PROVIDER NEWS

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

Issue 3, March 2025

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Highmark has recently rolled out three new initiatives to accelerate the prior authorization process for providers. These initiatives enable providers to save time and effort when submitting auth requests electronically via the Predictal Auth Automation Hub in the Availability® portal:

1. **Retrospective Claim Review:** Retrospective reviews can be requested via the portal, **effective March 14, 2025**. No more mailing retrospective requests! With this enhancement, providers can submit requests electronically for both Retrospective Claim Review and Retrospective Pre-Claim Review. Click here for more information.

2. **Ability to Withdraw Pending Auth Requests:** With the push of a button in the Predictal Auth Automation Hub, providers can now easily and quickly withdraw a pending authorization request. No need to call Highmark anymore — just click the **Withdraw** button on the **Authorization Detail** page in Predictal. Learn more by going here.

3. **Expansion of Gold Carding Program*:** 1,800 providers were added to the Gold Carding Program on **March 1, 2025**, bringing the total Gold Carded clinicians to over 23,000. In addition, the expanded program will include new hysterectomy codes, outpatient joint replacements, and pain modalities with additional CPT codes to expedite authorizations for these services. See the article in last month's *Provider News*.

We know the prior authorization process is a pain point for providers. Highmark is committed to enhancing this process, making it easier, faster, and more effective for providers and their teams.

We will continue to pursue initiatives that simplify transactions, reduce administrative burden, and increase efficiency for our networked providers and their teams. Our goal is to optimize our processes, freeing up providers and personnel to do what they do best — providing high-quality care to our members and your patients.

**Only applies to providers in Delaware, New York, and Pennsylvania. West Virginia has its own state-mandated Gold Carding program.*

REIMBURSEMENT CHANGES

for Highmark Inpatient DRG Methodologies for Acute Care Facilities

Highmark is updating its inpatient DRG reimbursement methodologies applicable to acute care facilities. These changes will impact acute care facilities that are paid cost outliers under a Highmark inpatient DRG reimbursement method.

Descriptions of the changes to the Highmark DRG reimbursement methodologies will be implemented through issuance of an updated *Hospital Inpatient Facility Manual for the Medicare Severity Diagnosis Related Grouping (MS-DRG) Based Payment Methodology* (or DRG Manual) which will be effective **May 30, 2025**.

Changes to the DRG Manual

Highmark is updating the language in the cost outlier provisions regarding "covered charges" and how those charges are calculated. Prior to this change, covered charges were not defined for purposes of the cost outlier calculation. Language has been added to the DRG Manual noting that "covered charge(s)" shall mean those services rendered to members which qualify for payment or reimbursement pursuant to the terms of the applicable Plan Document, the Agreement, and the Administrative Requirements, as outlined in your Highmark contract.

The DRG Manual has also been updated to note when Highmark will apply the hospital's inpatient cost to charge ratio (CCR) as a multiplier or when other multipliers will be used (specifically for implants and drugs) so that those covered charges more appropriately reflect realized costs for purposes of the cost outlier calculation.

During the week of March 31, 2025, Highmark will email updated DRG Manuals to applicable in-network facilities in Pennsylvania.

Four Reimbursement Policies to be Updated on May 30, 2025

To better manage health care costs for our members, Highmark is updating the four Reimbursement Policies (RPs) listed below.

The changes to these four RPs will be **effective May 30, 2025**.

- **RP-019A: Drugs and Biologicals (formerly RP-019N) – Professional and Facility Providers**

  To align with Highmark's reimbursement methodology for outpatient medications, RP-019A will now include inpatient drugs and biologicals; pricing adjustments to the Average Selling Price (ASP) +10% (Commercial) or ASP +6% (Medicare Advantage) and in the absence of ASP, Average Wholesale Price (AWP). This updated pricing will impact the calculation of covered charges used to determine eligibility for cost outliers under the Highmark DRG inpatient methodologies.

- **RP-040: Facility Routine Supplies and Services – Facility Providers**

  The list of routine supplies, services, and items that are not separately reimbursable will be updated.

- **RP-061: Implants and Implant Components – Facility Providers**

  Following industry best practices, Highmark will now apply the invoice cost for implants as the covered charge(s) for that implant when determining cost outliers under a Highmark DRG inpatient methodology that includes such outliers. Highmark will determine invoice pricing on each claim based on the national invoice average as codified in **RP-061**.

