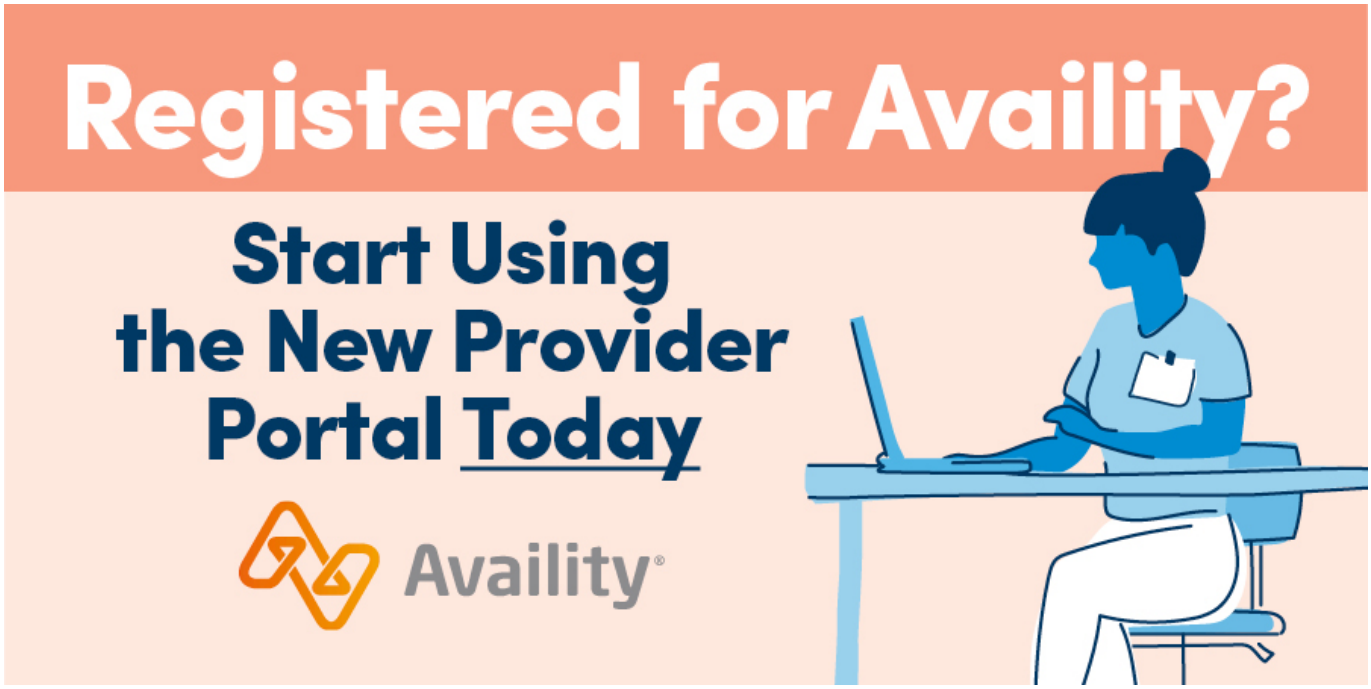
HIGHMARK NORTHEASTERN NEW YORK

PROVIDER NEWS

A newsletter for Highmark Blue Shield of Northeastern New York (Highmark BSNENY) network providers

Issue 10, October 2023



Does your office or organization currently use Availity® for other payers? If so, you can start using Availity for Highmark transactions — in the regions where you are contracted — *right now*.

That's right, you don't have to wait until **February 5, 2024**, which is the date when all Highmark providers will have access to Availity. Take advantage of this opportunity to shift all your Highmark transactions over to Availity before the year's end.

DID YOU KNOW? More than 70% of providers who are contracted with Highmark are already registered with Availity for other payers.

Please note providers with new Highmark contracts, effective after October 20, 2023, can register to use Availity now and don't have to wait until next year.

Phased Approach

Highmark is taking a phased approach as we move from NaviNet® and HEALTHeNET to Availity to ensure a seamless transition for providers. We started with pilot programs in August and September that helped us address provider questions and concerns before Controlled Deployment, our largest transition phase. As of last Sunday (October 22), we entered Controlled Deployment which allows providers — who already use Availity for other payers — to begin using Availity for Highmark.

The last phase will occur February 5 where we open registration for providers who do not already use Availity with other payers and are not new to the network. This will allow Highmark to provide focused support to those offices/facilities unfamiliar with the Availity platform.

Early Adoption – Top Reasons

If you are currently registered with Availity, here are some top reasons you should shift all Highmark-related transactions to our new provider portal as soon as possible:

1. **Fewer Portals, More Efficiency**
   New York providers that currently toggle between NaviNet and HEALTHeNET will be able to complete all their transactions within Availity, including accessing Risk Manager and Best Practice reporting and submitting batch 270 Eligibility Benefit Inquiries. The sooner you make the switch to Availity, the sooner all your Highmark transactions will occur in one portal, which makes it easier administratively for you and your team.

2. **More Time to Train Your Team**
   Even though your office or organization uses Availity, you may have some team members who lack experience using the new provider portal. By making the transition now, you give those team members who are less familiar with Availity more time to get up to speed.

