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PROVIDER NEWS

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

Issue 4, April 2023

On January 30, 2023, the federal government announced that the COVID-19 public health emergency (PHE) will expire on **May 11, 2023**.

In response to the COVID-19 pandemic and pandemic-related laws, Highmark implemented many policies and flexibilities waiving or requiring certain actions in response to the pandemic's effect on health care delivery.

Highmark's policy changes and insurance plans/product updates listed below will take effect on **July 6, 2023**. These changes were originally communicated via a Special Bulletin and Plan Central message on April 7, 2023.

Liability immunity has been extended to providers based on the Public Readiness and Emergency Preparedness (PREP) Act to allow for greater delivery of and access to medical countermeasures. These protections will expire on **October 1, 2024**.

Note: *Some state mandates regarding COVID-19 will still be in place once the federal PHE ends. Highmark will follow all federal and state regulations regarding COVID-19 policies.*

With the expiration of the PHE, Highmark has started the process of updating COVID-19-impacted policies and procedures including:

- COVID-Related Cost Share Waivers
- Telehealth Flexibilities
- COVID-19 Non-OTC Diagnostic Test Reimbursement
- Swabbing Codes for COVID Testing
- Prior Authorization Policies
- Medical Policies
- Credentialing Policies
- CMS Disaster Memo
- Reimbursement Policies
- Pharmacist Administered COVID-19 Testing
- Timely Requirements
- NY: COVID-19 Discharges
- Member Notification

COVID-Related Care – Cost Share Waivers Will Sunset

Highmark will extend the following waivers to Highmark members with **employer-sponsored or individual health insurance** coverage until **June 1, 2023***:

- $0 in-network and out-of-network COVID-19 vaccines
- $0 in-network and out-of-network COVID-19 diagnostic and antibody testing
- $0 over the counter (OTC) COVID-19 testing
- $0 prescription antiviral treatment

- $0 in-network and out-of-network related services to diagnose COVID-19 – office visit (in-person or telehealth), emergency room or urgent care

For **Medicare Advantage (MA)** members, Highmark will extend the following waivers with Highmark MA insurance coverage until **June 1, 2023***:

- $0 in-network and out-of-network COVID-19 vaccines
- $0 in-network and out-of-network COVID-19 diagnostic and antibody testing
- $0 in-network and out-of-network related services to diagnose COVID-19. Includes office visits (in-person or telehealth), emergency room visits or urgent care visits.
- $0 inpatient COVID-19 treatment – *covered through **December 31, 2023**, for Medicare Advantage members*

West Virginia: Cost share waiver mandates related to lab testing, OTC tests, and vaccinations may continue to be in place after the federal PHE ends.

**While this coverage applies to most Highmark members, every plan is a little different. If members have any questions, they should login to their member portal and send a message using the Message Center to Member Service. Members can also call Member Service using the number on the back of their insurance card.*

After June 1, 2023, the services above may have out-of-pocket costs based on member plan coverage.

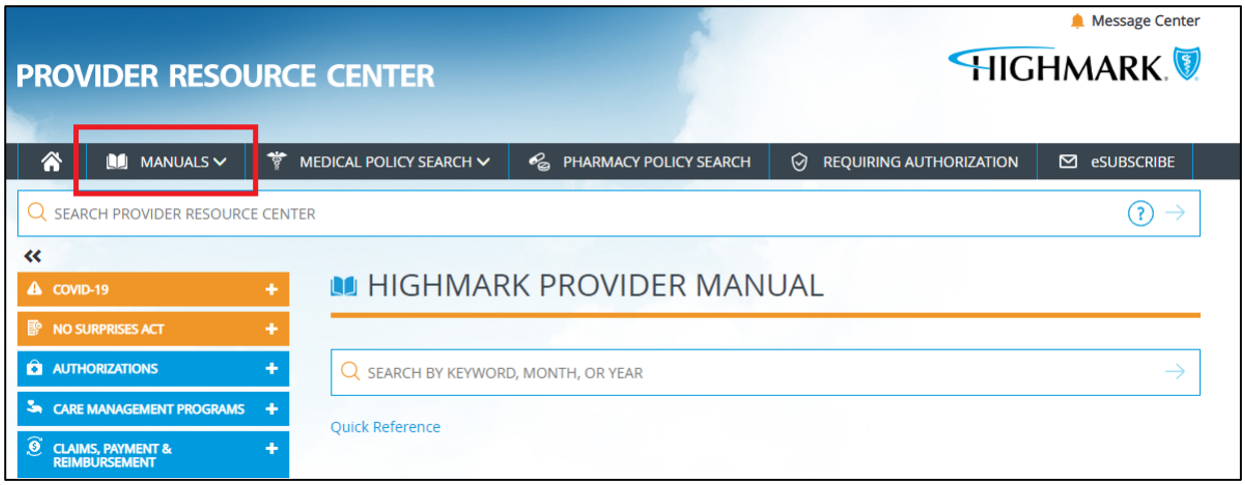
Retail Tests

Over the counter COVID-19 tests will no longer be covered, with members responsible for paying the full cost of these kits. Free tests from the federal government are available at www.covid.gov/tests until supplies run out.