- **NEW: RP-080 Integral or Necessary Services – Professional and Facility Providers**

  The intent of this policy is not to develop new guidance, but rather to provide stand-alone policy language clarifying Highmark's definition of "integral":

  - "Integral" refers to services that are needed or required during the provision of patient care which are inclusive of another service or component parts of a more comprehensive service.
  - "Integral" refers to supplies, equipment and certain services that are inherent, needed or required for the provision of patient care and are considered by Highmark as part of another service.

The updated reimbursement policies, including the new RP-080, will be available on the Provider Resource Center (PRC) starting on May 30, 2025. To view them, go to the PRC > **Claims & Authorization > Reimbursement Programs > Reimbursement Policies**. For **RP-019A**, you must be logged into Availity® to view on the PRC.

To stay informed of upcoming changes, subscribe to our monthly e-newsletter *Provider News* by clicking here.

Quick Claims Just Got Quicker:

Expanded Payer Options for Senior Health and Senior Solutions

Effective March 17, 2025, professional providers in Pennsylvania and West Virginia are now able to submit to Highmark Senior Health and Highmark Senior Solutions through Quick Claims in the Availity® portal.

With this enhancement, providers can submit claims for **both** commercial and Medicare Advantage (MA) members using a single submission. This means practitioners can upload a batch file for multiple patients — even when some are commercial members and others are MA members — all in the same submission.

Background

Quick Claims is a streamlined process designed for high-volume claim submissions, perfect for professionals like therapists who frequently submit claims for multiple patients. This tool allows practitioners to submit claims for **up to 50 patients** simultaneously, saving considerable time and eliminating paperwork.

For more on electronic claim submission, visit this page on the Provider Resource Center.

Latest Edition of MCG Care Guidelines

The 29th edition of MCG's Care Guidelines will be available on **June 30, 2025**.

After that date, you will be able to submit authorization requests using the 29th edition for any new requests. Any authorization requests with a start of care date **prior** to June 30, 2025, will be reviewed using the 28th edition.

We began incorporating clinical guidelines from MCG Health into our criteria of clinical support decisions in February 2023. This change has allowed us to enhance visibility to utilization management criteria while simplifying the authorization process for providers.

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

Providers can view a summary of changes for the 29th edition from their MCG site.

SHORT TAKES:

Unsolicited Attachments in Availity, MID Reimbursement, and More

Supporting Documents Can Be Attached When Submitting New Claims in Availity

Starting April 18, 2025, providers will be able to attach supporting documents when submitting new claims in Availity®. This will save practitioners time and effort, while accelerating the claim review and approval process for Highmark.

Read the full article in last month's *Provider News*.

Delayed Publication: MP V-3 Billing of Observational Services

Medical Policy (MP) V-3, Billing of Observational Services, originally scheduled to be updated on Nov. 4, 2024, will now be published on **March 31, 2025**.

To view this policy, go to the Provider Resource Center. Select **Policies & Programs > Medical Policies** and then scroll down to **Highmark Medical Policy Search**. Click on **Search for Medical Policies** and then, once you arrive at the new page, type "V-3" into the search bar.

Credentialing Update: Psychologists and BH Organizational Providers

Effective May 19, 2025, Highmark is updating and clarifying the credentialing for the following types of practitioners:

- Licensed Psychologists
- Behavioral Health (BH) Organizational Providers

To learn more, click here.

Reimbursement Changes for Some Medical Injectable Drugs

Effective April 1, 2025, Highmark is changing the reimbursement rates for some Medical Injectable Drugs (MIDs) for all regions in Delaware, New York, Pennsylvania, and West Virginia. Reimbursement rates will increase or decrease to align with the average selling price (ASP); drugs lacking an ASP will use the average wholesale price (AWP).

For the full list of injectables, see the article in December *Provider News*.

