HIGHMARK DELAWARE

PROVIDER NEWS

A newsletter for the Highmark Blue Cross Blue Shield Delaware providers

Issue 8, August 2023

TOP BILLING ERRORS and How to Avoid Them

When the processing of claims is delayed, it's frustrating for everyone involved — providers, administrative personnel, and members.

The chief cause of claim delays is missing, incomplete, or incorrect information. When that happens, then the claim cannot be processed.

What Can You Do

It's important to double-check all appropriate fields before submitting a claim.

To help administrative personnel who submit claims, we've compiled a list of top errors and how to avoid them below.

Use this list as a "cheat sheet" when you do a final review before submitting a claim:

Reporting Error	Correction
Incorrect provider number listed	Generally, the billing provider number is the assignment account, while the performing provider number is the individual practitioner. If practices are unsure which National Provider Identifier (NPI) to use (assignment account/group or individual practitioner/group member), they should contact Highmark Provider Services using the Highmark provider portal.
Performing provider name and number	The performing provider name and provider identification number should be reported on the claim when it is different than the billing provider identification number.
Invalid place of service codes submitted and/or the facility name and number are not listed	Ensure the correct place of service code is being used. When the place of service is different than the billing provider's address (e.g., Hospital or Skilled Nursing Facility), ensure a service facility location and identification number are reported.
NOC (not otherwise classified) codes listed without descriptions	Descriptions of the service provided must be reported on the claim for NOC codes.
Applicable coordination of benefits/other insurance information and/or documentation are not accompanying the claim	Please make an effort to report electronically or attach coordination of benefits/other insurance information.
Member identification numbers are incomplete	List the complete member identification number, including any alpha prefix.
Claims are range-dated, but the number of services does not clearly correspond with the date range (e.g., indication that services were performed 01-01-23 through 01-10-23 but list only five services)	When services span over a period of days, the number of services should correspond on a one-on-one basis if you are range-dating (indicating that services span from one date through another date). If they do not correspond on a one-on-one basis, you should itemize the services.

Submit Healthcare Common Procedure Coding System (HCPCS) codes that are not valid for the time the service was rendered (e.g., billing for a service performed in 2022 with a code that was not in place until 2023 or vice versa)	Report correct procedure codes that are valid for the date of service.
Invalid diagnosis code	Report diagnosis codes that are the highest degree of specificity and valid for the date of service.


HIGHMARK DELAWARE

PROVIDER NEWS

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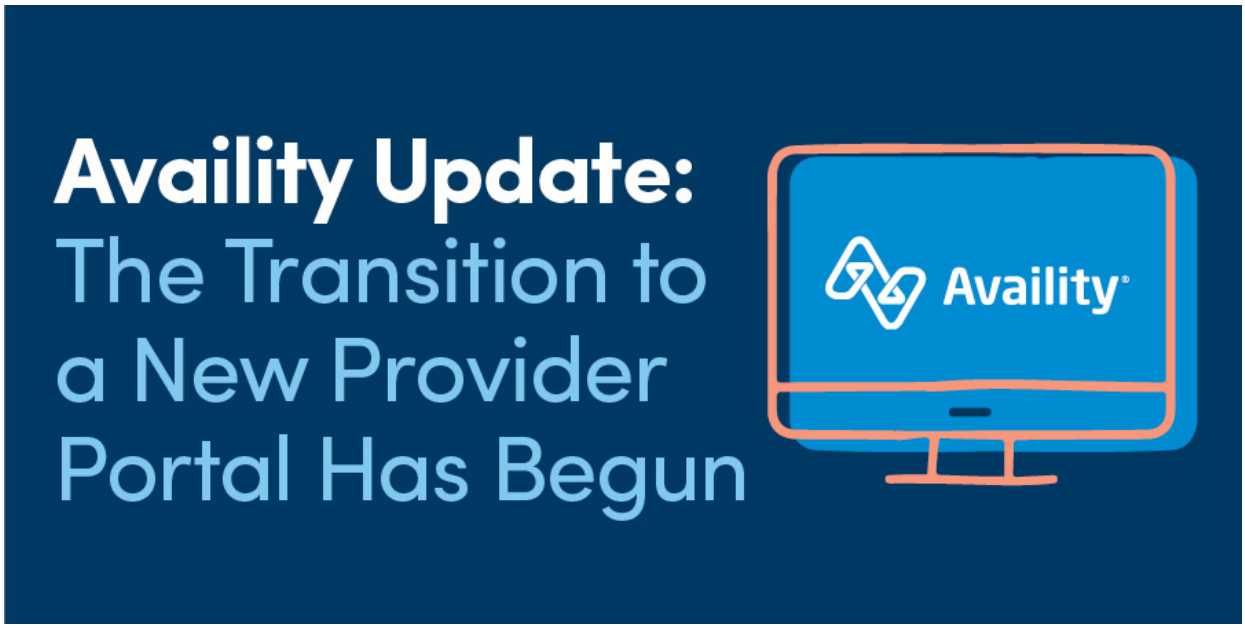
Issue 8, August 2023



