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PROVIDER NEWS

A newsletter for the Highmark Blue Shield providers in central Pennsylvania, the Lehigh Valley, northeastern Pennsylvania and southeastern Pennsylvania

Issue 2, February 2023

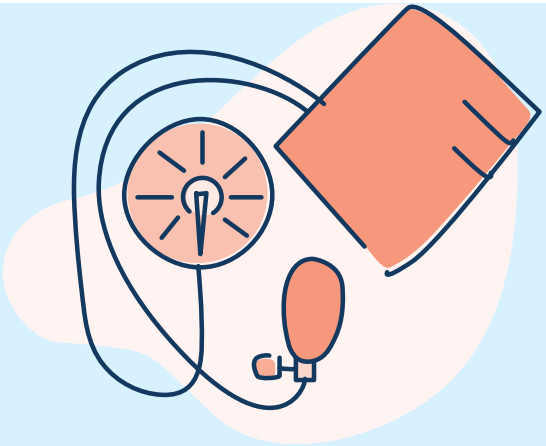
The annual Healthcare Effectiveness Data and Information Set (HEDIS®) Medical Record Review is being conducted now through May 2023.

This review assesses Highmark's contracted provider compliance with a set of standardized performance measurements that Highmark is required to report to the National Committee for Quality Assurance (NCQA). HEDIS data is collected and reported on an annual basis as part of Highmark's accrediting and governmental requirements.

The measurements this year are:

- Controlling High Blood Pressure
- Colorectal Cancer Screening
- Hemoglobin A1c Control for Patients with Diabetes

- Blood Pressure Control for Patients with Diabetes
- Eye Exam for Patients with Diabetes
- Transitions of Care
- Cervical Cancer Screening
- Childhood Immunization Status
- Immunizations for Adolescents
- Lead Screening in Children
- Prenatal and Postpartum Care
- Weight Assessment and Counseling for Nutrition and Counseling for Physical Activity for Children and Adolescents



For information on who will be conducting this year's review, who to contact with your questions, or what the COVID-19 procedures are, please review the recently published Plan Central Message: **Annual HEDIS® Medical Record Reviews to Begin in February 2023**.

To access it, log on to NaviNet® and click on **Resource Center** from the blue left-hand menu. Once you are redirected to the Provider Resource Center, go to the **Plan Central Library** which can be found under **NEWSLETTERS/NOTICES** on the left menu.

Disclaimers: HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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Public Health Emergency Ending on May 11

The federal government announced last month that the COVID-19 national emergency and public health emergency (PHE) will end on **May 11, 2023**.

Throughout the PHE, Highmark modified policies and procedures to allow for greater flexibility of care and ensure the best coverage possible for our members.

With the PHE ending, Highmark is currently evaluating those policies and procedures that were impacted, including (but not limited to):

- Reimbursement Policies
- Coverage and Cost Sharing Changes
- Medical Policies

- Credentialing
- Medicaid Redetermination

Highmark will share those changes with providers in future issues of this newsletter and through Special Bulletins on the homepage of the Provider Resource Center (PRC).

For current information about our COVID-19 policies, visit the PRC. Once on the site, select **COVID-19** from the left menu and click on **COVID-19 (Coronavirus) Information**.


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Cervical cancer is the fourth most frequent cancer in women globally, according to the World Health Organization. In the United States, approximately 13,000 new cases of cervical cancer are diagnosed and about 4,000 women die from this cancer annually.[1]

Providers can help female patients lower their risk of cervical cancer by recommending — and administering — vaccinations and appropriate screenings.

Vaccinations

The human papilloma virus (HPV) has been identified as a major cause of cervical cancer. The HPV vaccination can help protect women from multiple types of HPV infection.

The HPV vaccination is routinely recommended for preteens ages 11–12 (can start at age 9). Expanded guidelines for the HPV vaccine now include high-risk adults who are 27–45 years of age.

Appropriate Screenings

Cervical cancer is preventable with the HPV vaccination and regular screenings (Pap and/or HPV tests). Early detection helps in identifying cervical cancer when it is easier to treat.

The annual gynecological exam provides an excellent opportunity to discuss appropriate screenings with your patients to help them meet their individual health goals.

HEDIS® Measures

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a widely used set of healthcare performance measures for a variety of clinical procedures, including cervical cancer screenings.

The Cervical Cancer Screening (CCS) measure evaluates females, 21–64 years of age, who were screened for cervical cancer using any of the following criteria:

- 21–64 years who had cervical cytology performed within the last three years
- 30–64 years who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last five years
- 30–64 years who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years.

HEDIS® Exclusions for the CCS Measure

- Members who have had a total, abdominal, vaginal hysterectomy with no residual cervix, cervical agenesis, or acquired cervical absence are not required to have this screening performed.
- Members currently in hospice and/or have received hospice services during the measurement year.
- Members currently receiving palliative care.

