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PROVIDER NEWS

A newsletter for Highmark Blue Shield providers in northeastern New York

Issue 4, April 2024

FAXES BEING PHASED OUT:

Use the Availity Portal for ALL Authorization Requests

Clinical Services is phasing out fax prior authorization submissions. Providers are required to use the Availity® portal to electronically submit authorization requests, attach documentation, respond to inquiries, and check status. To view Highmark's current prior authorization list, go here.

We have training resources and guides available to walk you through the electronic authorization process.

How Electronic Authorization Requests Benefit Your Organization

Submitting authorization requests electronically benefits offices and facilities in these six important ways:

1. **Less Administrative Time –** Manual authorization requests take 11 minutes longer than electronic submissions.[1]
2. **More Cost Savings –** Submitting requests manually costs nearly three times as much as electronic requests — $10.26 vs. $3.64 per transaction.[2]
3. **Faster Turnaround Time –** Using Availity increases authorization turnaround time by 75% compared to alternative submission channels; some approvals are available immediately.[3]
4. **Higher Approval Rates –** Cases submitted via Availity see a 4% higher approval rate due to the submission of complete clinical information.[3] Higher approvals mean fewer denials, saving your team additional time.
5. **Real-Time Status Updates –** The status of prior authorization requests is always available in real time, eliminating the need for unnecessary phone calls.
6. **Easy Process for Sharing Clinical Information –** Providers can upload requests for additional clinical information quickly and easily through Availity and receive a faster response.

Not signed up for Availity? Visit www.availity.com and click on the **Get Started** link.

BONUS: 3 More Reasons for Using the Availity Portal

- Single source for Eligibility and Benefits, Claims, and Authorization data.
- Ability to easily submit prior authorization requests for all members including Out of Area.
- Convenient, multi-payer portal reduces complexity for providers.

Training Resources

Both Availity and Highmark's Provider Resource Center (PRC) offer valuable training resources for providers and their teams to make the adoption of the provider portal easy, understandable, and advantageous.

Training Courses

- Log into Availity.
- Select **Help & Training** tab on the homepage:
  - Click Get Trained from the drop-down menu to view recorded demos and webinars.

Registration Guides

- Availity Essentials Registration for Health Care Providers
- Availity Essentials Registration for Billing Services

Reference Guides

- Availity Essentials Reference Guide for Users
- Availity Essentials Reference Guide for Administrators

Highmark Resources

- Availity – Provider Portal Transition
- Availity – FAQs
- Procedures/Service Requiring Prior Authorization
    - **Guides**
        - Inpatient Authorization Submission (Both Urgent and Non-Urgent)
        - Outpatient Authorization Submission
    - **Videos**
        - Electronic Authorization Submission Process (Predictal via Availity)
        - Case Management Referral Process (Predictal via Availity)

References

1. 2022 CAQH INDEX® A Decade of Progress. p. 20.

2. 2020 CAQH INDEX® Closing the Gap: The Industry Continues to Improve, But Opportunities for Automation Remain. p. 6.

3. Based on Highmark Utilization Management data.

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UPDATED:

PT, OT, and Home Health: Prior Auth Changes Occurring on **May 1, 2024;**

Does NOT Apply to Outpatient Chiro

Effective May 1, 2024, Highmark Blue Shield providers will need to request prior authorization for outpatient physical therapy (PT), occupational therapy (OT), and home health services.

PT and OT – Commercial Plans

For Highmark Blue Shield members in Commercial plans, outpatient physical therapy and occupational therapy will require prior authorization starting **May 1, 2024**; however, authorization is not required for the initial evaluation.

**Administrative Services Only (ASO), Federal Employee Program (FEP), and Medicare Advantage are excluded from the prior authorization requirement.*

Home Health – Commercial Plans and ASO Groups

For Highmark Blue Shield members in **Commercial plans and ASO groups**, providers will need to request authorization for home health services, now starting **May 1, 2024**.

Note: *Medicare Advantage is excluded from the prior authorization requirement; FEP prior authorization not required for initial visits, per the plan limit. If a member needs additional visits (beyond the plan limit), then prior authorization is required.*

Prior Authorization Requests

Providers will be able to submit electronic prior authorization requests beginning **April 26, 2024**, for services occurring on or after **May 1, 2024**.

