HIGHMARK
NORTHEASTERN NEW YORK

PROVIDER NEWS

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

Issue 6, June 2023

Highmark invests heavily in listening to and understanding the people we serve; and that includes you, our providers. In response to your feedback, one of our long-term commitments is to enhance the overall provider experience — including our self-service tools like the **provider portal**, **Interactive Voice Response (IVR) system**, and our **Provider Resource Center websites**.

We're endeavoring to create state-of-the-art tools that streamline the way providers work with us. Tools that **reduce administrative burden, improve office workflows, and simplify complex transactions** — allowing providers to focus on delivering care to our members.

The first step in that process was identifying a partner for a new provider portal.

"With provider input and the future vision of Highmark's digital platforms in mind, we evaluated the advantages of our current provider portal and areas where we can improve.

We looked closely at our opportunities to offer an enhanced online experience and found that Availity meets many of the criteria that will help us better serve providers," said Lori Ashby, SVP Health Plan Capabilities Shared Services.

"Availity is just one step down a road where our relationship with providers is transformed; where we deliver on our Living Health model of a more connected, seamless experience," she continued.

Availity's multi-payer platform will further that mission by supporting the existing payer-provider transactions necessary to manage care for Highmark members and act as a gateway to our utilization management platform to perform authorization transactions.

Availity serves plans nationwide, including many Blue Cross Blue Shield Association licensees like us, making it easy for provider organizations to intuitively connect, communicate, and collaborate with other health plans on eligibility, authorizations, claims management, remittances, and other critical tasks.

"Availity is proud to partner with Highmark to support their provider engagement goals," said Leslie Antunes, Chief Growth Officer of Availity and the executive sponsor of the Highmark relationship. "Providers and payers need the right tools to quickly and accurately accomplish administrative and financial tasks without adding undue burden or abrasion to the process. We look forward to collaborating on Highmark's vision of creating an integrated, cost-effective, and fulfilling provider experience, grounded in patient-centricity across all markets and segments."

The transition to Availity will happen in stages:

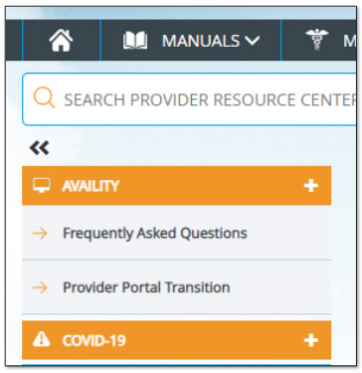
1. **August and September 2023:**
   Highmark will engage a pilot group of providers to ensure a seamless transition.

2. **October 22, 2023:**
   Providers who currently use Availity for other payers will see Highmark as an option in the states in which they are contracted.

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

4. **March – June 2024:**
   Highmark will retire its use of NaviNet® and HEALTHeNET (NY).

(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.)



We have a section of the Provider Resource Center dedicated to our transition to Availity. You can find it at the top of the left-hand website menu. That section includes additional background information on the transition as well as a list of frequently asked questions.

More information regarding registration and training will be shared in the coming months.

To ensure you receive updates from Highmark, sign up for our eSubscribe List HERE. Once you've subscribed, you will receive Highmark's monthly newsletter, *Provider News*, with the latest information about the transition to Availity Essentials. We may also post updates on our Provider Resource Center.

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2023 Preventive Schedule Mid-Year Update: New Anxiety Screening Benefit

An annual Anxiety Screening for children ages 8 to 18 — recommended by the United States Preventive Services Task Force (USPSTF) — is being added as a new benefit to the Highmark Preventive Schedule effective **July 1, 2023**.

Other changes to the Preventive Schedule include additional types of vaccines for the following:

- **Hepatitis A – New 4-Dose Vaccine**
  Members now have a 4-dose vaccine option, along with the previously approved series of 2-dose and 3-dose vaccinations.
- **Haemophilus Influenzae Type B – New 3-Dose Vaccine**
  Members can either choose the new 3-dose vaccine or the previously approved 4-dose option.

Benefit Coding for Anxiety Screening

Providers should use the following codes for the annual Anxiety Screening:

- **Z00121, Z00129, Z0000, Z0001, Z00121, Z00129** – Preventive office visit diagnosis
  OR
- **Z13.39, Z1330** – Screening examination for other mental health and behavioral disorders

In combination with code **96127** – Brief emotional/behavioral assessment.

To access the updated Preventive Health Guidelines, go to the Provider Resource Center, select **EDUCATION/MANUALS** from the left menu and click **Preventive Health Guidelines**.

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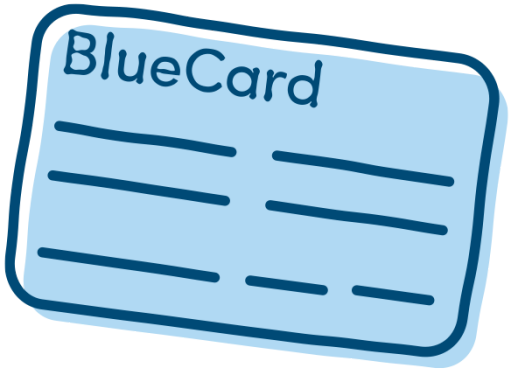
BlueCard Tips and Reminders



The summer travel season is upon us, and that means road trips, vacations, and out-of-area patients, including members from Blue Cross and Blue Shield Plans from other parts of the country.