NOTE: *Patients who have had an abdominal or vaginal hysterectomy with no residual cervix, and no previous abnormal PAP smears may not be required to have this screening performed unless there is a recent history of cervical dysplasia or cervical cancer.*

Tips

- **Exclusions** – Look back as far as possible in the member's history for exclusions.
- **Closing Gaps** – Be proactive by evaluating practice processes for opportunities to close care gaps every time a patient is seen.
- **Hysterectomies** – Documenting that a member had a hysterectomy does not exclude the member unless the cervix is totally removed.
- **Biopsies** – Do not count biopsies as they are diagnostic and therapeutic only. These are not valid for primary cervical cancer screening.
- **Labs** – Lab results that indicate the sample contained "No Endocervical Cells" may be acceptable if a valid result is reported for the test.

Documentation in the medical record must include both the following:

- A note indicating the date the procedure was performed.
- The result or finding.

Annual gynecological exams can be a life-saving appointment — remind your patients about their importance!

References:
1 https://www.cdc.gov/cancer/cervical/statistics

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SHORT TAKES:

First Priority Health, MCG Transition, and More

First Priority Health

Highmark Blue Cross Blue Shield members within the First Priority Health (FPH) HMO network may now request outpatient laboratory and radiology services from any participating facility, no matter the location. When requesting one of these services, providers must submit a script and authorization. Per this change, the FPH Outpatient Laboratory program in Luzerne and Lackawanna counties and the Outpatient Radiology program in Luzerne County (excluding Berwick and Hazleton areas) was eliminated on **January 1, 2023**. To read more, go here.

Reprocessing Effort for July BlueCard Plan Claims Continues

As previously communicated, a number of BlueCard claims submitted to Highmark between **July 1 and July 19, 2022**, were incorrectly processed as out-of-network. Highmark

continues to work with the Blue Plans who served as the Home Plans to reprocess these claims. Due to the volume of claims impacted, this has taken longer than anticipated. We believe that we will complete this process for most of the claims by the end of March, but it may take until the end of the second quarter to ensure we have addressed all the impacted claims. To read the entire **Special Bulletin**, go here.

Emergency Department Claim Audits

Effective **May 1, 2023**, Highmark will begin auditing all outpatient Emergency Department facility claims to ensure the correct procedure codes are being billed. This may result in a different reimbursement than expected, with Highmark updating the claim to correct the procedure code.

These audits are designed to determine the appropriate and fair level of facility reimbursement for emergency department services based on the Centers for Medicare and Medicaid Services (CMS) criteria to determine the appropriate procedure code. To read the **Special Bulletin**, go here.

Submitting Fractional Numbers for Ambulance Mileage

Effective **April 14, 2023**, for ambulance services claims, providers must submit the exact fractional mileage used. This includes wheelchair van, stretcher van, ground, and air ambulance transport claims submitted for commercial and Medicare Advantage members. To learn more, go here.

Follow-Up After Emergency Department Visit for Mental Illness

Highmark is committed to improving follow-up care for members with behavioral health needs. As a result, Highmark added a new flag to our Daily Emergency Room (ER) Provider Report on **February 13, 2023**. This flag will alert providers when a member has been seen in an emergency room with a diagnosis qualifying for the HEDIS® metric Follow-Up After Emergency Department Visit for Mental Illness (FUM).

To learn more, log on to NaviNet® and click on Resource Center from the blue left-hand menu. Once you are redirected to the Provider Resource Center, go to the **Plan Central Library** which can be found under **NEWSLETTERS/NOTICES** on the left-hand menu.

Transition to MCG

Effective **February 13, 2023**, Highmark incorporated MCG Health clinical guidelines into our criteria of clinical decision support, replacing Change Healthcare (InterQual). **This change is being made to align the clinical review processes and platforms for Highmark health plans.** To learn more, go here.

Telemedicine and Telehealth Update

Highmark is changing Reimbursement Policy-046: Telemedicine and Telehealth Services (RP-046) to again allow reimbursement for the following codes: 99446, 99447, 99448, and 99449. This update is for all commercial lines of business effective **February 20, 2023**. For more information, go here.

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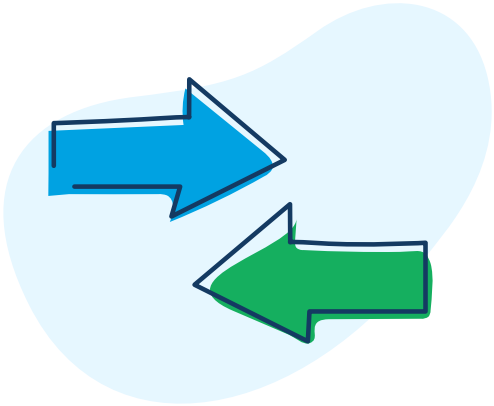
New and Updated Reimbursement Policies



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 upcoming and recently updated Reimbursement Policies (RP):

UPCOMING

May 1

RP-037 Emergency Evaluation and Management Coding Guidelines
Policy is being updated to provide direction on the Plan's analysis of evaluation and management codes for accuracy.