Training

Training videos are available on the Provider Resource Center (PRC) by clicking here. The recordings are listed under **Instructional Videos**.

Chiropractic CPT Codes Will Not Require Prior Authorization

Highmark has made the decision not to add chiropractic CPT codes to New York's prior authorization list; the following codes will not require prior authorization: 98925, 98926, 98927, 98928, 98929, 98940, 98941, 98942, and 98943. View the latest prior authorization list here.

Providers are encouraged to always check a member's eligibility and benefits in Availity Essentials to ensure you are aware of their coverage and benefit limits.

If chiropractors are performing and billing for **non-chiropractic** CPT codes, they should check the prior authorization list to see if those codes require prior authorization.

Practitioners who perform and bill with non-chiropractic CPT codes are encouraged to view the training videos on the PRC.

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MSK Procedures to Require Prior Authorization STARTING AUG. 1

Effective Aug. 1, 2024, Highmark Blue Shield is requiring prior authorization for **inpatient** and **outpatient** musculoskeletal (MSK) procedures. New and continuing authorization requirements for inpatient and outpatient MSK services will be managed directly by Highmark Blue Shield.

These changes apply to Highmark Blue Shield members enrolled in our fully insured Commercial, Medicare Advantage, Affordable Care Act (ACA) plans, and members of select self-insured (Administrative Services Only) groups.

Updated Prior Authorization List

Highmark's List of Procedures/DME Requiring Authorization will be updated with CPT codes for MSK procedures, including the following services:

- **Large joint surgeries**
- **Spine surgeries**
- **Interventional pain management procedures**

Requesting Authorization for MSK Services

Authorization requests should be submitted through Availity®, Highmark's online provider portal. Once you log in to Availity, you will access the Predictal™ Auto Automation Hub to request authorization for MSK procedures.

From Availity's main page, there are two ways to reach Predictal:

OPTION 1: Click **Payer Spaces** on the task bar and choose your Highmark plan. From Highmark Blue Shield Payer Spaces, scroll down to **Applications** and click **Predictal**.

OPTION 2: Click **Patient Registration** from the task bar, choose **Authorizations & Referrals** from the dropdown, and then select **Authorization Request**. You will need to fill in the requested information before being routed to **Predictal**.

Authorization Resources on the PRC

The Provider Resource Center (PRC) has educational guides for submitting authorization requests via Availity. To view the guides, go to **PRIOR AUTHORIZATION** on the left menu and then click **Procedures/Service Requiring Prior Authorization**.

If you need assistance regarding electronic authorization workflows, you can email us at ElecAuthSubmit@highmark.com.

Training

Training will be offered to help providers understand the new requirements and processes prior to Aug. 1. More information will be shared on the PRC and in upcoming issues of *Provider News*.

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SHORT TAKES:

Fee Schedules and Quick Claims Functionality in Availity

Quarterly Fee Schedules

The standard professional quarterly fee schedules were published during the week of April 14, 2024. To view them on the Provider Resource Center (PRC), log into Availity®, go to **Payer Spaces**, and then select **Provider Resource Center** under **Applications**. Once you arrive at the PRC, choose **CLAIMS, PAYMENT & REIMBURSEMENT** from the left menu and click **Fee Schedule Information**.

Quick Claims Functionality in Availity

Professional providers who use Availity Essentials™ for claim submission now have access to the Quick Claims functionality for Highmark members. Quick Claims allows providers to create templates that pre-populate certain fields when submitting a CMS-1500 claim. This will save time for providers who routinely submit claims for the same

patient or same service each week or each month. For more information, see the recent Special Bulletin.

