HIGHMARK NORTHEASTERN NEW YORK

PROVIDER NEWS

A newsletter for Highmark Blue Shield providers in northeastern New York

Issue 7, July 2024

Starting this Thursday, providers in Highmark's New York service areas will be required to use Availity Essentials® or the Interactive Voice Response (IVR) to check claim status or submit a claim inquiry.

Those tools are available 24/7 and will provide the quickest answers to common questions, allowing our Provider Service Center advocates to assist with more complex issues and your staff avoid unnecessary hold times on the telephone.

Effective **Aug. 1, 2024**, your claim status and claim inquiries will be addressed through Availity and IVR. If you call the Provider Service Center, you will be directed to our self-service tools:

- **Availity Essentials, Highmark's Provider Portal –** the primary method for submitting transactions to Highmark and accessing reports.
    - If your organization is not already registered with Availity, go to the Register and Get Started with Availity Essentials webpage for details on how to register.

We also recommend that you review the Manage My Organization user guide to ensure your organization is set up to transact with Highmark.

- **Interactive Voice Response (IVR) –** quickly manage routine inquiries, such as claim status or member benefits, without a live agent via the Provider Service Center.

There is a special section on the Provider Resource Center about our Self-Service Tools. By familiarizing yourself with these tools, you'll be able to increase office efficiencies and get more done faster.

For guidance on how to check claim status and conduct claim inquiries in Availity, click here.

Highmark first announced this change in our New York markets in April 2024. Read our previous communication here. The same requirement rolled out in Delaware, Pennsylvania, and West Virginia last year.

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HOW-TO GUIDE:

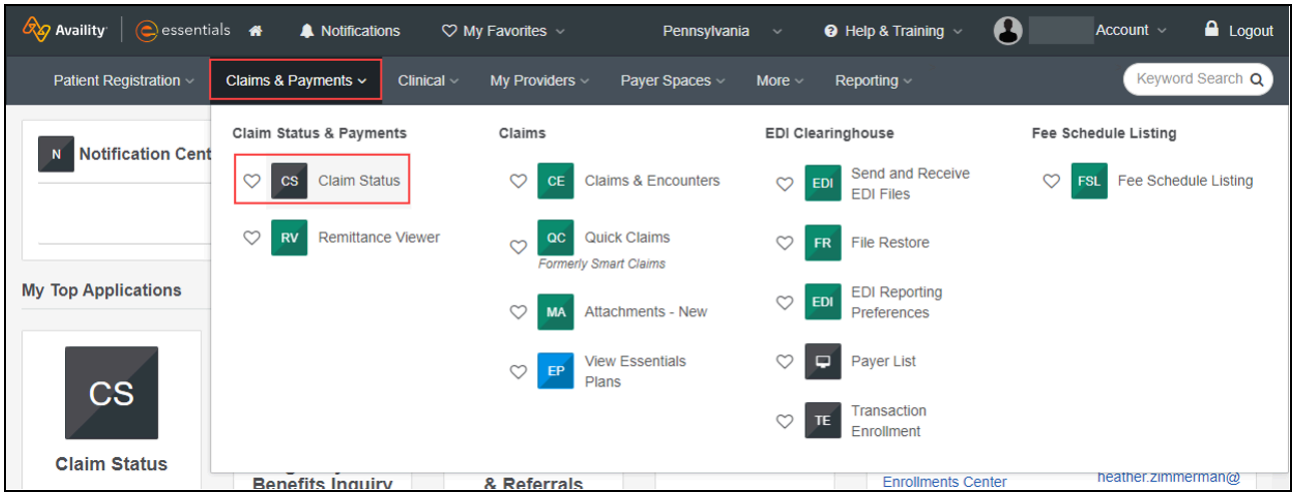
USING THE CLAIM STATUS AND CLAIM INQUIRY FUNCTIONS IN AVAILITY

The Availity® portal enables providers to quickly and easily check **Claim Status** and conduct **Claim Inquiries**. Follow the steps below on how to access and use both of these essential functions.