These patients are covered under the BlueCard® Program, which enables members of one Blue Plan to obtain health care service benefits while traveling or living in another Blue Plan's service area. The program links participating health care providers with the independent Blue Cross Blue Shield (BCBS) Plans across the country through a single electronic network for claims processing and reimbursement.

The BlueCard Program lets you conveniently submit claims for members from other Blue Plans, including international Blue Plans, directly to Highmark.

BlueCard Tips

As a provider treating patients with out-of-area plans, you may find the following tips helpful:

- **Member ID Cards**
  - Ask members for their most current ID card. Since new ID cards may be issued to members throughout the year, this will ensure that you have the most up-to-date information in the patient's file.
  - Look for the 3-character prefix that precedes the member's identification number on the ID card.
  - Make copies of the front and back of the member's ID card.

    - Capture all ID card data to ensure accurate claim processing. If the information is not captured correctly, you may experience a delay with the claim processing.

- **Eligibility Inquiries**
    - Submit a BlueExchange® Inquiry via NaviNet®; or
    - Submit a HIPAA 270 transaction to Highmark.
    - You can also call the BlueCard Eligibility Line at **800-676-BLUE (2583)** to verify eligibility.

- **The BlueCard Eligibility Line**
    - **Reminder:** This number is for eligibility, benefit, and precertification and referral authorization inquiries only; **it should not be used for claim status**. Direct all claim inquiries to Highmark.

Additional Resource

- *Highmark Provider Manual*, Chapter 2, Unit 6: The BlueCard Program.

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Top Auth Request Errors and How to Avoid Them

Anything that slows down the authorization process can cause needless frustration... for both you and your patients.

Highmark Blue Shield of Northeastern New York (BSNENY) is currently experiencing an increased volume of incorrect authorization requests.

Here are the top five auth request errors and how to prevent them:

1. Wrong Form – Some providers are still using outdated authorization request forms. Doing so will delay the processing of your authorization request. For the correct Highmark BSNENY authorization forms, go here.

2. Wrong Fax Number – Sending your auth request forms to the wrong fax number will — you guessed it! — cause processing delays. The old fax numbers will be turned off later this year. Here are the correct fax numbers:

Utilization Management (UM) Fax Numbers

Outpatient UM	833-619-5745
Inpatient UM	833-581-1868
Behavioral Health (BH) Outpatient	833-581-1867

Behavioral Health (BH) Inpatient	833-581-1866

3. Wrong Codes – Doublecheck that you're using the correct codes and modifiers for the requested services.

4. Wrong Member ID – Ask members for their current ID. Since new ID cards may be issued to members throughout the year, this will ensure that you have the most up-to-date information in the patient's file.

5. Not Using NaviNet® – Electronic transactions are quicker and more efficient than paper forms and faxes. Why rely on older and slower communication methods when there's a better solution? To sign up for NaviNet, go **here**.

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At Highmark, our vision is a world where ***everyone*** embraces health. Our Provider Supplier Diversity Initiative seeks to make this vision a reality by **increasing utilization** with diverse providers for the benefit of our members and communities. Highmark has committed to spending **$334 million** with **certified** diverse entities by 2025.

As part of this initiative, we are conducting a survey to gather demographic data on providers in our network to ensure that our overall network reflects the diversity of the members and patients we serve, as well as meets the requirements of our valued corporate and government customers.

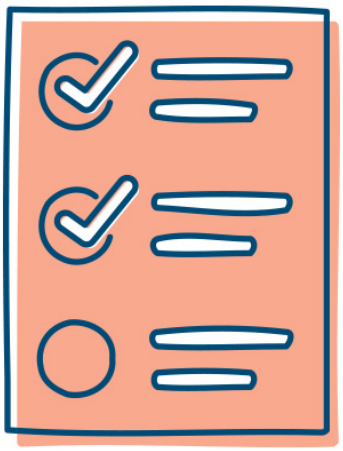
Complete the Online Survey

Please click here to complete this short online survey to capture your business classification by **Friday, August 4, 2023**.

Eligible diverse classifications include one or more of the following:

- Small Business
- Minority-Owned Business Enterprise (MBE)

- Woman-Owned Business Enterprise (WBE)
- Veteran-Owned Business Enterprise (VBE)
- Service-Disabled Veteran's Business Enterprise (SDVBE)
- Disability-Owned Business Enterprise (DOBE)
- Lesbian Gay Bisexual Transgender-Owned Business Enterprise (LGBTBE)



If you are having any problems completing the survey, contact us at supplierdiversity@highmark.com.

The Benefits of Becoming a Certified Diverse Business

Providers who own diverse businesses are encouraged to become certified. Benefits include:

- **Increased business opportunities** – Certified providers are intentionally engaged on contract opportunities. As mentioned, Highmark has earmarked $334 million to conduct business with certified diverse entities by 2025.
- **Referrals** – Certified providers become a part of a diverse advocacy organization network. These organizations host matchmaking programs that can enhance business opportunities for connections and growth.