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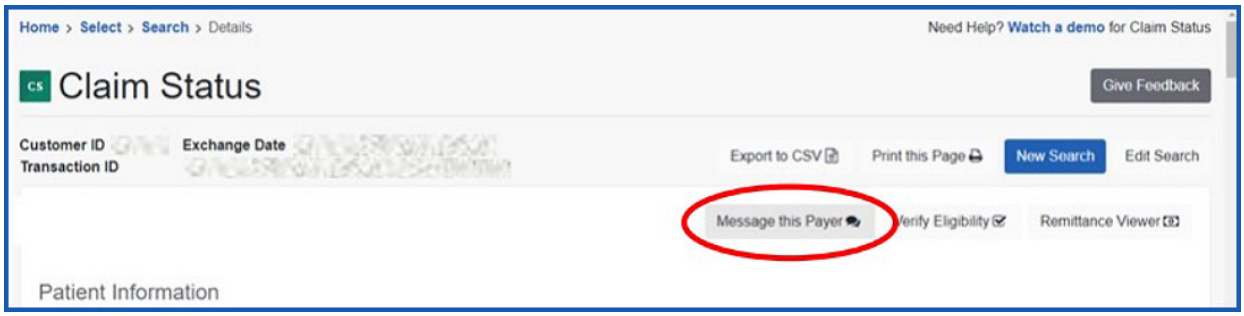
Access to Highmark's legacy provider portals, HEALTHeNet and NaviNet®, ended on Friday, April 26. That means all Highmark-contracted providers should be using Availity® for their Highmark transactions, including:

- Eligibility and benefit searches
- Authorization submissions and status checks
- Claim status, submissions, and inquiries
- Validation of directory information for professional providers through Highmark's Provider Data Maintenance (PDM) application
- View value-based reporting

Claim Investigations in NaviNet

If you initiated a claim investigation in NaviNet, and it was still open as of April 19, Highmark will provide our response to you via postal mail. All new claim investigations must be submitted via the Availity portal. Locate the claim in **Claim Status**, and then click **Message this Payer** to send your inquiry.



Availity Training

You can access recorded training courses and materials in the Availity Learning Center. In addition, Availity has the following resources available for providers and their teams:

- Availity.com/Highmark
- Register and Get Started
- Sign-Up Tips for Primary Administrators

Highmark Resources

The Provider Resource Center (PRC) has a variety of resources regarding Availity and the transition to a new portal, as well as guides and videos for submitting authorization requests electronically via Highmark's Availity portal.

- Availity – Provider Portal Transition
- Availity – FAQs
- Procedures/Service Requiring Prior Authorization
    - **Guides**
        - Inpatient Authorization Submission (Both Urgent and Non-Urgent)
        - Outpatient Authorization Submission
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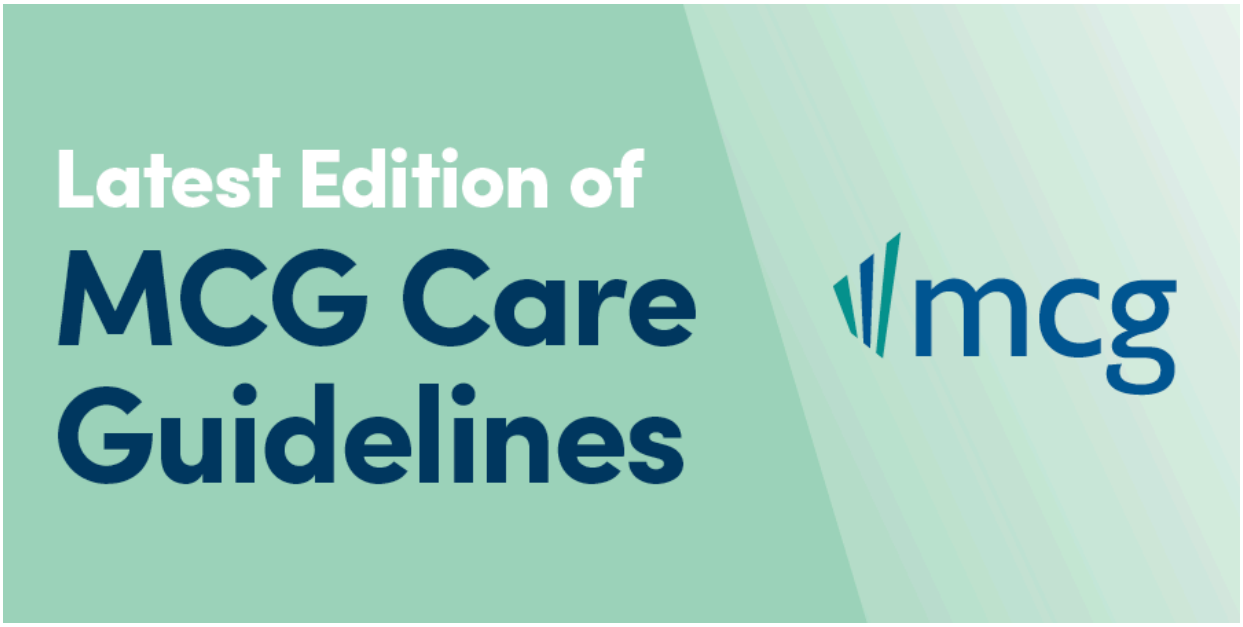

The 28th edition of MCG's Care Guidelines will be available on Aug. 1, 2024.