3. **More Time to Update Your Systems and Vendors**
   Ensure your practice/facility updates any internal systems and automation connected to the NaviNet and/or HEALTHeNET portals. If you work with a third party, such as a billing service, clearinghouse, or service bureau, ensure they are submitting transactions to Availity as well. The vendor should register its own account by following the instructions listed here.

4. **Start the New Year Ready to Go**
   Completing your transition to Availity in 2023 means you don't have to do it next year. When January rolls around, your office won't have to worry about completing a leftover task from the previous year — you and your team will be ready to go.

Training Sessions

Availity began live training to providers on October 23, 2023, and will continue through November 3, 2023. Hosted by Availity and Highmark representatives, these sessions are designed to show you how to navigate Highmark's new portal and get the most out of your experience. They will cover the following topics:

- Availity Essentials: Introduction to Highmark Providers (including Highmark's Authorization Tool)
- Claim Submission Applications for Highmark Providers
- Claim Follow-up and Payment Applications for Highmark Providers

To attend, you must be registered with Availity. All registered providers will receive an email invitation for the training sessions.

Training will be recorded and available after the live sessions. You can access these recorded trainings by logging into Availity Essentials and then navigating to **Help & Training > Get Trained**.

Additional training dates and information will be posted on the PRC when available. You also can receive training updates when you sign up for our eSubscribe list.

Availity FAQs

Our **Frequently Asked Questions (FAQs) page** on the Provider Resource Center (PRC) has numerous questions and answers about the move to Availity. Throughout the transition, we will continue to update this page.

Transition Timeline

The transition to Availity will occur in stages. Here's what you can expect going forward:

1. **October 22, 2023**
   1) Providers who currently use Availity for other payers will see Highmark as an option in the states where they are contracted; and 2) providers with new Highmark contracts effective after October 20, 2023, can register to use Availity.

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

3. **March 2024**
   Providers will no longer have access to NaviNet or HEALTHeNET (NY).*

More information on the retiring of existing portal(s) will be distributed as it becomes available. If you don't already receive emails for our provider newsletters, join our **eSubscribe list today.*

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

Availity is an independent company that contracts with Highmark to offer provider portal services.

NaviNet is a registered trademark of NaviNet Inc., which is an independent company that provides secure, web-based portal between providers and health insurance companies.

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Advanced Imaging and Cardiology Prior Auth Changes

Highmark Blue Shield (BS) is making changes to prior authorization requirements for the Advanced Imaging and Cardiology Services Program.

eviCore's management of these services for providers in the Highmark BS network will sunset on **December 31, 2023**. Highmark BS will begin the utilization management of these services **effective January 1, 2024**. *Highmark notified all BS providers on **October 2, 2023**, via email of this upcoming change.*

Prior authorization requirements for advanced imaging and cardiology services are applicable to all Highmark BS plans, including:

- **Commercial**
- **Medicare Advantage (MA)**
- **Affordable Care Act (ACA)**
- **Federal Employee Program (FEP)**
- **Administrative Services Only (ASO)**

These prior authorization requirements are subject to the member's benefit plan.

Medical Policy Update

The medical policies listed here will be established and become **effective January 1, 2024**.

Training

To help providers prepare for these upcoming changes, Highmark will offer both live and on-demand training. Training dates and information will be posted on the Provider Resource Center and be included in upcoming issues of *Provider News*.

Resources

Leading up to the **January 1, 2024 implementation**, *Provider News* will continue to be your source for additional information regarding these changes. If you're not currently receiving Highmark's monthly e-newsletter, you can sign up here.

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

Important Information Regarding Authorizations

The **List of Procedures/DME Requiring Authorization** for Highmark is subject to change. During the year, Highmark makes several adjustments to the full list of outpatient procedures, services, durable medical equipment, and drugs requiring authorization.

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Highmark Blue Shield (BS) is delaying the prior authorization requirement for outpatient physical medicine services until **April 1, 2024**. At that time, these changes — which impact **Commercial Plans only** — will include authorization requirements and medical policies.

Prior authorization will be required for the following outpatient physical medicine services, starting **April 1, 2024**:

- Physical therapy
- Occupational therapy
- Chiropractic
- Home health

The delay will allow providers time to transition to our new provider portal, Availity Essentials®, and become familiar with the Predictal™ Auth Automation Hub and Helion Arc — our electronic authorization solutions which are seamlessly integrated within Availity. The Auth Automation Hub and Helion Arc enable offices to submit, update, and query these authorization requests. They feature an easy-to-use interface that allows for faster reviews and greater transparency around the status of authorization requests.

Speech Therapy

Since **April 1, 2023**, prior authorization has been required for **Commercial Plans** for speech therapy (ST) in the Highmark BS service area. For more information, see the *Provider News* article from earlier this year.

Why Is Highmark Making This Change?

The goal of Highmark's prior authorization process is to ensure members are receiving appropriate services and lowering their total cost of care. Highmark continues to align our prior authorization guidelines across all its markets to ensure consistency in care among our membership. As part of ongoing evaluation of our guidelines, they are adapted periodically based on clinically evidenced criteria, safety and approval ratings indicating ongoing compliance.

