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PROVIDER NEWS

A newsletter for Highmark Blue Shield providers in northeastern New York

Issue 6, June 2024

2024 Mid-Year Preventive Schedule

The following updates were made to the 2024 Preventive Schedule:

- **Hepatitis C Screening for Infants** – The Centers for Disease Control and Prevention (CDC) now recommends hepatitis C screening for infants exposed to hepatitis C through their mother during pregnancy. ***This is a benefit expansion.***

- **Over-the-Counter (OTC) Drugs** – For **covered** OTC drugs and supplies, they must be purchased through in-network pharmacies at the pharmacy counter and not the retail counter.

- **Respiratory Syncytial Virus (RSV) Vaccines** – The CDC recommends the RSV vaccine for:
  - Children who are 2 and younger
  - Pregnant women
  - Adults aged 60 and older

NOTE: *These were already benefits for Highmark members.*

- **New Drug Recommended for Preexposure Prophylaxis for HIV** – Update includes injectable Apretude (procedure code J0739) to pay with no cost share. Previous recommendation included oral medication only.

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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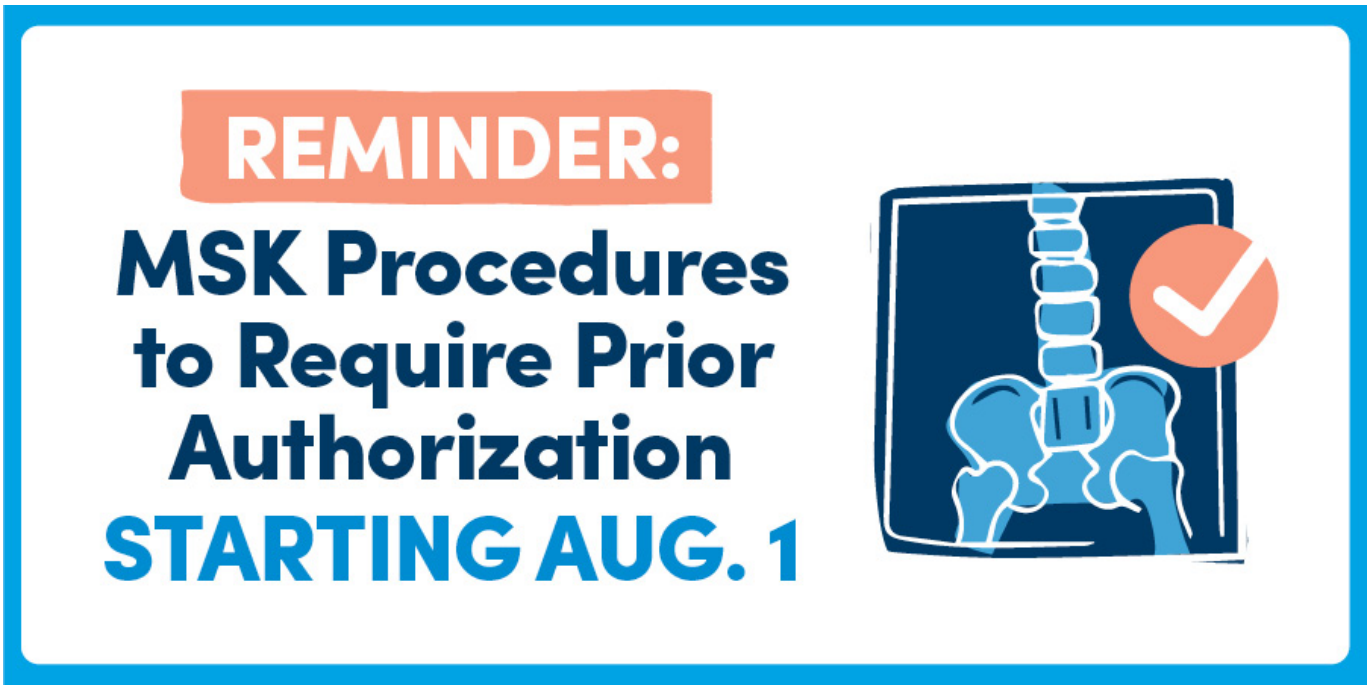

Effective Aug. 1, 2024, Highmark Blue Shield is requiring prior authorization for inpatient and outpatient musculoskeletal (MSK) procedures. New and continuing authorization requirements for inpatient and outpatient MSK services will be managed directly by Highmark Blue Shield.