After that date, you will be able to submit authorization requests using the 28th edition for any new requests. Any authorization requests with a start of care date **prior** to Aug. 1, 2024, will be reviewed using the 27th edition.

We began incorporating clinical guidelines from MCG Health into our criteria of clinical support decisions in February 2023. This change has allowed us to enhance visibility to utilization management criteria while simplifying the authorization process for providers.

Please continue to use the Predictal application in Availity® to submit authorization requests with clinical information included.

Providers can view a summary of changes for the 28th edition from their MCG site.

Questions

Contact Highmark **Clinical Services** or the **Provider Service Center** with any questions. Phone numbers for each region may be found in the Quick Reference Guide.

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Most members with Medicare Part D coverage are eligible to receive up to a **100-day supply for generic medications** on Tier 1 and Tier 2 of Highmark's formularies. When appropriate, providers are encouraged to write prescriptions for this higher day supply.

Some examples of Tier 1 or Tier 2 drugs eligible for a 100-day supply include Lisinopril, Metformin, and Atorvastatin. This change went into effect on **Jan. 1, 2024**.

Writing prescriptions for a 100-day supply will save your Medicare patients money and promote better adherence.

If you are unsure whether the member has this benefit, or what tier the medication is, see our Tip Sheet, which is accessible from the left menu on the Provider Resource Center (PRC) under **PHARMACY PROGRAM/FORMULARIES** and then click **Medicare Formularies**.

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Professional Providers Moving to Group Contracts

Highmark Blue Shield is beginning the process of moving professional providers in its New York markets onto Highmark Professional Agreements — which are group contracts that match the structure that is in place in the other Highmark service regions.

For offices with newly contracted individual practitioners, Highmark Professional Agreements(s) were sent out in December 2023. For practices **without** newly contracted individual practitioners, offices will start seeing new contracts in their email inboxes in the second quarter of this year.

For more information, click here.

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Many individuals with mental health concerns often delay care or find it difficult to schedule a visit with a mental health provider, according to statistics from the 2022 National Survey on Drug Use and Health.

For adults aged 18 and older diagnosed with a mental health disorder (roughly 15 million), only 67% received treatment. For those 12 years and older with substance use disorder, which is nearly 49 million individuals, the numbers are far grimmer, with less than 5% receiving treatment.

Some of your Highmark patients may face barriers to receiving mental health care due to a variety of reasons, including long wait times for appointments, transportation or geographic limitations, personal and work schedule conflicts, or discomfort with in-office appointments.

A Solution for Members

During Mental Health Awareness Month, which runs throughout May, Highmark is highlighting a high-quality mental and behavioral health care solution called **Highmark Mental Well-Being powered by Spring Health**.

It's available for most members with fully insured commercial, Affordable Care Act (ACA), Medicare Advantage, and Administrative Services Only (ASO) plans. The program offers expanded and timely access through customized interventions for eligible Highmark members (and their covered dependents ages 6+) from low-acuity wellness needs to high-acuity conditions.

Virtual and In-Person Care

Highmark Mental Well-Being powered by Spring Health features virtual and in-person (where available) appointments and a designated Care Navigator who will work to ensure our members get the right care at the right time, reducing improper emergency department (ED) utilization.

The program provides access to an expanded network of behavioral health providers who deliver evidence- and measurement-based care. Each member receives a customized care plan based on a digital assessment. Appointments for therapy and medication management are typically available within three business days. Members will also have access to a 24/7 crisis line. You can refer your eligible Highmark patients to **Mental Well-Being** using the form here. Members can also enroll in the program through their Highmark member portal.

Please note: If your patients have been seen in the ED for mental illness and/or substance use, follow-up is essential to make sure that they are receiving appropriate care.