Training

To help providers with these changes, Highmark will offer both live and on-demand training. Training dates and information will be posted on the Provider Resource Center and be included in upcoming issues of *Provider News*, closer to the **April 1, 2024**, implementation date.

Resources

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

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Effective January 1, 2024, Highmark is making some changes to the medications on our Medicare Part D formularies. These changes will ensure the safe and effective use of prescription medications while ensuring they are affordable for our members.

Most members with Medicare Part D coverage will be able to receive up to a **100-day supply for generic medications** on Tier 1 and Tier 2 of Highmark's formularies. When appropriate, providers are encouraged to write prescriptions for this higher day supply. Some examples of Tier 1 or Tier 2 drugs eligible for a 100-day supply include Lisinopril, Metformin, and Atorvastatin.

If you are unsure whether the member has this benefit, or what tier the medication is, see our Tip Sheet, which is accessible from the left menu on the Provider Resource Center (PRC) under **PHARMACY PROGRAM/FORMULARIES** and then click **Medicare Formularies**.

2024 Medicare Advantage Formulary Changes

Some medications may be removed from the formulary or have new restrictions in 2024. More information on the types of changes can be found in the Definition of Status and Definition of Restrictions sections of the online formularies, which are available on the PRC. Select **PHARMACY PROGRAM/FORMULARIES** from the left menu and then click **Medicare Formularies**.

Beginning November 10, 2023, Highmark will send letters to prescribing providers and members with more information about these changes. Once you receive your letter, you can either submit a coverage determination or request a different drug that Medicare Part D would cover.

Submitting Coverage Determination Requests

If your patients are still taking these affected medications, please consider changing them to a covered formulary alternative or request a coverage determination, so that they can continue receiving the same medication.

Coverage determination requests for the 2024 plan year may be requested beginning **November 13, 2023**. If a coverage determination is submitted, Highmark will review the request and notify you and the member of the decision.

Should you need to initiate a coverage determination, you may do so electronically through CoverMyMeds, which is available through Highmark's provider portal — either Availity® or NaviNet®.

This form is also available on the Provider Resource Center under **FORMS > Pharmacy Prior Authorization Forms > Request for Non-Formulary Drug Coverage**.

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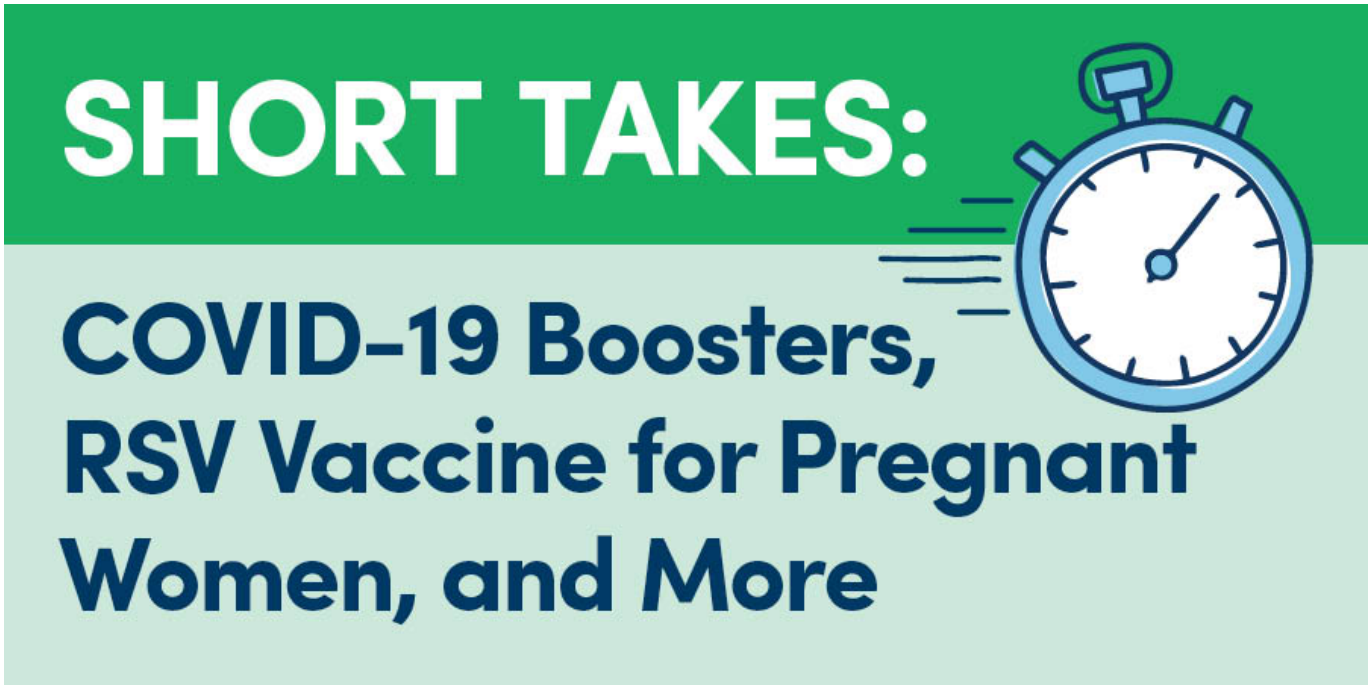

Short Takes: COVID-19 Boosters, RSV Vaccine for Pregnant Women, and More

The Centers for Disease Control and Prevention (CDC) has recently approved new, single-dose COVID-19 booster vaccines from Pfizer, Moderna, and Novavax to protect against the XBB variant. The Pfizer and Moderna boosters are for all persons 6 months and older; the Novavax vaccine is for individuals 12 and older. For more information, click here.