Accessibility Expectations – Updated for Professional Providers

Highmark recently updated its accessibility expectations for professional providers to align across all markets. Key changes include:

- Faster access to urgent care (immediate response)
- Shorter wait times for non-urgent appointments (48-72 hours) for both primary care physicians (PCPs) and behavioral health providers
- Routine care appointments within three weeks (with subsequent appointments within seven days)
- A new requirement for follow-up visits within five days of discharge or as clinically indicated

Credentialing Communication: Your Email Is Key

Highmark will primarily communicate with you regarding your credentialing via email. It's faster, easier, and accessible during non-business hours. To ensure a smooth process, please monitor your inbox daily, including spam and junk folders.

Keep in mind our team works various shifts, so you may receive emails outside of standard business hours, including evenings and weekends. If additional information is needed, your assigned Credentialing Specialist will contact you or your Credentialing Contact via email. **Please ensure your email address on file is current and accurate.**

During the Initial Credentialing process, Highmark will use the credentialing contact email provided on the initial application for all communication. If no credentialing contact is provided, we will defer to the email address on the application as the primary practice email.

At any time, professional providers can update their email address on the Provider Directory Update form. Facility and ancillary providers can update their email address on the Highmark Facility/Ancillary Change form.

HEDIS Reporting: Transition to ECDS-Only Reporting Underway

Electronic Clinical Data Systems (ECDS) is a HEDIS® reporting standard for health plans collecting and submitting quality measures to the National Committee for Quality Assurance (NCQA).*

In addition to ECDS, there are three other standards for currently reporting HEDIS data:

- **Administrative** – Data collected from office visits, hospitalizations, and pharmacy data.
- **Hybrid** – Administrative data pulled from claims as well as patient medical records.
- **Survey** – Information collected from member questionnaires.

The NCQA's goal is to move most, if not all, HEDIS measures to ECDS by **2030**.

Changes Occurring This Year

For measurement year (MY) 2025, NCQA made the following measure changes to ECDS-only reporting:

Measures ***new*** to HEDIS reporting via ECDS-only:

- Documented Assessment After Mammogram (DBM-E)
- Follow-Up After Abnormal Mammogram Assessment (FMA-E)
- Blood Pressure Control for Patients with Hypertension (BPC-E)

Measures ***transitioning*** to ECDS-only reporting:

- Childhood Immunization Status (CIS)
- Immunizations for Adolescents (IMA)
- Cervical Cancer Screening (CCS)

Last year, Colorectal Cancer Screening (COL) transitioned to ECDS-only reporting.

How will ECDS Affect the HEDIS Process?

Instead of relying on a sample patient size, ECDS will allow for measurement of the total eligible HEDIS population. Also, with ECDS, data can be collected year-round rather than just 12 weeks for hybrid measures. Both of these enhancements will result in more accurate and timely data.

What Impact Will ECDS Have on Providers?

One benefit is that more time can be focused on patient care rather than retrieving medical records for practices subscribing to and submitting their Electronic Medical Record (EMR) data to local Health Information Exchanges (HIEs).

In addition, as more accurate patient data becomes available through ECDS, the management of preventive care strategies is expected to shift from a retrospective focus to a more prospective one.

Current HEDIS Measures Using the ECDS Reporting Standard

- Childhood Immunization Status (CIS-E)
- Immunization for Adolescents (IMA-E)
- Breast Cancer Screening (BCS-E)
- Cervical Cancer Screening (CCS-E)
- Colorectal Cancer Screening (COL-E)
- Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)
- Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)
- Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DSM-E)

HEDIS® — which stands for Healthcare Effectiveness Data and Information Set — is a registered trademark of the National Committee for Quality Assurance (NCQA).

REDUCING READMISSIONS:
A Practical Guide for Medical Providers and Office Staff

Minimizing unplanned hospital readmissions is crucial for achieving better patient outcomes and meeting the 2025 Plan All-Cause Readmission (PCR) HEDIS® measure (January 1 – December 1). This standard focuses on readmissions within 30 days of an index hospital stay (IHS).

The following strategies will help reduce hospital readmissions, while also closing any gaps in the PCR measure.

1. **Proactive Monitoring:** Maintain awareness of daily admissions, discharges, and census to facilitate timely patient follow-up. Schedule post-discharge appointments within seven days whenever feasible.

2. **Medication Reconciliation:** Perform comprehensive medication reconciliation during the first post-discharge visit (in-person or telephonically). Ensure patients understand their medication regimens and address any concerns. **Note:** Patient presence is not mandatory for medication reconciliation.