Resources

Additional information about Highmark Mental Well-Being powered by Spring Health can be found on the Provider Resource Center by clicking **EDUCATION/MANUALS > Clinical Support Programs > Behavioral Health**.

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Quality Program Information for 2024

Highmark's Quality Program has been designed to improve the quality, safety, and equity of the clinical care and services providers render to our members. To do this, we continually review aspects of the program that affect the quality of the member care experience, including member satisfaction, and look for ways to make improvements.

Highmark works closely with the physician community in our efforts to address both the quality of the clinical care and service our members receive, as well as plan management for the services provided by Highmark (i.e., authorizations, claims handling, appeals, etc.).

We also use member satisfaction surveys and other tools to elicit feedback on how we're doing. These results are used to guide our future quality improvement activities and programs, supporting such areas as:

- **The Clinical Care and Service Received by Our Members**
- **The Provider Network**
- **Member Safety and Health Equity**

To learn more about the Quality Program, including information on program objectives, please visit the Provider Resource Center (PRC).

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

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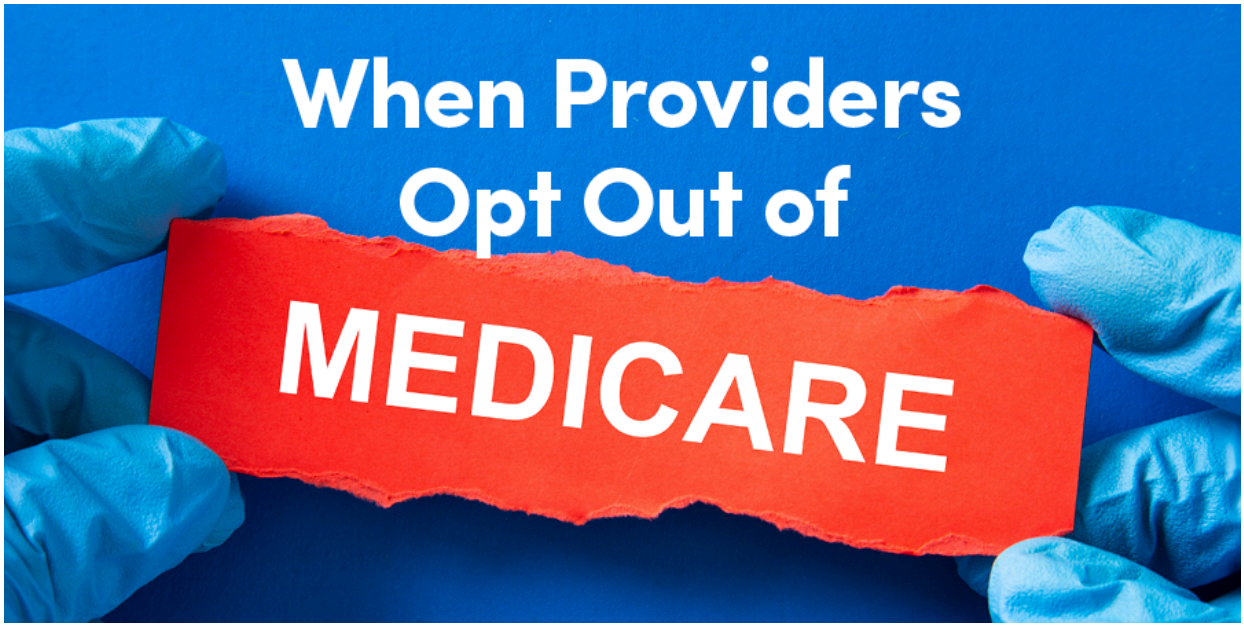

Federal regulations prohibit Medicare Advantage (MA) organizations, including Highmark Blue Shield, from paying for services rendered by providers who have chosen to **opt out** of the Medicare program, except in limited circumstances.

Medicare Participation

An MA organization may contract only with providers who are eligible for participation in the Medicare program and who have not opted out of Medicare (See Social Security Act § 42 CFR § 422.220). Opting out is not the same as "non-participating." Providers who opt out of Medicare cannot participate in our MA Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) networks.

Highmark Blue Shield will not cover any services provided by providers on or after the effective opt-out date... unless the service was eligible for payment as an emergency or urgently needed under applicable Medicare standards.