The links below will take you directly to the respective certifying entity based on classification.

- **MBE** – https://emsdc.org/certification
- **WBE** – https://www.wbenc.org/certification/certification-process
- **VBE and SDVBE** – https://www.navoba.org/certification
- **DOBE** – https://disabilityin.org/what-we-do/supplier-diversity/get-certified
- **LGBTBE** – https://nglcc.org/lgbtbe-certification

Get the process started by taking **our survey**!

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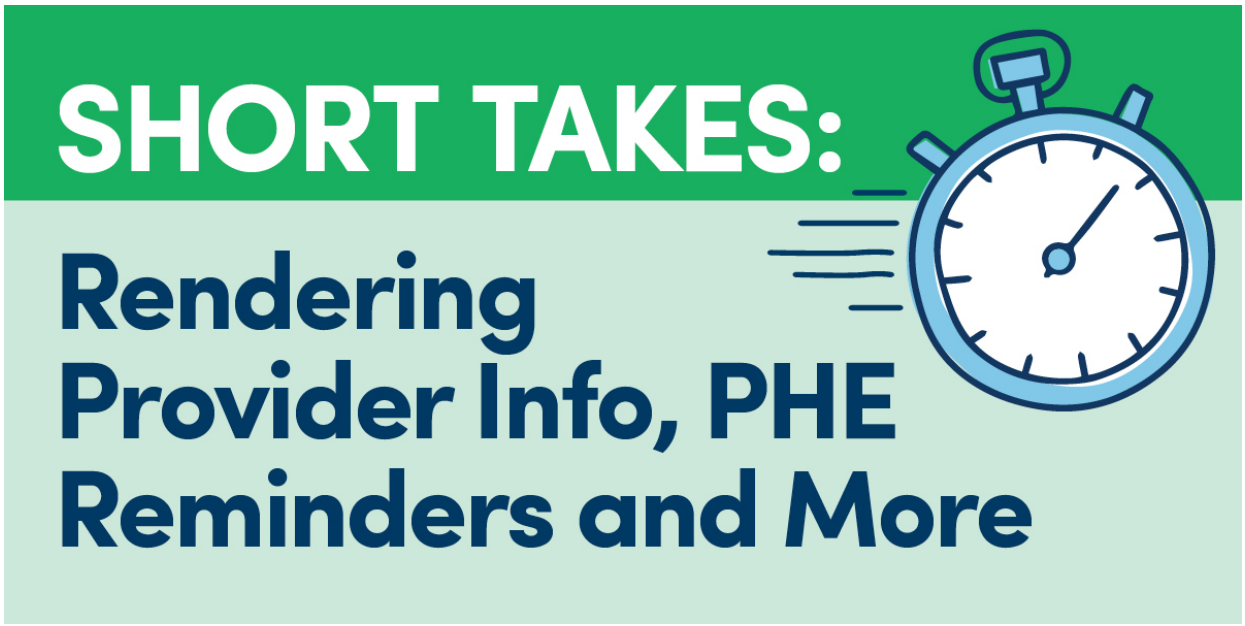

Important Reminder: Include Rendering Provider Information on All Claims

Highmark is continuing to see a significant volume of claims submitted with missing or incorrect rendering provider information. We want to remind you that all claims must contain the correct rendering/servicing provider information, including:

- National Provider Identifier (NPI)
- Provider Taxonomy Code

EXCEPTION: Behavioral Health (BH) Providers Covered Under a Billable Group
BH providers who are covered under a billable group (not individually credentialed with Highmark Blue Shield of Northeastern New York) and bill using a CMS 1500 claim form must include the NPI number of the billing provider group along with taxonomy code 101YM0800X. ***NOTE: The rendering provider loop must remain BLANK****. You do not need to include an NPI number or taxonomy code in this loop.*

To read the entire Special Bulletin, go here.

PHE Reminders

With the expiration of the Public Health Emergency (PHE), Highmark has started the process of updating COVID-19-impacted policies and procedures. Many changes will take effect **July 6, 2023**. Click here for more details.

Do you have patients affected by the Medicaid Redetermination process? Highmark has resources available for patients/members who are no longer eligible for Medicaid and who are looking for affordable health care options. Click here to learn more.

Medical Policy Update Newsletter

The June newsletter is available here.

Provider Attestation Update

Highmark's contract with vendor BetterDoctor will end on June 30, 2023. Professional providers will use the new Provider Data Maintenance tool — which launched earlier this month — to attest their information. See our story in the April *Provider News*. **Since January 2022**, facility and ancillary providers have been using our current vendor Atlas. These providers will continue to use Atlas to attest their information each quarter.

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Our quality improvement efforts are designed to ensure quality care and member satisfaction. To achieve these goals, Highmark continually reviews the aspects of our plan that affect member care and satisfaction and looks for ways to improve them. One way to do that is to share details with network practitioners about the languages patients in their area may speak and to provide information on available interpreting services.