As previously announced in April *Provider News*, these changes apply to Highmark Blue Shield members enrolled in our fully insured Commercial, Medicare Advantage, Affordable Care Act (ACA) plans, and members of select self-insured (Administrative Services Only) groups.

Preauthorization

Providers will be able to submit **electronic** preauthorization requests beginning **July 15, 2024**, for services occurring on or after Aug. 1, 2024.

How to Request Authorization for MSK Services

Authorization requests should be submitted through Availity®, Highmark's online provider portal. Once you log in to Availity, you will access the Predictal™ Auth Automation Hub to request

authorization for MSK procedures.

Authorization Resources on the PRC

The Provider Resource Center (PRC) has the following guides and videos for submitting authorization requests via Availity:

Guides

- Inpatient Authorization Submission (Both Urgent and Non-Urgent)
- Outpatient Authorization Submission

Videos

- Electronic Authorization Submission Process (Predictal via Availity)
- Case Management Referral Process (Predictal via Availity)

Updated Prior Authorization List

Highmark's List of Procedures/DME Requiring Authorization will be updated with CPT codes for MSK procedures, including the following services:

- Large joint surgeries
- Spine surgeries
- Interventional pain management procedures

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Childhood obesity is a complex issue with numerous contributing factors, including genetics, diet, physical activity, and sleep routines. According to the Centers for Disease Control and Prevention (CDC), nearly 1 in 5 American children struggle with obesity, putting them at increased risk for various health problems, including:

- **Asthma**
- **Sleep apnea**
- **Bone and joint problems**
- **Type 2 diabetes**
- **Heart disease**

- **High blood pressure**

Nearly 1 in 5 American children struggle with obesity

Fortunately, parents and caregivers can play a crucial role in helping children achieve and maintain a healthy weight. Here are five effective strategies to share with parents:

1. Support Healthy Habits in Early Care and Education Settings

Early childhood education programs provide an excellent opportunity to instill healthy habits. By encouraging healthy eating and physical activity, these programs can build a strong foundation for lifelong wellness.

2. Model a Healthy Eating Pattern at Home

Offer a variety of fruits and vegetables, choose whole grains over refined grains, and opt for lean protein sources. Limit sugary drinks and processed foods, while encouraging water consumption. By following these helpful nutrition guidelines, parents can set their children up for optimal health.

3. Get Active as a Family

Make physical activity a fun family affair. Go for walks, bike rides, play active games, or participate in sports together. Aim for at least 60 minutes of daily physical activity for children aged 6-17 and encourage movement throughout the day for younger children.

4. Prioritize Consistent Sleep Routines

Adequate sleep is crucial for children's physical and mental health. Establish consistent bedtime routines, limit screen time before bed, and ensure a sleep-conducive environment. Preschoolers need 11-13 hours of sleep, children aged 6-12 require 9-12 hours, and teenagers need 8-10 hours.

5. Replace Screen Time with Family Time

Limit screen time to promote healthy sleep, physical activity, and social interaction. Engage in family activities, such as board games, reading, or outdoor adventures. The American Academy of Pediatrics recommends creating a family media plan to manage screen time effectively.

By implementing these strategies, parents and caregivers can empower children to develop healthy habits and reduce their risk of obesity-related problems.

Additional Resources

Highmark has a variety of educational resources for combatting childhood obesity on the Provider Resource Center (PRC):

- Childhood Obesity Preventive Health Benefit
- Preventive Health Reminder Poster

You can access those resources by going to the PRC, selecting **EDUCATION/MANUALS** from the left menu, and clicking **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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Highmark is hosting a live webinar on **Aug. 15** from **12 to 12:45 p.m. EST**. This webinar will focus on **Mental Well-Being powered by Spring Health**, a behavioral health solution offering expanded access to high-quality providers for every level of care.

This program is ideal for patients seeking timely care, as first appointments are generally available within 3-5 days.

During this webinar, you will learn how:

- Mental Well-Being provides easy access to personalized health care, both virtual and in-person
- You can easily refer Highmark members directly to Spring Health using a simple online form
- Spring Health delivers positive outcomes based on individual needs and preferences

Speakers include:

- **Doug Henry, PhD**, vice president and medical director of enterprise behavioral health, Highmark Health
- **Mill Brown, MD**, chief medical officer, Spring Health

We will share more information and a registration link soon.

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Professional Providers Moving to Group Contracts

Highmark Blue Shield is beginning the process of moving professional providers in its New York markets onto Highmark Professional Agreements — which are group contracts that match the structure that is in place in all other Highmark service regions. For more information, click here.