CMS Regulations

The Centers for Medicare and Medicaid Services (CMS) regulations for opt-out physicians or practitioners also require a "private contract" between the Medicare beneficiary and the provider who opted out of Medicare. The private contract must include language such as, but not limited to, agreement that the Medicare beneficiary gives up Medicare payment — including payment from MA plans — for services furnished by the opt-out provider, as well as to pay the provider for services directly.

How to Cancel an Opt-Out

Providers may cancel their opt-out by submitting written notice to the Medicare Administrative Contractor no later than 30 days before the end of the current two-year opt-out period. If providers want early termination of their opt-out status, there are specific Medicare requirements that must be met in a timely manner and providers must not have previously opted out.

Physicians and practitioners must follow CMS rules regarding opting out of Medicare. The requirements and possible exceptions are outlined in the *CMS Medicare Benefit Policy Manual, Chapter 15, Covered Medical and Other Health Services.* The manual is accessible here.

Status Change

If your status with Medicare changes, you must notify us promptly by calling **800-346-6262**. More information for New York State providers is available from the local Medicare Administrative Contractor, National Government Services website.

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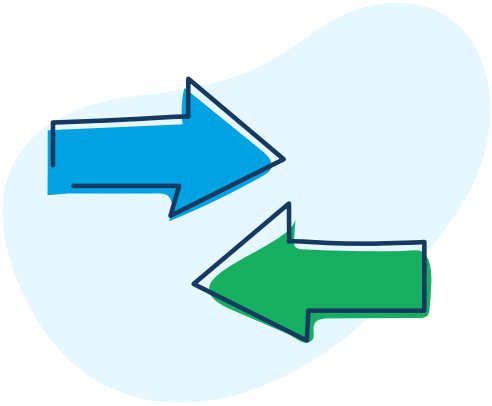
New and Updated Reimbursement Policies



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 recent and upcoming updates to reimbursement policies (RPs):

RECENTLY UPDATED

April 1, 2024

RP-006 Multiple Endoscopy Procedures
New York Commercial products are being applied to this policy direction effective **April 1, 2024**.

RP-034 Prolonged Detention or Critical Care
Code 93598 will be added to the "Prolonged Detention or Critical Care" section of this policy.

April 15, 2024

MRP-007 Modifiers CO and CQ
The reimbursement rate percentage was changed from 85% to 88%.

April 22, 2024

RP-057 Evaluation & Management Services
Medicare Advantage was made applicable to this policy, and a Medicare Advantage section was added to clarify direction that Centers for Medicare & Medicaid Services (CMS) guidelines are followed for Evaluation and Management services.

April 29, 2024

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

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

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

RP-041 Services Not Separately Reimbursed
Code 76140 will be added and will no longer be a separately reimbursed service.

UPCOMING

May 1, 2024

RP-006 Multiple Endoscopy Procedures
New York Medicare Advantage products are being applied to this policy direction effective **May 1, 2024**.

RP-026 Portable Radiography and ECG Services – Modifiers UN, UP, UQ, UR, US

Direction for "U" modifier reductions reported with code R0075 will be made applicable for Commercial.

June 1, 2024

RP-068 Mid-Level Practitioners and Advanced Practice Providers

This policy will be updated to include the new licensed associate marriage and family therapist (LAMFT) and licensed associate professional counselor (LAPC) specialties. It will also be restructured for clarity purposes.

June 24, 2024

NEW: RP-077 Intraoperative Neurophysiological Monitoring

Highmark has created RP-077 to provide direction on reimbursement for Intraoperative Neurophysiological Monitoring (IONM) services. *(NOTE: This policy will be available on the PRC on the effective date of June 24, 2024.)*

August 8, 2024

RP-053 Gene and Cellular Therapy

This policy will be updated with new drugs and therapies, as well as cross-references to medical policies. The name of RP-053 will change from "Gene and Cellular Therapy" to "Advanced Therapies (Gene Therapy and Cellular Immunotherapy)."