UPDATE: RSV Vaccine Now Approved for Pregnant Women

The Centers for Disease Control and Prevention (CDC) has approved respiratory syncytial virus (RSV) vaccines for infants, **pregnant women**, and adults 60 years of age and older. These vaccines are being retroactively added to the Highmark Preventive Schedules. Click here to read the updated **Special Bulletin**.

New BlueCard Fax Number for Medical Records Requests

The BlueCard fax number for Medical Records is **1-833-619-5751**. This new number will appear on medical records request letters, which include a barcode for identification purposes. Providers will need to fax back the requested medical records and the original medical record letter that features the barcode. This will help avoid delays. *If the medical records are received without the letter or barcode, they will be sent to general correspondence instead of being sent directly to the home plan.*

Note: This new fax number is only to be used for sending back BlueCard medical records.

FEP Claims Will Be Reviewed by Clinical Editing Tool Starting January 1, 2024

To align with our internal claim review process, Highmark Blue Shield (BS) will start using a clinical editing tool to analyze Federal Employee Program (FEP) claims, effective **January 1, 2024**. 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. For more information, click here.

All Highmark Member Claims Must be Sent to Highmark Blue Shield

As a reminder, network providers must submit all claims for patients covered by Highmark to Highmark Blue Shield (New York).

This includes patients enrolled with:

- Highmark Blue Cross Blue Shield (Pennsylvania)
- Highmark Blue Shield (Pennsylvania)
- Highmark Blue Cross Blue Shield (West Virginia)
- Highmark Blue Cross Blue Shield (Delaware) and Highmark Health Options (Delaware)

Please note that if Highmark is listed on the front or back of a patient's ID card, these claims must be submitted to Highmark Blue Shield. For more information, click here.

Error Corrected: Medical Policy S-248 Nerve Ablation and Injection

There was a typing error in the September 4, 2023, published version of **S-248 Nerve Ablation and Injection**. The Genicular Nerve Block section of the policy was inadvertently placed into the Genicular Nerve Radiofrequency Ablation section. The policy has been corrected and published on **September 27, 2023**.

Medical Policy Update Newsletter

The October newsletter is available here.

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SURVEY SAYS:

How CAHPS Can Help Improve the Patient Experience

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is an annual survey that asks a random sample of health plan members about their experiences with their health plan and providers in the past six months.

- CAHPS questions are based on members' **experience and perception** — meaning that any patient interaction can impact CAHPS scores.
- The Centers for Medicare and Medicaid Services (CMS) considers CAHPS and the member experience to be so important that currently, approximately **40% of a health plan's Medicare Star Rating** is based on the survey scores.

The CAHPS survey is scheduled to take place during the second quarter of 2024.

CAHPS Measures

There are nine CAHPS measures that are incorporated into a plan's Star Rating, with four presenting a strong opportunity for providers to positively impact the patient experience:

- Getting Appointments and Care Quickly
- Getting Needed Care
- Care Coordination
- Rating of Health Care Quality

These measures contain questions that ask members if they found it easy to get the care, tests, and treatment they needed; if they were able to get appointments for routine and specialist care when needed; if their doctor was informed about their care and helped to manage it and they received test results when they needed them; and the overall rating of the quality of their health care.

Collaboration Is Key

Collaboration between health plans and providers is key to ensuring that members/patients have positive health care experiences. **Providers and practices that have seen high patient satisfaction results generally do the following:**

- Follow up with patients when they have seen another provider or specialist.
- Ask about prescription drugs patients may now be taking.
- Share pertinent clinical information with your patient's other providers through a HIPAA-compliant health information exchange, such as Availity®.
- Assist patients with scheduling tests and referral appointments.
- Let patients know when to expect test results, and who will provide them.

Your staff can also improve patient satisfaction by:

- Leaving some open appointment slots each day for urgent and post-inpatient visits.
- Reducing perceived wait times by assigning staff to perform preliminary work-up activities, such as blood pressure and temperature checks.
- Providing brief and frequent updates for appointment schedule delays and offering options to reschedule or be seen by another provider.
- Encouraging patients to make routine checkup or follow-up appointments in advance.
- Proactively scheduling patients — by phone, text, or email — months in advance for tests, screenings, or physicals.

For more information about the CAHPS health plan survey, click here.

