PROVIDER NEWS
A newsletter for the Highmark Blue Cross Blue Shield West Virginia providers

HIGHMARK. WEST VIRGINIA
Issue 5, 2022

"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.

> **"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

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.

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.

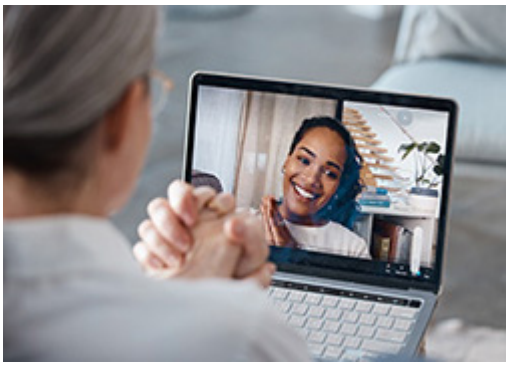
These efforts were part of a broader process to transform the VA mental health care system to an evidence-based and recovery-oriented system of care. As a result, this work led to robust improvements in patient outcomes and a fundamental change in the treatment culture and model.

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 telebehavioral[1] 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."

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[1] Telebehavioral is another name for virtual behavioral health care.

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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 sta 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.**

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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.

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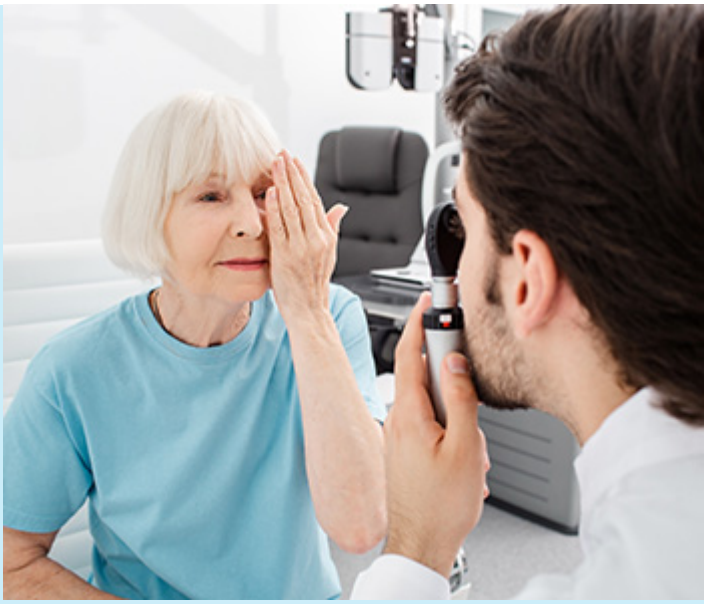
PREVENTING or DELAYING the onset of Diabetes Retinal Disease

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/compendia/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

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Can New Patients Find Your Practice?

It can be extremely difficult for new patients to learn about your practice... if you're not listed correctly in the Highmark Provider Directory.

With Open Enrollment underway throughout Highmark's six regions, you want to ensure that your provider information is accurate. Validating your information helps both new and current Highmark members to find and evaluate your practice when selecting a health care provider for 2023.

For example, if your address is incorrect, prospective patients may think your practice isn't close to their home or work, and then opt for another provider.

CMS Requirement

Every quarter, we are required by the Centers for Medicare & Medicaid Services (CMS) to ask you to validate your information and make sure it is correct. This review process is quick and easy through our partner Atlas:

1. Go to hub.primeatlas.com.
2. Log in.
3. Review your information.
4. If no changes, confirm.
5. If there are changes, update your information.

If you need additional information, Atlas' step-by-step guide is now on the Provider Resource Center. From the left navigation panel, select **PROVIDER TRAINING**, and then click on **Provider Training**. You will find the guide under the **PROVIDER QUARTERLY OUTREACH** header.

Stay Current

Per the No Surprise Act, providers who do not validate their information every 90 days may be removed from the Highmark Provider Directory. Once removed, new and current members will not see your office name; providers affiliated with your office; or your office address or phone number when searching for an in-network doctor.

By ensuring your information is accurate, you will enable new and current patients to easily nd your practice in Highmark's Provider Directory.

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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.