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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:

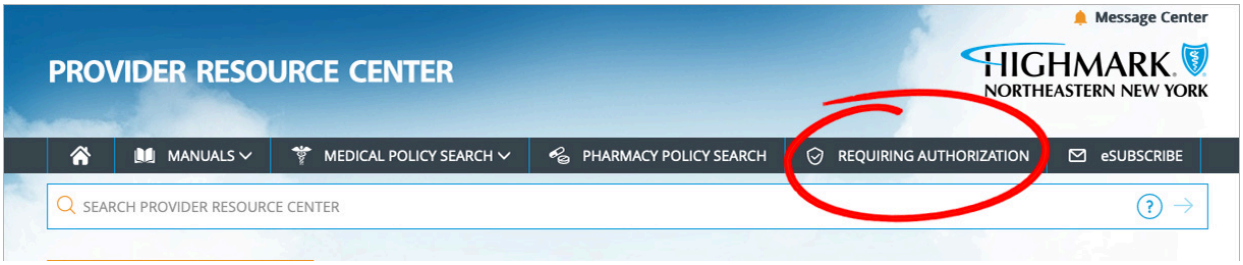
- Call the number on the back of the member's card,
- Check the member's eligibility and benefits via Availity®, or
- Search BlueExchange through the provider's local provider portal.

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

MSK Procedures to Require Prior Authorization Starting Aug. 1

Updated: PT, OT, and Home Health: Prior Auth Changes Occurring on May 1, 2024; Does Not Apply to Outpatient Chiro

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



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

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

Availity is the preferred method for:

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

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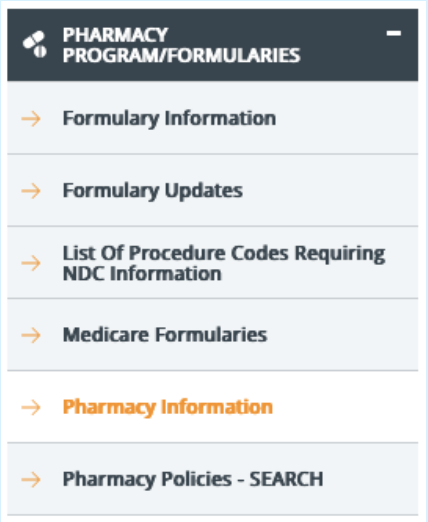
Quarterly Formulary Updates

View the January 2024 updates to Highmark's prescription drug formularies and related pharmaceutical management procedures at the Formulary Updates page on the **Provider Resource Center (PRC)**. From the left menu, select **PHARMACY PROGRAM/FORMULARIES** and then **Formulary Updates**.

Pharmaceutical Management Procedures

To learn more about how to use these procedures, go to the **PHARMACY PROGRAM/FORMULARIES** section on the PRC. Click on **Pharmacy Information** from the sidebar and then **Pharmaceutical Management** from the list on the right.



This section includes information on:

- Exception requests
- The process for generic substitutions
- Explanations of limits/quotas, therapeutic interchange, and step-therapy protocols

Federal Employee Program (FEP) Drug Formularies and Pharmaceutical Management Procedures

The FEP specific drug formularies are available online. Providers also may obtain formulary information by calling **866-763-3608** and following the prompts for *Pharmacy*.

To learn more about the FEP exception request processes for non-formulary drugs, click here.

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Directory Information – Here's How to Attest

When Highmark members are looking for a primary care physician (PCP) or specialist, they expect that our online provider directory presents information that is accurate and current.

That's why it is essential to ensure that your practice information on file with Highmark remains up to date.

Please be aware that providers who don't validate their data quarterly may be removed from the directory and their status within Highmark's networks may be impacted.

Reviewing Data Is Vital for You

The Centers for Medicare and Medicaid Services (CMS) requires Highmark to reach out to you every quarter and ask you to validate your provider directory information. We use this information to populate our online provider directory and to help ensure correct claims processing.

Your thorough review of your directory information confirms:

- **Each practitioner's name** is correct and matches the name on his/her medical license.
- **Each practitioner's National Provider Identifier (NPI) is correct.**

- **The practice name is correct** and matches the name used when you answer the phone.
- **All specialties are correctly listed** and are currently being practiced.
- **Practitioners listed at a location** currently see members and schedule appointments at that office on a regular basis.
    - All practitioners listed must be affiliated with the group. Practitioners who cover, read test results, or are hospitalists should not be listed in the provider directory.
- **The practitioner is accepting new patients** — or not accepting new patients — at the location.
- **The practitioner's address**, suite number (if any), and phone number are correct.