3. **Targeted Follow-up:** Implement a post-discharge follow-up plan, particularly for patients with multiple chronic conditions. This may involve scheduled phone calls or telehealth check-ins.

4. **Barrier Identification and Resource Navigation:** Engage patients in discussions to identify potential barriers (e.g., understanding discharge instructions, medication access, transportation, personal care needs) to avoiding readmission. Connect patients to appropriate community resources, care management services, or health plan support to address these barriers.

5. **Telehealth Utilization:** Schedule telehealth appointments for patients unable to attend in-person visits.

6. **Emergency Room (ER) Diversion:** In non-emergent situations, encourage patients to contact their primary care provider (PCP) before going to the ER.

(Continued)

Required Exclusions

The following hospital stays are excluded from the PCR calculation:

- Individuals who are pregnant, in hospice care, who die, and who have a principal diagnosis of a perinatal condition.
- Stays where the admission date and discharge date are the same.
- Stays where a direct transfer's discharge date occurs after Dec. 1, 2025.
- Planned hospital stays (e.g., elective surgeries with no acute principal diagnosis).
- Stays with a principal diagnosis of maintenance chemotherapy, rehabilitation, organ transplant, or a potentially planned procedure without an acute principal diagnosis.

Free Patient Resources

Highmark offers valuable resources to assist in patient education and practice compliance. These materials can be ordered through the Provider Resource Center (PRC) at no cost. Access these valuable tools via the Educational Resources – Member & Provider page on the Provider Resource Center:

- Discharge Brochure (English and Spanish versions)
- Where to Go For Care Flyer (English and Spanish versions)

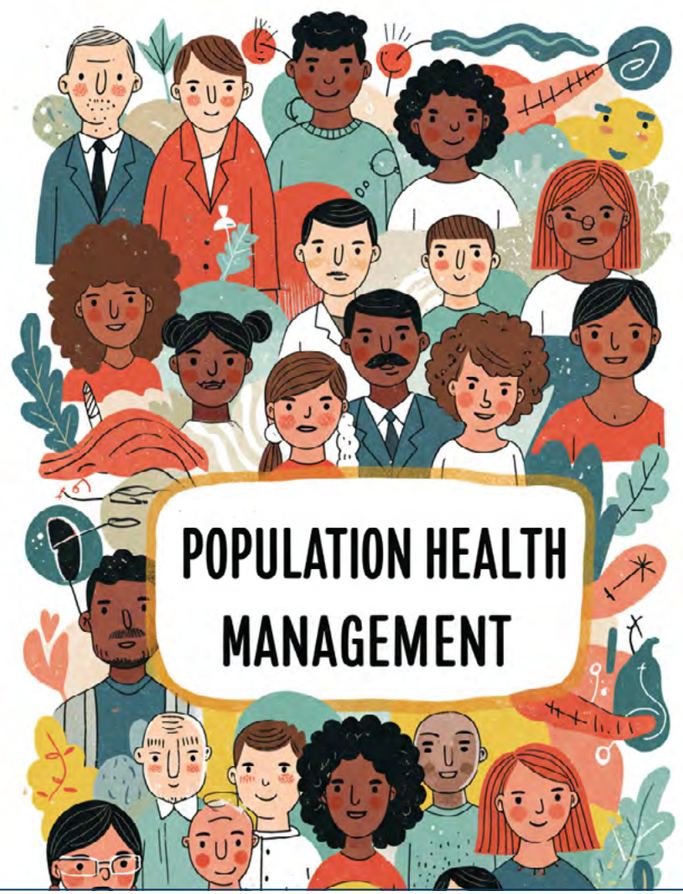
To order, go to the Inventory Request Form, select your region and then choose the items and quantity you want. It's that simple.

By implementing these strategies, medical providers and office staff can significantly contribute to reducing unplanned readmissions and enhancing the quality of patient care. Regular review of performance data and ongoing refinement of these processes are crucial for sustained success.

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.

HEDIS® — which stands for Healthcare Effectiveness Data and Information Set — is a registered trademark of the National Committee for Quality Assurance (NCQA). Information for this article was taken from HEDIS MY 2025 Volume 2: Technical Specifications.

