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PROVIDER NEWS

A newsletter for the Highmark Blue Cross Blue Shield providers in western Pennsylvania

Issue 3, March 2023

Highmark has launched a new Population Health University video series called Value-Based Care (VBC) 101, which provides an overview of our VBC methodology, programs, and successes.

"Our intent is to equip clinicians and our members with tools and resources to improve health," said Karen Hanlon, Executive Vice President and Chief Operating Officer at Highmark Health. "Throughout this series, you'll see examples of the value-based program success achieved with our partners in primary care, specialists, facility, and skilled care."

The five-part video series features Highmark leaders discussing the following topics:

I. **Focus on Provider Collaboration**

- **Karen Hanlon** – Executive Vice President and Chief Operating Officer, Highmark Health
- **Margaret Haney** – Vice President of Strategic Integration, Highmark Health

II. **More Effective and Meaningful Value-Based Care**

- **Derek Goldin** – Senior Vice President, Provider Transformation, Highmark Health
- **Dr. Bridgette Wiefling** – Senior Vice President, Clinical Transformation Leader, Highmark Health

III. **Coordination of Care in Measurable Improvements (Panel Discussion)**

Moderator:

- **Dr. Phil Majewski** - Senior Medical Director, Population Health Pharmacy & Quality Enablement, Highmark Health

Panelists:

- **Dr. Jackie Holder** – Clinical Transformation Physician Executive, Highmark Health
- **Dr. Chris Wheelock** – Clinical Transformation Physician Executive, Highmark Health
- **Mike Samczak** – Director, Value-Based Clinical Performance & Development, Highmark Health
- **Kim Mehta** – Director, Population Health Pharmacy & Quality Enablement, Highmark Health

IV. **Social Determinants of Health**

- **Deb Donovan** – Vice President, Social Determinants of Health Strategy & Operations, Highmark Health

V. **The Future of Value-Based Care**

- **Mike Bennett** – Executive Vice President, Chief Strategy & Transformation Officer, Highmark Health

CME Credits

You can earn Continuing Medical Education (CME) credits for completing all or part of the module for the VBC video series. To learn more, go here.

The Connection to Living Health

VBC plays an essential role in Highmark's Living Health model and health care transformation by aiming to lower costs for our members while delivering faster, aligned, and proactive care through more coordinated efforts between the payor and the provider.

"Our strategy emphasizes shared accountability for patient outcomes and expenses with our network providers," said Margaret Haney, Vice President of Strategic Integration. "We are equally committed to collaborating with physicians and hospitals across Highmark's footprint to help all providers thrive in value-based care."

By watching the VBC 101 series, you'll learn more about our Living Health model, the tools and resources that Highmark has to offer to assist you in this transformation, and thoughts for the future for value-based care.

How to Watch

To view the video series, visit the Provider Resource Center (PRC). Select **EDUCATION/MANUALS** from the left menu and click **Population Health University**. Once on that page, choose **Value-Based Care 101**.

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PROVIDER NEWS

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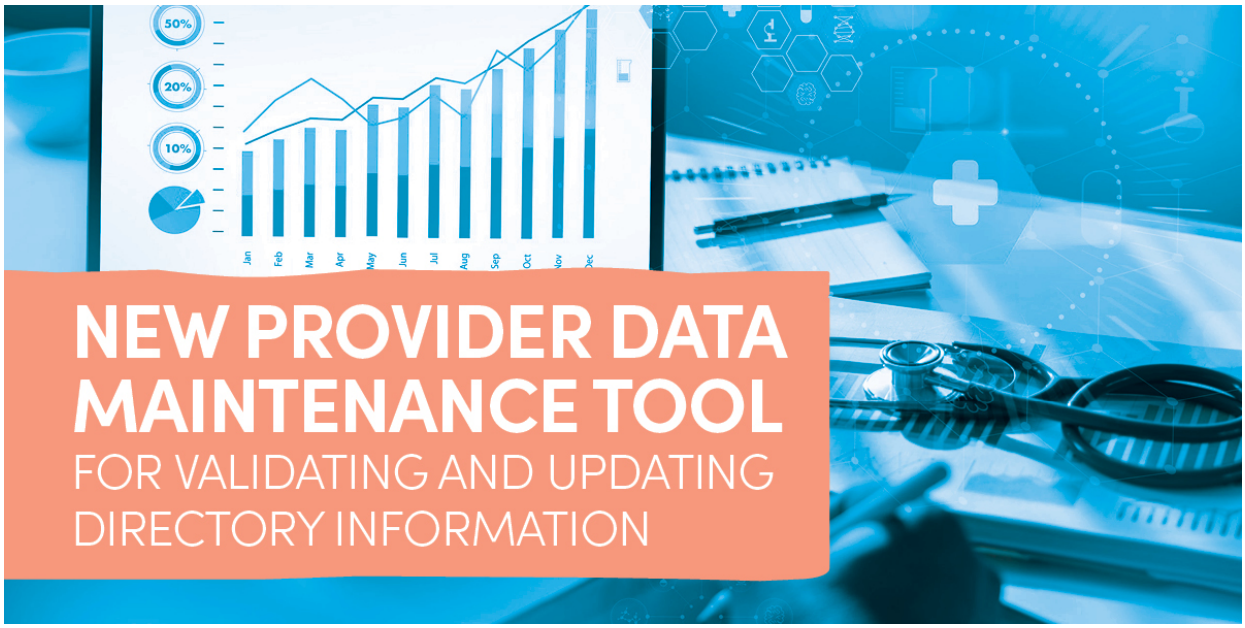
Issue 3, March 2023



