HIGHMARK WESTERN NEW YORK

PROVIDER NEWS

A newsletter for Highmark Blue Cross Blue Shield of Western New York (Highmark BCBSWNY) network providers

Issue 2, February 2023

Annual HEDIS® Medical Record Review Now Underway

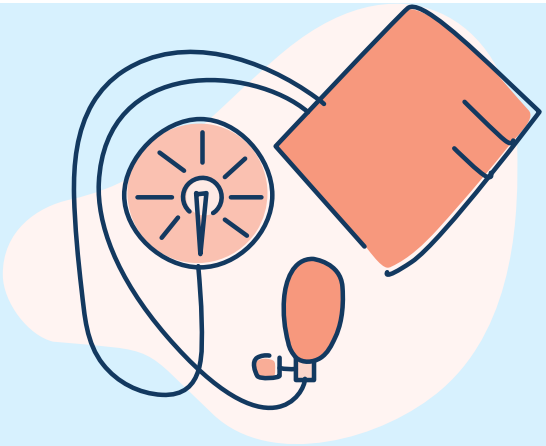
The annual Healthcare Effectiveness Data and Information Set (HEDIS®) Medical Record Review is being conducted now through May 2023.

This review assesses Highmark's contracted provider compliance with a set of standardized performance measurements that Highmark is required to report to the National Committee for Quality Assurance (NCQA). HEDIS data is collected and reported on an annual basis as part of Highmark's accrediting and governmental requirements.

The measurements this year are:

- Controlling High Blood Pressure
- Colorectal Cancer Screening
- Hemoglobin A1c Control for Patients with Diabetes

- Blood Pressure Control for Patients with Diabetes
- Eye Exam for Patients with Diabetes
- Transitions of Care
- Cervical Cancer Screening
- Childhood Immunization Status
- Immunizations for Adolescents
- Lead Screening in Children
- Prenatal and Postpartum Care
- Weight Assessment and Counseling for Nutrition and Counseling for Physical Activity for Children and Adolescents



For information on who will be conducting this year's review, who to contact with your questions, or what the COVID-19 procedures are, please review the recently published Plan Central Message: **Annual HEDIS® Medical Record Reviews to Begin in February 2023**.

To access it, log on to NaviNet® and click on **Resource Center** from the blue left-hand menu. Once you are redirected to the Provider Resource Center, go to the **Plan Central Library** which can be found under **NEWSLETTERS/NOTICES** on the left menu.

Disclaimers: HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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Public Health Emergency Ending on May 11

The federal government announced last month that the COVID-19 national emergency and public health emergency (PHE) will end on **May 11, 2023**.

Throughout the PHE, Highmark modified policies and procedures to allow for greater flexibility of care and ensure the best coverage possible for our members.

With the PHE ending, Highmark is currently evaluating those policies and procedures that were impacted, including (but not limited to):

- Reimbursement Policies
- Coverage and Cost Sharing Changes
- Medical Policies

- Credentialing
- Medicaid Redetermination

Highmark will share those changes with providers in future issues of this newsletter and through Special Bulletins on the homepage of the Provider Resource Center (PRC).

For current information about our COVID-19 policies, visit the PRC. Once on the site, select **COVID-19** from the left menu and click on **COVID-19 (Coronavirus) Information**.


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Cervical cancer is the fourth most frequent cancer in women globally, according to the World Health Organization. In the United States, approximately 13,000 new cases of cervical cancer are diagnosed and about 4,000 women die from this cancer annually.[1]

Providers can help female patients lower their risk of cervical cancer by recommending — and administering — vaccinations and appropriate screenings.

Vaccinations

The human papilloma virus (HPV) has been identified as a major cause of cervical cancer. The HPV vaccination can help protect women from multiple types of HPV infection.

The HPV vaccination is routinely recommended for preteens ages 11–12 (can start at age 9). Expanded guidelines for the HPV vaccine now include high-risk adults who are 27–45 years of age.

Appropriate Screenings

Cervical cancer is preventable with the HPV vaccination and regular screenings (Pap and/or HPV tests). Early detection helps in identifying cervical cancer when it is easier to treat.

The annual gynecological exam provides an excellent opportunity to discuss appropriate screenings with your patients to help them meet their individual health goals.

