PROVIDER NEWS

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

HIGHMARK

Issue 4, April 2025

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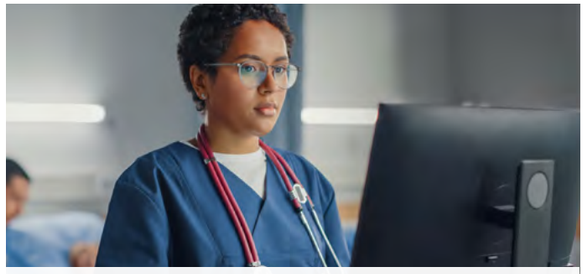

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IN THIS ISSUE

Starting in August, providers will submit requests for all initial **medical** authorizations via the **Authorizations & Referrals** workflow in Availity Essentials®. This transition is the first stage in a multi-phased plan to streamline the authorization process, making it easier, faster, and more intuitive for Highmark providers and their teams.

Currently, most medical authorization requests are submitted via the Predictal tile in Highmark's Payer Spaces. We are moving to the **Authorizations & Referrals** workflow in Availity to align with the submission process many providers are already utilizing with other payers or for out-of-area authorization requests.

Through Availity's authorization workflow, providers can:

- Submit initial authorization requests for inpatient and outpatient services
- Initiate retrospective pre-claim reviews and retrospective claim reviews
- Electronically attach supporting medical documentation
- Create and save multiple auth templates, increasing office efficiency and reducing administrative burden

The new process will also enable practitioners to access Availity's **Authorization Dashboard**, which provides a centralized platform for viewing authorization status information from multiple payers.

Predictal Processes

Providers will continue to perform the following functions via the Predictal Auth Automation Hub:

- Initiating requests for concurrent reviews
- Viewing phone and fax authorizations – only available in Predictal at this time

NOTE: *Pharmacy authorization requests should be submitted directly to CoverMyMeds.*

Additional information will be published in upcoming issues of *Provider News*. Stay informed by signing up for our mailing list to receive timely updates via email. Click **here** to subscribe.

New Resources to Help Providers with Authorizations

To help providers successfully submit authorization requests, Highmark has two new resources available on the Provider Resource Center (PRC).

1. Learn How to Submit an Authorization Guide

This interactive resource will assist providers in managing the current authorization process before the transition in August to the Availity Essentials® workflow.

Learn How to Submit an Authorization carefully outlines each step of the auth submission process with videos and other helpful resources, including authorization details based on place and type of service:

- Medical Inpatient
  - Planned
  - Unplanned / Urgent
- Medical Outpatient
- Behavioral Health
  - Inpatient
  - Outpatient

The guide, which is located on the Authorization Training & Resources page, also shows how the auth process is connected to vendors and their related services:

- **Home and Community Care –** Skilled nursing facility, inpatient rehabilitation, and long-term acute care
- **eviCore –** Musculoskeletal surgery and interventional pain management, advanced imaging and cardiology, and laboratory management (in DE, PA, and WV)
- **Helion –** Physical therapy, occupational therapy, speech therapy, and chiropractic

2. Updates to the MCG Clinical Criteria Page

Based on provider feedback, we've made it easier to access MCG Guidelines from the Provider Resource Center. The updated MCG page has links — where you can access the guidelines — for your region:

- Delaware
- New York – Northeastern and Western New York
- Pennsylvania – Central, Northeastern, Southeastern, Western
- West Virginia

More about MCG

Highmark incorporates MCG Health evidence-based clinical guidelines into our criteria of clinical decision support for the following types of care (except for delegated services):

- **Inpatient and Surgical Care**
- **General Recovery Care** – Serves as a companion to inpatient and surgical care guidelines
- **Ambulatory Care** – Guidelines for procedures, durable medical equipment, prosthetics, orthotics, and supplies; rehabilitation evaluations, services, and modalities
- **Recovery Facility Care** – Skilled nursing facility, inpatient rehabilitation facility
- **Home Care**
- **Behavioral Health**

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.