Telehealth Flexibilities – Many to Remain in Place

Many telehealth flexibilities expanded during the PHE will remain in place. Virtual COVID-19-related care will be treated like any other telehealth service.

Reminder: For years prior to the PHE, Highmark had allowed the delivery of virtual visits by practitioners. Please see the *Highmark Provider Manual*, **Chapter 2, Unit 5: Telemedicine Services** , for more information regarding the services that may be provided through this modality and other guidelines.



Changes Effective July 6, 2023

Unless otherwise noted, the following policy changes will go into effect on **July 6, 2023**:

COVID-19 Non-OTC Diagnostic Test Reimbursement

- Standardized pricing will be updated for CPT codes U0001 and U0002.
- Codes U0003 – U0005 will no longer be reimbursed as they are not eligible codes as of May 11, 2023.

Swabbing Codes for COVID Testing

- **Commercial**
  - CPT codes 99000 and 99001 will no longer be reimbursed.
- **Commercial and MA**
  - C9803 will continue to be reimbursed if billed separately with a member cost share.
  - G2023 and G2024 will no longer be reimbursed as they are not eligible codes as of May 11, 2023.

Prior Authorization Policies

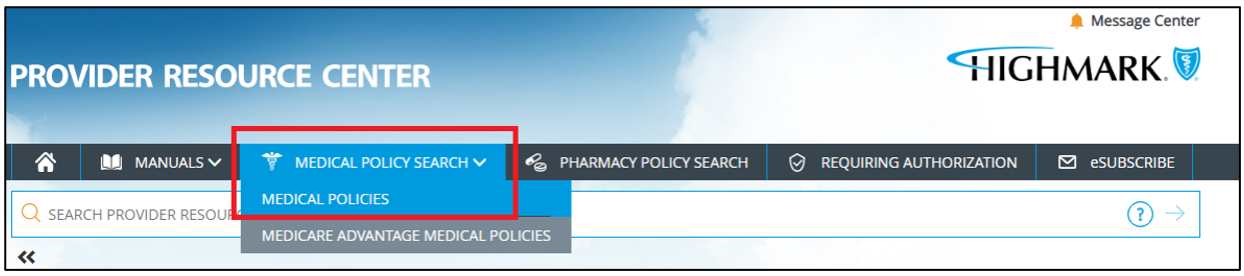
- The “Stabilize and Transfer” out-of-network protocol will be reinstated for all narrow network products.
- **For West Virginia only:** Existing state mandates will continue to be followed post-PHE.
- **For Delaware only:** Under the existing state mandate, insurers must continue to waive all prior authorization requirements for lab testing and treatment of confirmed or suspected COVID-19 patients.

Medical Policies

The following Medical Policies will be updated:

- M-74, Home Prothrombin Time INR Monitoring for Anticoagulation Management
- Y-5, Vision Therapy (Orthoptics and Pleoptics)

To review the Medical Policies, click on **MEDICAL POLICY SEARCH** in the gray Quick Links bar at the top of the Provider Resource Center.



CMS Disaster Memo: Paying All Out-Of-Network Claims as In-Network

- **Medicare Advantage**
    - All OON claims will pay under filed OON plan design coverage rules **after** June 11, 2023, given CMS regulations.

Credentialing Policies

Providers in our network were given COVID-19 exceptions, such as not having a Drug Enforcement Agency (DEA) number for the state they are practicing in. These providers will now need to meet the expectations of our existing credentialing policies.

- **For Delaware (DE) Only:** All credentialing exceptions related to the PHE will end, including those listed below:
    - Out-of-state license for mental health providers.
    - Out-of-state license if working in a hospital or long-term care facility.
    - DE expired license, if expired within the last five years.
    - DE facility expired license for mental health providers only.

Reimbursement Policies

Effective **July 6, 2023**, Telehealth and Virtual Health components of the following Reimbursement Policies (RP) will be removed:

RP–010: Incident To Services
The supervising physician must be physically present. Virtual supervision will no longer be allowed.

RP–027: Hemodialysis and Peritoneal Dialysis
Procedure codes 99401, 99402, 99403, 99404, 99411, and 99412, will no longer be eligible to be performed as telemedicine. Similarly, procedure codes, 99221, 99222 and 99223, will no longer be eligible to be performed as telemedicine.