HEDIS® Measures

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a widely used set of healthcare performance measures for a variety of clinical procedures, including cervical cancer screenings.

The Cervical Cancer Screening (CCS) measure evaluates females, 21–64 years of age, who were screened for cervical cancer using any of the following criteria:

- 21–64 years who had cervical cytology performed within the last three years
- 30–64 years who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last five years
- 30–64 years who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years.

HEDIS® Exclusions for the CCS Measure

- Members who have had a total, abdominal, vaginal hysterectomy with no residual cervix, cervical agenesis, or acquired cervical absence are not required to have this screening performed.
- Members currently in hospice and/or have received hospice services during the measurement year.
- Members currently receiving palliative care.

NOTE: *Patients who have had an abdominal or vaginal hysterectomy with no residual cervix, and no previous abnormal PAP smears may not be required to have this screening performed unless there is a recent history of cervical dysplasia or cervical cancer.*

Tips

- **Exclusions** – Look back as far as possible in the member's history for exclusions.
- **Closing Gaps** – Be proactive by evaluating practice processes for opportunities to close care gaps every time a patient is seen.
- **Hysterectomies** – Documenting that a member had a hysterectomy does not exclude the member unless the cervix is totally removed.
- **Biopsies** – Do not count biopsies as they are diagnostic and therapeutic only. These are not valid for primary cervical cancer screening.
- **Labs** – Lab results that indicate the sample contained "No Endocervical Cells" may be acceptable if a valid result is reported for the test.

Documentation in the medical record must include both the following:

- A note indicating the date the procedure was performed.
- The result or finding.

Annual gynecological exams can be a life-saving appointment — remind your patients about their importance!

References:
1 https://www.cdc.gov/cancer/cervical/statistics

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New Clinical Vendor for the House Call Program: Signify Health

We're pleased to announce that Signify Health has joined our **House Call** program team for 2023.

Since 2021, Highmark Blue Cross Blue Shield of Western New York has offered the House Call program for eligible members of Medicare Advantage and some other benefit plans. Signify Health will be our primary vendor for the House Call program going forward.

The goal of the House Call program is to help members stay healthy between regular check-ups, gain better understanding of their chronic conditions, and explain how they can access needed resources. Subsequently, the House Call program provides valuable insights to both our members and their PCPs to promote continuity of care.

Signify House Call Visits

House Call visits and screenings — conducted by a licensed Medical Clinician — provide a comprehensive view of the member's health.

During the visit, the Signify Medical Clinician will review a member's medications, check safety issues in the home, conduct depression screenings, assess activities of daily living and fall risk, and may recommend additional screenings.

If the member is clinically unstable, the Medical Clinician will call his or her Primary Care Physician (PCP) that day.

House Call visits do **not** replace regular doctor visits or annual wellness exams. Signify clinicians do not prescribe medications or perform and order invasive tests or procedures.

Members are encouraged to speak with their PCP about follow-up and further health care decisions.

What Happens after the House Call Visit

Your patient's health profile will be documented in a valid medical record, and you will receive a copy of the report and lab results (if applicable). In addition, a copy of the complete health risk assessment is available upon request by contacting Signify member services at 855-319-4448 (TTY: 711) Monday through Friday, 7 a.m. to 6 p.m. Central Time.

If your patients would like to schedule an appointment, they can do so at schedule.signifyhealth.com.

For more information about the House Call program, please contact your practice account manager or the Provider Service Center at 800-950-0051.

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SHORT TAKES:

Prior Auth Update, MCG Transition, and More

Step Therapy Prior Authorization for Hyaluronan Treatment

As of **January 1, 2023**, step therapy prior authorization requirements apply to select medical injectables related to hyaluronan treatment for Medicare Advantage (MA) members. This change will align with the requirements already in place for Highmark Blue Cross Blue Shield of Western New York members covered by commercial and Affordable Care Act (ACA) plans. Click to read more.

UPDATE: Transition to New Utilization Management Tool On Hold

The transition to our new utilization management (UM) tool is now on hold for Highmark Blue Cross Blue Shield of Western New York. Once we have a new implementation date, we will communicate that to our providers. For more information, click here.

