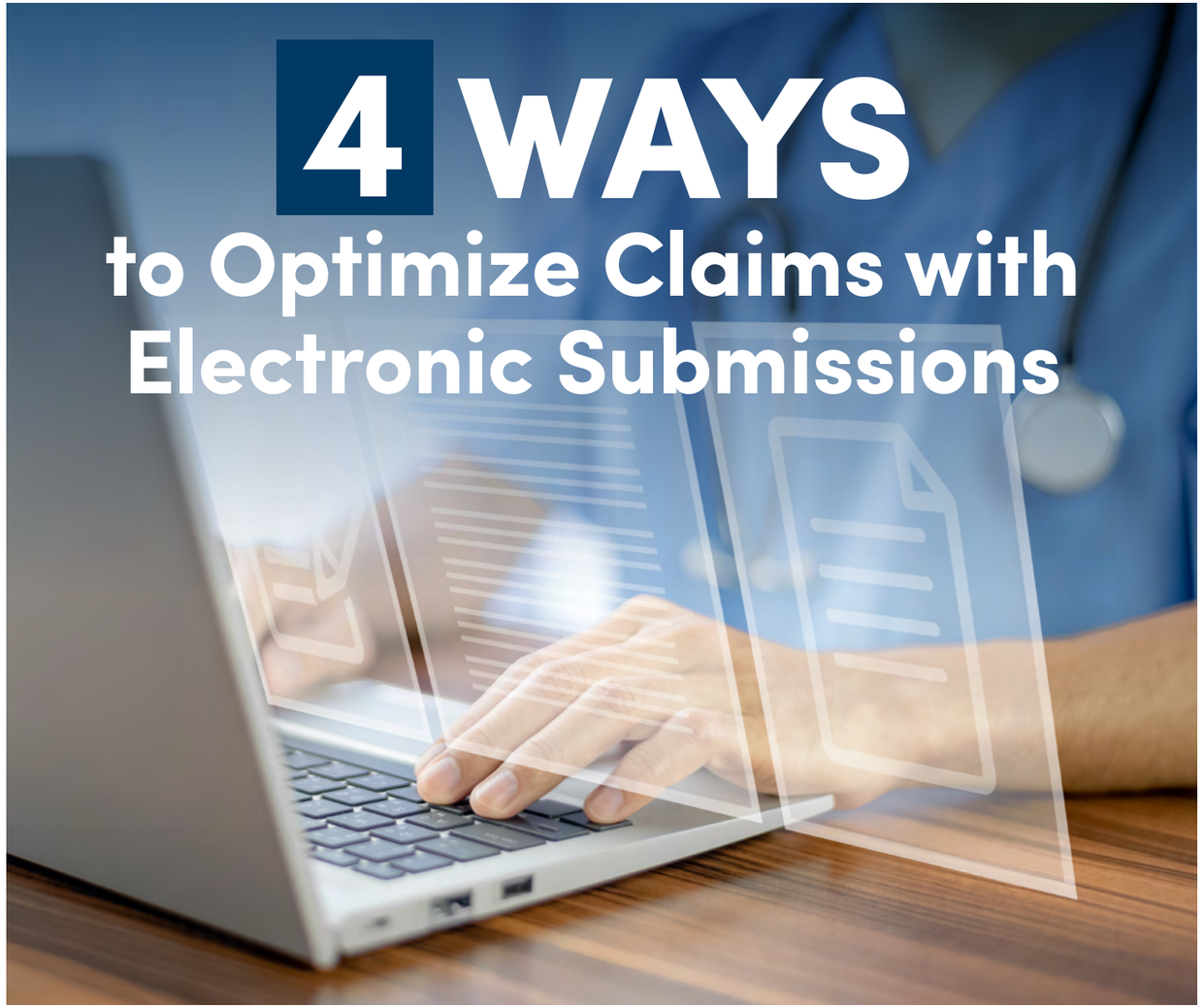


Low Back Pain: Reducing Unnecessary Imaging

e-SUBSCRIBE Today! Don't miss the latest updates!

IN THIS ISSUE



Paper claims are slow, costly, and labor-intensive. Learn how electronic claim and attachment submissions can streamline your processes and accelerate payments.

Here are four ways to boost electronic claim submissions in your office:

1 **Submit Bulk Claims via EDI** – Use EDI (Electronic Data Interchange) to submit bulk claims through a clearinghouse or directly from your practice management software.

For more information on EDI, choose the applicable link below:

- Delaware: edi.highmark.com/edi-bcbsde/index.shtml
- New York: edi.highmark.com/edi-ny/home*
- Pennsylvania: edi.highmark.com/edi/index.shtml
- West Virginia: edi.highmark.com/edi-wv/index.shtml

Sending attachments (275 transactions) via EDI is not currently available.

***Note:** The New York regions are currently transitioning from Administrative Services of Kansas (ASK) to Highmark's EDI**. Effective Jan. 1, 2026**, all New York providers should be using Highmark's EDI.