A group of pilot providers — from all four states served by Highmark — began using Availity® Essentials earlier this month to conduct Highmark-related transactions. A larger pilot group will start using Availity in September. The providers who agreed to participate in the pilot programs represent a diverse cross-section of physicians and organizations, from smaller private practices to large facilities and healthcare groups.

Highmark is using a phased rollout approach — with lots of testing — to ensure a seamless transition from its existing provider portal NaviNet® to Availity Essentials, with full implementation scheduled for **February 5, 2024**.

Next Phase

In October, providers who currently use Availity for other payers will see Highmark as an option in the states where they are contracted. In addition, providers newly contracted with Highmark can use Availity.

Got Questions about the Transition?

Check out our Frequently Asked Questions (FAQs) page on the Provider Resource Center (PRC). Currently, there are over 20 questions and answers about the move to Availity, including several recently added FAQs. Throughout the transition, we will continue to update this FAQ page as new questions come in.

Training

Availity will offer both live and on-demand training to providers. Training dates and information will be posted on the PRC when available. You also can receive training updates when you sign up for our eSubscribe list.

Transition Timeline

The transition to Availity will occur in stages. Here's the scheduled timeline:

1. **August and September 2023:**
   Highmark engages a pilot group of providers to ensure a seamless transition.
2. **October 22, 2023:**
   Providers who currently use Availity for other payers will see Highmark as an option in the states where they are contracted.
3. **February 5, 2024:**
   Availity will be available for all Highmark providers.
4. **March 2024:**
   Providers will no longer have access to NaviNet or HEALTHeNET (NY).*

*More information on the retiring of existing portal will be distributed as it becomes available. If you don't already receive emails for our provider newsletters, join our eSubscribe list today.

*(**Note:** Highmark Wholecare and Highmark Health Options will not transition to Availity; providers should continue to use their current portals for transactions related to these plans.)*

Availity is an independent company that contracts with Highmark to offer provider portal services.

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

HIGHMARK DELAWARE

PROVIDER NEWS

A newsletter for the Highmark Blue Cross Blue Shield Delaware providers

Issue 8, August 2023

When submitting professional and outpatient institutional claims electronically — with Medicare as the primary payer — providers need to include both claim level dollars and line level payment dollars. **Effective December 1, 2023**, electronic Medicare claims without line level dollar information will be rejected.

To ensure processing, these claim types must be submitted with line level Claim Adjustment Reason Code (CARC) dollars. Currently, Highmark is correcting Medicare claims with missing line level information; that practice will end on November 30, 2023.

Starting **December 1, 2023**, line level payment information must be included with the electronic Medicare claim. Submitted claims missing this information will be returned to the provider for correction and resubmission.

