healthfirst
Health Insurance for New Yorkers

FAQs

Healthfirst Laboratory Benefit Management Program

Healthfirst is revising billing and reimbursement policies and guidelines that will impact certain laboratory services, tests, and procedures. These revised billing and reimbursement policies and guidelines are based on proposals developed by Avalon Healthcare Solutions that have been reviewed and adopted by Healthfirst.

Effective **June 1, 2023**, Healthfirst will apply these updated billing and reimbursement policies to claims reporting laboratory services performed in office, hospital outpatient, and independent laboratory locations.

Are these policies Avalon's or Healthfirst's?

The new policies and guidelines recommended by Avalon have been reviewed and approved by Healthfirst and adopted as Healthfirst policies and guidelines.

Where do I find the most up-to-date information related to Healthfirst's reimbursement policies?

The updated policies are being published as they are finalized, and all will be available for review on the Healthfirst provider website (HFproviders.org) on **March 1, 2023**.

How are plan providers notified about changes to the policies?

Changes to Healthfirst's policies are communicated to Healthfirst providers through the usual channel–they are published on the Healthfirst website at HFproviders.org.

When is this program effective?

The updated policies and procedures and associated claim edits will be applied beginning with dates of service on or after **June 1, 2023**.

How will members be affected?

Policy enforcement should be transparent to members. These claim edits are applied post-service, so members are not denied access to care.

Frequently Asked Questions

How will providers be affected?

New/updated reimbursement policies for lab services are being published as they are finalized, and all will be available for review on the Healthfirst provider website (HFproviders.org) on **March 1, 2023**.

What types of policy rules will be applied?

Healthfirst will apply several types of edits:

- Mutually exclusive procedures
- Prerequisite procedures (add-ons)
- Unit limits on a single date of service (within and across claims)
- Unit limits over a period (e.g., 15 units permitted every three months)
- Frequency between procedures (e.g., minimum of 14 days between tests)
- Appropriateness of the ICD10 codes (i.e., analysis of all diagnosis codes on the claim)
- Demographic edits (limitations on age and gender appropriateness of testing)

Are all diagnoses on a claim reviewed?

Yes. All diagnosis codes on a claim will be reviewed.

How might a provider know if a patient received a test from another provider within a frequency limitation (e.g., HbA1c)?

The best approach would be to ask the patient.

If you have questions, please contact Healthfirst Provider Services at **1-888-801-1660**, Monday to Friday, 8:30am–5:30pm.