(Continued)

2 **Submission via Availity Essentials®** – Submit primary, secondary, and tertiary claims electronically and at no cost with Availity. Check out the Submitting Claims in Availity guide on the Provider Resource Center.

To learn more about submitting secondary and tertiary claims, log into Availity and then go **here**.

3 **Attach Supporting Documents in Availity** – You can now include attachments (275 transactions) when submitting **new claims**, thanks to a recent enhancement in Availity.

For pended and submitted claims, you also have options for sending attachments:

- **Pended Claims** – Attachments can be added for pended claims via **Claim Status Inquiry**. Click the **Add Attachments** button, choose the appropriate record types, and then add your attachments.
- **Submitted Claims** – Attachments can be sent via **Message this Payer** in Availity.

4 **For Supplemental Document Requests, Availity is Preferred** – Instead of faxing or mailing, you can now use Availity to send in requested documentation. If Availity isn't an option, follow the PWK (paperwork) procedures for faxing, as detailed in the *Provider Manual* 6.2, and be sure to include the applicable PWK cover sheet. You can find the cover sheets for each region on the PRC on the **Miscellaneous Forms page**.

a. **EDI** – If you currently work with a trading partner (software vendor and/or clearinghouse), or have an information technology department within your facility, they will be able to assist you with the technical aspects of the specifications for implementing the PWK.

Additional Resources

- **Provider Resource Center** – Visit the Electronic Claims Submission page, which has helpful guides and links on submitting claims electronically, including:
  - How to Submit a Claim Inquiry in Availity
  - Checking Claim Status
- **Availity Essentials –** From the home page, select **Help & Training** > **Get Trained**. Use the search tool in the upper right and type in "Claim Submission for Highmark Providers."

Coding Laboratory Claims: Preventive vs. Diagnostic

Highmark has been experiencing an uptick in improperly coded claims for laboratory services, which leads to delays in processing and payment for providers. Also, incorrect claims can shift additional costs to members.

Understanding which labs are on the Standard Preventive Schedule *and when they qualify as preventive or diagnostic* are key to successful claim submission and acceptance:

- **Preventive** – As part of the member's Annual Preventive Office Visit, screening tests on the Preventive Schedule are covered.
- **Diagnostic** – For members with chronic disease or symptoms, claims will have a medical diagnosis and apply cost share.

Additional Resources

- Preventive Health Guidelines
- Electronic Claims Submission

Screening Tests on the Preventive Schedule

The following annual screening tests are covered for members as part of their Annual Preventive Office Visit:

- **Cholesterol Screening/ Lipid Panel** – 80061 (Lipid Panel)
  - Components:
    - Total Cholesterol – 82465
    - HDL – 83718
    - Triglycerides – 84478
    - LDL – 83721
- Diabetes Screening with Glucose lab – 82947, 82948
- Hepatitis B Screening – 86704, 86705, 86706, 87340, 87341
- Hepatitis C Screening – 86803, 86804, 87520, 87521, 87522, G0472
- Latent Tuberculosis Screening – 86480, 86481, 86580

Screening Tests NOT on the Preventive Schedule

Below are examples of **non-covered labs when billed as preventive**. With a symptom or diagnosis of disease, these labs are covered under medical insurance with cost share application.

- General Health Panel – 80050
- Comprehensive Metabolic Panel – 80053
- Complete Blood Count with Auto Differential White Blood Cell Count (CBC W/Auto Diff WBC) – 85025
- Vitamin D 25 Hydroxy – 82306
- Assay Thyroid Stim Hormone – 84443
- Urinalysis Auto without Scope – 81003
- Urinalysis Auto with Scope – 81001
- Urinalysis Nonauto without Scope – 81002
- Complete Blood Count Automated – 85027
- Assays of Free Thyroxine – 84439
- Vitamin B-12 – 82607
- Metabolic Panel Total CA (Calcium) – 80048
- Assay of Prostate-Specific Antigen (PSA) Total – 84153*

**Mandated by Delaware and New York state law and covered as preventive for those two states.*

PROVIDER NEWS

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CLAIMS TIPS: Secondary Breast Screenings, Colonoscopies, and Members with Dual Enrollments

Incorrect claims result in increased administrative work and payment delays for providers. In addition, members may end up billed for treatment that otherwise would be fully or partially covered under their benefit plan.

The following correct coding tips will help accelerate the processing of your claim and payment while avoiding additional costs for your patients:

1 Secondary Screening – Breast MRIs and Ultrasound Post-Screening Mammogram

Some members require a secondary screening for breast cancer for a variety of reasons, including dense breasts, inconclusive mammogram, and family history of breast cancer.

Use code Z12.39 for **other breast cancer screening** when billing the MRI and ultrasound with medical reason as a secondary diagnosis.

This code Z12.39 attaches a **no cost share application** to the claim. Otherwise, patients will be liable for a deductible, coinsurance, or copayment when the claim processes.