RP–041: Services Not Separately Reimbursed
The following procedure codes 90887, 99024, 99374, 99377, 99378, 99379, 99380 and 99483 will no longer be eligible to be performed as telemedicine.

New York will no longer reimburse for code U0005.

RP–046: Telemedicine and Telehealth Services
The provision that — *Eligible Providers performing and billing telehealth services must be eligible to independently perform and bill the equivalent face-to-face service* — is being reinstated.

Note: Additional COVID-19-related language will be removed effective May 29, 2023.

Other Reimbursement Changes – Effective July 6, 2023

RP–015 Professional and Technical Components for Applicable Services
Exceptions for procedure codes 99000 and 99001 as diagnostic services are being eliminated.

RP–016: Physician Laboratory and Pathology Services
Exceptions for procedure codes 99000 and 99001 as clinical pathology tests are being eliminated.

RP–054: Ambulance Services
Destination requirements for ground transports that were waived during the PHE are being reinstated.

You can review all current Reimbursement Policies on the Provider Resource Center. Click on **CLAIMS, PAYMENT & REIMBURSEMENT** in the left-hand menu and scroll down to Reimbursement Policy.

Additional Changes

- **Pharmacist Administered COVID-19 Testing**
    - Many states expanded the scope of practice for pharmacists to include this type of testing. Continued pharmacist testing will be dependent on

whether these changes are made permanent at a state level.

- Clinical Laboratory Improvement Amendments (CLIA) waivers are needed by pharmacies to perform this type of testing. Pending additional CMS guidance for post-PHE expectations.
  - **For Delaware only:** Highmark is currently implementing a mandate to allow pharmacists to perform COVID-19 testing.

- **Timely Requirements**
  - Highmark will resume application of standard deadlines for the following items 60 days after the end of the PHE:
    - Requests for both internal (conducted by Highmark) and external appeals regarding adverse benefit determinations
    - Timeframes for filing claim
- **Ending of 20% Increase In DRG Weight Applied to COVID-19 Discharges**
  - **For New York (NY) only:** NY will revert to current contractual reimbursement schedules. Timeline will be based on our contractual obligations. Facilities will receive, at a minimum, a 60-day notice.

Member Notification

Highmark members were notified of changes related to coverage and cost share waivers through our website on **March 22, 2023**. These changes will affect members starting **June 1, 2023**. For additional information on these changes, visit highmarkanswers.com.

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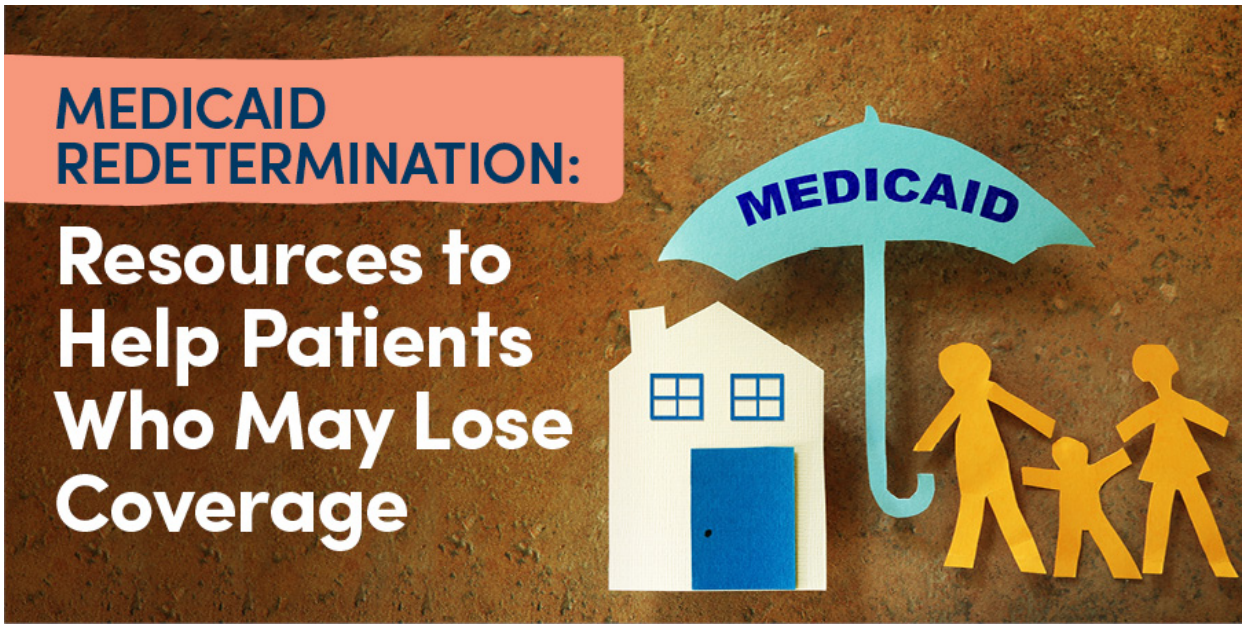
PROVIDER NEWS