Beginning **May 1, 2023**, professional providers will be required to validate their Highmark Provider Directory information within the new Provider Data Maintenance (PDM) tool in NaviNet® every 90 days. They will no longer receive calls from Atlas or use PRIME, Atlas' provider data management software, to update information.

The PDM tool will streamline the validation process by providing an easy-to-use electronic application to update, validate, and attest to the accuracy of your directory information in one electronic application. PDM also indicates the last time your directory information was validated and the due date for the next validation deadline.

EXCEPTION: *Facility, ancillary, and any Medicaid providers will continue to use Atlas to validate their information as they do today.*

Updates That Can Be Completed in PDM Versus PFM

PDM will be rolled out in phases necessitating certain changes continue to be made through Provider File Management (PFM). The table below outlines which PDM

functionality will be available in May 2023. Most updates will be reflected in real-time; those that will pend for review are indicated with an asterisk (*).

Professional providers will be able to navigate between both the PFM and the PDM tools simultaneously in two separate tabs while using NaviNet. If a change is made to either PFM or PDM, providers must refresh the other tab being used to see the reflected changes.

Update in PDM Tool	Update in PFM Tool
• **Office Information: address***, appointment phone number(s), email, website, handicap accessibility • **Group/Practitioner Information:** practitioner name*, languages spoken, acceptance of new patients, practitioner specialty/role*, locations, affiliated networks, NPI, education, and adding and deleting of practitioners • **Patient Age Ranges** • **Hospital Affiliations*** • **Walk-ins Welcome** • **Telehealth Services** • **ePrescribe and Electronic Medical Records**	• **Identification of provider benefit level – Standard or Enhanced (view only)** • **Credentialing status (view only), requests, changes, review of submitted changes (view only), and services** • **Accreditation requests, changes, and review of changes** • **Tax identification number (view only)** • **Practitioner medical license number submissions or changes** • **List of terminated addresses (view only)** • **Services offered at current location** • **Adding or deleting an address**

Tips for Using the PDM Validation Function

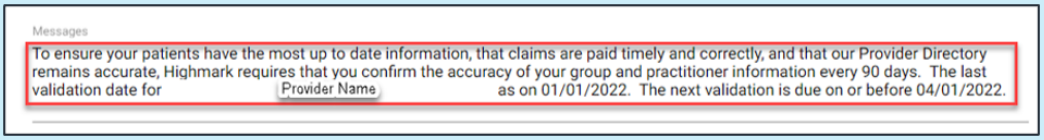
This section includes tips for using the PDM validation function within NaviNet; it is not a full guide. A guide on how to use this function is being created and will be posted on Plan Central once complete.

IMPORTANT: *Office staff workers who maintain the attestation data/information will need to have their NaviNet Security Officer grant them access to NaviNet to complete all future attestations.*

It is recommended that you begin the validation process at least 1–2 weeks prior to your unique validation due date, as you will not be able to validate your information until all pending requests are completed (see #4: Editing Information below).

1. Reviewing Last Validation Date:

- The top of the form will state the last date the provider validated their information and the next due date to validate their information.

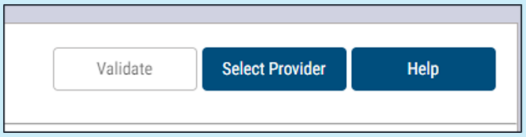


2. Confirming the Information Is Valid:

- In each section, you must either select YES that information is valid or NO and then update with the correct information.