Prior Authorization Changes Postponed

Highmark Blue Cross Blue Shield of Western New York (BCBSWNY) is postponing authorization requirement changes for some musculoskeletal (MSK) procedures and interventional pain management, molecular and genomic testing, and radiation oncology services for all lines of business **for the foreseeable future**.

Educational webinars will be rescheduled. We will send updated registration information and webinar dates prior to implementation of these eviCore programs. To read the entire **Special Bulletin**, go here.

Transition to MCG

Effective **February 13, 2023**, Highmark incorporated MCG Health clinical guidelines into our criteria of clinical decision support, replacing Change Healthcare (InterQual). **This change is being made to align the clinical review processes and platforms for Highmark health plans.** To learn more, go here.

Telemedicine and Telehealth Update

Highmark is changing Reimbursement Policy-046: Telemedicine and Telehealth Services (RP-046) to again allow reimbursement for the following codes: 99446, 99447, 99448, and 99449. This update is for all commercial lines of business effective **February 20, 2023**. For more information, go here.

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Partnering to Reduce Opioid Risk

Over the past two decades, the U.S. opioid crisis has been accelerated in part by the widespread prescribing of opioid medication for pain. This phenomenon contributed to misuse of both prescription and non-prescription opioids.

The Centers for Disease Control and Prevention (CDC) released *Clinical Practice Guideline for Prescribing Opioids for Pain* in 2016 and revised it in 2022. Yet in many busy practices, prescribers may not have full insight into all the services and medications patients receive, such as:

- **Opioid and concurrent benzodiazepine prescriptions from other providers**
- **Emergency department (ED) visits for non-fatal overdoses and other patterns of risk**

Since 2016, Highmark has partnered with Wayspring's axialHealthcare to provide assistance to prescribers in safe opioid management. axialHealthcare's advanced data analytics enables prescribers to identify at-risk members and provides timely, interactive tools for clinical decision-making. This service is called Risk Mitigation.

The interactive tools generate reports on prescribing and allow for voluntary consultation with the Clinical Consult Services (CCS) team of advanced practice providers, clinical

pharmacists, nurses, and engagement specialists to discuss optimal evidence-based opioid prescribing.

Highmark Blue Cross Blue Shield of Western New York (BCBSWNY) is partnering with axialHealthcare to extend its Risk Mitigation services effective March 1, 2023. This is a voluntary offering that we hope will provide deeper insights into the patterns of care provided to your Highmark BCBSWNY patients receiving opioids.

Provider Tools

Through this partnership, providers will have access to axialHealthcare's Risk Mitigation Solution. This online platform features a variety of tools for identifying and addressing opioid-related risk in patient populations, including:

- **Analytics highlighting members who fall into certain risk categories**, such as patients recommended for a Substance Use Disorder (SUD) evaluation, those receiving opioids from multiple providers, or using benzodiazepine with opioids.
- **Patient-specific snapshots of key clinical information** that summarize critical diagnoses and recent prescriptions.
- **Tying risk categories to clinical considerations** to help mitigate the risk.
- **An interactive opioid reduction tool** to assess patient readiness and motivation while supporting the development of patient-centric reduction plans when beneficial.
- **Insight into areas of patient risk** within a set of clinical measures for opioid prescribing.

Direct Provider Support

Each of these resources is supported by axialHealthcare's CCS team.

The CCS team's goal is to support you in the treatment of complex patients by applying their clinical expertise, offering detailed patient intelligence, and identifying care coordination opportunities and other relevant evidence-based solutions to support optimal patient health outcomes.

For access support or questions about the program, please contact the axialHealthcare CCS team by calling **412-679-6127** or emailing providersupport@axialHealthcare.com.

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Emergency Department Room Claim Audits

Starting **June 1, 2023**, Highmark will begin auditing all outpatient Emergency Department facility claims to ensure the correct procedure codes are being billed. This may result in a different reimbursement than expected, with Highmark updating the claim to correct the procedure code.

These audits are designed to determine the appropriate and fair level of facility reimbursement for emergency department services based on the Centers for Medicare and Medicaid Services (CMS) criteria to determine the appropriate procedure code. Highmark will review the diagnoses submitted as well as the services performed to determine the appropriate level of care for the visit on a scale of one (1) through five (5).