Physical Medicine Management: New High Performing Provider Program

On **Jan. 1, 2025**, Highmark will launch its High Performing Provider (HPP) Program for practitioners who provide outpatient physical therapy and occupational therapy services. The HPP Program allows greater self-management for providers who meet certain performance metrics. To learn more, go here.

How to Submit Prior Authorization Requests for Outpatient Physical Medicine Services

Prior authorization is required for outpatient physical medicine services. When requesting prior authorization for these services via the Predictal™ Auth Automation Hub in Availity®, providers must select "Physical Medicine" as a Sub-Service Type. For step-by-step instructions, click **here**.

Latest Edition of MCG Guidelines – Aug. 1, 2024

The 28th edition of MCG's Care Guidelines will be available on **Aug. 1, 2024**.

After that date, you will be able to submit authorization requests using the 28th edition for any new requests. Any authorization requests with a start of care date prior to Aug. 1, 2024, will be reviewed using the 27th edition.

Please continue to use the Predictal application in Availity® to submit authorization requests with clinical information included.

ASAM 4th Edition to be Implemented on July 1

Effective July 1, 2024, Highmark will transition from the American Society of Addiction Medicine (ASAM) Criteria 3rd Edition to the ASAM Criteria 4th Edition. Highmark uses ASAM criteria to review authorization requests for substance abuse services.

To learn more about the ASAM Criteria 4th Edition, go **here**.

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Low back pain (LBP) is incredibly common, affecting 75% of adults at some point in their lives. Each year, 2.5 million Americans seek outpatient care for 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.

Healthcare Effectiveness Data and Information Set (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.

Codes You Should Know

ICD-10 Uncomplicated Low Back Pain Code Ranges: M47.26–M47.898; M48.061–M48.08; M51.16–M51.87; M53.2X6–M53.88; M54.16–M54.9; M99.03–M99.84; S33.100A–S33.9XXA;

S39.002A-S39.92XS.

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:

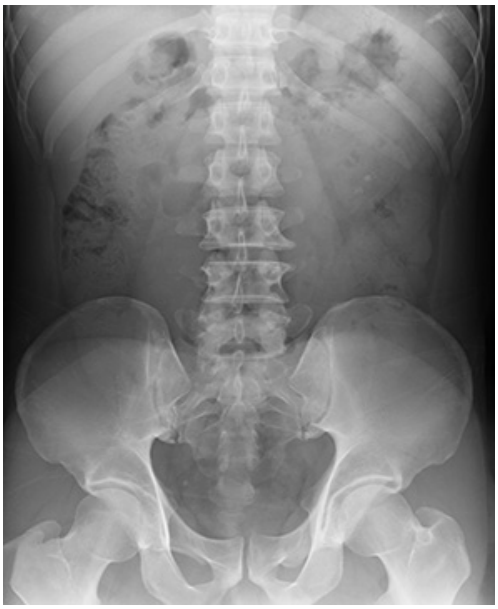
- Discitis, unspecified, lumbar & lumbosacral region
- Muscle spasm of back
- Contusion of lower back
- Abnormal reflex
- Unspecified superficial injury of lower back

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 past 12 months)
- Osteoporosis medication therapy
- History of lumbar surgeries
- Spondylopathy
- Recent uncomplicated LBP (past 6 months)



What Can Providers Do to Improve HEDIS Scores?

HEDIS measures the level of quality care provided by physicians and health plans. 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 if 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.

**HEDIS® — an acronym for Healthcare Effectiveness Data and Information Set — is a registered trademark of NCQA.*

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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Working to Meet Patients' Language Needs

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 provide information on available interpreting services.

Highmark annually assesses languages spoken by population in our service areas and compares them to the data that practitioners report on their network applications. Our 2024 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		X
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	✔	
Polish	✔	
Portuguese		X
Punjabi	✔	
Russian	✔	
Serbo-Croatian		X
Spanish	✔	
Swahili or another Central, Eastern, and Southern Africa	✔	
Tagalog (including Filipino)	✔	
Tamil	✔	
Telugu	✔	
Thai, Lao, or another Tai-Kadai	✔	
Ukrainian or another Slavic		X
Urdu	✔	
Vietnamese	✔	
Yiddish, Pennsylvania Dutch, or another West Germanic		X
Yoruba, Twi, Igbo, or another Western Africa	✔	

- The above data is from the 2022 U.S. Census – American Community Survey One 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 2023, Highmark received 33,914 calls — an increase of 652 from 2022 — from members speaking 71 different languages. The largest percentage of calls (87%) was from members speaking Spanish. The total number of calls serviced for Spanish was 29,382.