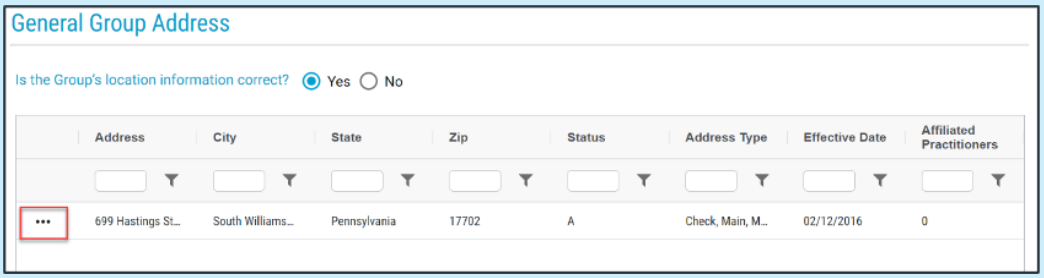
- If NO is selected:
  - A message to use the edit function to update the information will pop up. Once the information is updated, unless it goes to the pending queue (see #4 below), go back, and select YES.

- If YES is not selected, the Validate button will be greyed out and not clickable.



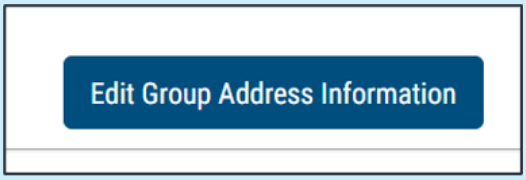
3. Reviewing More Information:

- To review more information or edit information in any of the sections, click the **ellipsis** at the left of the options.

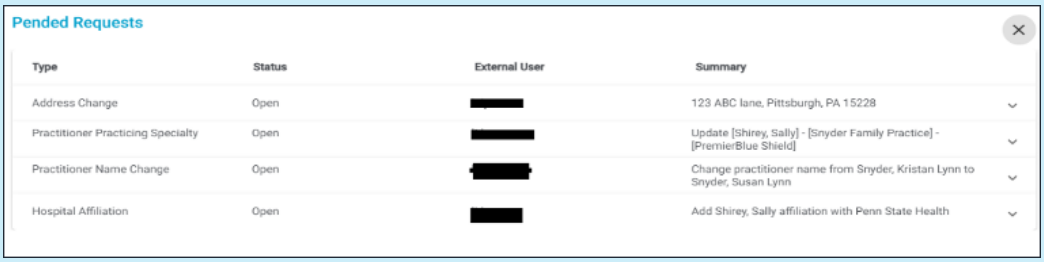


4. Editing Information:

- If a professional provider needs to make edits while reviewing more information, click the **edit button** on the review screen. **NOTE:** The edit button and review screen will state the specific information that can be edited and will look different depending on what section of the form the professional provider is working on.

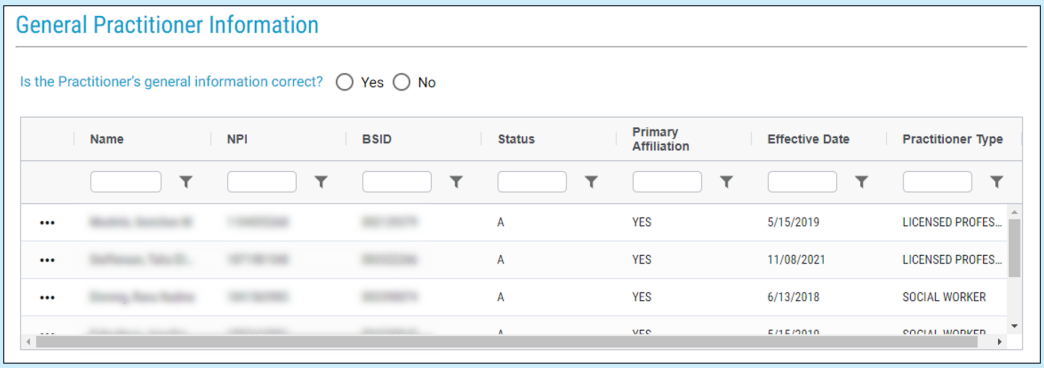


- Some information will pend for Highmark's review after you submit your edits. You will be able to check all pending requests in the Pending Queue by clicking the Pending Request link at the top of the form. Changes that will need to pend for Highmark review include practitioner name, specialty and role, hospital affiliations, and addresses — if updates are for out of state or out of region.