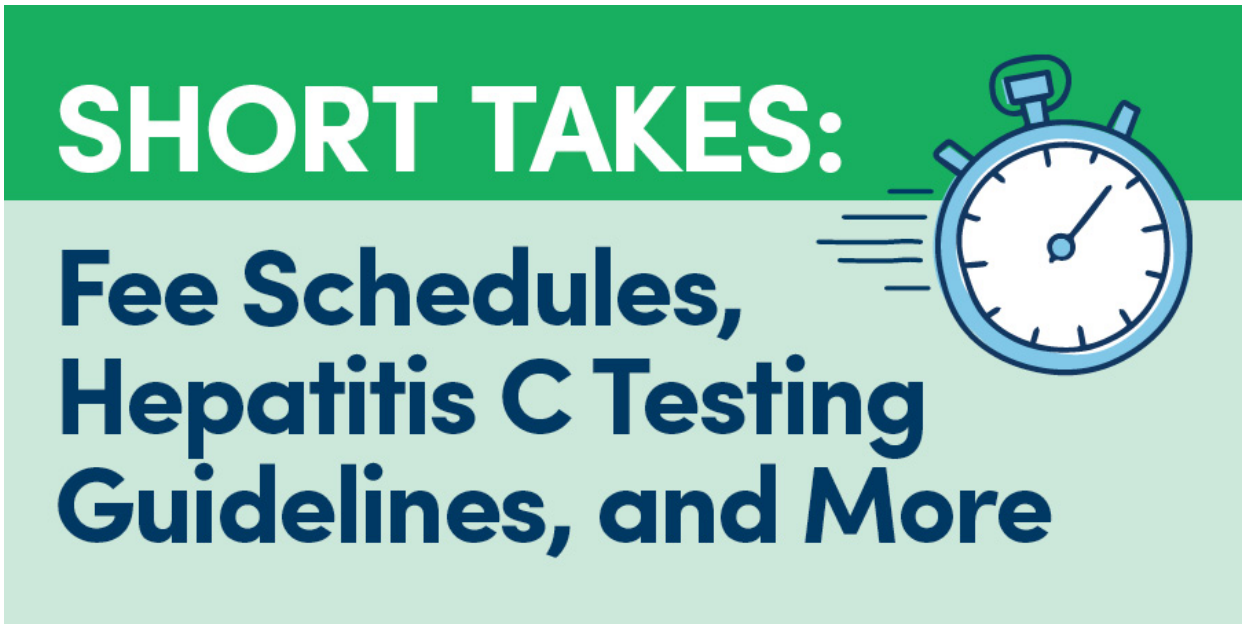
The line level information can be found on the Explanation of Benefits sent by Medicare when it pays a claim.

HIGHMARK DELAWARE

PROVIDER NEWS

A newsletter for the Highmark Blue Cross Blue Shield Delaware providers

Issue 8, August 2023



Annual Update to Highmark's Professional Fee Schedule

Effective October 1, 2023, Highmark will make its annual update to our standard professional fee and pricing methodology, which applies to the following Highmark service areas — Delaware, Pennsylvania, and West Virginia — for commercial lines of business. To read the Special Bulletin that was published on August 1, 2023, click here.

Quarterly Fee Schedules

The standard professional quarterly fee schedules were published on July 25, 2023. To view them on the Provider Resource Center (PRC), log into NaviNet® and select **Resource Center** from the left menu. Once you arrive at the PRC, choose **CLAIMS, PAYMENT & REIMBURSEMENT** from the left menu and click **Fee Schedule Information**.

Hepatitis C Testing – Single-Visit Approach

The Centers for Disease Control and Prevention (CDC) recently updated its guidelines for Hepatitis C Virus (HCV) testing, moving from a two-appointment to a single-visit approach. New guidance for completion of HCV testing supports operational strategies that collect samples at a single visit, and automatic HCV RNA testing on all HCV antibody reactive samples. Use of strategies that require multiple visits to collect samples should be discontinued.

- Automatic HCV RNA testing on all HCV antibody reactive samples will increase the percentage of patients with current HCV infection who are linked to care and receive curative antiviral therapy.
- Hepatitis C tests are covered under preventive with the diagnosis code **Z11.59**. Encounter for screening for other viral diseases with procedure codes G0472, 86803, 86804, 87520, 87521, 87522, G0472.

Annual SPH Analytics Survey

Over the next several weeks, SPH Analytics (an independent research firm) will be conducting a phone survey with a sample of professional providers to assess knowledge of the tools available to you and your staff to verify the products/networks in which you participate through your Highmark contract. To learn more, click here.