May 29

RP-003 Convenience Kits, Drug and Biological Wastage
Policy is being updated regarding the use of JZ and JW modifier, as well as skin substitute wastage documentation.

RP-019N Drugs and Biologicals
The policy is being updated with direction on the New York market's reimbursement of Drugs and Biologicals. This tiered reimbursement structure has been in place for many years, and it is being documented in a policy for provider consumption. To access, log into NaviNet® and select Resource Center from the left menu. Once redirected to the Provider Resource Center, choose **CLAIMS, PAYMENT & REIMBURSEMENT** from the left menu then **Reimbursement Policy**.

RP-041 Services Not Separately Reimbursed
This policy is being updated for Commercial products to add codes 38204, 90889, 92605, 92606, 92618, 93740, and R0076. These codes will be considered not separately reimbursed and rejected as non-billable to the member.

RP-057 Evaluation and Management Services
The policy is being 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.

NEW: RP-075 Appropriate Use Criteria for Advanced Diagnostic Imaging

Highmark has 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. For more information, click to read the Special Bulletin.

RECENTLY UPDATED

February 13

RP-064 Government Supplied Vaccinations and Antibody Treatments
Policy change to advise that the Emergency Use Authorization has been rescinded for codes Q0220, Q0221, M0220, and M0221.

February 20

RP-046 Telemedicine and Telehealth Services
Policy direction change on codes 99446, 99447, 99448, and 99449, which will

continue to be reimbursed.

February 27

RP-008 X-rays Using Film, Computed Radiography and Computed Tomography: Modifiers FX, FY, CT

Policy is being updated to clarify direction for the Highmark Blue Cross Blue Shield of Western New York (BCBSWNY) and Highmark Blue Shield of Northeastern New York (BSNENY) regions.

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Authorization Updates

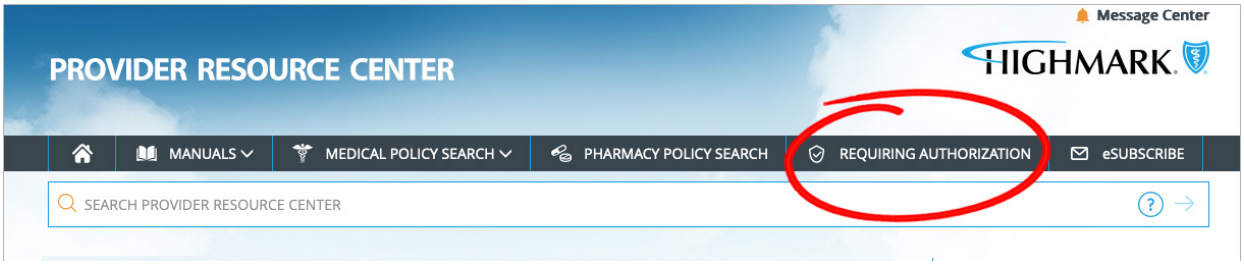
During the year, Highmark adjusts the List of **Procedures and Durable Medical Equipment (DME) Requiring Authorization**. For information regarding authorizations required for a member's specific benefit plan, providers may:

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

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

- Reminder: MCG Launched on February 13, 2023

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 December 2022 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.

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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:

- New York Provider Service phone numbers were consolidated to one phone number (800-950-0051) throughout the manual.
- InterQual information was removed, and MCG Clinical Guidelines were added throughout the manual.

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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 is an independent licensee of the Blue Cross and Blue Shield Association. Highmark Blue Shield serves the 21 counties of central Pennsylvania and the Lehigh Valley as a full-service health plan. 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.

Highmark Senior Health Company and Highmark Benefits Group are service marks of Highmark Inc. 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 plans. Highmark Health is the parent company of Highmark Inc.

The Blue Cross Blue Shield Association is an association of independent, locally operated Blue Cross and Blue Shield companies.

Atlas Systems, Inc. is a separate and independent company that conducts physician outreach for Highmark.

Current Procedural Terminology (CPT) is a registered trademark of the American Medical Association. Healthcare Effectiveness Data and Information Set (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.

Note: This publication may contain certain administrative requirements, policies, procedures, or other similar requirements of Highmark (or changes thereto) which are binding upon Highmark and its contracted providers. Pursuant to their contract, Highmark and such providers must comply with any requirements included herein unless and until such item(s) are subsequently modified in whole or in part.

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.