Highmark annually assesses languages spoken by populations in our service area and compares them to the data that practitioners report on their network applications. Our 2023 analysis concluded that New York had greater than 1,000 residents speaking the following languages:

Languages Spoken	PCPs are available who speak the language	PCPs are not available who speak the language
Amharic, Somali, or another Afro-Asiatic	✔	
Arabic	✔	

Armenian	✔	
Bengali	✔	
Chinese (including Mandarin and Cantonese)	✔	
French (including Cajun)	✔	
German	✔	
Greek	✔	
Gujarati	✔	
Haitian	✔	
Hebrew	✔	
Hindi	✔	
Ilocano, Samoan, Hawaiian, or another Austronesian		X
Italian	✔	
Japanese	✔	
Khmer		X
Korean	✔	
Malayalam, Kannada, or another Dravidian	✔	
Nepali, Marathi, or another Indic	✔	
Persian		X
Polish	✔	
Portuguese	✔	
Punjabi	✔	
Russian	✔	
Serbo-Croatian	✔	
Spanish	✔	
Swahili or another Central, Eastern, and Southern Africa	✔	
Tagalog (including Filipino)	✔	
Tamil	✔	

Telugu	✔	
Thai, Lao, or another Tai-Kadai	✔	
Ukrainian or another Slavic	✔	
Urdu	✔	
Vietnamese	✔	
Yiddish, Pennsylvania Dutch, or another West Germanic	✔	
Yoruba, Twi, Igbo, or another Western Africa	✔	

- The above data is from the 2021 U.S. Census – American Community Survey Five-Year Estimates.
- This information is based on state population and not Highmark membership population.

In addition, our telephone translation vendor provided a breakdown of all calls Highmark customer service representatives received during the year that required interpreter services. In 2022, Highmark received 33,262 calls — an increase of 1,436 from 2021 — from members speaking 66 different languages. The largest percentage of calls (89.1%) was from members speaking Spanish. The total number of calls serviced for Spanish was 29,637.

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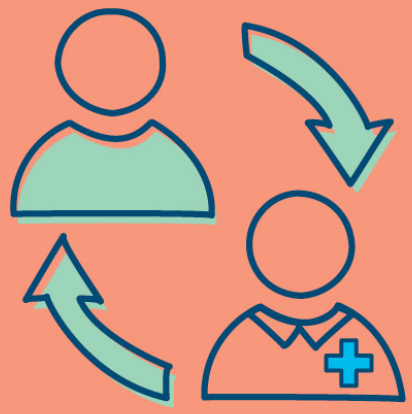
Out-of-Plan Referral Guidelines



Out-of-plan (OOP) referrals should be requested for Highmark Blue Shield of Northeastern New York patients only when:

- The patient is outside his or her service area
- Participating physicians in the area **cannot** provide the necessary services

Services must be requested by the patient's primary care physician or participating specialty provider. A request form for OOP coverage is available here.

The following information is required:

- Office notes, consultation reports, diagnostic studies, and in-plan provider documentation that supports the need for the patient to be seen by an OOP provider
- OOP provider name (requesting provider, assistant surgeon, co-surgeon)
- OOP provider address
- OOP provider specialty
- Planned services Current Procedural Terminology (CPT) codes, if applicable
- OOP provider assistant/co-surgeon information

Definitions

Non-participating provider (NPP): A provider (e.g., facility, vendor, physician, or other clinician) who does not participate with any Blue Cross/Blue Shield plans. Claims submitted by an NPP would process to the patient's out-of-network benefit unless an OOP referral is on file.

Out-of-network provider (OONP): A provider (e.g., facility, vendor, physician, or other clinician) who does not participate with the patient's home plan but does participate with the Blue Cross/Blue Shield plan in the provider's local area. Claims submitted by an OONP will process to the patient's out-of-network benefit unless an OOP referral is on file.

Out-of-network (OON) benefits: Coinsurance, copay, and/or deductible that the patient is financially responsible for when receiving services from a NPP or OONP. Typically, when a patient uses his or her OON benefit, he or she will incur higher out-of-pocket costs.

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Latest HEDIS Audit Results Now Available

You can now view the most recent performance measures for the Healthcare Effectiveness Data and Information Set (HEDIS®) via NaviNet® by following these steps:

- Click **Resource Center** from the left menu
- Once you arrive at the Provider Resource Center, select **EDUCATION/MANUALS**
- Click **HEDIS®**
- Choose **HEDIS Results**

These just-released results are based on services received in 2021 and reported in 2022. To help with benchmarking, the Quality Compass® 2022 national averages are also included with the HEDIS data.

Background

HEDIS is the most widely used set of performance measures in the managed care industry. The published results enable members and providers to compare how plans perform.

HEDIS data is collected annually and covers:

- Effectiveness of care
- Access/availability of care
- Experience of care

- Use of services

Developed by the National Committee for Quality Assurance (NCQA), HEDIS is part of the NCQA Accreditation Program and establishes accountability in health care through performance measurements used by the Centers for Medicare and Medicaid Services (CMS) and other third-party reporting agencies.