Medical Policy Update Newsletter

The August newsletter is available here.

HIGHMARK DELAWARE

PROVIDER NEWS

A newsletter for the Highmark Blue Cross Blue Shield Delaware providers

Issue 8, August 2023

September is National Childhood Obesity Awareness Month

Childhood obesity is a growing problem. Nearly 15 million children — that's one out of five kids! — are considered obese[1].

A childhood marked by obesity means today's youth are facing problems once seen only in adults, such as type 2 diabetes, high blood pressure, and heart disease[2].

The most recent findings[3] from the Centers for Disease Control and Prevention (CDC) document some troubling trends for children and adolescents aged 2–19 years:

- The prevalence of obesity was 19.7% and affected about **14.7 million** children and adolescents.
- Obesity prevalence was 12.7% among 2- to 5-year-olds, 20.7% among 6- to 11-year-olds, and 22.2% among 12- to 19-year-olds. Childhood obesity is also more common among certain populations.
    - Obesity prevalence was 26.2% among Hispanic children, 24.8% among non-Hispanic Black children, 16.6% among non-Hispanic White children, and 9.0% among non-Hispanic Asian children.
- Obesity-related conditions include high blood pressure, high cholesterol, type 2 diabetes, breathing problems such as asthma and sleep apnea, and joint problems.

What You Can Do

During National Childhood Obesity Awareness Month, you can take action by sharing available resources with parents... guides and tools that can get children on a path to healthy eating and active play[4]. The following government resources promote physical activity and healthier eating for children and adolescents:

- Physical Activity Guidelines for Americans
- CDC's interactive Move Your Way (available in Spanish)
- Screen Time vs. Lean Time
- MyPlate

In addition, Highmark has a variety of educational resources on combatting childhood obesity that can be downloaded from the Provider Resource Center (PRC):

- Childhood Obesity Bookmarks
- Childhood Obesity Preventive Health Benefit
- Preventive Health Reminder Poster

You can access those resources by going to the PRC, selecting **EDUCATION/MANUALS** from the left menu, and clicking **Educational Resources – Member And Provider**.

References

[1]Obesity is defined as a body mass index (BMI) at or above the 95th percentile of the CDC sex-specific BMI-for-age growth charts.

[2]Office of Disease Prevention and Health Promotion, https://health.gov/news/news-and-announcements/2018/09/toolkit-national-childhood-obesity-awareness-month.

[3]Read the CDC National Center for Health Statistics (NCHS) data brief.

[4]U.S. Department of Agriculture, https://wicworks.fns.usda.gov/resources/national-childhood-obesity-month.

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.

HIGHMARK. DELAWARE

PROVIDER NEWS

A newsletter for the Highmark Blue Cross Blue Shield Delaware providers

Issue 8, August 2023

Each year, approximately 2.5 million Americans visit an outpatient clinical setting for low back pain (LBP). It is estimated that 75% of adults will experience low back pain at some time in their lives.

Evidence has shown that unnecessary or routine imaging (X-ray, MRI, CT scans) for low back pain is **NOT** associated with improved outcomes. This exposes patients to unnecessary harms, such as radiation and unneeded treatment. Most individuals who experience low back pain will improve within the first two weeks of onset. Avoiding imaging for patients when there is no indication of underlying conditions can prevent unnecessary harm and reduce health care costs.[1]

HEDIS Measure

Healthcare Effectiveness Data and Information Set (HEDIS®) quality measure ***Use of Imaging for Low Back Pain (LBP)*** evaluates adults ages 18-75 with a principal ICD-10

diagnosis of uncomplicated LBP* who **did not** receive imaging studies (plain X-ray, MRI, or CT scan) within 28 days of diagnosis.

The care settings include outpatient evaluations, telemedicine/telehealth, emergency department, observation level of care, physical therapy, and osteopathic/chiropractic manipulative treatment.

Noncompliance occurs **when an imaging study is performed** for uncomplicated LBP within 28 days of initial diagnosis.