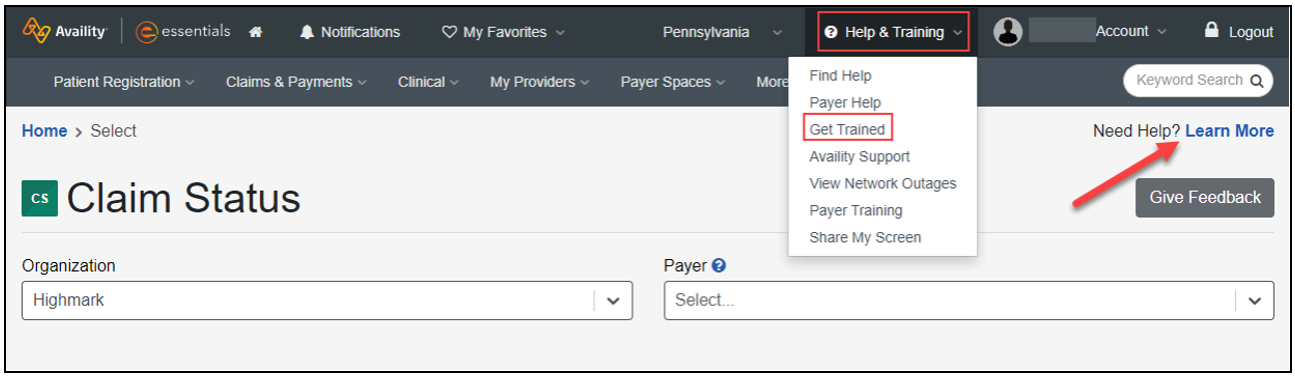
Claim Status

1. How to Access

- Once logged into Availity, you can access the **Claim Status** function under **Claims & Payments** in the Availity main website menu to search for claims or view a claim status.



- Under **Help & Training**, click **Get Trained** for additional information on **Claim Status**. You can also click on the **Learn More** link once you arrive at the **Claim Status** page.



2. How to Use

With **Claim Status**, you can search for claims using various criteria. You can also view information about each claim, such as its status and claim lines. Enhanced claim status provides additional payment information that is not found on the **HIPAA Standard** search.

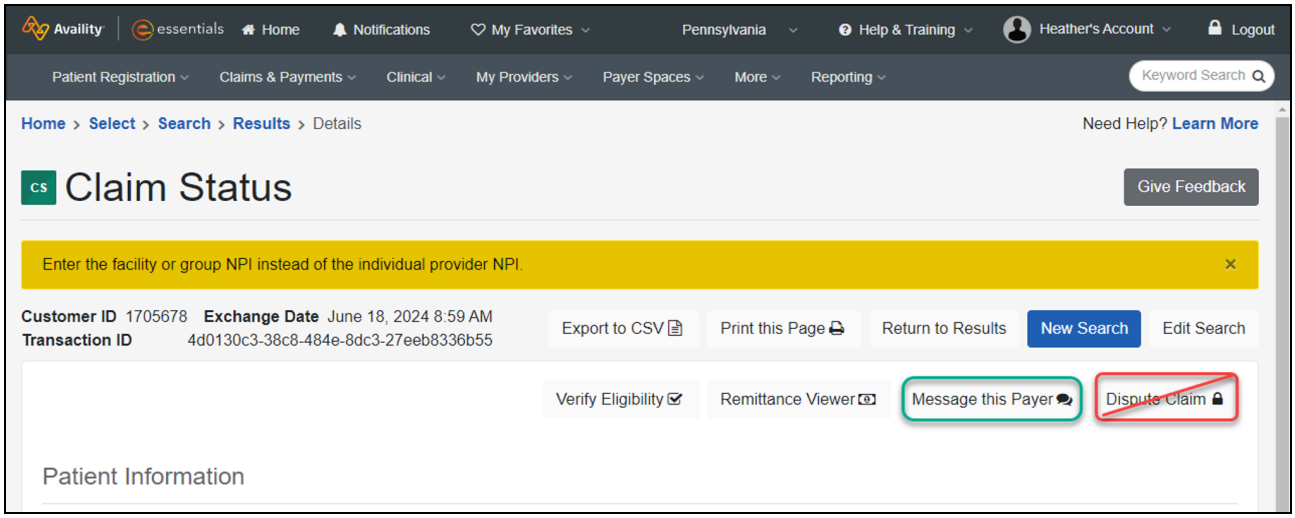
Consider these guidelines when viewing claims using **Claim Status**:

- Each claim is represented by a claim card, which displays summary information about a claim, including the claim number, claim service dates, claim status, amount billed, and amount paid.
- The color of the status bar on the left side of each claim card indicates its status:
  - **Green – The claim is finalized.**
  - **Yellow – Payment of the claim is pending.**
  - **Red – The claim was denied by the payer.**
- To search for an out-of-area member's claim, you must use the **HIPAA Standard** search. Be sure to include the member's prefix.

