



“This is a time of unprecedented need and opportunity for behavioral health care,” said Bradley Karlin, PHD, ABPP, MBA.

As executive medical director of Behavioral Health for Highmark Health since 2021, he is leading Highmark’s efforts to transform behavioral health (BH) care.

In a recent interview with *Provider News*, Dr. Karlin discussed the current challenges in BH care; the unique opportunities and benefits presented by virtual health care and other innovations; and Highmark Health’s enterprise behavioral health strategy.

Background

Dr. Karlin has dedicated his career to transforming behavioral health care in large public and private systems. Prior to joining Highmark Health, he served as vice president and chief of Mental Health and Aging at EDC, a global consulting firm. He is currently an adjunct professor in the Bloomberg School of Public Health at Johns Hopkins University in Baltimore, Maryland.

“Mental health problems are at an all-time high. There was a behavioral health care crisis prior to COVID-19, but the pandemic added fuel to an existing fire.”

— Bradley Karlin, PHD, ABPP, MBA
Executive Medical Director of Behavioral Health for Highmark Health

At the Department of Veteran Affairs (VA) in Washington, D.C., he served as the national mental health director for Psychotherapy and Psychogeriatrics. During his 7-plus-year tenure in this role, he led the nation's largest implementation of evidence-based psychological treatments and the transformation of geriatric mental health services.

These efforts were part of a broader process to transform the VA mental health care system to an evidence-based and recovery-oriented system of care. As a result, this work led to robust improvements in patient outcomes and a fundamental change in the treatment culture and model.

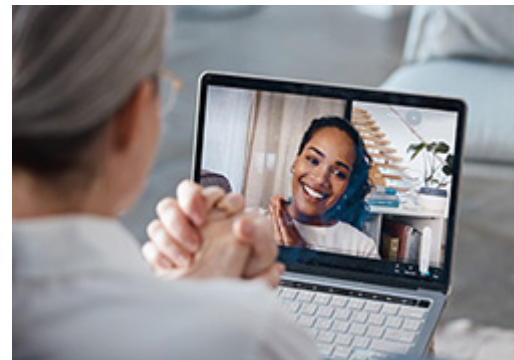
Current Situation

"Mental health problems are at an all-time high. There was a behavioral health care crisis prior to COVID-19, but the pandemic added fuel to an existing fire," Dr. Karlin said. "Now we have a behavioral health crisis that is even greater than what existed a couple of years ago."

"We know that **only 40%** of individuals who have a behavioral health problem receive any type of treatment," he said. "But even more sobering, is that only 15% receive what's considered minimally acceptable treatment according to clinical practice guidelines."

Balanced Perspective

While Dr. Karlin is clear-eyed about the current challenges, he's optimistic about the opportunities for transforming behavioral health care, especially the use of technology and innovation to expand access and quality.



"In 2020, we saw within Highmark close to a **7,000% increase** in virtual behavioral health care," he said. "Two years later, we're still seeing a very high degree of telebehavioral¹ health care delivery, outpacing every other specialty area."

Primary Care Physicians

Dr. Karlin praised primary care physicians (PCPs) for the critical role they play in the delivery of BH care: "Primary care providers are pivotal to both the detection and treatment of behavioral health issues."

"In addition to being the front line for behavioral health issues," he continued, "PCPs provide the majority of behavioral health care in the nation, not to mention the fact that upwards of 70% of cases seen in primary care have a psychological or behavioral component."

“What’s often challenging for primary care providers,” he said, “is having a mechanism to address some behavioral health issues once identified, particularly in the current environment of need and especially for those who require more specialized focus or referral to specialty care.”

Making Behavioral Health an Equal Pillar to Physical Health

Highmark Health is working to transform the clinical and business model of behavioral health care and enable behavioral health to be an equal pillar to physical health. This involves making BH care more proactive, more personalized, and more quality and value-focused. One key initiative designed to increase both access and quality is the development of a high-performance behavioral health network, with an expected initial launch in 2023.

The network—in conjunction with a partner organization—will significantly increase access to care by expanding the existing network, particularly for specialized needs and populations. In addition, this network will allow providers to more fully realize the “quality promise of behavioral health care,” emphasized Dr. Karlin, by advancing the delivery of Grade-A-recommended, evidence-based treatments, which are currently provided to a small minority of patients across systems. The high-performance network will also feature enhanced navigation and coordination, as well as a closed-loop physician referral program.