Just as providers bill the screening mammogram for breast cancer Z12.31, they need to bill similarly for follow-up screening MRI and ultrasound with Z12.39.

2 Screening Colonoscopies and Colonoscopies Performed Post Positive Other Screening Test

Use diagnosis code Z12.11 for colon cancer screening for all claims related to the colonoscopy including:

- Facility and professional claims for the colonoscopy procedure, anesthesia services, and pathology services.
- Use **date of service of the colonoscopy**, not the date when the pathology test is done.
- **NOTE:** The colonoscopy claim for the procedure must be in the system **first** to match the related services for no cost share application. **IMPORTANT:** If a related service is billed first, cost share will apply as there is no way to match it to a preventive service.

3 Members with Dual Enrollments

The most common scenario is when a member is a subscriber on a spouse's account (divorce settlement), while also having his/her own account.

To avoid payment delays, always double-check that the enrollment record on the claim — the record must match the one chosen during Availity Essentials portal submission.

Also Applies to Authorizations

When submitting an authorization request on the portal, always validate the enrollment record chosen to ensure that the correct one is selected.

Additional Resources

- Provider Resource Center – Electronic Claims Submission
- *Highmark Provider Manual* – Chapter 6: Billing and Payment

Expanded Use of Clinical Editing Tool to Include Inpatient Claims

To align with our outpatient claim review process, Highmark will start using a clinical editing tool to analyze inpatient claims on a prepay claim basis in the Highmark regions of Delaware, Pennsylvania, and West Virginia, effective **July 28, 2025**.

Clinical editing is an effective and efficient method for quickly reviewing and approving correct claims, while also identifying errors on incorrectly coded claims during the prepayment process.

Since 2016, Highmark has been using a clinical editing tool on a prepayment basis for outpatient facility and professional claims. Effective July 28, 2025, we will expand the prepayment use of the clinical editing tool to the inpatient facility claims, including Diagnosis-Related Group (DRG) claims.

Benefits of Prepayment Review

Historically, we've processed and paid claims and, at times, found discrepancies later post-payment. By using the clinical editing tool on a prepayment basis, we can avoid unnecessary claims adjustments as well as providers needing to refund monies to Highmark.

Beginning July 28, 2025, the clinical editing tool will quickly analyze inpatient claims on a prepayment basis. By completing these quality checks at the outset — when we initially receive your claims — you'll experience the following benefits:

- You'll be alerted of coding inaccuracies in claims ***before*** they are even processed, thus avoiding delays.
- The chances of claims adjustments and refunds will be reduced.
- You'll potentially save staff time previously spent researching and adjusting claims that have already been processed and paid.
- You'll experience greater uniformity in claims payment policies across the industry, as Highmark's processes fall in line with those of other insurers who have already implemented similar enhancements.

Claims Appeals

We recognize that there may be times when the services for which you bill may differ from our medical and claims payment policies. If you disagree with the payment decision, you have the right to appeal the determination.

For more information on the claim appeal process, please refer to Chapter 5, Unit 5 of the ***Highmark Provider Manual***.

REMINDER: When Correcting a Claim, Changes Go Directly on the Replacement Claim

Providers should make corrections directly on the Replacement Claim, rather than the Adjustment Claim, when submitting a Frequency Type 7 claim or Type of Bill that ends in 7. This change — which was originally slated for **Aug. 23, 2024** — only applies to the following lines of business: Commercial, Medicare Advantage, and Federal Employee Program (FEP).

NOTE: *This change does not apply to Medicaid products, including Highmark Wholecare, Highmark Health Options Delaware, or Highmark Health Options West Virginia.*

In Health Insurance Portability and Accountability Act (HIPAA) 837I and 837P claim transactions, the Frequency Type 7 claim is reported in the 2300 Loop, CLM05-3 element. The original claim number is reported in Loop 2300, as "Orig Clm No."

For transactions via Availity Essentials, corrected claims can be submitted within the **claim entry screen** by selecting Frequency Type 7 and providing the original claim number.