Important Disclaimers

The source of the data contained in this publication is Quality Compass® 2022 and is used with the permission of the NCQA. Quality Compass 2022 includes certain Consumer Assessment of Healthcare Providers and Systems (CAHPS®) data. Any data display, analysis, interpretation, or conclusion based on this data is solely that of the authors. The NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion.

Quality Compass is a registered trademark of the NCQA. CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Additional information related to 2022 CAHPS reporting can be found here.

Per CMS guidance, 2021 Medicare product survey results were not reported or released for comparison.

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Free Coding Webinar on Depressive Disorders

"Depressive Disorders" will be the topic for the Coding and Quality Knowledge College webinar on **Wednesday, July 12, 2023, at 12:15 p.m.**

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

For the fall webinar, the following topic will be presented:

- **Cancer – October 11**

Continuing Medical Education (CME) Credits

Attendees are eligible to receive 0.5 CME credit. Preregistration is required and an Allegheny Health Network (AHN) CME account is needed to receive credit.

You can learn more about the Coding and Quality Knowledge College on the Provider Resource Center via NaviNet® by:

- Choosing **Resource Center** from the left menu
  - You will be redirected to the Provider Resource Center (PRC)
- Selecting **EDUCATION/MANUALS** from the left menu on the PRC
- Clicking **Coding Education/HCC University**

Once there, you can find instructions to create an AHN CME account, register for the next class, or view past coding webinars. Also, on the same page, you can access the Disease Burden Capture videos, which were featured in last month's *Provider News*.

To register for the July 12 webinar on Depressive Disorders, go **here**.

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If your practice or facility cares for Medicare-eligible patients, read this important notice and share it with your colleagues.

Q	What kind of training is required annually by Highmark?
A	Highmark requires Medicare First-tier, Downstream and Related (FDR) entities to complete annual compliance training.
Q	**Who must complete these trainings?**
A	Every individual who is associated with your practice or facility and works with Highmark's Medicare Advantage and/or Medicare Part D Prescription Drug Plan (PDP) members who fall into one of these categories: • Employee • Governing-body member • Temporary worker • Contractor • Subcontractor • Volunteer

Q	**Why does Highmark require these trainings to be completed by employees, vendors, and others?**
A	Highmark requires compliance training to ensure that all practices and facilities receiving Medicare dollars understand how to comply with the laws, regulations, guidelines, and policies for the Medicare program and how to prevent, detect, and correct Medicare fraud, waste, and abuse (FWA).
Q	**When does Highmark require these individuals to complete these trainings?**
A	Compliance training must be completed: • At the beginning of their employment, contract, or appointment: **Within 90 days** • During employment, contract, or appointment: **Between January 1 and December 31 every year**
Q	**Where can individuals go to access these trainings?**
A	Individuals have several options for completing these training requirements. They can: • Complete compliance trainings online via the CMS Medicare Learning Network • Complete the compliance and FWA training offered by your practice or facility
Q	**What proof must be provided that the trainings were completed?**
A	Individuals must review the training programs in their entirety and present one of the following acceptable forms of evidence: • Sign-in sheets • Individual employee attestations • Electronic certifications The records must include: • Time • Attendance • Topic • Certificates of completion (if applicable) • Test scores (if applicable)

	Proof of training completion must be provided to Highmark upon request. Training records must be maintained for the period of the provider's contract with Highmark, plus an additional 10 years.
Q	**Are there any exceptions to these guidelines?**
A	Yes. FDRs who have met the FWA training and education certification requirements through enrollment into Parts A or B of the Medicare program or through accreditation as a supplier of durable medical equipment, prosthetics, orthotics, and supplies are deemed to have met Highmark's annual compliance training requirements.

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CLAIMS CORNER:

2 Ways to Conduct a Claim Status Inquiry

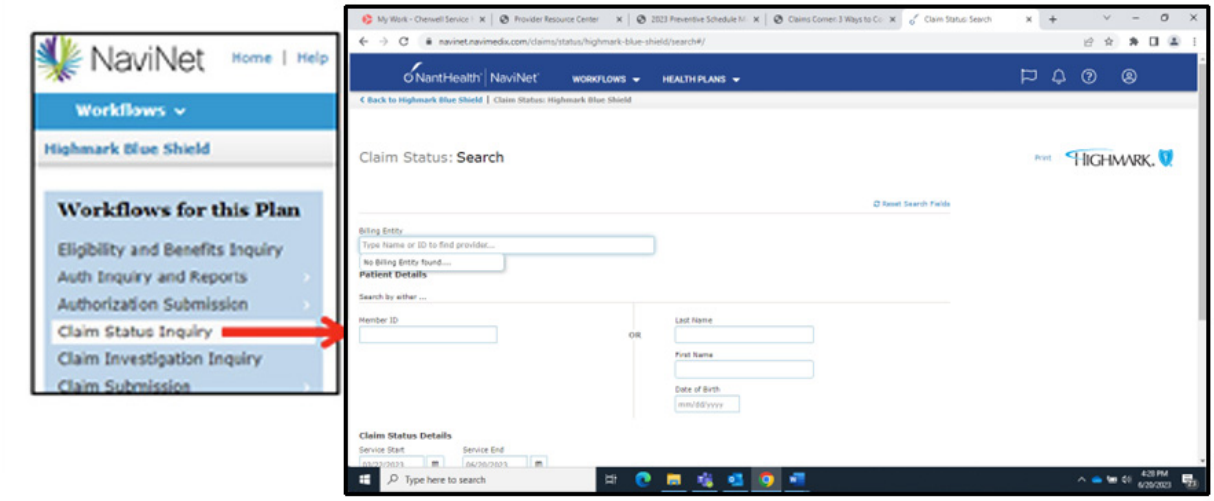
Finding out the status of your claim is quick and easy using these two electronic methods:

1. **NaviNet® Claim Status Inquiry**
2. **BlueExchange® – For BlueCard® Claims**

1. NaviNet Claim Status Inquiry

The Claim Status Inquiry function lets you view real-time, detailed claims information for any member, whether claims were submitted electronically or on paper. You can track the status of a claim from the start of the adjudication process until the time of payment, or you can look up claims dating back seven years.

To check claim status, log in to NaviNet, select **Claim Status Inquiry** under **Workflows for this Plan** to access the **Search** screen and enter the patient and claim details.



2. BlueExchange – For BlueCard Claims

You actually have two options to check the status on out-of-area claims. You can use the Claim Status Inquiry function in NaviNet or you can access BlueExchange through NaviNet.

- NaviNet's Claim Status Inquiry is not just for local claims; it can also be used to find the latest status on out-of-area claims. To view out-of-area claims electronically, you must **include the prefix** when entering the member's identification number.
- BlueExchange through NaviNet enables you to obtain BlueCard claim status. The Claim Status Inquiry Option in BlueExchange even allows you to search for the status of out-of-area Medicare cross-over claims or those filed directly to the member's Home Plan.

Additional Resources

These electronic methods for making claim status inquiries are easy to use and deliver status updates quickly, saving you and your team valuable time. For more information regarding claims inquiries, see the *Highmark Provider Manual*:

- Chapter 2 – Product Information, Unit 6: The BlueCard Program
- Chapter 6 – Billing & Payment, Unit 1: General Claim Submission Guidelines

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Reimbursement Changes to Incident To Services

Reimbursement Policy (RP)–010: Incident To Billing Services and Advanced Practice Provider Reductions is being updated to reflect these changes:

Commercial

For West Virginia: Effective **September 25, 2023**, Highmark will no longer recognize Incident To services for Commercial products.

For Pennsylvania: Incident To services for Commercial products will no longer be recognized, effective **January 1, 2023**.

For Delaware: Primary Care Physician (PCP) Incident To services will still be covered; non-PCP Incident To services will no longer be covered, effective **January 1, 2023**.

For New York: RP-010 has **New York** inadvertently checked for Commercial; this error will be corrected when the policy is updated.

No Change for Medicare Advantage Products

Highmark will continue to reimburse for Incident To services in all regions for Medicare Advantage products.

New Reimbursement Policy – RP-068

Highmark will continue to reimburse for Mid-Level Practitioners and Advanced Practice Providers, with direction provided in a new policy, **RP-068: Mid-Level Practitioners and Advanced Practice Providers**, which will be effective **September 25, 2023**.

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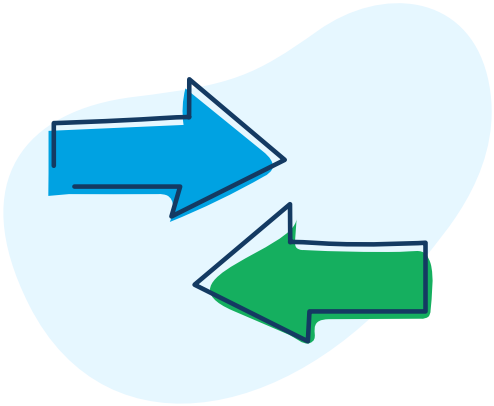
New and Updated Reimbursement Policies



Highmark regularly issues new or updated reimbursement policies. Keep an eye on the Provider Resource Center (PRC) homepage for Special Bulletins announcing upcoming policy changes and the Reimbursement Policy page for specific policy updates.

Below is a list of recently updated and upcoming Reimbursement Policies (RPs):

RECENTLY UPDATED

May 29

RP-003 Convenience Kits, Drug and Biological Wastage
Direction for modifier JZ and skin substitute wastage has been added. The name of the policy was changed, having formerly been *Drug Wastage and Convenience Kits*.

RP-026 Portable Radiography and ECG Services
A "Related Highmark Policies" section was added.

RP-041 Services Not Separately Reimbursed
Codes 38204, 90889, 92605, 92606, 92618, 93740, and R0076 were added for Commercial products. These codes will be considered not separately reimbursed and rejected as non-billable to the member.

RP-048 Independent Diagnostic Testing Facility (IDTF)
This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-050 Inpatient Readmissions
This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-051 Multiple Procedure Payment Reduction for Therapy Services
This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-057 Evaluation & Management Services
The policy was updated to align with recent changes to Centers for Medicare and Medicaid Services (CMS) guidance for selecting the level of a reported Evaluation and Management (E/M) service and the eligibility for E/M reimbursement based on the fulfillment of the required criteria. As of January 1, 2023, all Evaluation and Management services are now selected and scored based on medical decision-making (MDM) or time.