PA CHIP:

All Auth Requests Must Be Submitted Electronically via Availity Essentials

To maintain adherence with Highmark's Pennsylvania Children's Health Insurance Program (CHIP) contract, all prior authorization requests for Highmark Healthy Kids (CHIP) members must be submitted electronically through Availity Essentials®. This change will be effective no later than **June 1, 2025**.

Detailed instructions on how to submit authorization requests via Availity can be found on the Provider Resource Center. Choose **Claims & Authorizations** from the main menu and then click **Obtaining Authorization**.

Annual Update to Highmark's Standard Professional Fee Schedule and Pricing Methodology

Effective July 1, 2025, Highmark will make its annual update to the standard professional fee and pricing methodology[1], which applies to the Highmark service areas in Delaware, Pennsylvania, and West Virginia, and includes these lines of business:

- Commercial
- Medicare Advantage
- Affordable Care Act (ACA)

The annual update will include adjustments to fee allowances for laboratory services and durable medical equipment (DME).

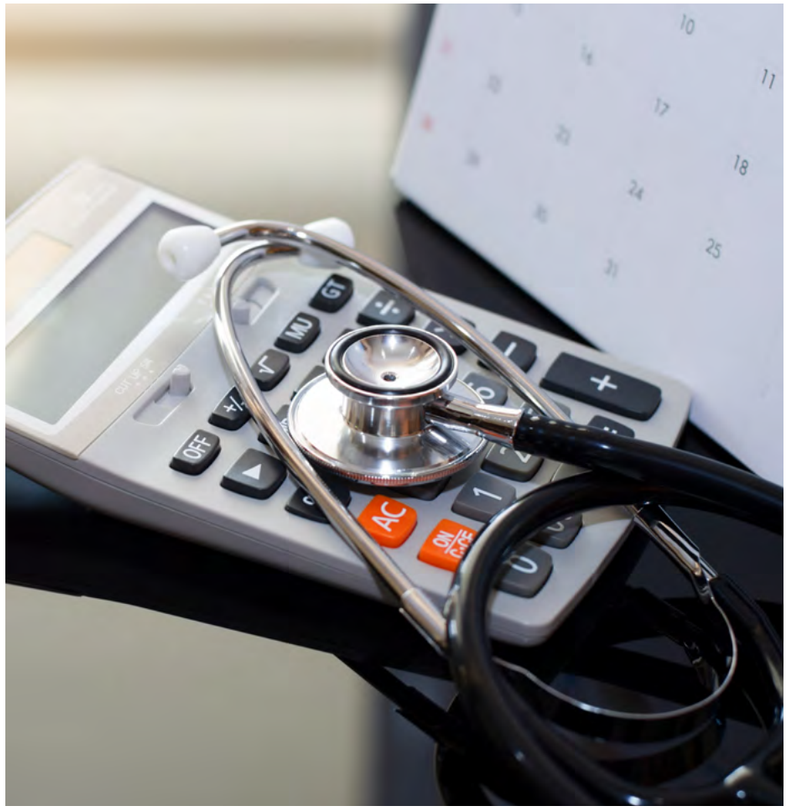
There are no changes to Highmark's Medicaid plans or any value-based fee schedule adjustments. The annual update is part of Highmark's continued effort to align with industry standard values and remains non-negotiable for contracted providers.

The yearly review of our standard professional fee schedule and pricing methodology enables Highmark to:

- Update our fee allowances based on industry research by leveraging different sources and data points, including changes the Centers for Medicare and Medicaid Services (CMS) made to the 2025 Medicare Physician Fee Schedule.
- Continue to bring our fee schedules in closer alignment with Highmark's Value-Based Reimbursement strategies through uniform standard fees.
- Make changes that reflect current factors and trends in the marketplace.