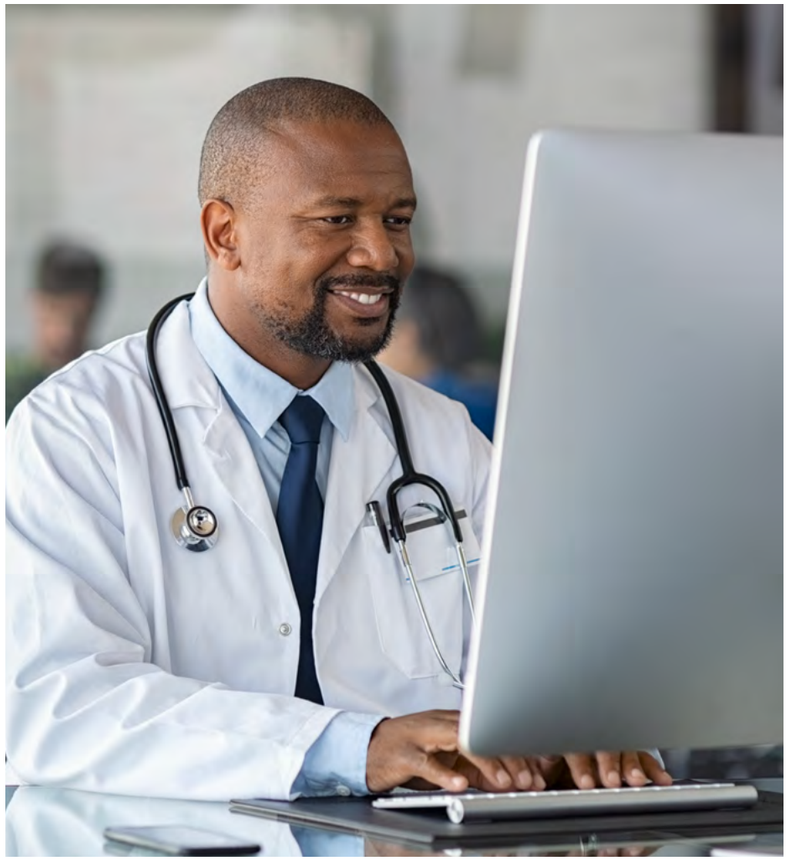
Previous Process

Here's how the previous correction or adjustment claims process worked:

1. Provider submits a claim for services.
2. Identifies an error on the original claim.
3. Provider then submits a Frequency Type 7 claim or Type of Bill that ends in 7 (Replacement Claim) to correct the original claim.
4. The Adjustment Claim appears in the reference field of the Replacement Claim.
5. The Claims Processing System makes the changes on the original claim.

What Has Changed

The Replacement Claim now processes as the new claim and any future reference to the changes would be made on the Replacement Claim. The Adjustment Claim serves as a notification to providers that a correction has been made; the Replacement Claim documents the actual correction(s).



SHORT TAKES:

Initial Medical Auth Requests, Fee Schedules, and More

Streamlining Initial Medical Authorization Requests

Starting in August, providers will submit requests for all initial **medical** authorizations via the **Authorizations & Referrals** workflow in Availity Essentials®. This transition is the first stage in a multi-phased plan to streamline the authorization process, making it easier, faster, and more intuitive for Highmark providers and their teams.

Currently, most medical authorization requests are submitted via the Predictal tile in Highmark's Payer Spaces. We are moving to the **Authorizations & Referrals** workflow in Availity to align with the submission process many providers are already utilizing with other payers or for out-of-area authorization requests.

Through the new authorization workflow, providers can:

- Submit initial authorization requests for inpatient and outpatient services
- Initiate retrospective pre-claim reviews and retrospective claim reviews
- Electronically attach supporting medical documentation
- Create and save multiple auth templates, increasing office efficiency and reducing administrative burden

The new process will also enable practitioners to access Availity's **Authorization Dashboard**, which provides a centralized platform for viewing authorization status information from multiple payers.

For more information, see the lead article in April *Provider News*.

Updated Quarterly Fee Schedules Including MID Reimbursement Changes

The standard professional quarterly fee schedules*, including new reimbursement rates for select Medical Injectable Drugs (MIDs), were published on May 5, 2025.

MID Update

Originally, the new MID rates were scheduled to be published on April 1 but were moved back based on Highmark receiving updated information from the Centers for Medicare and Medicaid Services (CMS). As a result, Highmark implemented the new rates retroactively on April 8 with an April 1 effective date.

For more information, read the **Special Bulletin**.

**Any changes to the commercial standard professional fee schedule and pricing methodology will comply with 18 Del. Code §§ 3342B and 3556A.*

(Continued)

Four Reimbursement Policies to be Updated on May 30, 2025

To better manage health care costs for our members, Highmark is making updates to the following reimbursement policies effective May 30:

- RP-019A: Drugs and Biologicals (formerly RP-019N)
- RP-040: Facility Routine Supplies and Services
- RP-061: Implants and Implant Components
- **NEW:** RP-080 Integral or Necessary Services

For more information, go **here**.

Latest Edition of MCG Care Guidelines

The 29th edition of MCG's Care Guidelines will be available on **June 30, 2025**.

After that date, you will be able to submit authorization requests using the 29th edition for any new requests. Any authorization requests with a start of care date **prior** to June 30, 2025, will be reviewed using the 28th edition.

To access the current guidelines, visit the **MCG Clinical Criteria Page**.

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

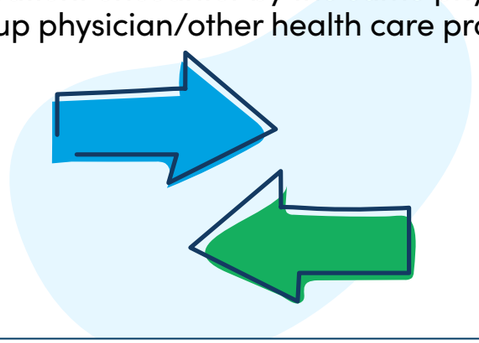
May 1, 2025

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

This policy was 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. Details pertaining to what is included in the various types of visits were also added.