5. Practitioner Information:

- To access information about each individual practitioner, professional providers will need to click on the **ellipsis** next to each practitioner separately. Once you click the **ellipsis**, you will be taken to a new page with information about the individual practitioner's specialty, whether the provider is accepting new patients, what languages the provider speaks, and other helpful information.



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PROVIDER NEWS

A newsletter for the Highmark Blue Cross Blue Shield providers in western Pennsylvania

Issue 3, March 2023

Evaluation and Management Coding Changes

In alignment with the Office and Outpatient Evaluation and Management (E/M) Coding Guidelines changes that were effective **January 1, 2021**, the following code sets were revised **January 1, 2023**:

- **Non-Office E/M codes** (99221–99223, 99231–99239)
- **Consultation codes** (99242–99245, 99252–99255)*
- **Emergency Department codes** (99281–99285)
- **Nursing Facility Service codes** (99304–99310, 99315, 99316)
- **Home or Residence Service codes** (99341, 99342, 99344, 99345, 99347–99350)

**Please refer to Reimbursement Policy RP-063 for additional information related to Consultation Services.*

Time or Medical Decision Making

Except for Emergency Department codes (99281–99285), providers may choose the appropriate E/M level of care based on either Time or Medical Decision Making (MDM). Emergency Department codes (99281–99285) use only MDM to determine level of care.

Documentation Guidelines

Please see the Documentation Guidelines for E/M Services 2023 for additional details on how to correctly report these services. To access the 2023 Documentation Guidelines — as well as 2023 Auditor's Scoring Worksheets and a revised list of frequently asked questions — visit the Provider Resource Center (PRC).

Once there, select **CLAIMS, PAYMENT & REIMBURSEMENT** from the left menu, click **Documentation Guidelines For Evaluation And Management Services**, and then go to **2023 RESOURCE LINKS** on that page.


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PROVIDER NEWS

A newsletter for the Highmark Blue Cross Blue Shield providers in western Pennsylvania

Issue 3, March 2023

Free Coding Webinar on Cardiac Conditions

"Cardiac Conditions" will be the topic for the Coding and Quality Knowledge College webinar on **Wednesday, April 12, 2023, at 12:15 p.m.** The college presents quarterly webinars aimed at providing education on the proper coding of medical diagnoses, along with the associated quality measurements that impact documentation.

For the summer and fall webinars, the following topics will be presented:

- **Depressive Disorders – July 12**
- **Cancer – October 11**

Continuing Medical Education (CME) Credits

Attendees are eligible to receive 0.5 CME credit. Preregistration is required and an Allegheny Health Network (AHN) CME account is needed to receive credit.

You can learn more about the Coding and Quality Knowledge College on the Provider Resource Center via NaviNet by:

- Choosing **Resource Center** from the left menu

    - You will be redirected to the Provider Resource Center (PRC)
- Selecting **EDUCATION/MANUALS** from the left menu on the PRC
- Clicking **Coding Education/HCC University**

Once there, you can find instructions to create an AHN CME account, register for the next class, or view past coding webinars. To register for the April 12 webinar on Cardiac Conditions, go here.

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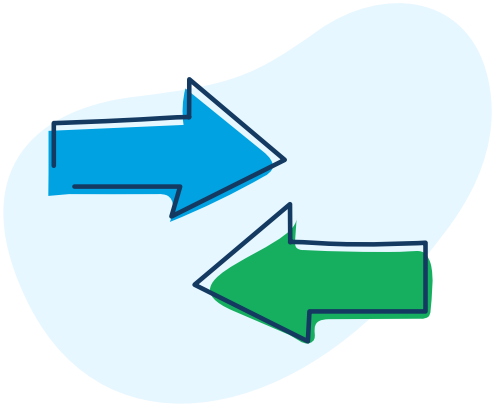
PROVIDER NEWS

A newsletter for the Highmark Blue Cross Blue Shield providers in western Pennsylvania

Issue 3, March 2023

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):

April 3

RP-072 Injection and Infusion Services
This policy is being updated with the addition of codes Q5127 and Q5130.

June 5

RP-045 Purchased Services
This policy is being updated to clarify pass-through billing direction for independent laboratories. A provider may not report a professional service that is performed by another entity.

REMINDER: Here are additional upcoming RP changes that were announced in the February 2023 issue of *Provider News*:

May 1

RP-037 Emergency Evaluation and Management Coding Guidelines
This 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
This policy is being updated regarding the use of JZ and JW modifier, as well as skin substitute wastage documentation.

RP-019N Drugs and Biologicals
This 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 advisement. To access this reimbursement policy, 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 about this RP, click to read the Special Bulletin.

HIGHMARK.