“Within this referral program, referring PCPs will receive communication regarding the disposition of the BH case following the referral, a piece often missing from the current process,” said Dr. Karlin.

Under Dr. Karlin’s leadership—along with support and contributions from key partners throughout the organization—Highmark developed an enterprise behavioral health strategy in 2021, with the overarching goal to elevate behavioral health to be an equal pillar with physical health in the [Living Health model](#). The strategy involved fundamentally changing how behavioral health care is delivered. Key priorities of the strategy include:

- 1. Expanding Access**
- 2. Advancing Quality and Clinical Excellence**
- 3. Transforming the Business Model**
- 4. Increasing Engagement, Personalization, and Moving Care Upstream**



Reasons for Optimism

Dr. Karlin emphasizes that the increased focus on and priority of behavioral health care—combined with recent technological and clinical innovations—present a considerable and unprecedented opportunity to fundamentally transform the field of BH care.

To achieve this transformation and effectively solve current needs, he urged, “We must not only expand access, but also ensure that the most effective treatments and technology solutions that science has to offer are the treatments those in need receive. We must also be proactive in engaging individuals in personalized care and support much sooner than the average 8–10 years it takes for those who seek care after symptoms present.”

Final Thoughts

Dr. Karlin sees the field of BH care at a defining moment.

“This is a moment we are not likely to see again in this generation. How we approach this unprecedented time of need and opportunity will shape the future of the field and our ability to change the clinical trajectories of many.”

He noted that health economists estimate that with the advancement of digital and virtual behavioral health care, the field has innovated over the past two years the equivalent of 20–30 years prior to the pandemic.

“We need to transform,” he continued, “what has been a somewhat sleepy industry for decades and build on this innovation and momentum to change how behavioral health care is delivered and financed in the years to come.”

¹ Telebehavioral is another name for virtual behavioral health care.





MCG chosen as Utilization Management Clinical Criteria Vendor

Highmark has selected MCG Health, part of the Hearst Health network and an industry leader in evidence-based guidance, as our acceptable use criteria vendor to review utilization management (UM) requests beginning **February 2023**.

Highmark's transition from Change Healthcare (InterQual) to MCG will more fully support our [Living Health](#) strategy and allow us to upgrade our UM capabilities and automation.

These capabilities will enable us to provide:

- **Improved Payer-Provider Collaboration:** MCG is known in the industry as an independent publisher of clinical decision support widely used by both payers and providers alike (nine of the largest U.S. health plans as well as nearly 2,600 hospitals). Working from a common clinical language, Highmark hopes to enhance communication and reduce payer-provider abrasion.
- **Optimized, Evidence-Based Care:** MCG criteria contains thousands of references to the medical literature to provide ample support for appropriate, evidence-based clinical decision-making. MCG updates this content annually



as scientific evidence evolves, helping you guide the best care for Highmark members.

- **Efficiency Gains:** Highmark will be integrating an [MCG solution](#) which will help automate authorization decisions and provide payer-provider communication between the Pega platform and participating hospital EHRs.

Highmark will work with MCG's education support team to develop training for providers and their staff members. More information will be shared with you as it becomes available.

While the vendor for acceptable use criteria may be changing, the overall process for how Highmark's nurses and medical directors **review and decision authorization requests will not change.**



Member Migration on January 1, 2023

On January 1, 2023, the final group of your Highmark Blue Cross Blue Shield of Western New York patients will be moved onto Highmark's system as we complete our phased integration.



These Highmark members are served by the following plans:

- Medicare Advantage
- Essential Plan
- Individual markets
- Remaining large groups and Administrative Services Only (ASO)

What This Means for You

For all your Highmark patients starting January 1, you will need to use [NaviNet[®]](#)  for:

- Checking eligibility and benefits
- Submitting preauthorization requests
- Checking claims status

If you do not have a NaviNet account by now, you will need to register by January 1. Please [click here](#) to set up your account. If you think you are already registered with NaviNet for other payers, you can check your registration status [here](#).

Electronic claims for all your Highmark patients can still be submitted through ASK and paper claims should be submitted to:

**PO Box 4208
Buffalo, NY 14240-0080**

For all Highmark patients starting January 1, **providers should follow Highmark’s pharmacy drug and medical policies and other guidelines** outlined in the [Highmark Provider Manual](#), which is available on the Provider Resource Center.