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

Issue 4, April 2023



Millions of Americans are expected to lose their Medicaid-related health coverage due to the continuous enrollment requirement for Medicaid, which ended on **March 31, 2023**. This will be a disruptive, stressful time for our members and your patients affected by this change.

Background

In response to the COVID-19 pandemic, the federal government declared a Public Health Emergency (PHE) on **January 31, 2020**. Income eligibility requirements for Medicaid were waived, to help millions of Americans who lost their employer-sponsored health insurance.

In December 2022, Congress passed its year-end omnibus spending bill, which **delinked** the Medicaid continuous coverage requirement from the PHE, establishing the date of **April 1, 2023**, for resuming Medicaid redetermination. As states begin reviewing eligibility requirements for Medicaid, many current recipients will be disenrolled.

Available Resources to Share with Your Patients

The resources below might help members/patients who no longer qualify for Medicaid-related coverage find affordable health care coverage:

Highmark Resources for Members/Patients

Region	Number	Website
Delaware	833-585-7334	www.highmark.com/plans/individual-families
New York (Northeastern)	800-700-8482	
New York (Western)	800-888-5407	
Pennsylvania (Central)	833-585-7332	
Pennsylvania (Northeastern)	833-585-7333	
Pennsylvania (Western)	833-585-7331	
West Virginia	833-585-7335	

FAQs on the PRC

For more information on the Medicaid redetermination process, you can view the Frequently Asked Questions (FAQs) document on the Provider Resource Center (PRC).

To access the FAQs, go to the **PRC**, select **COVID-19** from the left menu and then click **COVID-19 (Coronavirus) Information**. Once on the page, the FAQs can be found under the **Medicaid Redetermination** section.

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PROVIDER NEWS

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

Issue 4, April 2023

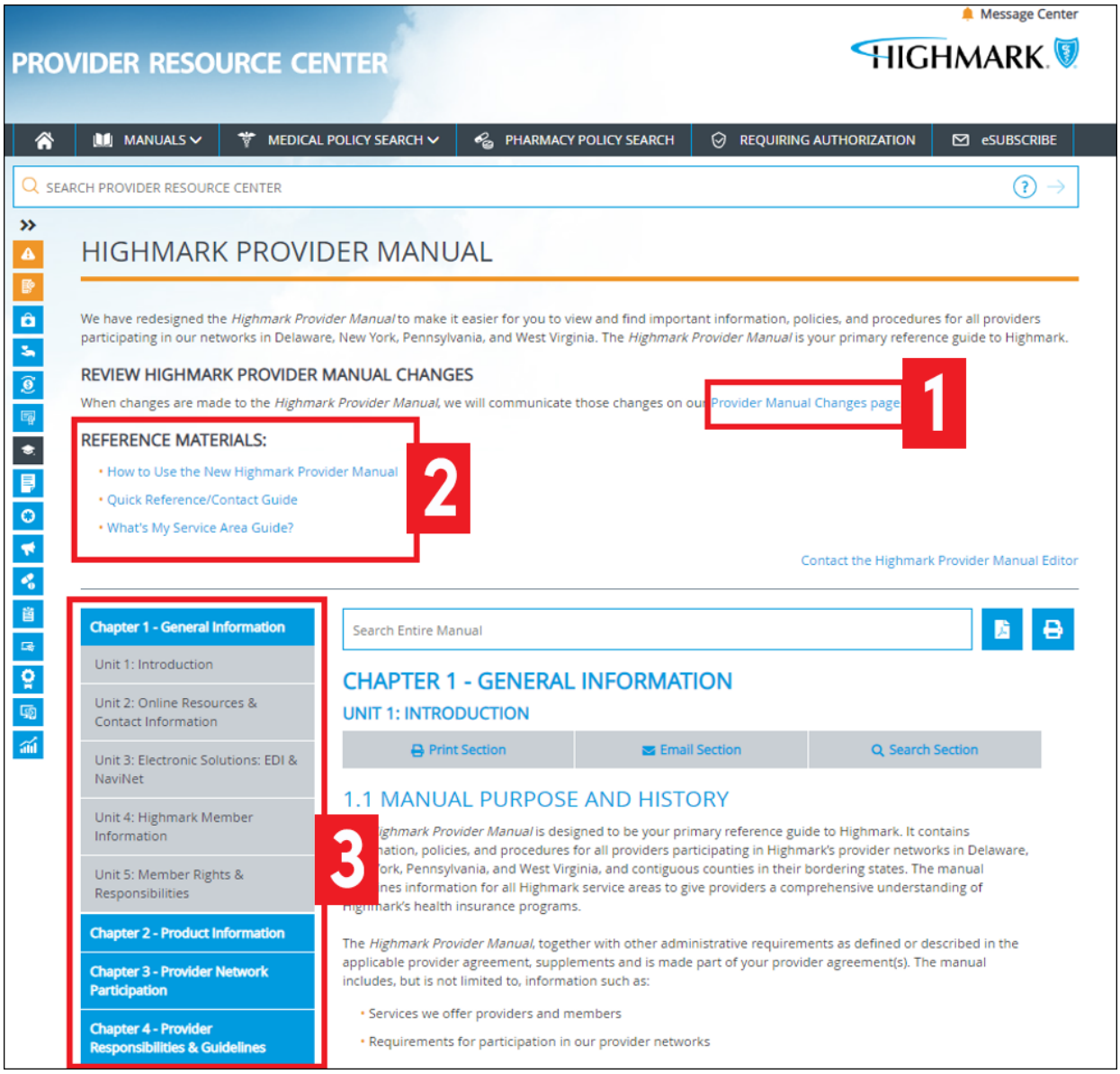
The *Highmark Provider Manual* is getting a facelift.