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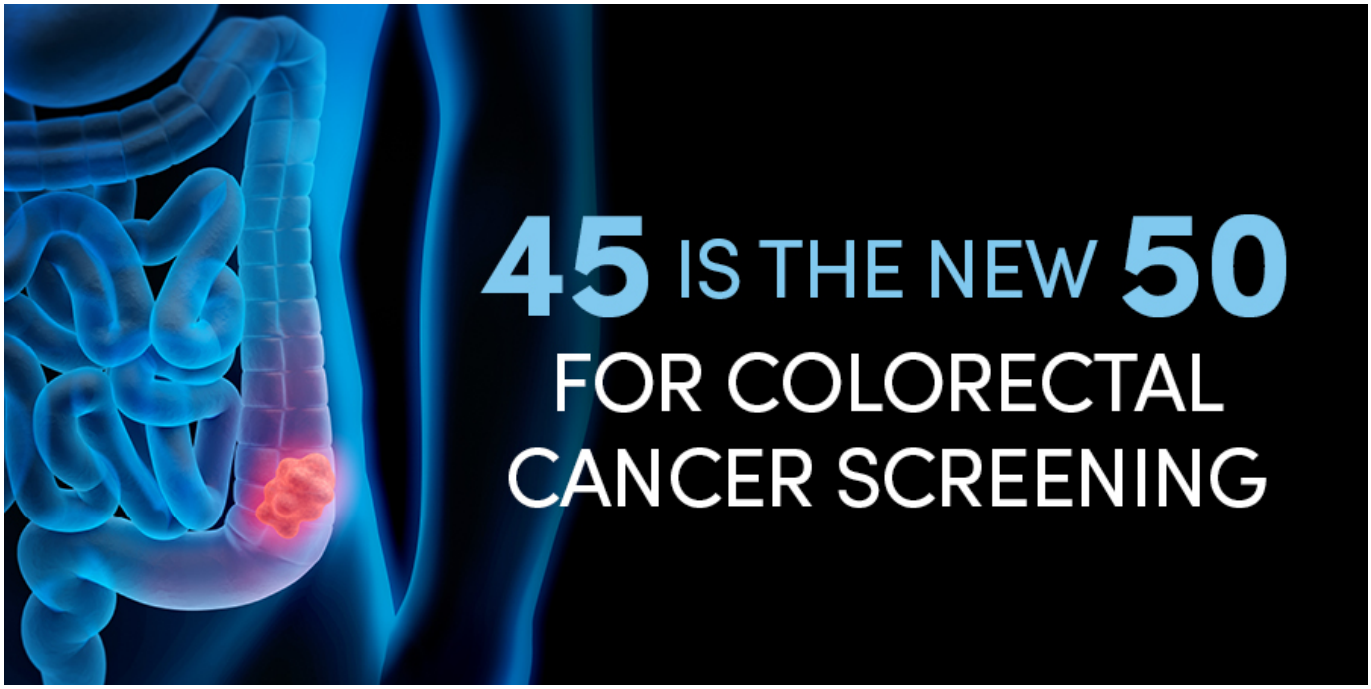

The U.S. Preventive Services Task Force (USPSTF) recommends all adults be screened for colorectal cancer starting at age 45. Previously, it was age 50. The USPSTF lowered the screening age in 2022 due to the higher incidence of colorectal cancer in young and middle-aged people.

Many patients are unaware of the change. It occurred during the middle of the pandemic. Preventive health appointments were often canceled or postponed, as people tended to avoid going to the doctor unless absolutely necessary.

As things return to normal, there are multiple ways to inform eligible patients of this change:

- Face-to-face discussion during preventive health (and other) appointments
- Flyers and handouts during checkout
- Reminders on the patient portal
- Information included with bills and other mailed correspondence

For a list of free patient education resources on colorectal cancer screening, see the **Special Bulletin** published earlier this year.

Screening Options

Colonoscopy is classified as a tier one screening by the U.S. Multi-Society Task Force on Colorectal Cancer. It is the most effective screening to detect and prevent colorectal cancer before symptoms develop. In addition, during the procedure, the physician can remove polyps or other areas of abnormal tissue and take biopsies if deemed necessary. Beginning at age 45, persons should receive a colonoscopy every 10 years.

Individuals at an elevated risk — whether due to lifestyle factors and/or family history — may necessitate earlier or more frequent screening.

An annual Fecal Immunochemical Test (FIT) is also considered a tier one screening.

Highmark Preventive Health Guidelines

Highmark Preventive Health Guidelines include colorectal cancer screenings for eligible members. Please note that most, although not all, of our employer groups follow the Highmark Preventive Schedule. Therefore, not all Highmark members may have coverage for services on the preventive schedule.

To access the Preventive Health Guidelines, go to the **Provider Resource Center > EDUCATION/MANUALS >** Preventive Health Guidelines.

Highmark does not recommend particular treatments or health care services. This information is not intended to be a substitute for professional medical advice, diagnosis, or treatment. You should determine the appropriate treatment and follow-up with your patient. Coverage of services is subject to the terms of each member's benefit plan. Additionally, state laws and regulations governing health insurance, health plans and coverage may apply and will vary from state to state.