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July Coding Webinar: Cancer

"Cancer" will be the topic for the Coding and Quality Knowledge College webinar on **Wednesday, July 10, 2024, at 12:15 p.m.**

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

Here's the topic schedule for the rest of the year:

- **Aug. 14** – Respiratory Conditions
- **Sept. 11** – V28 Updates*
- **Oct. 9** – Depression
- **Nov. 13** – BMI, Morbid Obesity, and Malnutrition
- **Dec. 11** – Cardiac Conditions

All webinars are held **12:15 – 12:45 p.m. EST** on the second Wednesday of the month.

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 (PRC). Select **EDUCATION/MANUALS** from the left menu and then click **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. To register for the July webinar on Cancer, go here.

**V28 will be the new Centers for Medicare and Medicaid Services (CMS) Payment Model. The current payment system is a combination of both the V24 (which was the previous model) and V28 models. The V28 model goes into full effect for dates of service starting Jan. 1, 2025.*

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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 and 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 the individual's employment, contract, or appointment: **Within 90 days** • During employment, contract, or appointment: **Between Jan. 1 and Dec. 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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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
- 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:

Prior Authorization Changes Occurring on Sept. 30, 2024

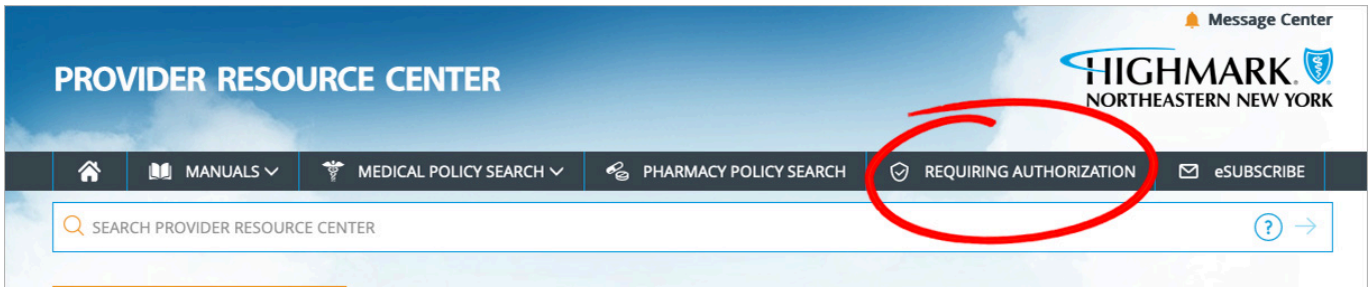
Effective Sept. 30, 2024, nearly 100 codes will be added to the prior authorization list, including codes related to the following procedures and/or treatments:

- Implantable defibrillator
- Insertion of new or replacement pacemaker; Removal of permanent pacemaker
- Mastectomy
- Nasal/sinus endoscopy
- Rhinoplasty
- Prostatectomy
- Revascularization
- Tonsillectomy and adenoidectomy
- Transcatheter aortic valve replacement

Codes to be Added to Prior Authorization List

These additional codes will not appear on the Prior Authorization list until the effective date of **Sept. 30, 2024**. To view the codes now, click here.

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 is the preferred method for:

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

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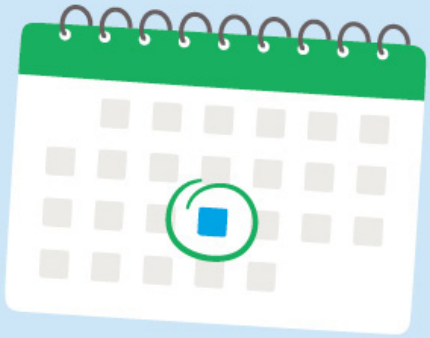
Medically Unlikely Edits: **Providers Must Bill for Individual Dates, Instead of Span Dating**



Highmark applies Medically Unlikely Edits (MUEs) to submitted claims to ensure members receive appropriate, cost-efficient care based on evidence-based, clinical guidelines. Using MUEs, Highmark has detected an increasing number of claims with primary procedure codes being span-dated (or range-dated) while the add-on codes are not, which results in processing errors.