Download and Review the Fee Schedule

You can review the updated standard professional fee schedule within Availity Essentials® beginning **June 1, 2025**. Once you log into Availity, select **Claims & Payments** from the task bar and then **Fee Schedule Listing** from the right side. You can also access fee schedules by going to **Highmark's Payer Spaces** in Availity, and then select **Provider Resource Center (PRC)** under **Applications**. Once you arrive at the PRC, select **Claims & Payments > Reimbursement Programs > Fee Schedule Information**.



[1]*Any changes to the commercial standard professional fee schedule and pricing methodology will comply with 18 Del. Code* §§ 3342B and 3556A.

Reimbursement Update for Outpatient Services Prior to Inpatient Admission and Inpatient Readmissions

Highmark is changing **Reimbursement Policy-039: Outpatient Services Prior to an Inpatient Admission** and **Reimbursement Policy-050: Inpatient Readmissions**.

The updated reimbursement policies (RPs) will now consider services rendered across facilities within the same health system for related diagnoses or conditions *as part of the initial inpatient admission*.

The new policies will be effective **July 1, 2025,** for Commercial and Medicare Advantage lines of business.

What's Changing?

RP-039 Outpatient Services Prior to An Inpatient Admission

When a Highmark member is seen for outpatient services within 72 hours prior to an inpatient admission for a related diagnosis at ***any*** facility within the same health system, those outpatient services will be considered part of the inpatient stay.

RP-050 Inpatient Readmissions

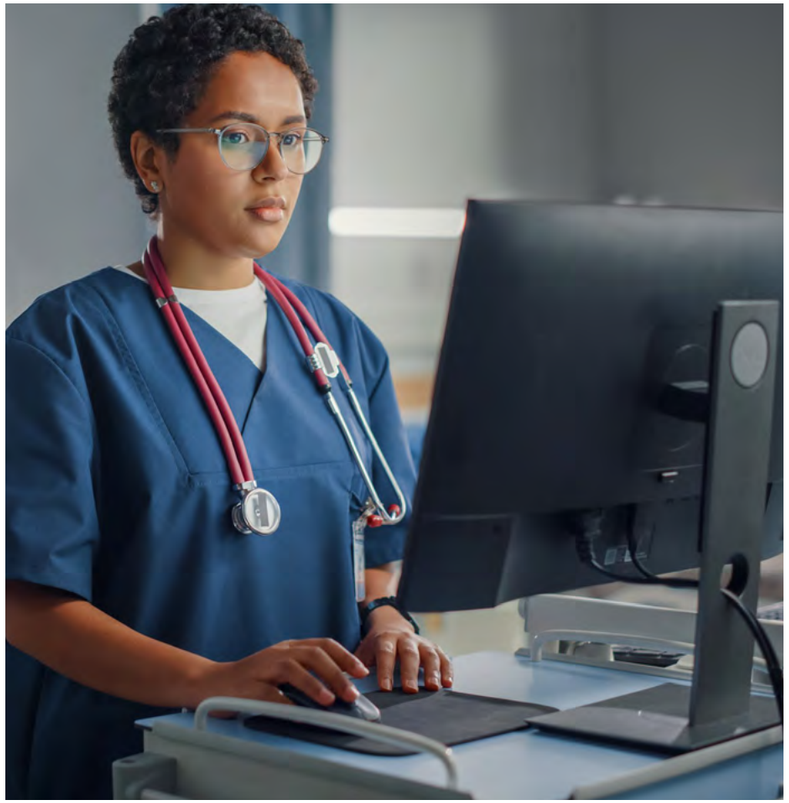
When a Highmark member is readmitted to ***any*** inpatient hospital within the same health system for a related diagnosis within 15 days from the initial stay, all services over the two stays will be considered part of the initial stay.