On **February 27, 2023**, Highmark will update Reimbursement Policy RP-037: Emergency Evaluation and Management Coding Guidelines with a full description of these changes.

How To Determine If Your Claim Was Changed

If the audit determines your claim warrants the level of care at which the claim was billed, the claim will not be changed. If we determine the claim warrants a different level of care, Highmark will add a new line with the correct procedure code and reimburse you at the updated rate.

If Highmark lowers your level of care, you will be able to see the new procedure code on your Explanation of Benefits (EOB). The code you originally submitted on the claim and the code Highmark adds to the claim will be stored in our systems for CMS audits. However, your EOB will only show the procedure code that Highmark inserts onto the claim.

Appealing the Updated Rate

If you disagree with the level of care that Highmark determined through the audit, you can file an appeal with Highmark. To appeal, you will need to submit all related medical records to Highmark's Medical Review team as outlined in Chapter 5 Unit 5 of the *Highmark Provider Manual*.

To locate the *Highmark Provider Manual*, hover over **Manuals** in the quick access bar at the top of the **Provider Resource Center** and select **Highmark Provider Manual**.

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PrEP Guidelines for HIV Prevention

The New York State Department of Health (NYSDOH) Clinical Education Initiative's HIV clinical guidelines recommend speaking to your patients about Pre-Exposure Prophylaxis (PrEP) as a preventive measure.

Studies described in the clinical guidelines show that patients taking antiretroviral medication significantly reduce their risk of becoming infected with HIV.

According to the guidelines, PrEP should be offered as part of a comprehensive prevention plan for your HIV negative patients — including adolescents — who are at an increased risk of contracting HIV.

As part of the comprehensive prevention plan, it is recommended that your patients receive:

- Counseling and education about adherence to PrEP and risk reduction
- Discussions about additional HIV prevention options, including condom use and safe drug injection practices
- Monitoring with routine lab tests

Please note: PrEP is not a preventive measure for other viral and bacterial sexually transmitted infections (STIs). Patients taking PrEP can still contract and spread STIs and you should continue to educate your patients on safe-sex practices.

We encourage you to speak with your adult and adolescent patients about the importance of HIV prevention.

Click the links below to view additional resources:

- New York State's End The Epidemic – HIV/AIDS Plan
- HIV Clinical Guidelines
- NYSDOH PrEP Information
- CDC HIV Prevention Guidelines

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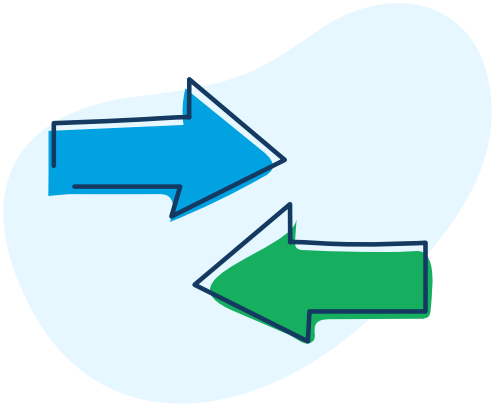
New and Updated Reimbursement Policies



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):

UPCOMING

May 29

RP-003 Convenience Kits, Drug and Biological Wastage
Policy is being updated regarding the use of JZ and JW modifier, as well as skin substitute wastage documentation.

RP-019N Drugs and Biologicals
The 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 consumption. To access, 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-037 Emergency Evaluation and Management Coding Guidelines
Policy is being updated to provide direction on the Plan's analysis of evaluation and management codes for accuracy.

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, click to read the Special Bulletin.

RECENTLY UPDATED

February 13

RP-064 Government Supplied Vaccinations and Antibody Treatments
Policy change to advise that the Emergency Use Authorization has been rescinded for codes Q0220, Q0221, M0220, and M0221.

February 20

RP-046 Telemedicine and Telehealth Services
Policy direction change on codes 99446, 99447, 99448, and 99449, which will continue to be reimbursed.

February 27

RP-008 X-rays Using Film, Computed Radiography and Computed Tomography: Modifiers FX, FY, CT

Policy is being updated to clarify direction for the Highmark Blue Cross Blue Shield of Western New York (BCBSWNY) and Highmark Blue Shield of Northeastern New York (BSNENY) regions.