Exclusions

The following conditions are **not** considered uncomplicated and would exclude the member from the LBP measure. Imaging within 28 days would be acceptable for the following conditions (this is not a complete list):

- Discitis, unspecified, lumbar region
- Discitis, unspecified, lumbosacral region
- Muscle spasm of back
- Contusion of lower back
- Unspecified superficial injury of lower back

Recognizing that each patient is unique, National Committee of Quality Assurance (NCQA) has identified exclusions for medical conditions that may require imaging within 28 days of initial diagnosis. If any of these conditions exist, include diagnosis on your submitted claim.[2]

- Cancer or members in hospice/palliative care
- Recent trauma/fractures (anytime during three months prior to diagnosis)
- IV drug abuse (12 months prior)
- Neurologic impairment (12 months prior)
- Human immunodeficiency virus (HIV)
- Spinal infection (12 months prior)
- Kidney/major organ transplant
- Prolonged use of corticosteroids (90 consecutive days of treatment within 12 months prior)
- Osteoporosis medication therapy
- History of lumbar surgeries
- Spondylopathy
- Recent history uncomplicated low back pain (six months prior)

(Note: This list is not all-inclusive. This information is not about a change in policy, but a reference to quality improvement activities).

How to Improve HEDIS Scores

- Avoid ordering diagnostic studies (x-rays, CT, or MRI Scans) within 28 days of diagnosis for a new onset of uncomplicated LBP in the absence of an excluded medical condition.
- Document in medical record all findings and use correct coding. Use exclusionary codes if applicable (as noted above) to justify if imaging is warranted.
- Provide patient education on conservative treatments. Recommendations include:
    - Use of non-steroidal anti-inflammatory drugs (NSAIDS) and, if appropriate, muscle relaxers.
    - Exercise to strengthen the core and low back.
    - Move and be active to limit muscle stiffening.
    - Place pillow while resting or sleeping between legs if sleeping on side or under knees when sleeping on back to reduce back discomfort.

Please refer to John Hopkins HealthCare LLC's "LBP – Use of Imaging Studies for Low Back Pain" for additional information: Use of Imaging Studies for Low Back Pain (hopkinsmedicine.org).

Additional Resources

The Provider Resource Center (PRC) has the following educational materials, which can be accessed by going to the PRC, selecting **EDUCATION/MANUALS** from the left menu, and clicking **Educational Resources – Member And Provider**:

- Back Pain Brochure
- Back Pain Post Card
- Back Pain Poster

References

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.

[1]NCQA HEDIS Measures and Technical Resources: https://www.ncqa.org/hedis/measures/use-of-imaging-studies-for-low-back-pain.

[2]Information taken from HEDIS MY 2023 Volume 2: Technical Specifications.

[*](ICD-10 Uncomplicated Low Back Pain Codes: M47.26-M47.898; M48.061-M48.08; M51.16-M51.87; M53.2X6-M53.88; M54.16-M54.9; M99.03-M99.84; S33.100A-S33.9XXA; S39.002A-S39.92XS)


HIGHMARK DELAWARE

PROVIDER NEWS

A newsletter for the Highmark Blue Cross Blue Shield Delaware providers

Issue 8, August 2023

The Diabetes Prevention Program – Help for Prediabetic Members

The Diabetes Prevention Program (DPP) is a structured lifestyle and health behavior change program with the goal of preventing the onset of type 2 diabetes in individuals who are prediabetic. The 12-month program — certified by the Centers for Disease Control and Prevention (CDC) — includes:

- Choice of an in-person classroom setting or an online/mobile app program
- 16 "core" sessions
- Monthly follow-up meetings

The program's primary goal is to help participants achieve at least five percent (5%) average weight loss. According to the CDC, losing five percent of your weight can help prevent diabetes.

Highmark has partnered exclusively with two vendors to deliver the Diabetes Prevention Program. Members can choose the in-person classroom program available at participating YMCA locations or the online program through Livongo Retrofit.SM

Program Eligibility Criteria

Eligible members must be at least 18 years of age and meet criteria of being "prediabetic," which includes:

- Body Mass Index (BMI) of 25 or greater
- Fasting blood glucose of 100-125mg/dl
- No previous diagnosis of diabetes,

Members may also be identified as at-risk via the CDC risk screening questionnaire tool available on the YMCA and Livongo Retrofit websites as part of the enrollment process.