What This Means for You

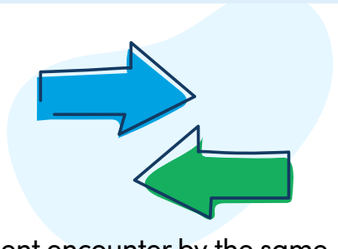
Preadmission services performed within the same health system as the admitting hospital for a related diagnosis will need to be billed as part of the inpatient claim**.**

For readmissions within the same health system, providers must include all appropriate documentation of the previous inpatient stay if for a related diagnosis. Services for the readmission must be billed as part of the initial inpatient stay under the initial admitting hospital.

The updated policies will be available on the **Provider Resource Center (PRC),** on July 1, 2025. To access these RPs, go to the PRC > **Claims & Authorization** > **Reimbursement Programs > Reimbursement Policies**.



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

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 were removed from this policy.

April 28, 2025

RP-033 Anesthesia Services

The Screening Colonoscopy section of this policy was updated to add information about code 00812.

UPCOMING

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-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 5, 2025

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: Since the March issue of Provider News, the effective date for this policy has been updated from May 1, 2025, to May 5, 2025. 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.*)

(Continued)

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 Essentials®). 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.

July 1, 2025

For more information about the policy updates (RP-039 and RP-050) listed below, CLICK HERE.

RP-039 Outpatient Services Prior to an Inpatient Admission

When a Highmark member is seen for outpatient services within 72 hours prior to an inpatient admission for a related diagnosis at *any* facility within the same health system, those outpatient services will be considered part of the inpatient stay.

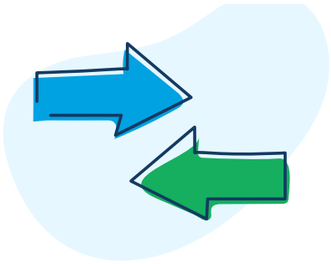
RP-050 Inpatient Readmissions

When a Highmark member is readmitted to *any* inpatient hospital within the same health system for a related diagnosis within 15 days from the initial stay, all services over the two stays will be considered part of the initial stay.

Aug. 1, 2025

RP-047 Venipuncture and Lab Services

This policy will be made applicable to Medicare Advantage professional.



SHORT TAKES:

Claim Attachments, Quick Claims, and More

Attachments Enabled When Submitting New Claims in Availity

Starting April 18, 2025, providers can now attach supporting documents when submitting new claims in Availity Essentials®. This will save practitioners time and effort, while accelerating the claim review and approval process for Highmark. Click here for more information.

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. Learn more here.

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. Read the full article here.

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.

MENTAL WELL-BEING SOLUTION:
Driving Positive Outcomes for Highmark Members

Since its launch in January 2024, Highmark's Mental Well-Being solution powered by Spring Health has helped members get quick, reliable, and convenient access to mental health support.

During its first year, the Mental Well-Being solution achieved these positive results:

- Members accessed mental health care significantly faster, with an average wait time of **1.44 days**, compared to a national average of 25 days.
- **80% of members** connected with care for the first time in at least 18 months, demonstrating improved access.
- **3x faster remission** of symptoms for patients with moderate to severe depression compared to the national average.
- Members self-reported a **69% improvement** in depression symptoms and a **69% improvement** in anxiety symptoms.
- High post-visit satisfaction (9.3/10, on average) and member satisfaction (55 NPS) scores.
- **51,000+ members** registered.

(Continued)

> *"I am a senior citizen dealing with life events common to aging: chronic illness, grief, and lifestyle changes. Spring Health's online therapy has given me a chance to connect with a compassionate and competent therapist who is coaching me on ways to foster a more positive and healthy outlook as I enter my seventies. Journaling, creative time, physical activity, and other strategies are helping me move forward with grace and gratitude."*
>
> – Highmark Member Testimonial

Addressing Members' Needs

Mental Well-Being offers a range of treatment options, including therapy, coaching, medication management, and self-guided modules like meditation and stress management. This May, during Mental Health Awareness Month, presents an ideal opportunity to encourage your patients to prioritize their mental well-being.