NEW: RP-079 Transabdominal and Transvaginal Ultrasounds

This new policy – applicable to Commercial and Medicare Advantage markets – 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.



May 5, 2025

NEW: RP-076 Medical Nutrition Therapy

This new policy directs 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.

May 16, 2025

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.

(Continued)

May 19, 2025

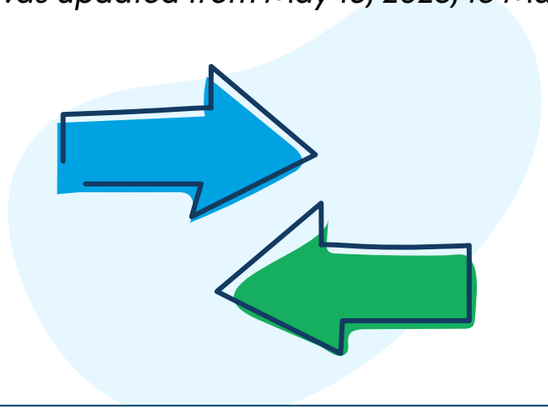
RP-017 Evocative or Suppression Testing Panels

Effective **May 19, 2025**, this policy is no longer in use and was archived.

RP-041 Services Not Separately Reimbursed
Code 96041 was removed.

NEW: RP-082 Lab Panel Testing

This new policy provides 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: Since the April issue of Provider News, the effective date for this policy was updated from May 16, 2025, to May 19, 2025.)*



UPCOMING

May 30, 2025

For more information about the policy updates (RP-019N, RP-040, and RP-061) and policy addition (RP-080) listed below, CLICK HERE.

RP-019N Drugs and Biologicals
(*policy number will change to **RP-019A***)

To align with Highmark's reimbursement methodology for outpatient medications, RP-019N (*soon to be **RP-019A***) will include inpatient drugs and biologicals; pricing will be adjusted to the Average Selling Price (ASP) +10% (Commercial) or ASP +6% (Medicare Advantage) and in the absence of ASP, Average Wholesale Price (AWP) will be utilized.

To view this reimbursement policy, access the PRC via the provider portal (Availity Essentials®). Once redirected to the PRC from the provider portal, hover over **Claims & Authorization** in the main menu, then click **Reimbursement Polices** under **Reimbursement Programs**.

RP-040 Facility Routine Supplies and Services

The list of routine supplies, services, and items that are not separately reimbursable will be updated.

RP-061 Implants and Implant Components

Following industry best practices, Highmark will apply the invoice cost for implants as the covered charge(s) for that implant. Highmark will determine invoice pricing on each claim based on the national invoice average as codified in RP-061.

NEW: RP-080 Integral or Necessary Services

The intent of this policy is not to develop new guidance, but rather to provide standalone policy language clarifying Highmark's definition of "integral":

- "Integral" refers to services that are needed or required during the provision of patient care which are inclusive of another service or component parts of a more comprehensive service.
- "Integral" refers to supplies, equipment, and certain services that are inherent, needed, or required for the provision of patient care and are considered by Highmark as part of another service.

(*NOTE: This policy is not yet available on the PRC.*)

(Continued)

June 2, 2025

RP-024 Eye Procedures Done in Stages or Sessions

This policy was reviewed as part of our standard review process. No changes in direction will be made.

RP-025 Implantation of Subcutaneous Intravascular Catheter

This policy was reviewed as part of our standard review process. No changes in direction will be made.

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

This policy was reviewed as part of our standard review process. No changes in direction will be made.

June 30, 2025

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

This policy will be updated to add additional billing information and guidelines concerning what is included in the various types of Evaluation and Management Services for Commercial and Medicare Advantage.

July 1, 2025

For more information about the policy updates (RP-039 and RP-050) listed below, CLICK HERE.

RP-039 Outpatient Services Prior To An Inpatient Admission

When a Highmark member is seen for outpatient services within 72 hours prior to an inpatient admission for a related diagnosis at *any* facility within the same health system, those outpatient services will be considered part of the inpatient stay.

RP-050 Inpatient Readmissions

When a Highmark member is readmitted to *any* inpatient hospital within the same health system for a related diagnosis within 15 days from the initial stay, all services over the two stays will be considered part of the initial stay.

Aug. 1, 2025

RP-047 Venipuncture and Lab Services

This policy will be made applicable to Medicare Advantage professional.