In May, we will transition the contents of the entire manual — approximately 1,250 pages — from a PDF-based platform to a web-based one. The new format will make it easier to view and search the manual, including within individual chapters and units.

The *Highmark Provider Manual* is designed to be your primary reference guide to Highmark. It contains information, policies, and procedures for all providers participating in Highmark's provider networks in Delaware, New York, Pennsylvania, West Virginia, and contiguous counties in bordering states.

The manual combines information for all Highmark service areas to give providers a comprehensive understanding of Highmark's health insurance programs.

Here are some of the features of the updated *Highmark Provider Manual*:



#1 Provider Manual Changes Page

When changes are made, we will communicate those changes on this webpage. It will contain a running list of updates, organized by date, with the most recent at the top.

#2 Reference Materials

- How to Use the New *Highmark Provider Manual Guide*
    - This document will walk you through the format changes to the *Highmark Provider Manual* including organization, search functionality, and saving/printing.
- Quick Reference/Contact Guide
    - This valuable resource contains all the regional numbers for Provider Service and Clinical Services.
- What Is My Service Area Guide

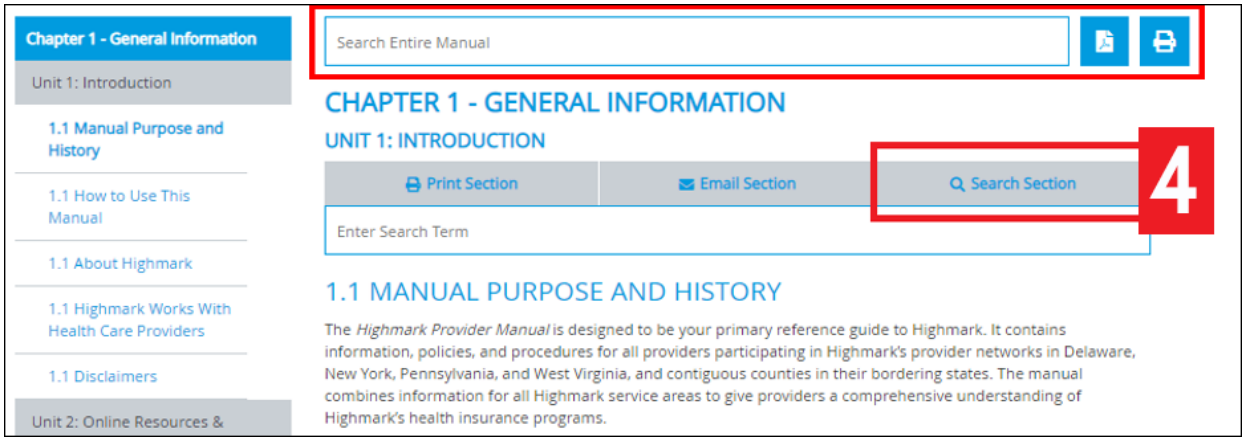
- If you have questions about which Highmark region is your service area, please refer to this map.

#3 Provider Manual Menu

The manual is organized by chapters and units. Chapters and their titles are listed in the navigation menu on the left side of the manual webpage. Click on a chapter to expand the menu, revealing the units and the list of topics covered within that chapter. All chapters, units, and topics are hyperlinked for easy access. To collapse a menu, click twice.