RP-064 Government Supplied Vaccinations and Antibody Treatments
Direction was updated for the following codes that had the emergency use authorization rescinded: 0001A – 0004A, 0011A, 0012A, 0013A, 0051A, 0052A – 0054A, 0064A, 0071A – 0074A, 0081A – 0083A, 0091A – 0094A, 0111A – 0113A, 91300, 91301, 91305 – 91309, and 99311.

Codes 0121A, 0141A, 0142A, 0151A, 0171A, and 0172A were added.

REMINDER: RP-075 Appropriate Use Criteria for Advanced Diagnostic Imaging
This new policy — which was made available for review on the PRC on February 27, 2023 *(click to read the Special Bulletin)* — is now in effect. Highmark created RP-075 to provide direction to practitioners on how to successfully increase the rate of advanced diagnostic imaging services based on Appropriate Use Criteria. This policy follows CMS' current *suggested* direction. CMS has not indicated when, or if, this direction will become mandatory. Providers are encouraged to follow the direction in this policy, but it is not mandatory.

June 5

RP-042 Global Surgery and Subsequent Services
This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-043 Care Management
This policy was reviewed as part of our standard review process. No changes in direction were made.

June 12

RP-055 Nominal Charges
This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-056 Delivery Payment Equivalency
This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-058 Acupuncture When Billed with Evaluation and Management Services
This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-059 Associated Services
This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-061 Implants and Implant Components
This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-062 Durable Medical Equipment MUE Value
This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-066 Sleep Study Supplies and Services
This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-067 Specific Service Daily Maximum
This policy was reviewed as part of our standard review process. No changes in direction were made.

UPCOMING

July 3

RP-007 Multiple Procedure Payment Reduction for Certain Diagnostic Imaging Procedures
Codes 0807T and 0808T will be added to the APPENDIX A – Procedure Codes Applicable To Professional And Technical Component Reduction section. Code 0804T will be added to the APPENDIX B – Applicable Cardiovascular Procedure Codes section.

RP-042 Global Surgery and Subsequent Services
Codes 0793T, 0795T, 0796T, 0797T, 0798T, 0799T, 0800T, 0801T, 0802T, 0803T, 0805T, 0809T, and 0810T will be added to the global YYY codes sections for Medicare Advantage and Commercial.

July 10

RP-015 Professional and Technical Components for Applicable Services
The Public Health Emergency (PHE) exception note will be removed. Codes 99000 and 99001 will return to pre-PHE policy direction. *(The PHE ended on May 11, 2023.)*

RP-016 Physician Laboratory and Pathology Services
The PHE exception note will be removed. Codes 99000 and 99001 will return to pre-PHE policy direction. *(The PHE ended on May 11, 2023.)*

RP-027 Hemodialysis and Peritoneal Dialysis
Policy exception notes pertaining to the PHE — *which ended on May 11, 2023* — will be removed. A definitions section will be added.

RP-041 Services Not Separately Reimbursed
PHE exception notes and end-dated codes G2023, G2024, and U0005 will be removed. Codes 99000, 99001, 90887, 99024, 99374, 99377, 99378, 99379, 99380, and 99483 will return to pre-PHE direction. *(The PHE ended on May 11, 2023.)*

RP-046 Telemedicine and Telehealth Services
This policy will be updated with post-PHE direction. *(The PHE ended on May 11, 2023.)*

RP-054 Ambulance Services
The PHE exception note for destination requirements will be removed. *(The PHE ended on May 11, 2023.)*

RP-064 Government Supplied Vaccinations and Antibody Treatments
Direction will be updated for codes 91303, 0031A, and 0034A.

August 31 (Effective September 1):

RP-019N Drugs and Biologicals
An updated version of this policy will be available for review on the PRC on August 31, 2023, and will be effective beginning **September 1, 2023**. Drug tiering is being eliminated for Delaware, Pennsylvania, and West Virginia. To access this reimbursement policy, log into NaviNet® and select Resource Center from the left menu. Once redirected to the PRC, select **CLAIMS, PAYMENT & REIMBURSEMENT** in the left menu and then click **Reimbursement Policy**.

September 25

RP-010 Incident To Billing Services and Advanced Practice Provider Reductions

For West Virginia: Incident To services for Commercial products will no longer be recognized. Highmark will continue to reimburse for these services for Medicare Advantage products, as well as for Mid-Level Practitioners and Advanced Practice Providers.*

For Pennsylvania: Incident To services for Commercial products will no longer be recognized, effective **January 1, 2023**. Highmark will continue to reimburse for these services for Medicare Advantage products, as well as for Mid-Level Practitioners and Advanced Practice Providers.*

For Delaware: Only non-Primary Care Physician (PCP) Incident To services will no longer be applicable to the policy, effective **January 1, 2023**. PCP Incident To services will still be covered. Highmark will also continue to reimburse for these services for Medicare Advantage products, as well as for Mid-Level Practitioners and Advanced Practice Providers.*