Population Health Management – Helping Members Achieve Better Health



Population Health Management (PHM) involves identifying and helping individuals achieve the highest quality of life possible. Health is influenced by a variety of factors, ranging from behavioral and psychological to medical and genetic, as well as social, financial, and cultural issues.

To improve the quadruple aim – better health care, better patient experience, lower health care costs, and higher clinician satisfaction — it is necessary to perform measurement, monitoring, analysis, and interpretation about the health status of populations and subpopulations, including the impact of social determinants of health (SDOH).

Improving Patient Health

PHM services are offered to Highmark Blue Shield members as part of their health insurance plan.

Through a series of clinically supervised interventions, PHM targets health care needs or conditions to help patients and caregivers:

- Optimize care
- Prevent future complications
- Maximize opportunities for wellness at all points along a member's personal health care journey.

Who Can Benefit from PHM?

PHM programs use clinical, utilization and predictive modeling indicators to help identify members who could benefit from such services. Indicators include, but are not limited to, the following:

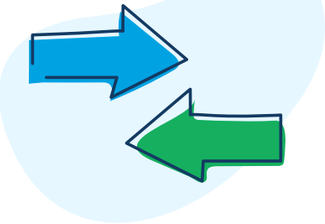
- High-risk diagnoses
- Complex disease processes (including HIV)
- Catastrophic medical events
- High-cost cases
- Quality of care
- Situational and discharge planning needs
- Psycho-social issues
- Financial issues
- Complex care coordination needs
- Multiple admissions and readmissions
- Multiple emergency department (ED) visits and lack of care coordination

  Medication adherence issues
- Health risk assessment screenings

These programs focus on whole person health — addressing medical, behavioral, emotional, and economic needs. Through outreach and education, patients receive help implementing care plans and goals, while having access to behavioral health and social services support through community partnerships.

If you feel a patient would benefit from Population Health Management, please call us at **800-950-0051**.

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) for announcements regarding upcoming policy changes. As specific policy changes go into effect, the updated policies can be found on the Reimbursement Policies page of the PRC.

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

RECENTLY UPDATED

March 3, 2025

RP-001 Assistant at Surgery Services

This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-002 Co-Surgery

This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-003 Convenience Kits, Drug and Biological Wastage

This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-014 Bilateral and Multiple Surgical Procedures

This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-015 Professional and Technical Components for Applicable Services

This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-023 Newborn Care, Obstetrical Delivery, Antepartum and Postpartum Care and Associated Services

This policy was reviewed as part of our standard review process. No changes in direction were made.

March 10, 2025

RP-046 Telemedicine and Telehealth Services

Code 98016 was removed from this policy.

UPCOMING

April 1, 2025

RP-064 Government Supplied Vaccinations and Antibody Treatments

Codes M0220 - M0223, M0240, M0241, M0243 - M0247, Q0220 - Q0222, Q0240, Q0243 - Q0245, and Q0247 will be removed from this policy.

May 1, 2025

RP-020 Preventive Medicine and Office/Outpatient Evaluation and Management Services

This policy will be updated to apply a reduction to Office/Outpatient E/M codes appended with modifier 25 when reported in the same visit as a preventive medicine service. The preventive medicine service will continue to be fully reimbursed at 100% of the allowable contracted rate. The Office/Outpatient E/M component, when appropriately billed with modifier 25 to signify a separately identifiable service, will be subject to 50% of the allowable contracted rate. Details pertaining to what is included in the various types of visits are also being added.

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: The effective date for this policy has been updated from April 14, 2025, to May 1, 2025. This policy is not yet available on the PRC.)*

(Continued)

NEW: RP-079 Multiple Ultrasounds

This new policy — applicable to Commercial and Medicare Advantage markets — will address circumstances surrounding the appropriate reporting of non-obstetrical and obstetrical transabdominal and transvaginal ultrasounds. Reimbursement for multiple procedure payment reductions may be applicable when multiple services are provided during a patient encounter by the same physician or same group physician/other health care professional. *(NOTE: This policy is not yet available on the PRC.)*

May 16, 2025

NEW: RP-081 Critical Care with Home Discharge

If a critical care service is submitted with revenue code 045X and a discharge status code of 01 (to home or self-care) on the same day, then the critical care services will not be reimbursable. *(NOTE: This policy is not yet available on the PRC.)*

NEW: RP-082 Lab Panel Testing

This new policy will provide the plan's direction for lab testing CPT codes 87661, 87491, and 87591. When more than one of these codes are billed, regardless of number of units, by the same provider on the same date of service, they will be reimbursed under the comprehensive panel code 87801. *(NOTE: This policy is not yet available on the PRC.)*

May 30, 2025

For more information about the policy updates (RP-019N, RP-040, and RP-061) and policy addition (RP-080) listed below, CLICK HERE.