#4 Search Function

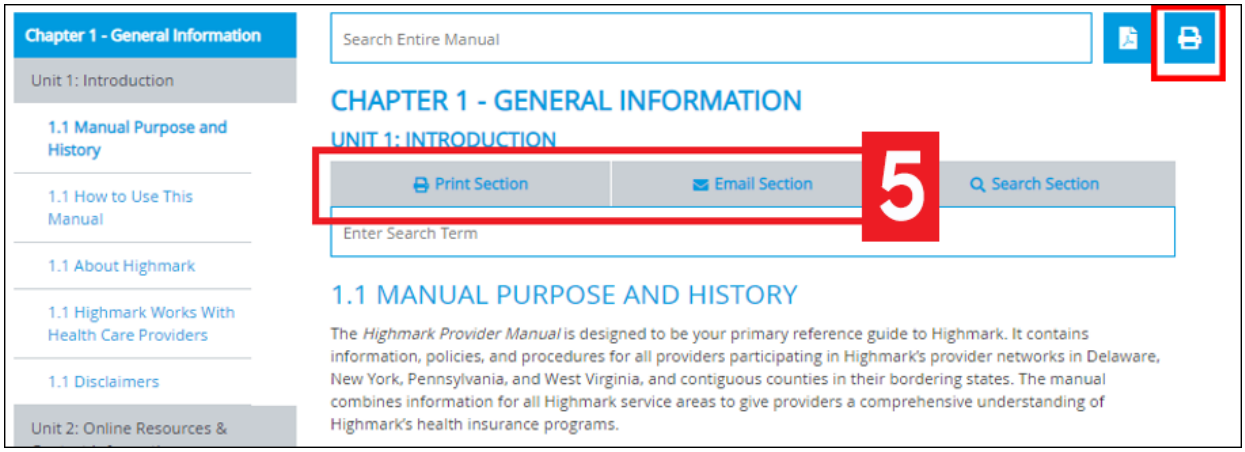
The web-based *Highmark Provider Manual* features a comprehensive search function that will show you the text around keywords, providing additional context when searching.



#5 Email/Print Functionality

With one click, you can email or print (as a PDF) individual sections of the *Highmark Provider Manual* — or the entire manual.

REMINDER: All revisions to the *Highmark Provider Manual* are controlled electronically. Paper copies, screen prints, and all alternate versions are considered uncontrolled and should not be relied upon for any purpose, as they may not be the most recent revision.



We hope you will enjoy the enhancements to the *Highmark Provider Manual*. If you have any questions about the manual, you can email HPMeditor@highmark.com.

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PROVIDER NEWS

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

Issue 4, April 2023

Quality Program Information

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 goals and a report on progress toward meeting those goals, please visit the Provider Resource Center.

Once on the Provider Resource Center, select ***Highmark Provider Manual*** from the gray navigation bar at the top. See "Chapter 5: Care & Quality Management, Unit 6: Quality Management."

HIGHMARK.

PROVIDER NEWS

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

Issue 4, April 2023

Beginning in 2022, the Centers for Medicare and Medicaid Services (CMS) required home health agencies to submit a one-time Notice of Admission (NOA), using Type of Bill (TOB) 32A. However, Highmark's implementation of TOB 32A had been delayed.

Effective **July 14, 2023**, Highmark will require home health agencies that submit Medicare Advantage claims in the Provider Driven Grouper Model (PDGM) format to use TOB 32A on all admissions.

TOB 32A Payment Adjustments

The prompt submission of TOB 32A is necessary to determine whether payment adjustments should be applied (for timeliness), under CMS' PDGM. Like CMS, Highmark will apply payment penalties to the final claim (TOB 329) when the associated NOA is submitted late.

The NOA must be submitted within the first five calendar days of the admission date, or a payment reduction will be incurred. While Highmark will not issue payment on the claims

with TOB 32A, the claim is still required to prevent payment penalties on the associated TOB 329 claims.

As the **July 14, 2023** implementation date approaches, additional communications will be provided. Please ensure you are checking the Provider Resource Center regularly, so you don't miss important updates.


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PROVIDER NEWS

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

Issue 4, April 2023

SHORT TAKES:

New Provider Data Maintenance Tool

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.*

To learn more, read the March 27 Special Bulletin.