Provider News, Issue 5, 2022 | © 2022 Highmark Blue Cross Blue Shield of Western New York

Medicaid Redetermination: When Will It Restart and What to Expect

The process of Medicaid redetermination has been on hold since March 2020 when the federal government declared a public health emergency (PHE) in response to the COVID-19 pandemic.

States were allowed to waive eligibility requirements for Medicaid to assist millions of Americans who lost their jobs, along with their employee-subsidized health insurance, as unemployment rose precipitously during the early months of the COVID crisis.



Since the onset of the pandemic, Medicaid has gained more than **14 million beneficiaries** without the normal disenrollments that were routine prior to the pandemic.

Highmark Resources for Patients Facing a Disruption in Coverage

Region	Number	Website
Western PA	888-234-5406	www.highmarkbcbs.com 
Central PA	888-234-5406	www.highmarkblueshield.com 
Delaware	888-234-5406	www.highmarkbcbsde.com 
West Virginia	888-234-5406	www.highmarkbcbswv.com 
Western New York	844-885-1004	www.mybcbswny.com/stateplans 

The PHE was recently extended by the Department of Health and Human Services another 90 days from **October 13, 2022, to January 11, 2023**. The federal government will provide 60-days’ advance notice when it decides to terminate the PHE. This will help providers, Medicaid recipients, and insurance companies prepare for the adjustment period. If the PHE does conclude on January 11, 2023, then the advanced notification date will be November 12, 2022.

A Challenging Return to Normal

When the PHE ends, states will start reviewing the eligibility requirements of Medicaid beneficiaries, as they had done previously, and it is estimated that millions of current recipients will lose their Medicaid benefits as states revert to pre-pandemic protocols.


Since the Medicaid redetermination process hasn’t occurred in more than two years, it will be prudent to keep the following factors in mind:

- There will be new enrollees who aren’t familiar with the process
- Longer-term beneficiaries who may have forgotten how the process works
- State agencies may be challenged by the increased demand for services

Information for Patients

Highmark has many insurance options for patients who are shopping for a new plan, including Affordable Care Act and Medicare Advantage options. Here are the customer service numbers and websites that will be helpful for your patients seeking to transition to a new Highmark insurance plan:

Region	Number	Website
Western PA	888-234-5406	www.highmarkbcbs.com 
Central PA	888-234-5406	www.highmarkblueshield.com 
Delaware	888-234-5406	www.highmarkbcbsde.com 
West Virginia	888-234-5406	www.highmarkbcbswv.com 
Western New York	844-885-1004	www.mybcbswny.com/stateplans 

For information about how the Centers for Medicare & Medicaid Services is preparing to assist states with the “unwinding” of the PHE, click [here](#). 

PREVENTING or DELAYING the onset of Diabetes Retinal Disease



Diabetes and prediabetes are on the rise. Since 2020, more than 11 million Americans have been diagnosed with either diabetes or prediabetes.¹ Combined, 133 million people in the U.S. are living with those chronic conditions.²

Consequently, that means the incidence of diabetes-related retinal disease (DRD) is also expected to increase. DRD, along with diabetes-related macular edema (DME), are the leading causes of visual impairment and loss in adults between the ages of 20 and 74.¹ Both diseases can be prevented and/or delayed with regular eye exams.

The Importance of Yearly Eye Examinations

An estimated 20% of people with diabetes first learn about their condition through an eye exam.³

A comprehensive eye examination should include:

- Age
- Ethnicity
- Diabetes status
- Modifiable risk factors –
(A1C results, blood pressure, cholesterol, and smoking status)

Additional information for eye exams should include BMI (body mass index), nutritional concerns, and current medications.



Retinal Photography

Retinal fundus photography—a standard for DRD imaging—features a larger field of view that captures more of the retina and provides greater ability to observe peripheral changes. Providers can educate patients by reinforcing the importance of screening and follow-up care.

Note: Retinal photos are not a substitute for a comprehensive, in-person eye examination, and dilated eye exams should be performed at least initially and as recommended by an eye care professional (ECP).

Mutual Patients, Shared Information

After a diabetes-related eye exam, the ECP should communicate and share information with the patient's primary care physician (PCP). The report should include the current stage of DRD, presence of DME, summary of retinal imaging results, telemedicine screening, and/or other diagnostic tests. Treatment and follow-up recommendations should be provided, along with a referral for the patient to see a retinal specialist, if appropriate.

A focus on ensuring better ocular outcomes requires cooperation and communication between both ECPs and PCPs, with practitioners aware of their shared patient's overall medical status, and that by working together, they can enhance the quality of life for people with diabetes.