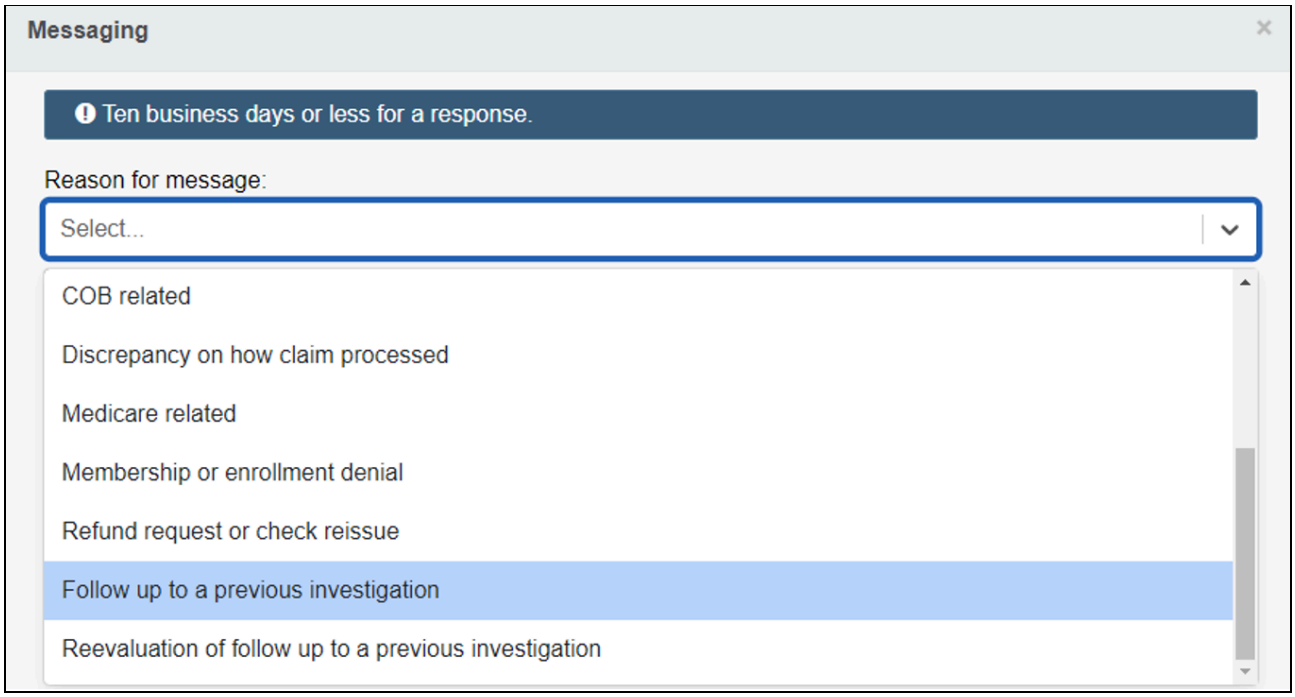
Claim Inquiries

How to Submit an Inquiry

- Locate the claim when using **Claim Status**, and then click **Message this Payer** to send your inquiry to Provider Service.
    - **IMPORTANT:** Do **not** click the **Dispute Claim** button. It is **NOT** currently operational for Highmark.



- You must wait **30 days** before sending a follow-up to a previous inquiry if you haven't received a response.
- If you have received a response, but you don't agree with it or you require additional information, locate the claim in **Claim Status**, select **Message this Payer**, and then click "**Follow up to a Previous Investigation**" to send an additional (second) inquiry to Provider Service.



- You may submit additional **Claim Inquiries** if needed by following the above instructions and choosing “Reevaluation of a follow up to a previous investigation" from the dropdown.