Aug. 25, 2025

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

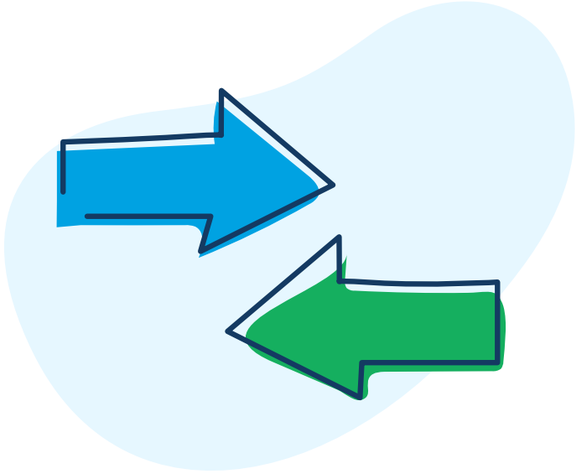
Criteria and direction for various visits and exam types will be added.

RP-059 Associated Services

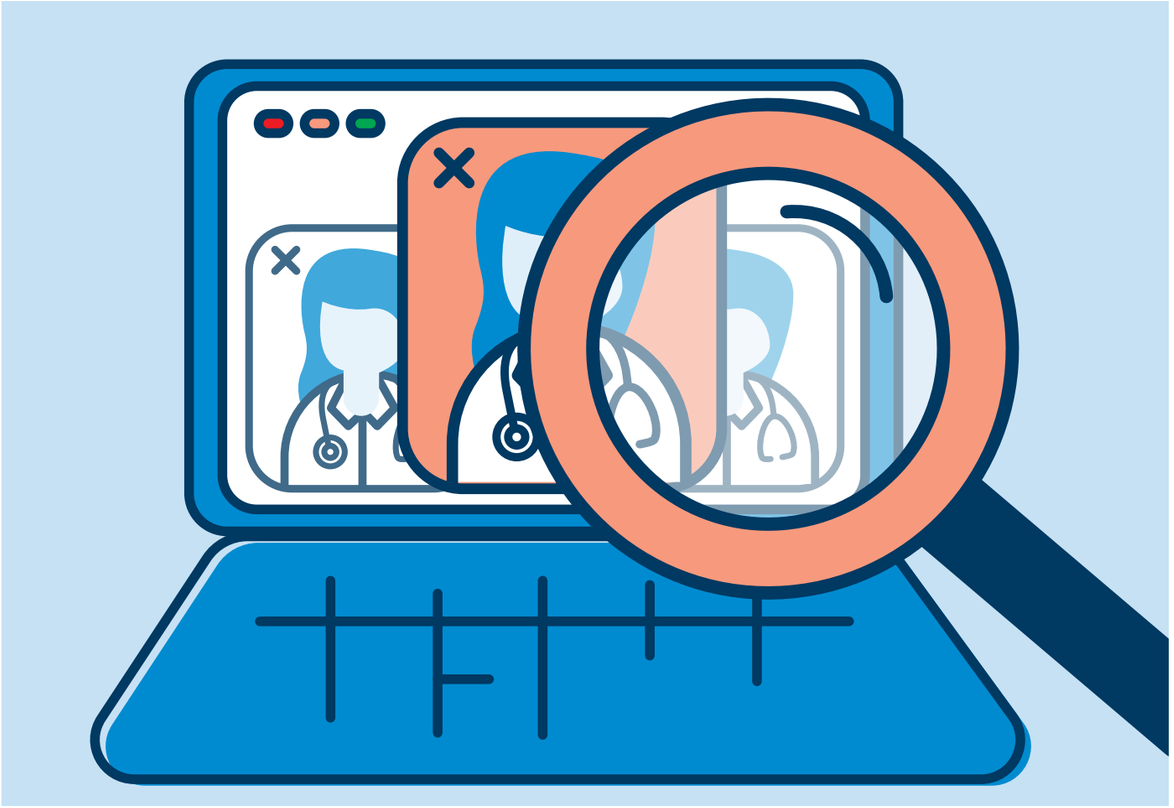
Direction in this policy will be updated to include primary procedure medical necessity denials.

RP-078 Postoperative Sinus Debridement

The policy direction is being amended.



FIND A DOCTOR UPDATE: Leading Health Care Tech Company to Manage Member Search Tool



Beginning in the second quarter of 2025, we'll be moving the management of Highmark's **Find a Doctor** to Kyruus, a leading provider of health care search and scheduling solutions. This shift not only maintains existing functionality for the popular search tool, but also sets the stage for future enhancements.

What's Changing (and What's Staying the Same)

The core features and functionality of **Find a Doctor,** which is available on the myhighmark.com portal, will remain the same:

- **Find/Compare Providers:** Members can still easily search for and compare providers based on various criteria.
- **Schedule Appointments:** Members also can continue to schedule appointments directly using **Find a Doctor**.
- **Care Cost Estimator:** This valuable tool, which uses negotiated rates and historical claims data to estimate patient bills, will continue to provide members with cost transparency.

The transition to Kyruus will be done in phases. Full implementation — for all Commercial, ACA, Medicare Advantage, and Pennsylvania CHIP members — is expected to be completed by early Q3 this year.