For New York: New York was inadvertently checked as an applicable Commercial market in the current version of RP-010. This will be corrected in the updated policy. Highmark will continue to reimburse for these services for Medicare Advantage products, as well as for Mid-Level Practitioners and Advanced Practice Providers.*

Direction for continued reimbursement for Mid-Level Practitioners and Advanced Practice Providers will be published in a new policy, RP-068 (see below), effective on **September 25, 2023.*

NEW: RP-068 Mid-Level Practitioners and Advanced Practice Providers Incident
Highmark has created RP-068 to provide direction on reimbursement for Mid-

Level Practitioners and Advanced Practice Providers. *(NOTE: This policy is not yet available on the PRC.)*

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HIGHMARK NORTHEASTERN NEW YORK

PROVIDER NEWS

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Issue 6, June 2023

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:

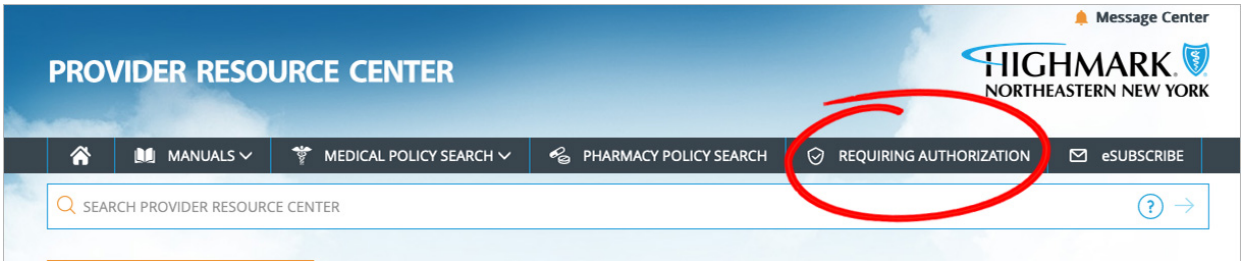
- Call the number on the back of the member's card,
- Check the member's eligibility and benefits via NaviNet®, or
- Search BlueExchange through the provider's local provider portal.

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:

NEW! Enhanced Clinical Documentation for Continued Stay Review in NaviNet

Updated List of Procedures/Durable Medical Equipment Requiring Authorization

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.

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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Quarterly Formulary Updates

View the April 2023 updates to Highmark's prescription drug formularies and related pharmaceutical management procedures on the Formulary Updates page on the **Provider Resource Center (PRC)**. From the left menu, select **PHARMACY PROGRAM/FORMULARIES** and then **Formulary Updates**.

Pharmaceutical Management Procedures

To learn more about how to use these procedures, go to the **PHARMACY PROGRAM/FORMULARIES** section on the PRC. Click on **Pharmacy Information** from the sidebar and then **Pharmaceutical Management** from the list on the right.

This section includes information on:

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

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

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

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

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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 include:

- **Chapter 4, Unit 2: Behavioral Health Providers & Chapter 5, Unit 4: Behavioral Health** – The contact information for Highmark Behavioral Health (BH) Services was updated to include a fax number for Delaware, Pennsylvania, and West Virginia. In addition, Highmark BH Services no longer offers Sunday hours of operations.
- **Chapter 5, Unit 1: Care Management Overview** – The *High-Risk Maternity (NY Only)* section was updated to include additional guidance under "Interventions for High-Risk Patients."
- **Chapter 6, Unit 1: General Claim Submission Guidelines** – The *Additional Diagnostic Code Reporting (NY Only)* section was updated under "Sleep Studies" to include a qualifying statement for Chemotherapy, Transfusion, Cast Room, Infusion Therapy, and Treatment Room that the service could pay up to $50 per day for a room charge. This qualifying statement was in the *Highmark Provider Manual* on the HealthNow provider websites but was inadvertently omitted when transitioned to the Highmark Provider Resource Center websites.

- **Chapter 6, Unit 2: Electronic Claim Submission** – The *Submitting Claims (NY Only)* section was updated under "Claim Adjustment Policy." The policy for New York was corrected to reflect that providers have 365 days, rather than 180 days, to file a claim adjustment request.

To see the full list of recent changes, visit the **Highmark Provider Manual Changes** page.

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Issue 6, June 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

Highmark Blue Shield of Northeastern New York (Highmark BSNENY) is a trade name of Highmark Blue Shield of Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield Association. Blue Shield and the Shield symbol are registered marks, and BlueCard and Blue Distinction are registered trademarks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield companies. BlueCard, Blue Distinction, Blue Distinction Center, and the Federal Employee Program are registered marks and Blues On Call is a service mark of the Blue Cross and Blue Shield Association.

Information on this website is issued by Highmark 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.

HEALTHeNET™ is 2019 copyright of WNYHealtheNet LLC, All Rights Reserved. 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.

Current Procedural Terminology (CPT) is a registered trademark of the American Medical Association. HEDIS and Quality Compass are registered trademarks of the National Committee for Quality Assurance (NCQA). Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a registered trademark of the Agency for Healthcare Research and Quality. CORE is a registered trademark of CAQH. InterQual is a registered trademark of McKesson Health Solutions, LLC.

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.