RP-019N Drugs and Biologicals (policy number will change to RP-019A)

To align with Highmark's reimbursement methodology for outpatient medications, RP-019N (***soon to be RP-019A***) will include inpatient drugs and biologicals; pricing will be adjusted to the Average Selling Price (ASP) +10% (Commercial) or ASP +6% (Medicare Advantage) and in the absence of ASP, Average Wholesale Price (AWP) will be utilized.

To view this reimbursement policy, access the PRC via the provider portal (Availity®). Once redirected to the PRC from the provider portal, hover over **Claims & Authorization** in the main menu, then click **Reimbursement Polices** under **Reimbursement Programs**.

RP-040 Facility Routine Supplies and Services

The list of routine supplies, services, and items that are not separately reimbursable will be updated.

RP-061 Implants and Implant Components

Following industry best practices, Highmark will apply the invoice cost for implants as the covered charge(s) for that implant. Highmark will determine invoice pricing on each claim based on the national invoice average as codified in RP-061.

NEW: RP-080 Integral or Necessary Services

The intent of this policy is not to develop new guidance, but rather to provide standalone policy language clarifying Highmark's definition of "integral":

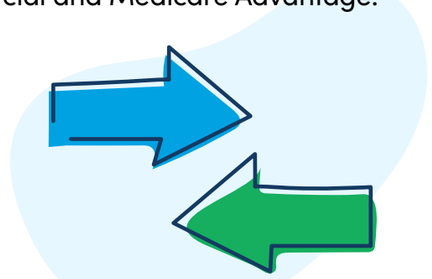
- "Integral" refers to services that are needed or required during the provision of patient care which are inclusive of another service or component parts of a more comprehensive service.
- "Integral" refers to supplies, equipment, and certain services that are inherent, needed, or required for the provision of patient care and are considered by Highmark as part of another service.

(NOTE: This policy is not yet available on the PRC.)

June 30, 2025

RP-020 Preventive Medicine and Office/Outpatient Evaluation and Management Services

This policy will be updated to add additional billing information and guidelines concerning what is included in the various types of Evaluation and Management Services for Commercial and Medicare Advantage.



Important Highmark Reminders: Utilization Review, Patient Notification, Member Rights, and More

Appropriate Utilization Decision Making

Highmark makes utilization review decisions based only on the necessity and appropriateness of care, service, and the existence of coverage. In addition, Highmark does not reward practitioners, providers, Highmark employees, or other individuals conducting utilization review for issuing denials of coverage or service, nor does the company provide any financial incentives to utilization review decision-makers to encourage denials of coverage.

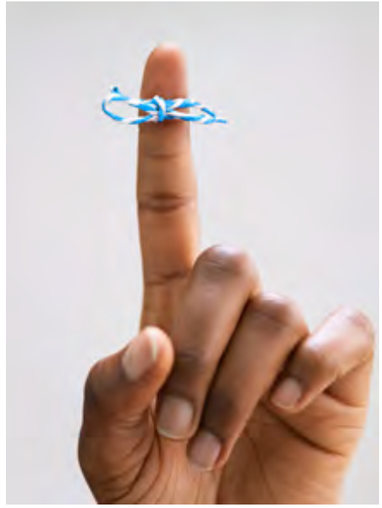
Request for Criteria

Highmark uses resources such as nationally recognized clinical review criteria, medical policy, and Medicare guidelines in determining whether a requested procedure, therapy, medication, or piece of equipment meets the requirements of medical necessity and appropriateness. This is done to ensure the delivery of consistent and medically appropriate health care for our members.

If a primary care physician (PCP) or specialist requests a service that a clinician in Utilization Management is unable to approve based on criteria/guidelines, the clinician will refer the request to a Highmark Physician Reviewer. The reviewer may contact the PCP or specialist to discuss the request or to obtain additional clinical information.