(Continued)

Ensuring Data Accuracy

Maintaining accurate provider information in our **Find a Doctor** search depends upon providers submitting timely updates to us. *If your directory information is incorrect, members may not be able to find your office in the **Find a Doctor** search results.*

The process for updating your information remains unchanged:

- **Highmark's Provider Data Maintenance (PDM) Tool** is accessible under **Applications** in Highmark's **Payer Spaces** within Availity Essentials. For detailed instructions, consult the PDM user guide on the Provider Resource Center by clicking **here.** Information about appointment scheduling and new patient status can also be kept current here.
- For updates, such as practitioner or group name, address, phone number, email, website address, and specialty, or to remove a practitioner from a group, you may also use the **Provider Directory Update Form** found on our Provider Resource Center.

Care Cost Estimator

The care cost estimator is based on negotiated rates and historical claims data. While Kyruus has designed this process for accuracy, estimates are subject to change. Please encourage your patients to:

- Verify in-network status before scheduling.
- Confirm costs with your office prior to their appointment or service.
- Remember that provider network participation is regularly updated.

Search Prioritization and Member Access

The **Find a Doctor** search results allow members to sort by Best Match, Distance, or Name (A-Z or Z-A). Upon full implementation, all Commercial, ACA, and Medicare Advantage members in Pennsylvania, Delaware, West Virginia, and New York, along with Pennsylvania CHIP members, will have access to the tool through their Highmark member portal.

Your Practice Information – Is It Up to Date?

Find a Doctor is an excellent resource for our members, but its accuracy is based on the data you have given us. If your practice information is correct, then members — especially new ones — will be able to easily find your practice. If that data is incorrect, members may have difficulty finding your practice and contacting your office.

Case Management Referrals: Caring for Members with Complex Conditions

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

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

To access this feature:

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

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

Additional Resource

To learn more about making case management referrals, watch the **this video**, which is available on the Provider Resource Center.

Low Back Pain: Reducing Unnecessary Imaging

Each year, 2.5 million Americans seek outpatient care for low back pain (LBP). While most LBP resolves within two weeks, unnecessary imaging (X-rays, MRIs, CT scans) is often ordered. Avoiding imaging for patients when there is **no indication** of underlying "red flag" conditions can prevent unnecessary harm and reduce health care costs.

HEDIS® Measure – *Use of Imaging for Low Back Pain (LBP)*

Compliance occurs when adults — ages 18-75 with a principal/primary ICD-10 diagnosis of uncomplicated LBP — do **NOT** receive imaging studies within 28 days of their initial diagnosis.

Here are some tips for meeting or exceeding the requirements of the HEDIS measure for LBP:

- Avoid ordering diagnostic studies within 28 days of diagnosis for a new onset of uncomplicated LBP when there are no "**red flags**."
- Document in the medical record all findings and submit correct primary diagnosis code. Use exclusionary codes if applicable to justify when imaging is warranted.
- Provide patient education on conservative treatments.
  - Use of non-steroidal anti-inflammatory drugs (NSAIDs) and, if appropriate, muscle relaxers.
  - Exercise to strengthen the core and low back.
  - Move and be active to limit muscle stiffening.
  - Place pillow between legs while resting or sleeping (if sleeping on side), or under knees when sleeping on back to reduce back discomfort.

(Continued)

Are There Conditions that Remove a Member from the HEDIS Uncomplicated LBP Measure?

Yes, the following conditions are **not** considered uncomplicated LBP-related. If submitted as the principal/primary diagnosis, imaging would be acceptable for these conditions:

- Discitis, unspecified, lumbar & lumbosacral region
- Muscle spasm of back
- Contusion of lower back
- Abnormal reflex
- Unspecified superficial injury of lower back

Note: *This is not a complete list.*

Exclusions/Red Flag Conditions

Sometimes, imaging may be necessary for LBP. The following "**red flag**" conditions suggest a more serious underlying issue and may warrant imaging. These conditions would exclude the member from the HEDIS LBP measure:

- Cancer
- Recent trauma/fractures
- IV drug abuse (past 12 months)
- Neurologic impairment (past 12 months)
- HIV
- Spinal infection (past 12 months)
- Kidney/major organ transplant
- Prolonged corticosteroid use (90 days within the past 12 months)
- Osteoporosis medication therapy
- History of lumbar surgeries
- Spondylopathy
- Recent uncomplicated LBP (past 6 months)