YMCA'S Classroom Program – In-Person

The YMCA Diabetes Prevention Program provides a supportive environment where participants work together in a small group to learn about healthier eating and increasing their physical activity in order to reduce their risk for developing diabetes. The program is led by a trained Lifestyle Coach in a classroom setting over a 12-month period.

Retrofit's Online/Mobile Program

Retrofit's online 12-month Diabetes Prevention Program provides personalized coaching from experienced clinicians through online sessions, personalized one-on-one coaching, tracking tools, and peer support.

What You Can Do

If you have patients who are prediabetic, encourage them to learn more about DPP by visiting their Highmark member website and selecting the Diabetes Prevention link. The Diabetes Prevention Program page has information about prediabetes, risk factors, and the YMCA and Retrofit program options.

Once patients select a program link, they then complete a risk assessment — the CDC Prediabetes Screening Test — to determine whether they qualify for the program. If they qualify, they will receive further instructions on how to enroll.

For a printable Diabetes Prevention Program flier to post in your office or share with patients, click here

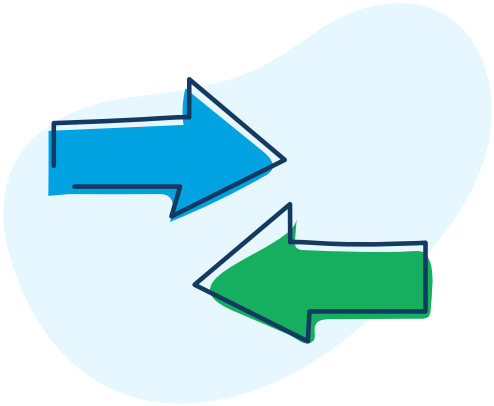
HIGHMARK DELAWARE

PROVIDER NEWS

A newsletter for the Highmark Blue Cross Blue Shield Delaware providers

Issue 8, August 2023

New and Updated Reimbursement Policies



Highmark regularly issues new or updated reimbursement policies. Keep an eye on this newsletter and the Provider Resource Center (PRC) homepage for announcements regarding upcoming policy changes. As specific policy changes go into effect, the updated policies can be found on the Reimbursement Policy page of the PRC.

Below is a list of recently updated and upcoming Reimbursement Policies (RPs):

RECENTLY UPDATED

August 7

RP-032 Pain Management
This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-034 Prolonged Detention or Critical Care
This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-041 Services Not Separately Reimbursed
This policy was made applicable to facility (UB) claims.

August 14

RP-035 Correct Coding Guidelines
This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-052 Surgical Team
This policy was reviewed as part of our standard review process. No changes in direction were made.

UPCOMING

RP-010 Update

RP-010 Incident To Billing Services and Advanced Practice Provider Reductions

For West Virginia: West Virginia was inadvertently checked as an applicable Commercial market in the current version of RP-010. This will be corrected in the updated policy. Highmark will continue to reimburse for these services for Medicare Advantage products, as well as for Mid-Level Practitioners and Advanced Practice Providers who have been enumerated and bill using their own provider ID.*

For Pennsylvania: Incident To services for Commercial products will no longer be recognized, effective **January 1, 2024**. Highmark will continue to reimburse for these services for Medicare Advantage products, as well as for Mid-Level Practitioners and Advanced Practice Providers.*

For Delaware: Only non-Primary Care Physician (PCP) Incident To services will no longer be applicable to the policy, effective **January 1, 2024**. PCP Incident To services will still be covered. Highmark will also continue to reimburse for these services for Medicare Advantage products, as well as for Mid-Level Practitioners and Advanced Practice Providers.*

For New York: New York was inadvertently checked as an applicable Commercial market in the current version of RP-010. This will be corrected in the updated policy. Highmark will continue to reimburse for these services for Medicare Advantage products, as well as for Mid-Level Practitioners and Advanced Practice Providers who have been enumerated and bill using their own provider ID.*