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With two months left in the year, there's still time to close any remaining immunization gaps for children under two. To meet the quality measure for **Childhood Immunization Status (CIS)**, all required immunizations must be completed by a child's second birthday. **IMPORTANT:** *If one immunization is missed, the entire measure is seen as noncompliant.*

Children by their second birthday should have received the following immunizations in the correct dosage:

Vaccination	Doses
Diphtheria, tetanus, and acellular pertussis (DTaP)	4
Polio (IPV)	3
Measles, mumps, and rubella (MMR)	1
Haemophilus influenza type B (HiB)	3

Hepatitis B (HepB)	3
Chicken pox (VZV)	1
Pneumococcal conjugate (PCV)	4
Hepatitis A (HepA)	1
Rotavirus (RV)	2 – 3
Influenza (flu)	2

Staying on Track

During the pandemic, preventive health appointments for infants and children may have been missed. As we return to a regular cadence for wellness appointments, it's important that children get back on track and stay on track for scheduled immunizations, which helps prevent serious illness.

Maintaining Updated Patient Records

Proper record-keeping is critical for accurately capturing patients' immunization history. Providers are required by law to record certain information in a patient's medical record, which can be in electronic or paper form.

For immunization history, the following information should be included in the patient record:

- Date of administration
- Vaccine manufacturer
- Vaccine lot number
- Name and title of the person who administered the vaccine and address of the facility where the permanent record will reside.
- Vaccine information statement (VIS)
    - Date printed on the VIS.
    - Date the VIS was given to the patient or parent/guardian.

Immunization Information Systems

Immunization Information Systems (IISs) are confidential, computerized databases that record and consolidate information on all vaccine doses administered by participating providers.

Using an IIS to document vaccines administered can help keep patient vaccination records up to date. Another advantage is that the IIS gives all medical providers in a practice access to complete

and accurate information about the patient's immunization history.

Additional Resources

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

- Childhood Immunization Brochure & Schedule
- Childhood Immunization Flyer

To access them, go to the PRC, select **EDUCATION/MANUALS** from the left menu and then click **Educational Resources – Member And Provider**.

Highmark does not recommend particular treatments or health care services. This information is not intended to be a substitute for professional medical advice, diagnosis, or treatment. You should determine the appropriate treatment and follow-up with your patient. Coverage of services is subject to the terms of each member's benefit plan. Additionally, state laws and regulations governing health insurance, health plans and coverage may apply and will vary from state to state.

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Clinical Practice Guidelines Available Online

Highmark's Preventive Health Guidelines have been updated, and are consistent with U.S. Preventive Services Task Force, Bright Futures, Woman's Preventive Health, and Advisory Committee on Immunization Practices (ACIP) guidelines.

The following clinical practice guidelines have been reviewed and approved by the Highmark Blue Shield (BS) Quality Management Committee (QMC) and can be viewed on the Provider Resource Center (PRC). Choose **EDUCATION/MANUALS** from the left menu and then select Preventive Health Guidelines.

Once there, you will find these resources:

Preventive Health Guidelines

- Prenatal/Perinatal Guidelines
- Children Ages 0-6 Guidelines
- Children Ages 7-18 Guidelines
- Adult Ages 19-64 Guidelines
- Adult 65 and Older Guidelines
- Women's Preventive Health Services Addendum
- Perinatal Depression Prevention Counseling Coding Guidelines
- PrEP Related Services Coding Guidelines

Immunizations Schedules

- Children Ages 0–18 Immunization Schedule
- Adult Ages 19 and Older Immunization Schedule

HIV Guidelines

In addition, the QMC has reviewed and approved the HIV Guidelines, which are available here.

To request a paper copy of any of these guidelines, please call **877-878-8785**, option 2. Leave your name, address, and the specific guideline you are requesting.

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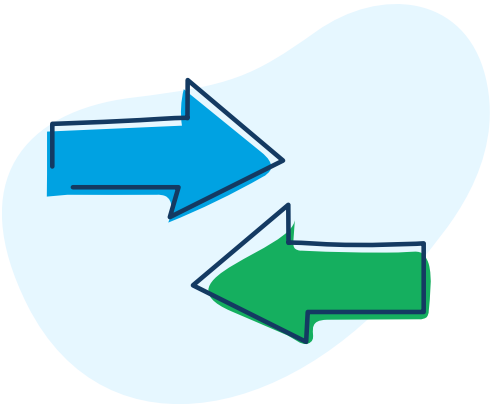
New and Updated Reimbursement Policies



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

Below is a list of recent and upcoming updates to Reimbursement Policies (RPs):

RECENTLY UPDATED

October 9

RP-064 Government Supplied Vaccinations and Antibody Treatments
Policy was updated with new and deleted vaccine codes.

October 16

RP-007 Multiple Procedure Payment Reduction for Certain Diagnostic Imaging Procedures
Policy was updated with new and deleted imaging codes.

October 23

RP-049 Merit-based Incentive Payment System (MIPS) for Out of Network Providers
This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-055 Nominal Charges
This policy was made applicable to professional (1500) claims.

RP-060 Genetic Testing Ordering Requirements
This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-069 DME Maintenance, Repair and Replacement
This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-071 Incremental Nursing
This policy was reviewed as part of our standard review process. No changes in direction were made.

October 30

RP-026 Portable Radiography and ECG Services – Modifiers UN, UP, UQ, UR, US
This policy will be made applicable to Medicare Advantage. Additional direction will be added for modifiers UN, UP, UQ, UR, and US when submitted with code R0075 (a transportation service code). These modifiers are also required to be included on all related claims, and the Commercial section will be updated with direction to reflect this requirement.