Effective Sept. 22, 2024, Highmark is requiring providers to submit primary codes and add-on codes with individual dates of service vs. a span date. This is to ensure correct processing of the primary and/or add-on code for a specific date.

Span-dated claims that contain primary procedures with add-on codes will be rejected or denied by Highmark.

Background on MUEs

Highmark follows National Correct Coding Initiative (NCCI) guidelines created by the Centers for Medicare and Medicaid Services (CMS). MUEs and NCCI MUE edits are applied to claims based on the values posted by the CMS. Highmark reserves the right to apply MUE edits outside of the CMS values when it is deemed clinically appropriate, or to use statistical methods to determine MUEs when no industry standard MUEs are available.

For more information, see **Reimbursement Policy (RP)-035 Correct Coding Guidelines**, which is available on the Provider Resource Center. Select **CLAIMS, PAYMENT & REIMBURSEMENT** from the left menu and click on **Reimbursement Policy**. Once on the page, type "035" into the search bar.

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Corrected Claim Process Update: Changes Will Go Directly on Replacement Claim

Starting Aug. 23, 2024, providers will 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 only applies to the following lines of business: Commercial and Medicare Advantage.

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®, corrected claims can be submitted within the **claim entry screen** by selecting Frequency Type 7 and providing the original claim number.

Current Process

Here's how the current correction or adjustment claims process works:

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 Is Changing

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

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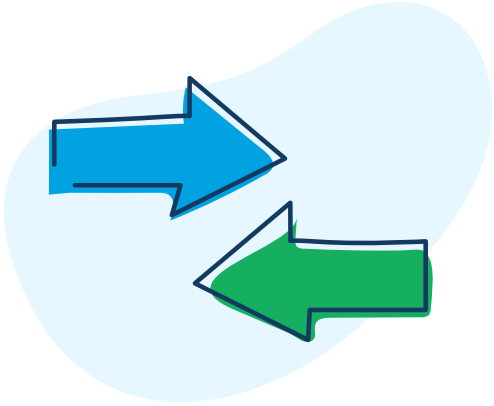
New and Updated Reimbursement Policies, Including Changes to RP-051



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

June 1, 2024

RP-068 Mid-Level Practitioners and Advanced Practice Providers
This policy will be updated to include the new licensed associate marriage and family therapist (LAMFT) and licensed associate professional counselor (LAPC) specialties for Delaware and Pennsylvania. It will also be restructured for clarity purposes.

June 3, 2024

RP-067 Specific Service Daily Maximum
Reference to NaviNet – Highmark's former provider portal – was removed from this policy.

June 24, 2024

NEW: RP-077 Intraoperative Neurophysiological Monitoring
Highmark has created RP-077 to provide direction on reimbursement for Intraoperative Neurophysiological Monitoring (IONM) services. *(NOTE: This policy will be available on the PRC on the effective date of June 24, 2024.)*

UPCOMING

July 1, 2024

RP-006 Multiple Endoscopy Procedures
Code 0884T will be added to the "Group 14: Esophagoscopy – Endo Base Procedure 43200" section of this policy. Code 0885T will be added to the "Group 23: Colonoscopy through Rectum – Endo Base Procedure 45378" section. Code 0886T will be added to the "Group 22: Sigmoidoscopy – Endo Base Procedure 45330" section.

RP-011 Procedure Codes Not Applicable to Commercial Products
Codes G5019 – G5031 will be added to this policy.

July 25, 2024

RP-051 Multiple Procedure Payment Reduction for Therapy Services
In the current version of RP-051, New York is marked in error as being an applicable Medicare Advantage market. The policy will be updated on July 25, 2024, to correct this and it will be removed from the NY PRCs.

August 8, 2024

RP-053 Gene and Cellular Therapy
This policy will be updated with new drugs and therapies, as well as cross-references to medical policies. The name of RP-053 will change from "Gene and Cellular Therapy" to "Advanced Gene and Cellular Therapies."