Professional Providers – Use the PDM Tool

Professional providers are now required to validate their Highmark Provider Directory information within the Provider Data Maintenance (PDM) tool every 90 days.

To access PDM, sign in to Availity®, choose the state you practice in, click **Payer Spaces** from the task bar, and then select the Highmark plan you participate in. Once you arrive at the **Payer Spaces** page, scroll down, and select **Provider Data Maintenance** under **Applications**.

Facility, Ancillary, and Medicaid Providers – Use Atlas

The attestation process through Atlas is quick and easy. Just follow these steps...

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

If you haven't attested your provider directory information this quarter, you will receive a letter from Atlas to review your provider information. Some providers may also receive emails from Highmark about validating their directory information through the Atlas website. To ensure delivery of emails from Highmark, please add the following email address, resourcecenter@highmark.com, to your address book.

During the attestation process, always double-check your current email address(es) to ensure that you can receive electronic communications from Highmark without delay.

If you need additional information regarding the attestation process, Atlas' step-by-step guide is available on the Provider Resource Center.

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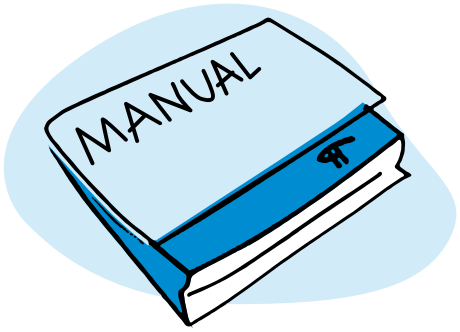
Staying Up to Date with the *Highmark Provider Manual*

Ensure you are regularly reviewing the *Highmark Provider Manual* for our most recent guidance on:



- Participation Rules
- Credentialing/Recredentialing Criteria and Procedures
- Medical Record Criteria
- Requirements for 24/7 Coverage

Some recent noteworthy changes occurred in the following chapters and units:

- **Chapter 2, Unit 6: The BlueCard Program**
- **Chapter 3, Unit 2: Professional Provider Credentialing**
- **Chapter 5, Unit 4: Behavioral Health**
- **Chapter 5, Unit 5: Denials, Adverse Benefit Determinations, Grievances, and Appeals**
- **Chapter 5, Unit 6: Quality Management**
- **Chapter 6, Unit 2: Electronic Claim Submission**

To see the full list of recent changes, visit the Highmark Provider Manual Changes page.

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About This Newsletter

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

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

Regular topics include:

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

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

Another Valuable Resource

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

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

Comments/Suggestions Welcome

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

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HIGHMARK NORTHEASTERN NEW YORK

PROVIDER NEWS

A newsletter for Highmark Blue Shield providers in northeastern New York

Issue 4, April 2024

Legal Information

Highmark Blue Shield of Northeastern New York (Highmark BSNENY) is a trade name of Highmark Blue Shield of Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield Association. Blue Shield and the Shield symbol are registered marks, and BlueCard and Blue Distinction are registered trademarks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield companies. BlueCard, Blue Distinction, Blue Distinction Center, and the Federal Employee Program are registered marks and Blues On Call is a service mark of the Blue Cross and Blue Shield Association.

Information on this website is issued by Highmark BSNENY, which serves 13 counties in northeastern 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.

HEALTHeNET™ is 2019 copyright of WNYHealtheNet LLC, All Rights Reserved. Payers participating in HEALTHeNET provide "Other Insurance" information which is member self-reported. The accuracy of this data CANNOT be guaranteed by HEALTHeNET but rather serves as an indicator that there MAY be other insurance coverage for the member. It is your responsibility to verify "Other Insurance" information returned on an eligibility response.

Highmark BSNENY has adopted Highmark Inc. medical policies as its own policies applicable to Highmark BSNENY 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 BSNENY members who remain on the BSNENY Legacy System

(i.e., have not yet moved to the Highmark System), certain BSNENY Legacy System medical protocols (found at bsneny.com) shall apply and control until the earlier of such time as such member is no longer on the BSNENY Legacy System or Highmark BSNENY communicates otherwise to you.

View the BENENY Privacy Statement.

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.