UPCOMING

November 13

RP-064 Government Supplied Vaccinations and Antibody Treatments
Policy will be updated to delete vaccine codes.

January 15, 2024

RP-037 Emergency Evaluation and Management Coding Guidelines
Outpatient surgery will be removed from the exclusion criteria.

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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:

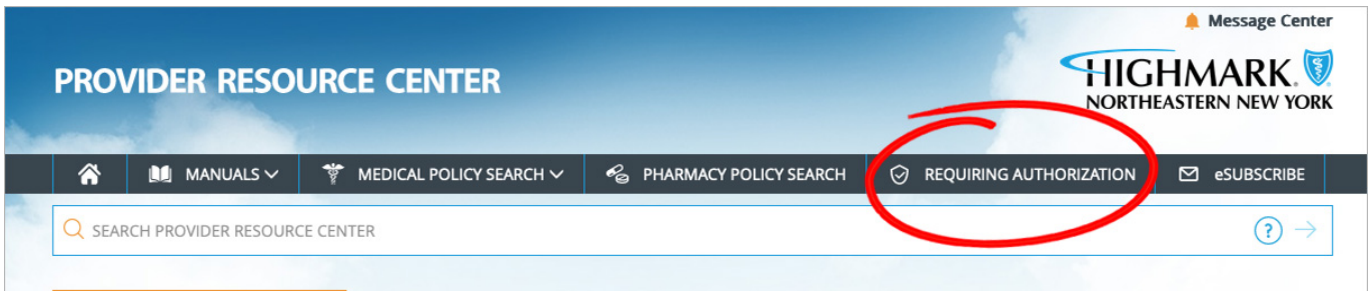
- Call the number on the back of the member's card,
- Check the member's eligibility and benefits via Availity® or NaviNet®, or
- Search BlueExchange through the provider's local provider portal.

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

Advanced Imaging and Cardiology: Prior Auth Changes Occurring in the New Year

Physical Medicine: Prior Authorization Changes Moved Back to April 2024

To view the full List of Procedures/DME Requiring Authorization, click **REQUIRING AUTHORIZATION** in the gray bar near the top of the PRC homepage.



Once redirected to the **Procedures/Service Requiring Authorization** page, click **View the List of Procedures/DME Requiring Authorization** under **PRIOR AUTHORIZATION CODE LISTS**.

Please note that the Highmark member must be eligible on the date of service and the service must be a covered benefit for Highmark to pay the claim.

Availity or NaviNet is the preferred method for:

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

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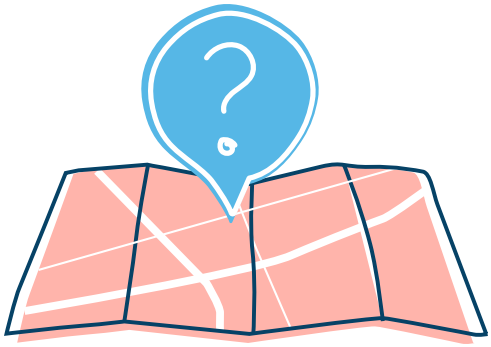
Can New Patients Find Your Practice?



It can be extremely difficult for new patients to learn about your practice if you're not listed correctly in the Highmark Provider Directory.

With Open Enrollment underway throughout Highmark's footprint, you want to ensure that your provider information is accurate. Validating your information helps both new and current Highmark members to find and evaluate your practice when selecting a health care provider for 2024.

For example, if your address is incorrect, prospective patients may think your practice isn't close to their home or work, and then opt for another provider.

Required Outreach

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

Professional Providers – PDM Tool

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

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

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

Your thorough review of your directory information confirms:

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

To learn more about the PDM tool, click here.

Facility, Ancillary, and Medicaid Providers – Atlas

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

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

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

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

HIGHMARK NORTHEASTERN NEW YORK

PROVIDER NEWS

A newsletter for Highmark Blue Shield of Northeastern New York (Highmark BSNENY) network providers

Issue 10, October 2023

Staying Up to Date with the *Highmark Provider Manual*

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

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

Recent noteworthy changes occurred in the following sections:

- Chapter 1, Unit 3: Electronic Solutions: EDI and Availity
- Chapter 1, Unit 4: Highmark Member Information
- Chapter 2, Unit 6: The BlueCard Program
- Chapter 4, Unit 1: PCPs and Specialists
- Chapter 4, Unit 2: Behavioral Health Providers
- Chapter 5, Unit 6: Quality Management
- Chapter 6, Unit 2: Electronic Claim Submission
- Chapter 7 – Appendix > Chapter 7, Unit 6: Professional Regulations

For detailed descriptions of these recent changes, visit the Highmark Provider Manual Changes page.

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Issue 10, October 2023

About This Newsletter

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

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

Regular topics include:

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

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

Another Valuable Resource

For medical policy and claims administration updates, including coding guidelines and procedure code revisions, please refer to the ***Medical Policy Update Newsletter***.