COMING SOON

Effective Date to Be Determined

NEW: RP-076 Medical Nutrition Therapy

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

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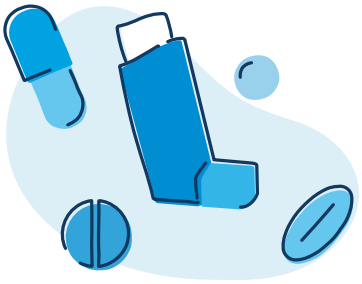
Quarterly Formulary Updates



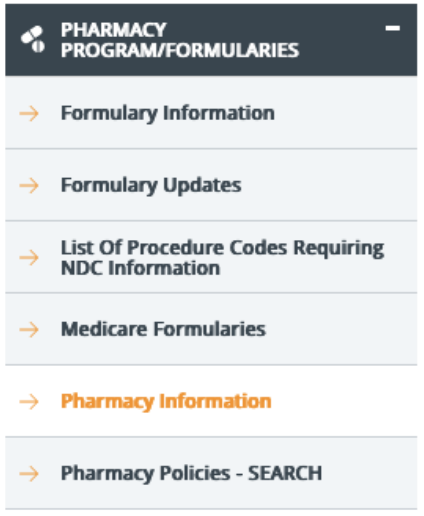
View the April 2024 updates to Highmark's prescription drug formularies and related pharmaceutical management procedures at the Formulary Updates page on the **Provider Resource Center (PRC)**. From the left menu, select **PHARMACY PROGRAM/FORMULARIES** and then **Formulary Updates**.

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.

HIGHMARK NORTHEASTERN NEW YORK

PROVIDER NEWS

A newsletter for Highmark Blue Shield providers in northeastern New York

Issue 6, June 2024

Directory Information – Here's How to Attest

When Highmark members are looking for a primary care physician (PCP) or specialist, they expect that our online provider directory presents information that is accurate and current.

That's why it is essential to ensure that your practice information on file with Highmark remains up to date.

Please be aware that providers who don't validate their data quarterly may be removed from the directory and their status within Highmark's networks may be impacted.

Reviewing Data Is Vital for You

The Centers for Medicare and Medicaid Services (CMS) requires Highmark to reach out to you every quarter and ask you to validate your provider directory information. We use this information to populate our online provider directory and to help ensure correct claims processing.

Your thorough review of your directory information confirms:

- **Each practitioner's name** is correct and matches the name on his/her medical license.
- **Each practitioner's National Provider Identifier (NPI) is correct.**
- **The practice name is correct** and matches the name used when you answer the phone.

- **All specialties are correctly listed** and are currently being practiced.
- **Practitioners listed at a location** currently see members and schedule appointments at that office on a regular basis.
    - All practitioners listed must be affiliated with the group. Practitioners who cover, read test results, or are hospitalists should not be listed in the provider directory.
- **The practitioner is accepting new patients** — or not accepting new patients — at the location.
- **The practitioner's address**, suite number (if any), and phone number are correct.

Professional Providers – Use the PDM Tool

Professional providers are now required to validate their Highmark Provider Directory information within the Provider Data Maintenance (PDM) tool every 90 days.

To access PDM, sign in to Availity®, choose the state you practice in, click **Payer Spaces** from the task bar, and then select the Highmark plan you participate in. Once you arrive at the **Payer Spaces** page, scroll down, and select **Provider Data Maintenance** under **Applications**.

Facility, Ancillary, and Medicaid Providers – Use Atlas

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

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

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

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

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

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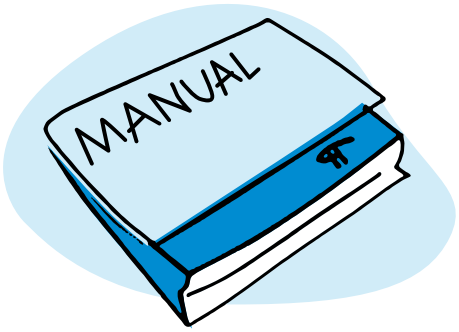
Staying Up to Date with the *Highmark Provider Manual*

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



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

Some recent noteworthy changes occurred in the following chapters and units:

- **Chapter 1, Unit 2: Online Resources & Contact Information**
- **Chapter 3, Unit 2: Professional Provider Credentialing**
- **Chapter 3, Unit 3: Professional Provider Guidelines**
- **Chapter 5, Unit 1: Care Management Overview**
- **Chapter 5, Unit 2: Authorizations**
- **Chapter 5, Unit 5: Denials, Adverse Benefit Determinations, Grievances, and Appeals**
- **Chapter 5, Unit 6: Quality Management**
- **Chapter 6, Unit 1: General Claim Submission Guidelines**

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

HIGHMARK NORTHEASTERN NEW YORK

PROVIDER NEWS

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Issue 6, June 2024

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.

HIGHMARK NORTHEASTERN NEW YORK

PROVIDER NEWS

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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

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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.