**Direction for continued reimbursement for Mid-Level Practitioners and Advanced Practice Providers will be published in a new policy, RP-068 (see*

***NEW:* RP-068** *further down in this article), effective on September 25, 2023.*

August 31 (Effective September 1):

RP-019N Drugs and Biologicals
An updated version of this policy will be available for review on the PRC on August 31, 2023, and will be effective beginning **September 1, 2023**. Drug tiering is being eliminated for Delaware, Pennsylvania, and West Virginia. To access this reimbursement policy, log into NaviNet® and select Resource Center from the left menu. Once redirected to the PRC, select **CLAIMS, PAYMENT & REIMBURSEMENT** in the left menu and then click **Reimbursement Policy**.

September 25

NEW: RP-068 Mid-Level Practitioners and Advanced Practice Providers
Highmark has created RP-068 to provide direction on reimbursement for Mid-Level Practitioners and Advanced Practice Providers. *(NOTE: This policy will be available on the PRC on September 25, 2023.)*

October 30

RP-026 Portable Radiography and ECG Services – Modifiers UN, UP, UQ, UR, US
This policy will be made applicable to Medicare Advantage. Additional direction will be added for modifiers UN, UP, UQ, UR, and US when submitted with code R0075 (a transportation service code). These modifiers are also required to be included on all related claims, and the Commercial section will be updated with direction to reflect this requirement.

HIGHMARK DELAWARE

PROVIDER NEWS

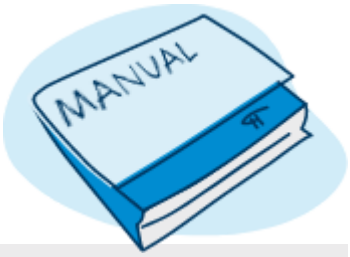
A newsletter for the Highmark Blue Cross Blue Shield Delaware providers

Issue 8, August 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



Recent noteworthy changes occurred in the following sections:

- **Chapter 2, Unit 6:** The BlueCard Program > 2.6 NAIC Codes > PENNSYLVANIA
- **Chapter 3, Unit 2:** Professional Provider Credentialing > 3.2 Highmark Network Credentialing Policy > 24/7 AVAILABILITY REQUIREMENTS
- **Chapter 3, Unit 2:** Professional Provider Credentialing > 3.2 Credentialing Requirements For Facility-Based Providers > FACILITY-BASED PRACTITIONER CREDENTIALING POLICY
- **Chapter 3, Unit 4:** Organizational Provider Participation (Facility/Ancillary) > 3.4 Urgent Care Centers/Medical Aid Units > Billing Guidelines
- **Chapter 6, Unit 2:** Electronic Claim Submission > 6.2 NAIC Codes > PENNSYLVANIA

For detailed descriptions of these recent changes, visit the Highmark Provider Manual Changes page.

HIGHMARK DELAWARE

PROVIDER NEWS

A newsletter for the Highmark Blue Cross Blue Shield Delaware providers

Issue 8, August 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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HIGHMARK DELAWARE

PROVIDER NEWS

A newsletter for the Highmark Blue Cross Blue Shield Delaware providers

Issue 8, August 2023

Legal Information

Highmark Blue Cross Blue Shield Delaware is an independent licensee of the Blue Cross and Blue Shield Association. BlueCard is a registered trademark of the Blue Cross and Blue Shield Association.

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 Health is the parent company of Highmark Inc.

The Blue Cross Blue Shield Association is an association of independent, locally operated Blue Cross and Blue Shield companies.

Atlas Systems, Inc. is a separate and independent company that conducts physician outreach for Highmark.

Current Procedural Terminology (CPT) is a registered trademark of the American Medical Association. Healthcare Effectiveness Data and Information Set (HEDIS)® and Quality Compass® are registered trademarks of the National Committee for Quality Assurance (NCQA). Consumer Assessment of Healthcare Providers and Systems (CAHPS)® is a registered trademark of the Agency for Healthcare Research and Quality. CORE is a registered trademark of CAQH.