References

1 <https://diabetesjournals.org/compensia/article/2022/3/8/147199/How-to-Interpret-a-Diabetes-Related-Eye>



2 <https://www.cdc.gov/diabetes/data/statistics-report/index.html>



3 <https://www.ahip.org/news/articles/diabetic-eye-disease-from-diagnosis-to-treatment>



Disclaimer

Highmark does not recommend particular treatments or health care services. This information is not intended to be a substitute for professional medical advice, diagnosis, or treatment. You should determine the appropriate treatment and follow-up with your patient. Coverage of services is subject to the terms of each member's benefit plan. Additionally, state laws and regulations governing health insurance, health plans and coverage may apply and will vary from state to state.



Need CME for 2022?

With the year quickly winding down, here's an important question to ask yourself: **Have you completed your Continuing Medical Education (CME) for 2022?**


If you said "yes," congratulations!

If the answer is "no," not to worry... You can earn up to 5.5 CME credits online – at no cost – through Highmark's Population Health University.




Two online modules for CME credit are available:

- **Emergency Department Utilization** – 3 CMEs available
- **Transitions of Care** – 2.5 CMEs available

To receive CME credit, you must log on to or register for an Allegheny Health Network (AHN) CME account [here](#) . After you create an AHN account, you won't need to re-register in the future for other CME opportunities through this portal.

You will be eligible to receive full credit for completing each module. Partial credit is available for individual module components. Nurses can also use these CMEs for their license renewal.

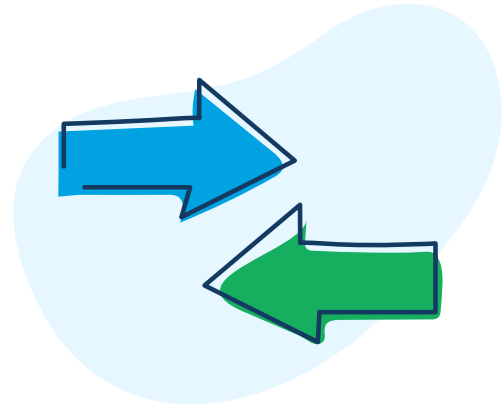
Click [here](#)  for additional information about the Population Health University modules, including creating an AHN account and CME credit breakdown.





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) and Medicare Advantage Reimbursement Policies (MRP):


Upcoming

- **RP-040** [Update: New Items Added to Routine Supplies And Services; Additional Guidance Provided](#) Effective December 19, 2022, additional supplies and items will qualify as routine.
- **RP-046** [Telemedicine and Telehealth Services](#) Effective January 30, 2023, Highmark will require providers to use all telehealth modifiers appropriately as defined by correct coding and Centers for Medicare & Medicaid Services (CMS) guidelines, as was done prior to the COVID-19 pandemic.








Coding Changes

- **RP-011** [Procedure Codes Not Applicable to Commercial Products Codes](#) G0310, G0311, G0312, G0313, G0314, G0315, and A0021 are being added to this policy. An appendix B was created on the policy to clarify the codes that are not applicable to commercial products because they are Medicaid-specific.
 - **RP-053** [Gene and Cellular Therapy](#) Effective October 1, 2022, code C9098 representing drug Ciltacabtagene Autoleucel, was replaced with new code Q2056.
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Medicare Advantage–Related Changes – All Regions

- **RP-033** [Anesthesia Services](#)  This policy has been updated to remove a reference to Medicare Advantage (MA) medical policy N-118.
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Medicare Advantage–Related – New York Regions

- **MRP-001** [Microsurgery](#) 
- **MRP-002** [Reporting Clinical Pathology Services](#) 
- **MRP-003** [Collection and Handling of Specimens](#) 
- **MRP-004** [Prolonged Services](#) 
- **MRP-005** [Repairs, Maintenance, and Replacement of Durable Medical Equipment](#) 
- **MRP-006** [Wrong Surgery](#) 
- **MRP-007** [Modifiers CO and CQ](#) 

**NOTE: The above MRPs will be posted on the Provider Resource Center for Western New York on January 1, 2023—when they become applicable for this region.*