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PROVIDER NEWS

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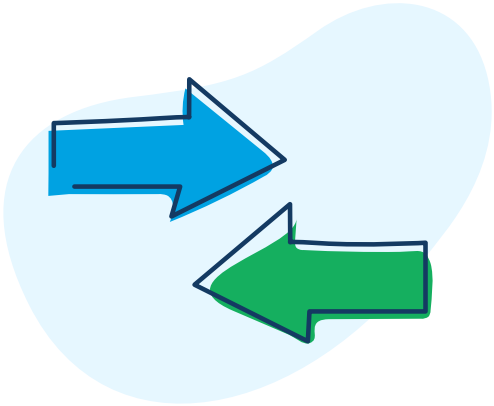
Issue 4, April 2023

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 recently updated and upcoming Reimbursement Policies (RPs):

RECENTLY UPDATED

April 3

RP-047 Venipuncture and Lab Services
This policy was reviewed as part of our standard review process. No changes were made.

RP-072 Injection and Infusion Services
Codes Q5127 and Q5130 were added to this policy.

April 10

RP-064 Government Supplied Vaccinations and Antibody Treatments
Code 0174A was added to this policy.

April 24

RP-009 Modifiers 25, 59, XE, XP, XS XU, and FT
This policy was reviewed as part of our standard review process. No changes were made.

RP-012 Rigid Immobilization
This policy was reviewed as part of our standard review process. No changes were made.

RP-013 Electrocardiogram and Medical Imaging Interpretation
This policy was reviewed as part of our standard review process. No changes were made.

UPCOMING

IMPORTANT: With the public health emergency (PHE) coming to an end, the following reimbursement policies (RPs) will have Telehealth and Virtual Health components changed or removed, or will otherwise return to pre-PHE direction, effective **July 6, 2023**:

RP-010 Incident To Billing Services and Advanced Practice Provider Reductions
The supervising physician must be physically present. Virtual supervision will no longer be allowed.

RP-015 Professional and Technical Components for Applicable Services
Exceptions for procedure codes 99000 and 99001 as diagnostic services are being eliminated.

RP-016 Physician Laboratory and Pathology Services
Exceptions for procedure codes 99000 and 99001 as clinical pathology tests are being eliminated.

RP-027 Hemodialysis and Peritoneal Dialysis
Procedure codes 99401, 99402, 99403, 99404, 99411, and 99412, will no longer be eligible to be performed as telemedicine. Similarly, procedure codes, 99221, 99222 and 99223, will no longer be eligible to be performed as telemedicine.

RP-041 Services Not Separately Reimbursed
The following procedure codes 90887, 99024, 99374, 99377, 99378, 99379, 99380 and 99483 will no longer be eligible to be performed as telemedicine.

New York will no longer reimburse for code U0005.

RP-046 Telemedicine and Telehealth Services

The provision that — *Eligible Providers performing and billing telehealth services must be eligible to independently perform and bill the equivalent face-to-face service* — is being reinstated.

NOTE: Additional COVID-19-related language will be removed effective May 29, 2023.

RP-054 Ambulance Services

Destination requirements for ground transports that were waived during the PHE are being reinstated.

For more information about changes following the end of the PHE, go to the COVID-19 (Coronavirus) Information page on the PRC.

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HIGHMARK.

PROVIDER NEWS

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

Issue 4, April 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:

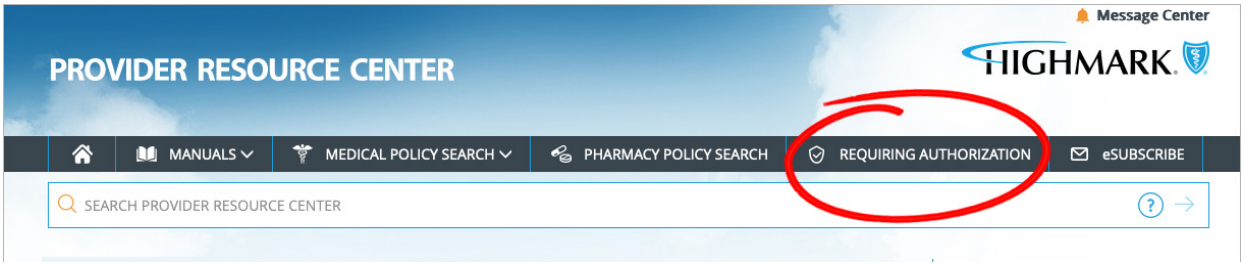
Medical Injectable/Specialty Drug Authorization Submissions

In addition, the PRC has a variety of educational resources available regarding the authorization automation process, including:

- Auth Automation Hub Frequently Asked Questions
- Inpatient Authorization Guides:
  - Non-Urgent Inpatient Authorization Submission
  - Urgent Inpatient Authorization Submission
- Outpatient Authorization Guide
- MCG Guidelines Product Acronym List
- MCG Instructional Video (available until May 1, 2023)
- Helion Arc Authorization Guide

To access these resources, select **AUTHORIZATIONS** from the left menu and then click **Procedures/Service Requiring Prior Authorization**. Once on the page, scroll down to down the **Obtaining Authorizations** section.