The Mental Well-Being solution directly addresses Highmark members' top reported issues:

- Focus
- Family stressors
- Depression
- Psychological stress
- Excessive worry

With over 2.3 million Highmark commercial, MA, ASO, ACA, and CHIP PA members ages six and older eligible for Mental Well-Being, we encourage you to speak to and directly refer your Highmark patients that could benefit from this solution.

Improving Follow-Up Care: The FUM Measure

The Mental Well-Being solution can help your Highmark patients with comorbidities navigate and improve their mental health so they can focus on improving their physical health, reducing the rate of hospital readmissions. Eligible members also have access to a 24/7 crisis support line. As a reminder, if your Highmark patients experience a mental health crisis that includes an emergency department (ED) visit, prompt and appropriate follow-up is crucial.

The **Follow-Up After ED Visit for Mental Illness** (FUM) is a HEDIS® measure that assesses the percentage of ED visits — with a principal diagnosis of mental illness or self-harm — that receive follow-up care within seven or 30 days.

This timely follow-up significantly reduces repeat ED visits, improves patient outcomes, and increases treatment plan adherence.

A follow-up visit meets FUM criteria if it has a principal diagnosis of a mental health disorder (or intentional self-harm with any mental health diagnosis). Acceptable visit types include outpatient behavioral health visits, telephone visits, and e-visits/virtual check-ins. FUM applies to members six years and older.

Specific CPT II and ICD-10 codes can be found on the HEDIS Measures Provider Information document (Availity Essentials® login required) on the Provider Resource Center (PRC).

For additional guidance on this measure, please refer to the FUM Measure Overview Tip Sheet on the PRC under **Resources & Education > Educational Programs > Behavioral Health Toolkit.**

Learn more about Mental Well-Being

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.

Spring Health is an independent company that provides mental health care services through its agents. Spring Health does not provide Blue Cross and/or Blue Shield products or services. Spring Health is solely responsible for their mental health care services

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.

Medicare Stars Static Reports Moving to Value Insight Center

As part of the ongoing transition of member and quality data to the Value Insight Center, the final Program Year (PY) 2024 Medicare Advantage Stars static reports are scheduled to publish **April 25, 2025**. You will still have access to all the 2024 static reports after that date.

For PY 2025 data, reports will no longer be posted; rather, all of the most current Medicare Advantage and Commercial results and insights will be available in the Value Insight Center. There, you can download, save, and utilize the information that is most important to your practice and use it in the most effective manner.

What is the Value Insight Center?

The Value Insight Center is an improved and easy-to-navigate self-service application designed to provide early, intuitive, and actionable data you can use to close care gaps and improve quality and outcomes for your attributed Highmark patients. Attribution, claims, and quality data are updated each month to provide more current information than is available in static reports.

Same Data, New Delivery Method

Be assured, the same data and information that has been in static reports is also available in Value Insight Center. Only the way you get that information is changing, as described in the chart below.

Results You Need	How to View the Information
• View Entity/Practice Star Score • View AWV Opportunities • View compliance in triple-weighted measures* *applies to Stars only	Navigation Bar> Gap Closure> Stars or Quality Summary Tab
• View Medicare Advantage and Commercial Member Detail or Member Gaps	Navigation Bar> Gap Closure> Stars or Quality Summary Tab **OR** Stars Measure Analysis **OR** Filter Panel> Member Search
• View how many gaps closures needed to achieve 5.0- or 5.5-Star rating per measure • Generate list of noncompliant patients by measure	Navigation Bar> Gap Closure> Stars or Quality Measure Analysis

To access the Value Insight Center, log into the Availity Essentials® portal and click **here**.

Quality Program Information for 2025

Highmark's Quality Program has been designed to improve the quality, safety, and equity of the clinical care and services providers render to our members. To do this, we continually review aspects of the program that affect the quality of the member care experience, including member satisfaction, and look for ways to make improvements.

Highmark works closely with the physician community in our efforts to address both the quality of the clinical care and service our members receive, as well as plan management for the services provided by Highmark (i.e., authorizations, claims handling, appeals, etc.).