- **RP-004** [Modifiers 52-53](#)  **Modifier 52** – 50% reduction and **Modifier 53** – 50% reduction will be applied for MA in New York.
 - **RP-005** [Modifiers 54, 55, and 56](#) 
 - **Modifier 54** – Claim lines will be reimbursed at 70% of the approved allowance.
 - **Modifier 55** – Claim lines will be reimbursed at 20% of the approved allowance.
 - **Modifier 56** – Claim lines will be reimbursed at 10% of the approved allowance.
 - **RP-049** [Merit-Based Incentive Payment System \(MIPS\) for Out of Network Providers](#)  Changes were effective September 1, 2022, and applicable to the MA business in the New York regions only.
 - **RP-067** [Specific Service Daily Maximum](#)  Effective September 1, 2022, this policy is being updated to include New York MA as applicable to the direction already present in the New York section of the policy.
 - **RP-071** [Incremental Nursing](#)  Changes were effective September 1, 2022, and applicable to the MA business in the New York regions only.
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Vaccine–Related

- **RP-064** [Government Supplied Vaccinations and Antibody Treatments](#)  The following two changes were recently published:
 - Effective January 24, 2022, the Federal Drug Administration (FDA) has rescinded the emergency use authorization for the monoclonal antibody therapy **Casirivimab** and **Imdevimab**, identified by codes Q0240, Q0243,

Q0244, as well as the administration of that service identified by codes M0240, M0241 and M0244. Therefore, for dates of service on and after January 24, 2022, these codes will no longer be eligible for reimbursement.

- The American Medical Association has released new codes 91312, 91313, 0124A, 0134A, which are retroactively effective August 31, 2022, and are being added to the policy. Effective January 25, 2022, the FDA has rescinded the emergency use authorization for the monoclonal antibody therapy **Bamlanivimab** and **Etesevimab**, identified by code Q0245, as well as codes M0245 and M0246 for administration of that service. Therefore, on and after January 25, 2022, those three codes are no longer eligible for reimbursement.


To access Highmark reimbursement policy bulletins, select **CLAIMS, PAYMENT & REIMBURSEMENT** from the Provider Resource Center main menu, and then click on **REIMBURSEMENT POLICY**.





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:

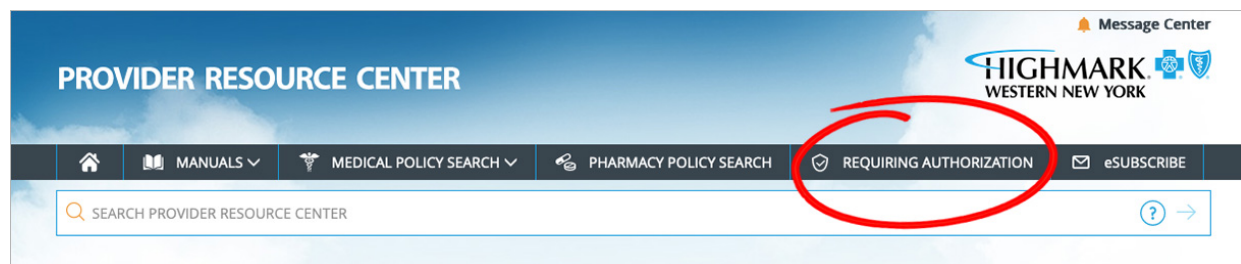


- Call the number on the back of the member's card,
- Check the member's eligibility and benefits via [NaviNet®](#) , or
- Search BlueExchange through the provider's local provider portal.

These changes are announced in the form of Special eBulletins that are posted on Highmark's Provider Resource Center (PRC). The most recent eBulletins regarding prior authorization are below:

- [Process and Authorization Requirement Changes Coming for MSK Procedures and Pain Management, Molecular and Genomic Testing, and Radiation Oncology](#) 
- [Five Injectables to Require Prior Authorization Beginning January 1, 2023](#) 

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




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

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 additions include:

- **Davis Vision vendor information has been added to Chapter 5, Unit 1**
- **New York Medicaid and CHP information has been added to Chapter 2, Unit 3**
- **West Virginia and New York guidance on Independent Review Organization fees has been added to Chapter 6, Unit 8**
- **Additional Guidance on Submitting Claims with More than 36 Diagnosis Codes has been added to Chapter 5, Unit 6**




About This Newsletter

Provider News is a valuable resource for health care providers who participate in our networks. The publication 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.


Currently, *Provider News* is published six times a year—in February, April, June, August, October, and December. We are happy to announce that *Provider News* will move to a monthly publishing schedule in 2023. We look forward to sharing even more stories and timely content with you in the coming year.

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 .





Legal Information

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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.