A decision is made after all the clinical information has been reviewed.

At any time, the PCP or specialist may request a copy of the criteria/guidelines used in making health care decisions by calling the telephone number identified on the determination letter or the telephone number of the back of the member identification card. Criteria/guidelines are also available on the Provider Resource Center website.



Patient Notification of Approvals, Denials

All network providers are expected to notify their patients who are Highmark members of both approval and denial-of-coverage decisions as soon as possible upon their office receiving notification of the decision from Highmark or a delegated entity of Highmark.

Member Rights and Responsibilities

Our members have certain rights and responsibilities that are a vital part of membership with a managed care or PPO plan. These rights and responsibilities are included in the member handbooks and are reviewed annually in the member newsletter.

We also make them available online for our network providers to help you maintain awareness and support your relationship with your patients who are Highmark members.

To review members' rights and responsibilities, review Chapter 1, Unit 5 of the *Highmark Provider Manual*. A paper copy of the Member Rights and Responsibilities is available upon request.

(Continued)

Peer-to-Peer Conversations: Availability of Physicians, Behavioral Health Practitioners, and Pharmacist Reviewers*

Highmark provides you with an opportunity to discuss utilization review denial decisions with a clinical peer reviewer following notification of a denial determination. Clinical peer reviewers are licensed and board-certified physicians, licensed behavioral health care practitioners, and licensed pharmacists who are available to discuss review determinations during normal business hours.

Your call will be connected directly to the peer reviewer involved in the initial review determination if he or she is available. If the original peer reviewer isn't available when you call, another clinical peer will be made available to discuss the denial determination within one business day of your request. To request a peer-to-peer conversation, you may call the appropriate number listed in the chart below.

***IMPORTANT NOTE:** The peer-to-peer review process is no longer available for Medicare Advantage members. See Chapter 5, Units 3 and 5 of the *Highmark Provider Manual* for details.

Practitioner/Ordering Provider	UM Issue	Telephone Number
Practitioners	Medical/Surgical UM Decisions	866-634-6468
Behavioral Health Providers	Behavioral Health	866-634-6468
Pharmacists	Pharmacy Services	Telephone number identified on determination letter
Practitioners	Advanced Radiology Imaging	Telephone number identified on determination letter
Practitioners	Radiation Therapy	Telephone number identified on determination letter
Practitioners	Physical Medicine	Telephone number identified on determination letter

Provider Accessibility Expectations

To stay healthy, our members must be able to see their physicians when needed. Highmark has set forth specific time frame standards in which network providers should respond to member needs based on symptoms.

Physicians are encouraged to see members with scheduled appointments within 15 minutes of their scheduled appointment time. A reasonable attempt should be made to notify members of delays.

More specific information on Highmark's time frame requirements is available in Chapter 1, Unit 4 of the *Highmark Provider Manual*.

Quarterly Formulary Updates

View the January 2025 updates to Highmark's prescription drug formularies and related pharmaceutical management procedures at the Formulary Updates page on the **Provider Resource Center (PRC).**

Pharmaceutical Management Procedures

To learn more about how to use these procedures, click on **Polices & Programs** from the top menu on the PRC. Select **Pharmacy Programs** and then **Pharmaceutical Management**.

This section includes information on:

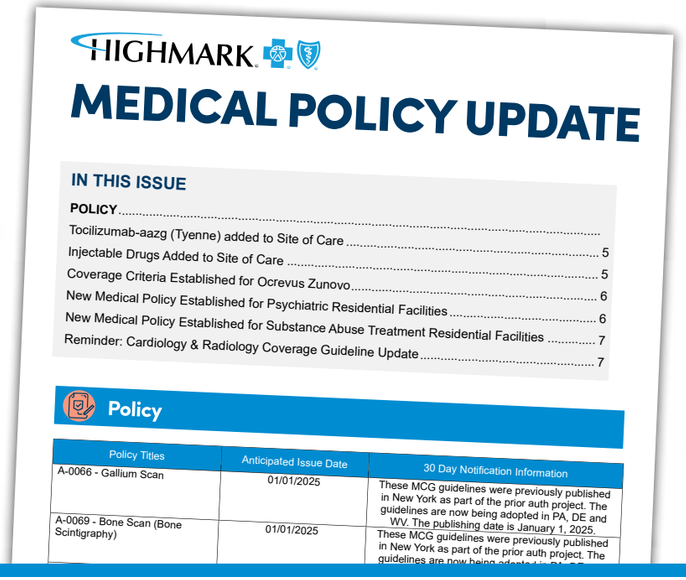
- Exception requests
- The process for generic substitutions
- Explanations of limits/quotas, therapeutic interchange, and step-therapy protocols. **Federal Employee Program (FEP) Drug Formularies and Pharmaceutical Management Procedures**

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.