We also use member satisfaction surveys and other tools to elicit feedback on how we're doing. These results are used to guide our future quality improvement activities and programs, supporting such areas as:

- **The Clinical Care and Service Received by Our Members**
- **The Provider Network**
- **Member Safety and Health Equity**

To learn more about the Quality Program, including information on program objectives, please see Chapter 5: Care & Quality Management, Unit 6: Quality Management in the *Highmark Provider Manual*, which is available on the Provider Resource Center.

Important Reminder for Providers: Verifying Network Status for Referrals

Recently, we have experienced some issues with providers referring Highmark members to specialists and Ambulatory Surgery Centers (ASC) that are out of network. Ensuring referrals are within our network is crucial for our members to receive the most cost-effective care and avoid potentially unexpected out-of-pocket expenses.

How to Verify Network Status

You or your patients may use our online Provider Directory to verify in-network provider participation at any time.

- Visit MyHighmark.com
- Click on FIND DOCTORS AND RX
- Locate your service region and click FIND CARE
- Click FIND A DOCTOR
- Click the dropdown by Network
- Ensure that the city, state, and ZIP Code are correct
- Type the specialty in the search bar or browse by category

Thank you for ensuring our members have seamless access to the care they need while taking advantage of high-quality, low-cost care. If you have any questions or require further information, contact Highmark's Provider Service.

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 2, Unit 6: The BlueCard® Program**
- **Chapter 3, Unit 1: Network Participation Overview**
- **Chapter 4, Unit 1: PCPs and Specialists**
- **Chapter 4, Unit 6: Prescription Drug Programs**
- **Chapter 5, Unit 1: Care Management Overview**
- **Chapter 5, Unit 2: Authorizations**
- **Chapter 5, Unit 3: Medicare Advantage Procedures**
- **Chapter 5, Unit 4: Behavioral Health**
- **Chapter 5, Unit 5: Denials, Adverse Benefit Determinations, Grievances, and Appeals**
- **Chapter 5, Unit 6: Quality Management**
- **Chapter 6, Unit 6: Coordination of Benefits**
- **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 Essentials for Your Highmark Transactions?

LEGACY PORTALS NOW DEACTIVATED

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.

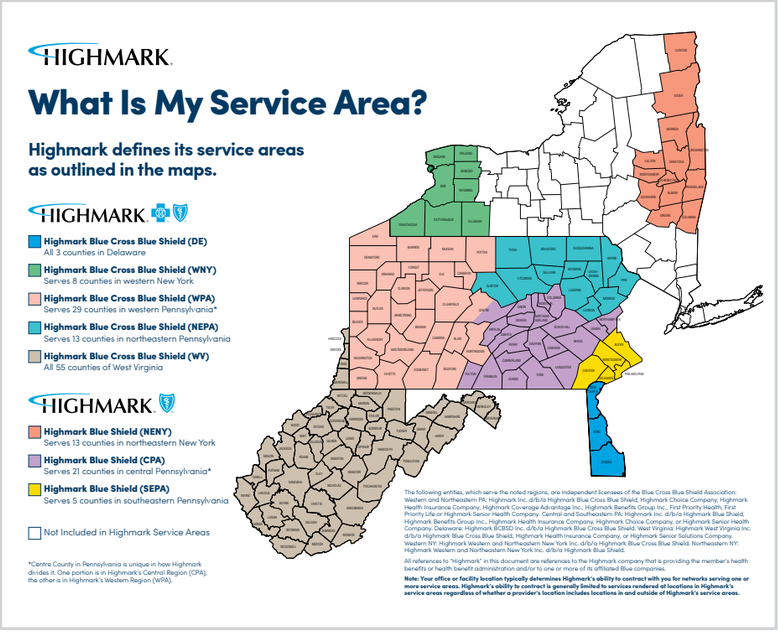
Comments/Suggestions Welcome

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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