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In May, Highmark named Jerry Walsh as Senior Vice President (SVP) of Provider Contracting. Walsh had previously served at Highmark as a SVP, Market Executive, responsible for the overall performance of the Northeastern Pennsylvania and Delaware markets. He has over 25 years of experience in the health care industry managing provider networks, developing dynamic partnerships, and implementing innovative strategies to improve health care delivery.

As SVP of Provider Contracting, Walsh is responsible for managing Highmark's provider network to deliver market-leading cost and quality outcomes that meet the evolving needs of Highmark's members.

We sat down with Mr. Walsh to ask him about several topics related to our networks, providers, and reimbursement strategies.

Q What are your current priorities and key focus areas within your new role?

In the short term, my focus is on getting to know the team and understanding their needs. I'm looking at our goals as an organization and what we need to get done over the next three years — ensuring we have the people and capabilities to achieve those goals. I'm also focused on maintaining Highmark's strategy which is having networks in place that serve the diverse needs of the people we serve — and ensuring that those networks are achieving both the cost and quality transformation goals that we desire as a company.

Q What do you believe are the biggest challenges in building and maintaining provider networks?

I would say the biggest challenge as a health insurance company is balancing that most people we serve, whether that be group customers or individual purchasers, believe they want the broadest network possible because they want choice and they want access to it. But at the same time, they want the lowest cost and the best quality, but sometimes those don't always go together.

When it comes to network providers, we have to work with likeminded providers who are truly interested in the same things we are, which are improving the member experience, improving the provider experience while managing a better total cost of care and better-quality outcomes. To do that, you must be working together, sharing information, and creating joint solutions.

Q How does Highmark ensure its provider partnerships are continually adding value for both network providers and members?

It's really been a constant state of evolvement since I started with Highmark in 2015. Highmark is always seeking better ways to work with providers.

We maintain metrics that we use to evaluate our relationships to ensure that we're delivering a better total cost of care for the populations that are being served — while maintaining or improving quality. We're also looking at our membership in those markets where we have partnerships to ensure growth and support of those providers.

When we launched Living Health, we really changed our thinking on how to partner with our providers with the goal of transforming care delivery. Today, we have a more diverse team with different backgrounds and perspectives involved in those discussions. We're bringing together people like me who really understand the health insurance business along with clinicians who have

practiced and recognize the needs there. Then, add in technology and the people who are helping to create solutions to improve the experience of our providers and our members. It's a more collaborative approach.

Q How is Highmark working to improve outcomes and lower costs through its Value-Based Care strategy?

Highmark has been at the forefront of value-based reimbursement (VBR) starting with our hospitals and health systems over 20 years ago — and more recently with our True Performance program for primary care physicians which was groundbreaking at the time. We continue to expand and improve upon existing programs to address emerging health challenges.

We're going through a process now to refresh the toolbox. Our goal is to increase the percentage of spend that is covered under value-based care programs versus straight fee-for-service. We've been improving that number year over year and will continue to do so. What we've also focused on in the last few years is identifying provider partners who are willing to work with us to create a global value-based reimbursement model that creates a higher level of financial, clinical, and analytical alignment. And that's not always easy to do. We're running a health plan and they're running a health system or physician practice. We must find a way to create a balance there — with a focus on better outcomes for the people we serve.

We've been able to stay ahead of the curve, and I think we'll continue to do that.

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Annual Fee Schedule Update Will Occur on Nov. 1, 2024

Our annual fee schedule update for commercial and Medicare Advantage products in our New York regions will take effect on **Nov. 1, 2024**. Updates include some incremental increases and decreases throughout the fee schedule to align with Highmark's fee schedules.

Fee schedules are divided into two sections: "Primary Care" and "Other," so primary care providers (PCPs) and specialists, as well as other providers, can quickly find the fee schedules that apply to their practice.

The updated fee schedules will be published by **Aug. 2** on the Provider Resource Center, accessible through Availity.

Accessing Fee Schedules via Availity®:

- Log on to Availity and choose **New York** from the task bar at the top of the home page.
- Click **Payer Spaces** and then select the Highmark plan you participate in.
- Once you arrive at the next page, scroll down and click **Provider Resource Center**.
- From the left menu, click **CLAIMS, PAYMENT & REIMBURSEMENT** and then **Fee Schedule Information** from the dropdown menu.