Coding Information

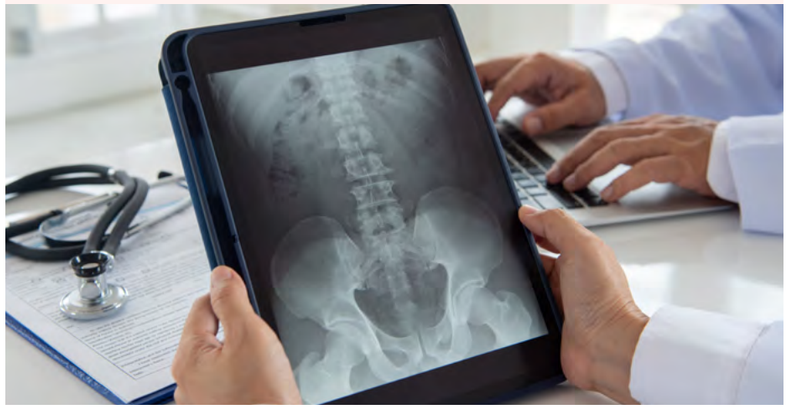
For codes related to uncomplicated low back pain, log into Availity Essentials® , click **here** , and then scroll to the **Use of Imaging Studies for Low Back Pain (LBP)** section.

Additional Resource

The Highmark has the following free patient education available for download:

- Back Pain Brochure

To order copies for your practice, go **here** on the Provider Resource Center and **Select Printable Item**. Click the down arrow and then select the item(s) you wish to order. Complete the form and click the **ADD TO ORDER** button.



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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.

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 2, Unit 6: The BlueCard® Program**
- **Chapter 4, Unit 1: PCPs and Specialists**
- **Chapter 4, Unit 4: Ancillary Services**
- **Chapter 5, Unit 1: Care Management Overview**
- **Chapter 5, Unit 2: Authorizations**
- **Chapter 5, Unit 4: Behavioral Health**
- **Chapter 6, Unit 1: General Claim Submission Guidelines**
- **Chapter 6, Unit 4: Professional (1500/837P) Reporting Tips**

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

Quarterly Formulary Updates

View the April 2025 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:

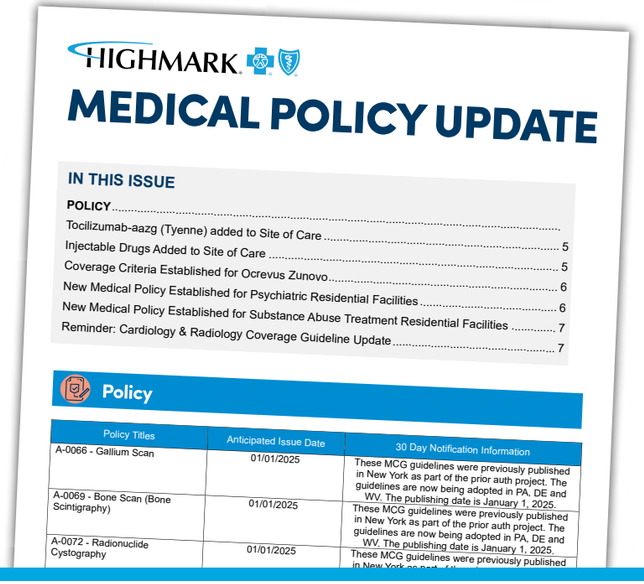
- Exception requests
- The process for generic substitutions
- Explanations of limits/quotas, therapeutic interchange, and step-therapy protocols.

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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MEDICAL POLICY UPDATE

IN THIS ISSUE

POLICY

Policy

Policy Titles	Anticipated Issue Date	30 Day Notification Information
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

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.

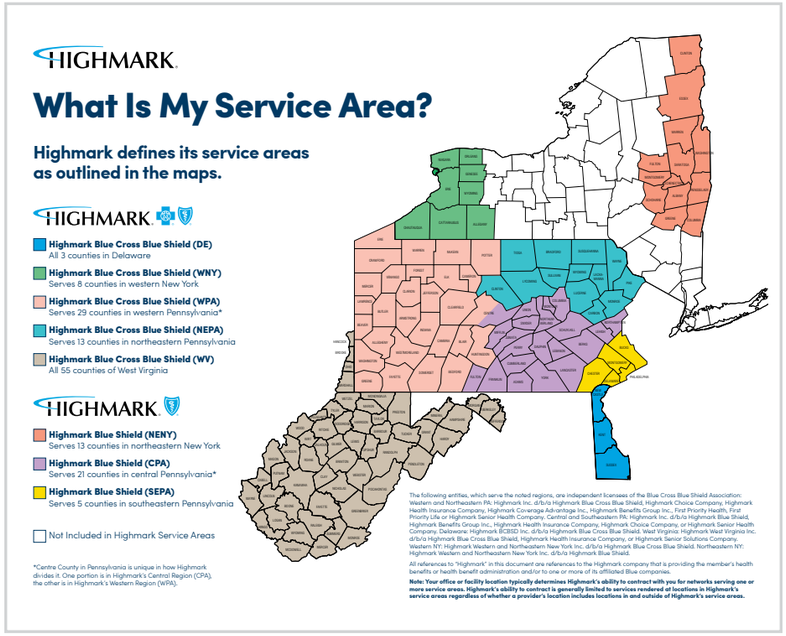
Comments/Suggestions Welcome

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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