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Authorization Updates

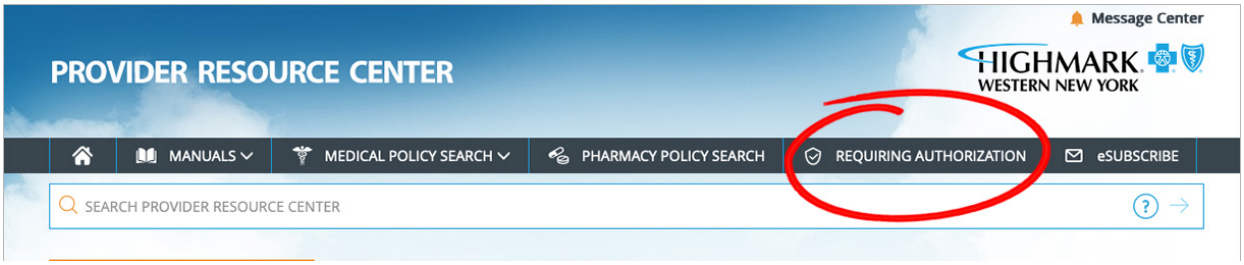
During the year, Highmark adjusts the List of **Procedures and Durable Medical Equipment (DME) Requiring Authorization**. For information regarding authorizations required for a member's specific benefit plan, providers may:

- 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:

- UPDATE: Transition to New Utilization Management Tool On Hold
- Reminder: MCG Launched on February 13, 2023
- Prior Authorization Changes Postponed

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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Quarterly Formulary Updates

View the December 2022 updates to Highmark's prescription drug formularies and related pharmaceutical management procedures at 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.

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Keep Your Information Current with BetterDoctor

Every quarter, Highmark Blue Cross Blue Shield of Western New York (BCBSWNY) is required by the Centers for Medicare & Medicaid Services (CMS) to ask you to validate your information and make sure it is correct.

Accurate provider information makes it easy for our members to find and select their doctors from our online Provider Directory.

Outreach from BetterDoctor

QUEST ANALYTICS BetterDoctor

We partner with vendor BetterDoctor to help keep our network provider information current. It is important that you respond and attest to BetterDoctor's quarterly outreach. When you update your demographic information with us, you will also need to contact BetterDoctor's Customer Service team to let them know about any changes.

Validate or Update

Failure to keep your demographic information current with BetterDoctor may disrupt your claims from processing. To contact BetterDoctor's Customer Service team, email support@betterdoctor.com or call **844-668-2543**.

If you are already registered with BetterDoctor, the firm will send us your current information. If you are not registered, you may receive a request to validate your information online as part of a new outreach campaign.


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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:

- New York Provider Service phone numbers were consolidated to one phone number (800-950-0051) throughout the manual.
- InterQual information was removed, and MCG Clinical Guidelines were added throughout the manual.

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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.

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Legal Information

Highmark Blue Cross Blue Shield of Western New York (Highmark BCBSWNY) is a trade name of Highmark Western and Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield Association. Blue Shield and the Shield symbol are registered marks, and BlueCard and Blue Distinction are registered trademarks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield companies. 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.

Information on this website is issued by Highmark BCBSWNY, which serves the 8 counties in western New York.

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.

Highmark BCBSWNY has adopted Highmark Inc. medical policies as its own policies applicable to Highmark BCBSWNY members who have moved to the "Highmark System" (i.e., *information systems of Highmark Health and/or its subsidiaries/affiliates*). Please note that for providers with Highmark BCBSWNY members who remain on the BCBSWNY Legacy System (i.e., have not yet moved to the Highmark System), certain BCBSWNY Legacy System medical protocols (found at bcbswny.com) shall apply and control until the earlier of such time as such member is no longer on the BCBSWNY Legacy System or Highmark BCBSWNY communicates otherwise to you.

Current Procedural Terminology (CPT) is a registered trademark of the American Medical Association. 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. InterQual is a registered trademark of McKesson Health Solutions, LLC.

View the BCBSWNY Privacy Policy.

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.