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Highmark is committed to connecting our members with chronic conditions to meaningful support. Our Clinical Support Programs provide personalized support and guidance to help your patients manage their chronic conditions between office visits.

For example, a patient with type 1 or type 2 diabetes will be eligible for our virtual Diabetes Management Program and a Highmark member diagnosed with congestive heart failure (CHF) and/or chronic obstructive pulmonary disease (COPD) can be enrolled in CHF and COPD Management powered by Vida.

Accurate coding is crucial to ensure that your patients gain access to these valuable programs. Their eligibility is based on the diagnosis codes you send us through claims. Please help us offer the right programs to Highmark members who need them by:

- Reviewing patient records, and accurately documenting and coding diagnoses and conditions
- Staying up to date on the latest coding guidelines
- Ensuring your patients are aware of their diagnoses

By working together, we can make sure that your patients have access to the resources they need and support your office by helping your patients stay healthy and stick to their care plans.

Resources

Coding guidance can be found on the Provider Resource Center (PRC) . From the left menu, you can select the following resources:

- **EDUCATION/MANUALS > Coding Education/HCC University**
- **EDUCATION/MANUALS > Population Health University > Coding Education**

To learn more about Highmark's Clinical Support Programs, including patient eligibility information, please go to:

- **EDUCATION/MANUALS > Clinical Support Programs**

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ENCOURAGING MEDICARE PATIENTS TO IMPROVE HEALTH OUTCOMES

Older patients are at a higher risk for falls, incontinence, emotional health issues, and problems with medication management. To improve patients' well-being and encourage continued open discussion about their health status, we recommend focusing on the following items:

- **Conducting annual wellness visits with your patients**, especially those who are Medicare Advantage members. Encourage patients to schedule their visit for the following year before they leave.
- **Screening patients for fall risk** and developing a fall risk reduction plan for patients who screen positive.
- **Documenting the screening** (and fall risk reduction plan if applicable) and including the appropriate CPT II code on your claim.

- **Asking patients if they have experienced urinary incontinence**, and providing information and resources that can help them.
- **Checking in on patients' emotional health** and referring them to appropriate resources.
- **Having direct conversations about starting, increasing, or maintaining physical activity** with patients.
- **Conducting medication reconciliation** for appropriate usage with patients.
- **Encouraging patients to stay up to date on health care visits and screening opportunities**, while notifying their care team regarding any changes in their health status.

Additional Resources

Highmark has created the Care Conversation video series to encourage members to discuss fall risk and bladder control with their health care providers. If you'd like to view these videos and share them with your patients, click the links below:

- Care Conversations: Fall Risk
- Care Conversations: Bladder Control

Highmark members may also have programs available through their health plan to support their physical and mental health. They can get additional information by contacting Member Service at the number on the back of their member ID card.

How are these outcomes measured?

The Medicare Health Outcomes Survey (HOS) is an annual survey — administered from July through November by the Centers for Medicare and Medicaid Services (CMS) — to a random sample of Medicare Advantage (MA) members.

Every year, a new cohort of MA patients receives a baseline survey; then two years later, those same respondents are surveyed again. HOS measures members' perceptions of their physical and mental health, and how their health has changed over time.

HOS includes five Healthcare Effectiveness Data and Information Set (HEDIS®) measures that contribute to the health plan's Medicare Star Rating:

- **Monitoring physical activity**
- **Reducing the risk of falling**

- **Improving bladder control**
- **Improving or Maintaining Physical Health**
- **Improving or Maintaining Mental Health**

Survey responses are confidential and may be completed by MA patients or their designated representatives. Initiating discussions about the HOS topics may lead to better health outcomes for your patients. Such conversations also help support gap closure programs.

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.

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

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Quarterly Fee Schedules

The standard professional quarterly fee schedules were published on July 26, 2024. The Corporate Drug Fee Schedules files have been divided into two fee schedules:

- Commercial Drug fee schedule
- Medicare Advantage Drug fee schedule

To view the quarterly fee schedules on the Provider Resource Center (PRC), log into Availity®. Click **Payer Spaces > Your Highmark Plan > Provider Resource Center**.

Once you arrive at the PRC, choose **CLAIMS, PAYMENT & REIMBURSEMENT** from the left menu and click **Fee Schedule Information**.