Note: *This publication may contain certain administrative requirements, policies, procedures, or other similar requirements of Highmark Delaware (or changes thereto) which are binding upon Highmark Delaware and its contracted providers. Pursuant to their contract, Highmark Delaware and such providers must comply with any requirements included herein unless and until such item(s) are subsequently modified in whole or in part.*

QUICK REFERENCE

HIGHMARK PROVIDER SERVICE CENTERS

Please use NaviNet® for all of your routine eligibility, benefit, and claim inquiries.
For non-routine inquiries that require analysis and/or research, contact Highmark's Provider Services.

What Is My Service Area?

PENNSYLVANIA:

- Western Region: Professional Providers **1-800-547-3627**; Facilities **1-800-242-0514**
  Hours of Availability: 8 a.m. to 5 p.m. EST, Monday through Friday
- Central & Northeastern Regions: Professional Providers **1-866-731-8080**; Facilities **1-866-803-3708**
  Hours of Availability: 8 a.m. to 5 p.m. EST, Monday through Friday
- Eastern Region **1-800-975-7290**
  Hours of Availability: 9 a.m. to 12 noon, 1 p.m. to 4:30 p.m. EST, Monday through Friday.
- Medicare Advantage:
  - Freedom Blue PPO: **1-866-588-6967**
  - Community Blue Medicare HMO: **1-888-234-5374**
  - Community Blue Medicare PPO: **1-866-588-6967**
  - Security Blue HMO (Western Region only): **1-866-517-8585**
- Behavioral Health:
  - Western & Northeastern Regions: **1-800-258-9808**
  - Central & Eastern Regions: **1-800-628-0816**

DELAWARE:

- Highmark Delaware Provider Services: **1-800-346-6262**
  Hours of Availability: 8:30 a.m. to 5 p.m. EST, Monday through Friday
- Behavioral Health: **1-800-421-4577**

WEST VIRGINIA:

- Highmark West Virginia Medical: **1-800-543-7822**
- Highmark Senior Solutions Medicare Advantage Freedom Blue PPO: **1-888-459-4020**
  Hours of Availability: 8 a.m. to 8 p.m. EST, Monday through Sunday
- Behavioral Health: **1-800-344-5245**

NEW YORK:

- Highmark Blue Cross Blue Shield of Western New York: **1-800-950-0051 or (716) 884-3461**
- Highmark Blue Shield of Northeastern New York: **1-800-444-4552 or (518) 220-5620**
  Hours of Availability: 8 a.m. to 8 p.m. EST, Monday through Sunday
- Behavioral Health: **1-844-946-6264**
  - Fax: Behavioral Health Outpatient: **1-822-581-1867;** Behavioral Health Inpatient **1-833-581-1866**

Please listen carefully to the available options to reach the appropriate area for your inquiry.

HIGHMARK CLINICAL SERVICES

NaviNet® is the preferred for authorization requests. Contact Clinical Services for inquiries that cannot be handled via NaviNet.® **Hours of Availability:** Monday-Friday 8:30 a.m.-7 p.m.; Saturday & Sunday 8:30 a.m.-4:30 p.m. for urgent issues.

PENNSYLVANIA:

- Western Region:
  - Medical Services: Professional Providers **1-800-547-3627**; Facilities **1-800-242-0514**
  - Behavioral Health: **1-800-258-9808**

- Central Region:
  - Medical Services: Professional Providers **1-866-731-8080**; Facilities **1-866-803-3708**
  - Behavioral Health: **1-800-628-0816**
- Northeastern Region: Medical Services **1-800-452-8507**; Behavioral Health **1-800-258-9808**
- Eastern Region: Call Independence Blue Cross at **1-800-862-3648**

DELAWARE:

- Medical Services **1-800-572-2872**; Behavioral Health **1-800-421-4577**

WEST VIRGINIA:

- Highmark West Virginia Products for Medical and Behavioral Health Services: **1-800-344-5245**
- Medicare Advantage Freedom Blue PPO: **1-800-269-6389**

NEW YORK:

- Medical Services: **1-844-946-6263**
  - Fax: Medical Outpatient **1-833-619-5745**; Medical Inpatient **1-833-581-1868**

Please see the *Highmark Provider Manual's* Chapter 1.2 for additional contact information.