PROVIDER NEWS

A newsletter for the Highmark Blue Cross Blue Shield providers in western Pennsylvania

Issue 3, March 2023

Authorization Updates

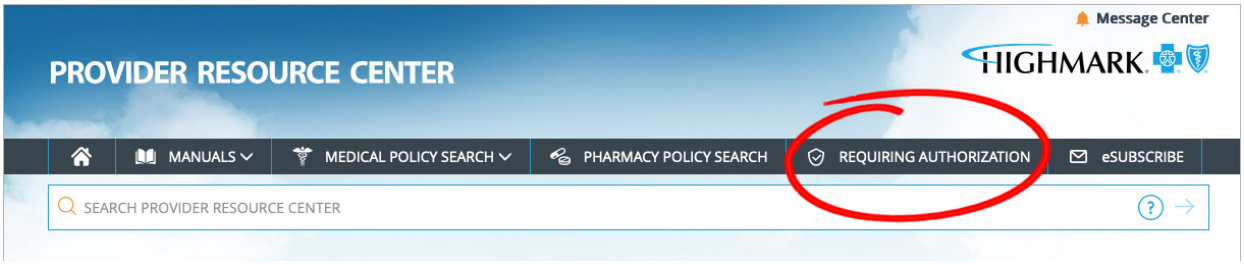
During the year, Highmark adjusts the List of **Procedures and Durable Medical Equipment (DME) Requiring Authorization**. For information regarding authorizations required for a member's specific benefit plan, providers may:

- 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:

- Authorizations For Home Health, Hospice & Outpatient Therapy Routed to New UM Tool
- Prior Authorization Soon Required for SOC Infusion Drugs Included In FEP
- Medical Injectable/Specialty Drug Authorization Submissions

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

HIGHMARK.

PROVIDER NEWS

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Issue 3, March 2023

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. A Highmark Physician 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 medical/surgical decisions by calling Highmark at **800-421-4744**. To request a copy of the criteria/guidelines used in making behavioral health decisions, call **800-258-9808**.

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.

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*.

HIGHMARK.

PROVIDER NEWS

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Issue 3, March 2023

Quarterly Formulary Updates

View the January 2023 updates to Highmark's prescription drug formularies and related pharmaceutical management procedures on the Formulary Updates page on the **Provider Resource Center (PRC)**. From the left menu, select **PHARMACY PROGRAM/FORMULARIES** and then **Formulary Updates**.

Pharmaceutical Management Procedures

To learn more about how to use these procedures, go to the **PHARMACY PROGRAM/FORMULARIES** section on the PRC. Click on **Pharmacy Information** from the sidebar and then **Pharmaceutical Management** from the list on the right.

This section includes information on:

- Exception requests
- The process for generic substitutions
- Explanations of limits/quotas, therapeutic interchange, and step-therapy protocols

Federal Employee Program (FEP) Drug Formularies and Pharmaceutical Management Procedures

The FEP specific drug formularies are available online. Providers also may obtain formulary information by calling **866-763-3608** and following the prompts for Pharmacy.

To learn more about the FEP exception request processes for non-formulary drugs, click here.

HIGHMARK.

PROVIDER NEWS

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Issue 3, March 2023

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:

- Chapter 2 Unit 3 – **Other Government Programs:**
  - Information on CHIP eligibility has been updated to reflect all eligibility forms and questions should be directed to the Department of Human Services instead of Highmark.
- Chapter 3 Unit 2 – **Professional Provider Credentialing:**
  - Information on sanctions has been added throughout this unit.
  - The facility-based practitioner credentialing policy has been updated.
- Chapter 4 Unit 4 – **Ancillary Services,** Chapter 5 Unit 1 – **Care Management Overview,** Chapter 5 Unit 2 - **Authorizations,** Chapter 5 Unit 3 – **Medicare Advantage Procedures:**
  - References to Tivity or WholeHealth Network have been replaced by the company's new name, WholeHealth Living.
- Chapter 6 Unit 2 – **Electronic Claim Submission:**

- The NY address and fax number have been added to Electronic Claim Attachments.
- The New York NAIC Codes/Plan Codes have been updated.

HIGHMARK.

PROVIDER NEWS

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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.

HIGHMARK.

PROVIDER NEWS

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Legal Information

Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association. Highmark Blue Cross Blue Shield serves the 29 counties of western Pennsylvania. 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 Coverage Advantage are service marks of Highmark Inc. 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.

NaviNet is a registered trademark of NaviNet, Inc., which is an independent company that provides a secure, web-based portal between providers and health care insurance companies.

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.