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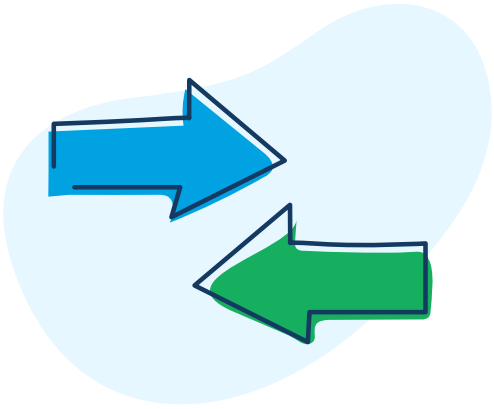
New and Updated Reimbursement Policies



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 speci c 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-speci c.
- **RP-053** Gene and Cellular Therapy Effective October 1, 2022, code C9098 representing drug Ciltacabtagene Autoleucel, was replaced with new code Q2056.
- **RP-072** Injection and Infusion Services Code J3590 was replaced with code J0491 and code J0222 was removed from the policy.

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.

Medicare Advantage-Related Changes – PA, WV, and DE Regions

- **RP-005** Modifiers 54, 55, and 56

  Below is a summary of the MA changes effective September 1, 2022, for the Pennsylvania, West Virginia, and Delaware regions.

  - **Modifier 54** – The Plan will reimburse claim lines at the code specific pre-op and intra-op percentages (of the approved allowance) as defined on the Medicare Physician Fee Schedule (MPFS).
  - **Modifier 55** – The Plan will reimburse claim lines at the code speci c post-op percentages (of the approved allowance) as defined on the MPFS multiplied by the percentage of the post-op period for which the physician provided care.
  - **Modifier 56** – The Plan does not apply a reduction.

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**.

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Authorization Updates

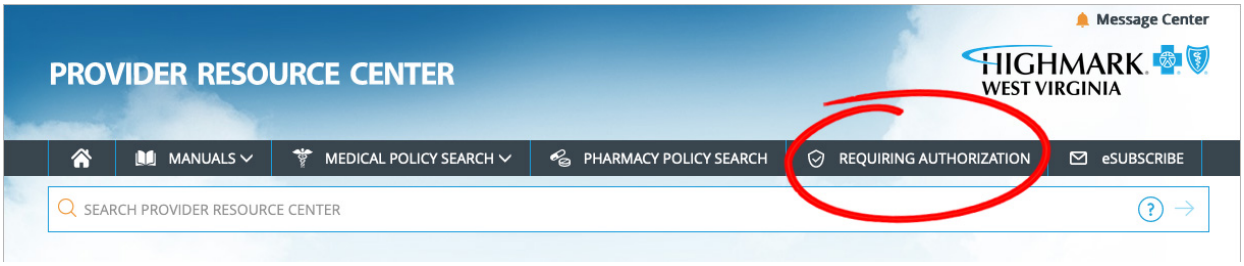
During the year, Highmark adjusts the List of Procedures and Durable Medical Equipment (DME) **Requiring Authorization**. For information regarding authorizations required for a member's specific benefit plan, providers may:

- 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 eBulletins that are posted on Highmark's Provider Resource Center (PRC). The most recent eBulletins regarding prior authorization are below:

- Pre-Approvals Not Required for Authorizations Submitted Between 8/22 – 10/3*
- Five Injectables to Require Prior Authorization Beginning January 1, 2023
- NEW! Initial Inpatient Authorization Approvals Valid Longer and Concurrent Reviews Due Later
- Authorization Period for Most Outpatient Services Extended to 180 Days

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

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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 additions include:

- **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**

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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.

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Legal Information

It is the policy of Highmark Blue Cross Blue Shield West Virginia and Highmark Senior Solutions Company to not discriminate against any employee or applicant for employment on the basis of the person's gender, race, color, age, religion, creed, ethnicity, national origin, disability, veteran status, marital status, sexual orientation, or any other category protected by applicable federal, state, or local law. This policy applies to all terms, conditions, and privileges of employment, including recruitment, hiring, training, orientation, placement and employee development, promotion, transfer, compensation, benefits, educational assistance, layoff and recall, social and recreational programs, employee facilities, and termination.

Highmark Blue Cross Blue Shield West Virginia and Highmark Senior Solutions Company are independent licensees of the Blue Cross and Blue Shield Association. Blue Cross, Blue Shield, the Cross and Shield symbols, BlueCard, Blue Distinction, Blue Exchange, and SuperBlue are registered service marks and Blues On Call, Freedom Blue, Quality Blue, and Blue Rx are service marks of the Blue Cross and Blue Shield Association. Highmark is a registered mark of Highmark Inc. Highmark Health is the parent company of Highmark Inc.

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

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

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

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

Note: *This publication may contain certain administrative requirements, policies, procedures, or other similar requirements of Highmark West Virginia and Highmark Senior Solutions Company (or changes thereto) which are binding upon Highmark West Virginia*

and Highmark Senior Solutions Company and its contracted providers. Pursuant to their contract, Highmark West Virginia and Highmark Senior Solutions Company 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.