Express Scripts Pharmacy to No Longer Stock a Limited Set of Medications

Effective Aug. 19, 2024, Express Scripts Pharmacy will no longer stock a limited set of medications for all lines of business. Members currently receiving impacted drugs will have the option to fill an alternative drug at Express Scripts home delivery, but those who want to or need to continue filling the impacted drugs will need to do so from an alternative, in-network retail pharmacy. For more information and to see the list of impacted medications, click here.

Professional Providers: Sign and Return Group Contracts

Highmark Blue Shield is beginning the process of moving professional providers in its New York markets onto Highmark Professional Agreements. Group agreements will reduce the administrative burden of requiring each practitioner to sign an individual contract. Instead, the practice will sign for all participating practitioners. Once your office receives your group contract, we ask that you sign it and send it back promptly.

Save the Date: Mental Well-Being powered by Spring Health Webinar

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. To register, click here.

Reminder: MSK Procedures to Require Prior Authorization Starting Aug. 1

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.

These changes apply to Highmark Blue Cross 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.

To learn more, click here.

Highmark Expands Free Market Health to Our Pharmacy Market in New York

Beginning August 2024, Highmark will welcome Free Market Health (FMH) into our pharmacy market in our New York regions:

- Highmark Blue Cross Blue Shield (WNY)
- Highmark Blue Shield (NENY)

Free Market Health's care driven marketplace seamlessly connects members to a curated selection of high-quality specialty pharmacies. FMH's technology platform enables us to make sure our members receive the most clinically appropriate care at the most competitive pricing.

To learn more, 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.

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HEDIS Measure: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis

Overprescribing antibiotics is a major health concern in the United States. Most cases of acute bronchitis are caused by viruses against which antibiotics are ineffective. Antibiotic resistance has become one of the greatest health threats today. Antibiotics can save lives, but in certain conditions these drugs are not always the answer. Using antibiotics appropriately helps combat antimicrobial resistance and ensures these lifesaving drugs will be available in the future.[1]

Healthcare Effectiveness Data and Information Set (HEDIS®) Measure

Complying with the HEDIS quality measure A**voidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)** occurs when patients three months and older — with a diagnosis of

acute bronchitis (J20X) or bronchiolitis (J21X) — are **not** dispensed an antibiotic on the day of their visit or within three days after.

Exclusionary conditions that will remove the member from the measure:

There are some competing and co-morbid diagnoses that will **exclude/remove** the member from the AAB measure such as: acute pharyngitis, tonsillitis, suppurative otitis media, sinusitis, pneumonia, disease upper respiratory tract, acute lymphangitis, urinary tract infection (UTI), cancer, chronic obstructive pulmonary disease (COPD), HIV, respiratory failure, tuberculosis (TB), among others.

After examination, if a patient medically requires an antibiotic prescription due to one of the above competing diagnoses, please submit the additional ICD-10 code on the claim.

Strategies for Improving the AAB HEDIS Measure

- Avoid prescribing antibiotics for certain illnesses such as acute bronchitis, without pneumonia, when there is no comorbidity of chronic obstructive pulmonary disease (COPD), pulmonary fibrosis, or other chronic lung disease.
- Inform patients of the potential side effects and adverse events related to antibiotic use, even when such antibiotics are necessary and appropriate.
- Recommend supportive care measures such as rest, fluids, and over-the-counter medications.
- Provide clear and concise explanations to patients why antibiotics are not always effective for acute bronchitis.

Antibiotic prescribing is a complex issue, but simple changes can potentially create a significant impact. For additional education on antibiotic stewardship, click here for free courses and webinars from the Centers for Disease Control and Prevention (CDC).

References

[1] Antibiotic Use and Antimicrobial Resistance Facts | Antibiotic Prescribing and Use | CDC

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Getting your patients and our members the care they need in a timely manner is our top priority. Here are 7 tips that will result in faster processing of authorization requests and, ultimately, faster approval of appropriate treatment.

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1. Submit Authorization Requests through Availity®

This is Highmark's online provider portal and this is the fastest way for authorization requests to be reviewed and approved.

Our Utilization Management data shows that using Availity increases authorization turnaround time by 75% compared to alternative submission channels; some approvals are available immediately.

In addition, Highmark is in the process of phasing out fax and phone for authorization requests. Why wait until the last minute? The sooner you make the switch to Availity, the sooner your practice will see the benefits.