Have You Seen This Month's **Medical Policy Update Newsletter?**



HIGHMARK

MEDICAL POLICY UPDATE

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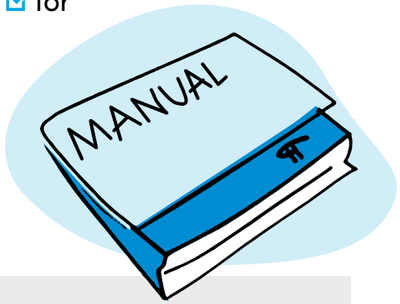
Policy

Policy Titles	Anticipated Issue Date	30 Day Notification Information
A-0066 - Gallium Scan	01/01/2025	These MCG guidelines were previously published in New York as part of the prior auth project. The guidelines are now being adopted in PA, DE and WV. The publishing date is January 1, 2025.
A-0069 - Bone Scan (Bone Scintigraphy)	01/01/2025	These MCG guidelines were previously published in New York as part of the prior auth project. The guidelines are now being

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 3: Other Government Programs**
- **Chapter 3, Unit 1: Network Participation Overview**
- **Chapter 3, Unit 2: Professional Provider Credentialing**
- **Chapter 3, Unit 4: Organizational Provider Participation (Facility/Ancillary)**
- **Chapter 5, Unit 1: Care Management Overview**
- **Chapter 6, Unit 4: Professional (1500/837P) Reporting Tips**
- **Chapter 6, Unit 8: Payment Review**

To see the full list of recent changes, visit the ***What's New in the Highmark Provider Manual*** page.

Availity®

Are You Using Availity for Your Highmark Transactions?

LEGACY PORTALS NOW DEACTIVATED

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.

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, which is available on the **Provider Resource Center > Latest Updates > Medical Policy Update**.

To subscribe to our newsletters, click Join Our Mailing List.

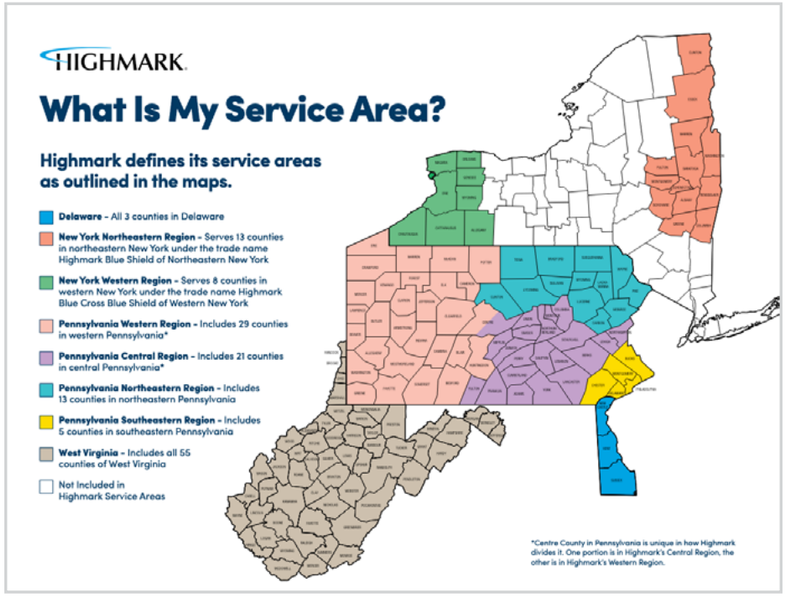
Comments/Suggestions Welcome

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 Quick Reference

To contact Highmark, click here.

Service Areas



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Availity is an independent company that contracts with Highmark to offer provider portal services. Highmark Health is the parent company of Highmark Inc.

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

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