To view the full List of Procedures/DME Requiring Authorization, click **REQUIRING AUTHORIZATION** in the gray bar near the top of the PRC homepage.



Once redirected to the **Procedures/Service Requiring Authorization** page, click **View the List of Procedures/DME Requiring Authorization** under **PRIOR AUTHORIZATION CODE LISTS**.

Please note that the Highmark member must be eligible on the date of service and the service must be a covered benefit for Highmark to pay the claim.

NaviNet® is the preferred method for:

- Checking member benefits and eligibility
- Verifying whether an authorization is needed
- Obtaining authorization for services

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PROVIDER NEWS

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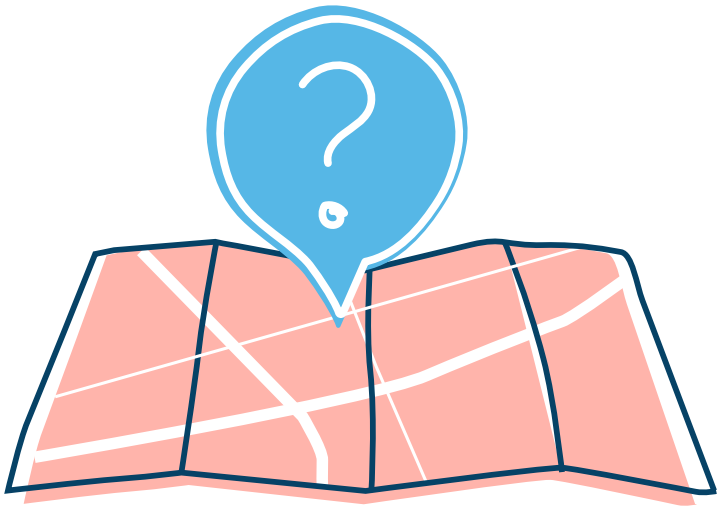
Issue 4, April 2023

Ensure Your Directory Information Stays Current

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.

- **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 on an occasional basis should not be listed.
- **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 – New PDM Tool

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.

To learn more about the new PDM tool, read the **March 27 Special Bulletin**.

Facility, Ancillary, and Medicaid Providers – Continue to 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.

HIGHMARK.

PROVIDER NEWS

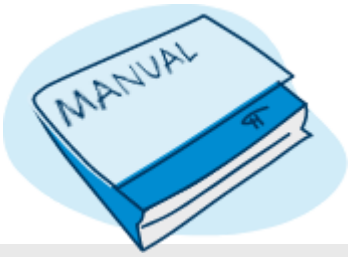
A newsletter for the Highmark Blue Cross Blue Shield providers in western Pennsylvania

Issue 4, April 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 3 Unit 2:** Professional Provider Credentialing – updated the credentialing process throughout the unit and included NY Medicaid/Child Health Plus (CHP) instructions.
- **Chapter 3 Unit 4:** Organizational Provider Participation (Facility/Ancillary) – added guidance that FEP members do not have coverage for procedure code S9088.
- **Chapter 4 Unit 2:** Behavioral Health Providers – updated the levels of care for behavioral health providers and removed the requirement for Medical Directors to submit claims for PHPs/IOPs.

HIGHMARK.

PROVIDER NEWS

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

Issue 4, April 2023

About This Newsletter

Provider News is a valuable resource for health care providers who participate in our networks. Published monthly on the last Monday of the month*, *Provider News* conveys important product, policy, and administrative information, including billing, claims, and program updates.

The publication also features the latest news, information, tips, and reminders about our products and services, as well as relevant interviews, articles, and stories, for health care professionals who serve Highmark members.

Regular topics include:

- New and Updated Reimbursement Policies
- Authorization Updates
- Staying Up to Date with the *Highmark Provider Manual*

*When a holiday falls on the last Monday of the month, *Provider News* will be published on the preceding Friday.

Another Valuable Resource

For medical policy and claims administration updates, including coding guidelines and procedure code revisions, please refer to the ***Medical Policy Update Newsletter***.

You can access both *Provider News* and the Medical Policy Update Newsletter on the Provider Resource Center from the **NEWSLETTERS/NOTICES** link on the sidebar. Email subscriptions are available via the **eSubscribe** button on the PRC taskbar.

Comments/Suggestions Welcome

We want *Provider News* to meet your needs for timely, effective communication. If you have any suggestions, comments, or ideas for articles in future issues, please email the *Provider News* team at ResourceCenter@Highmark.com.

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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.