To register for Availity, go here.

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2. Don't Procrastinate — Timeliness Matters

For each type of Behavioral Health treatment, there are specific timeframes for submitting authorization requests. See below. If you miss those windows, your request will be rejected.

- **Initial Clinical:** Must be submitted within 7 days of admission.
- **Concurrent:** Must be submitted on the last coverage date (LCD). Requests submitted 7 days or more after the LCD will not be reviewed.
- **Face-to-Face Requirements:**
  - **Psychiatric (Inpatient) and Withdrawal Management:** Face-to-face within 24 hours of admission.
  - **Psychiatric Residential and Residential-Rehab (Substance Use Rehab):** Face-to-face within 7 days of admission.

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3. Know Your Codes

Be clear on the level of care requested and submit the correct CPT codes. This will ensure a faster review of your request. The wrong codes will result in unnecessary delay.

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4. Don't Throw in the Kitchen Sink

Only provide relevant documentation with the request. Don't send the entire chart; instead, provide a synopsis of the clinical information. Other **prohibited** attachments include:

- Insurance Verification Notes
- Copies of Member Benefits
- Past Clinical Records
- Call Logs

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5. Always Specify the Level of Care

In Behavioral Health, there are multiple levels of care; each with its own requirements. Be specific. Is it Urgent or Non-Urgent? If it's Urgent, is it Psychiatric (Inpatient) or Withdrawal Management? The more specific you can be, the faster your request can be reviewed.

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6. Don't Forget the Basics

It happens. You're busy... you're rushing... you're doing seven other things... and then you hit submit. But you forgot to include something essential, such as:

- **Member Information:** Name, Date of Birth, Unique Member Identifier (UMI)
- **Facility Information:** Name and Address
- **Level of Care:** Specify the level of care requested [e.g., Psychiatric (Inpatient), Psychiatric Residential, Withdrawal Management, Residential-Rehab (Substance Use Rehab)]
- **Your Contact Information:** Phone and Fax Numbers

Always double-check your authorization request to ensure that all the necessary information is included.

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7. Provide a Synopsis

Summarize the clinical information instead of attaching the entire chart. Tell us the patient's symptoms and condition and the recommended treatment. This will speed up the authorization review process.

For more tips on submitting BH authorization requests, click here.

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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®
- 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

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

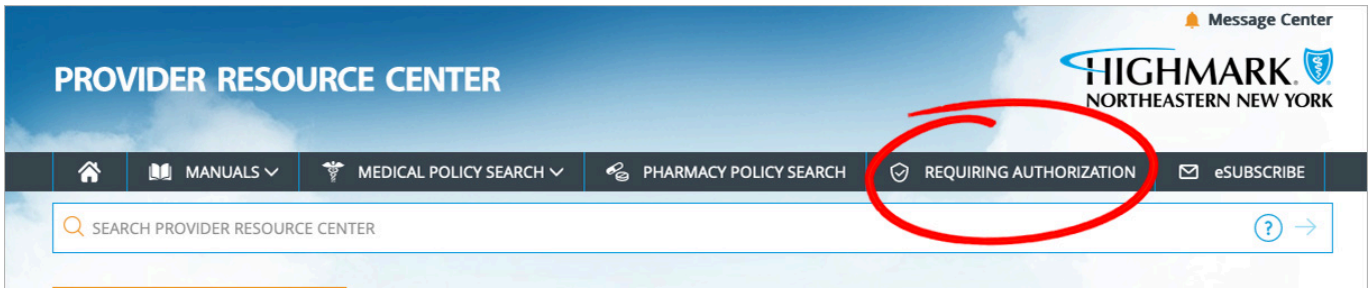
Electronic Authorization Tool Update: Enhanced Functionality and Important Reminders

Highmark is pleased to announce recent updates to our Electronic Authorization Tool, Predictal, available through Availity Essentials. These updates are designed to improve your experience and streamline the authorization process, and they are available now for you and your staff to start exploring. Key enhancements include:

- Searchable Provider Dropdown
- Contact Information Edits
- "Copy as Performing Provider" Feature