You can access both *Provider News* and the Medical Policy Update Newsletter on the Provider Resource Center from the **NEWSLETTERS/NOTICES** link on the sidebar. Email subscriptions are available via the **eSubscribe** button on the PRC taskbar.

Comments/Suggestions Welcome

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

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Legal Information

Information on this website is issued by Highmark BSNENY, which serves 13 counties in northeastern New York.

NaviNet is a registered trademark of NaviNet, Inc., which is an independent company that provides a secure, web-based portal between providers and health care insurance companies.

 Payers participating in HEALTHeNET provide "Other Insurance" information which is member self-reported. The accuracy of this data CANNOT be guaranteed by HEALTHeNET but rather serves as an indicator that there MAY be other insurance coverage for the member. It is your responsibility to verify "Other Insurance" information returned on an eligibility response.

Highmark BSNENY has adopted Highmark Inc. medical policies as its own policies applicable to Highmark BSNENY members who have moved to the “Highmark System” (i.e., *information systems of Highmark Health and/or its subsidiaries/affiliates*). Please note that for providers with Highmark BSNENY members who remain on the BSNENY Legacy System (i.e., have not yet moved to the Highmark System), certain BSNENY Legacy System medical protocols (found at bsneny.com) shall apply and control until the earlier of such time as such member is no longer on the BSNENY Legacy System or Highmark BSNENY communicates otherwise to you.

View the BENENY Privacy Statement.

QUICK REFERENCE

HIGHMARK PROVIDER SERVICE CENTERS

Please use NaviNet® for all of your routine eligibility, benefit, and claim inquiries.
For non-routine inquiries that require analysis and/or research, contact Highmark's Provider Services.

What Is My Service Area?

PENNSYLVANIA:

- Western Region: Professional Providers **1-800-547-3627**; Facilities **1-800-242-0514**
  Hours of Availability: 8 a.m. to 5 p.m. EST, Monday through Friday
- Central & Northeastern Regions: Professional Providers **1-866-731-8080**; Facilities **1-866-803-3708**
  Hours of Availability: 8 a.m. to 5 p.m. EST, Monday through Friday
- Eastern Region **1-800-975-7290**
  Hours of Availability: 9 a.m. to 12 noon, 1 p.m. to 4:30 p.m. EST, Monday through Friday.
- Medicare Advantage:
  - Freedom Blue PPO: **1-866-588-6967**
  - Community Blue Medicare HMO: **1-888-234-5374**
  - Community Blue Medicare PPO: **1-866-588-6967**
  - Security Blue HMO (Western Region only): **1-866-517-8585**
- Behavioral Health:
  - Western & Northeastern Regions: **1-800-258-9808**
  - Central & Eastern Regions: **1-800-628-0816**

DELAWARE:

- Highmark Delaware Provider Services: **1-800-346-6262**
  Hours of Availability: 8:30 a.m. to 5 p.m. EST, Monday through Friday
- Behavioral Health: **1-800-421-4577**

WEST VIRGINIA:

- Highmark West Virginia Medical: **1-800-543-7822**
- Highmark Senior Solutions Medicare Advantage Freedom Blue PPO: **1-888-459-4020**
  Hours of Availability: 8 a.m. to 8 p.m. EST, Monday through Sunday
- Behavioral Health: **1-800-344-5245**

NEW YORK:

- Highmark Blue Cross Blue Shield of Western New York: **1-800-950-0051 or (716) 884-3461**
- Highmark Blue Shield of Northeastern New York: **1-800-444-4552 or (518) 220-5620**
  Hours of Availability: 8 a.m. to 8 p.m. EST, Monday through Sunday
- Behavioral Health: **1-844-946-6264**
  - Fax: Behavioral Health Outpatient: **1-822-581-1867;** Behavioral Health Inpatient **1-833-581-1866**

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

HIGHMARK CLINICAL SERVICES

NaviNet® is the preferred for authorization requests. Contact Clinical Services for inquiries that cannot be handled via NaviNet.® **Hours of Availability:** Monday-Friday 8:30 a.m.-7 p.m.; Saturday & Sunday 8:30 a.m.-4:30 p.m. for urgent issues.

PENNSYLVANIA:

- Western Region:
  - Medical Services: Professional Providers **1-800-547-3627**; Facilities **1-800-242-0514**
  - Behavioral Health: **1-800-258-9808**

- Central Region:
  - Medical Services: Professional Providers **1-866-731-8080**; Facilities **1-866-803-3708**
  - Behavioral Health: **1-800-628-0816**
- Northeastern Region: Medical Services **1-800-452-8507**; Behavioral Health **1-800-258-9808**
- Eastern Region: Call Independence Blue Cross at **1-800-862-3648**

DELAWARE:

- Medical Services **1-800-572-2872**; Behavioral Health **1-800-421-4577**

WEST VIRGINIA:

- Highmark West Virginia Products for Medical and Behavioral Health Services: **1-800-344-5245**
- Medicare Advantage Freedom Blue PPO: **1-800-269-6389**

NEW YORK:

- Medical Services: **1-844-946-6263**
  - Fax: Medical Outpatient **1-833-619-5745**; Medical Inpatient **1-833-581-1868**

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