To learn more, 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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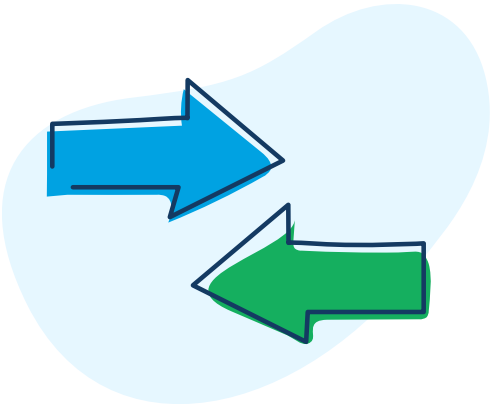
New and Updated Reimbursement Policies



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

Below is a list of recent and upcoming updates to reimbursement policies (RPs):

RECENTLY UPDATED

July 1, 2024

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

RP-007 Multiple Procedure Payment Reduction for Certain Diagnostic Imaging Procedures
Codes 0876T, 0897T, and 0898T were added to this policy.

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

RP-042 Global Surgery and Subsequent Services
Codes 0867T and 0888T were added to the "Services Assigned CMS Global Days Indicator YYY" sections of this policy for Medicare Advantage and Commercial.

July 25, 2024

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

UPCOMING

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."

October 28, 2024

RP-054 Ambulance Services
Direction from Medicare Advantage (MA) Medical Policy T-2 (Ground Ambulance) will be transferred to RP-054, which will become applicable to MA effective **Oct. 28, 2024**. There will be no changes to the MA direction.

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

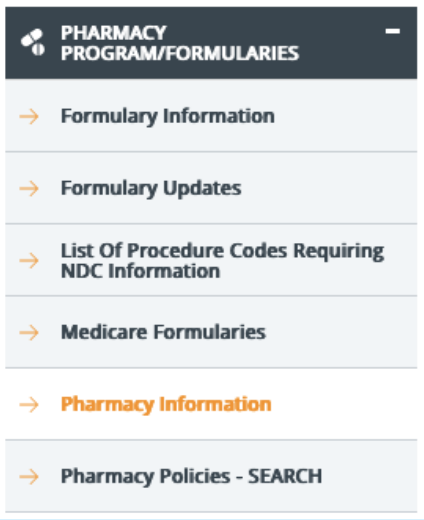
View the June 2024 updates to Highmark's prescription drug formularies and related pharmaceutical management procedures at the Formulary Updates page on the **Provider Resource Center (PRC)**. From the left menu, select **PHARMACY PROGRAM/FORMULARIES** and then **Formulary Updates**.

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 7, July 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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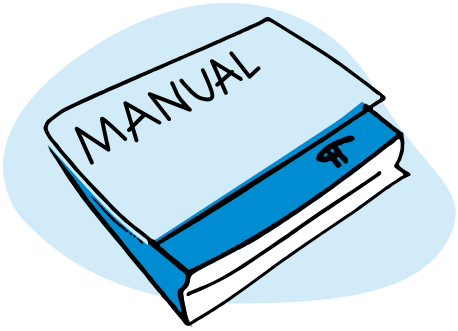
Staying Up to Date with the *Highmark Provider Manual*

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 2, Unit 2: **Medicare Advantage Products & Programs**
- Chapter 3, Unit 2: **Professional Provider Credentialing**
- Chapter 4, Unit 2: **Behavioral Health Providers**
- Chapter 5, Unit 4: **Behavioral Health**
- Chapter 5, Unit 5: **Denials, Adverse Benefit Determinations, Grievances, and Appeals**
- Chapter 6, Unit 3: **Facility (UB-04/8371) Billing**
- Chapter 6, Unit 4: **Professional (1500/837P) Reporting Tips**

Relinquishment of Washington County, Ohio

Highmark Blue Cross Blue Shield in West Virginia relinquished the Washington County, Ohio, service area. The change — which was requested by Highmark — was approved by the Blue Cross Blue Shield Association (BCBSA) in November 2023.

For this reason, references to Washington County, Ohio, were removed from the following areas of the manual:

- **1.1 About Highmark**
- **1.2 Highmark Websites** (PUBLIC WEBSITES section)
- **2.1 Introduction** (HIGHMARK'S CORPORATE ENTITIES section)
- **3.1 Directing Care to Network Providers** (LOCATING NETWORK PROVIDERS section)

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 7, July 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

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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.

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.