CHAPTER 4: PROVIDER RESPONSIBILITIES AND GUIDELINES

UNIT 5: OUTPATIENT RADIOLOGY AND LABORATORY

IN THIS UNIT

What Is My Service Area?

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**

The **PA ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.

The **DE ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.

The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

4.5 ADVANCED IMAGING AND CARDIOLOGY SERVICES PROGRAM

Introduction

Effective January 1, 2019, Highmark is partnering with eviCore healthcare (eviCore) for Highmark's Advanced Imaging and Cardiology Services Program. This program incorporates a comprehensive, evidence-based clinical review, including predictive intelligence, clinical decision support, and peer-to-peer discussions.

This program replaces the long-standing Radiology Management Program for which Highmark partnered with National Imaging Associates, Inc. (NIA). eviCore is responsible for the same Highmark member population and conducts clinical reviews for similar advanced imaging and cardiology services as was done under the previous program with NIA.

Why blue italics?

IMPORTANT! Transition to eviCore from NIA program

eviCore will begin accepting authorization requests on December 17, 2018, for dates of service beginning January 1, 2019, and beyond.

*For dates of service prior to January 1, 2019, please refer to the sections of this unit for the **Radiology Management Program** under NIA. Highmark will honor exisiting prior authorizations for continuity of care on claims for advanced imaging or cardiology services that overlap during the transition to the new program.*

Advanced imaging component

The following outpatient, non-emergent, elective advanced imaging procedures require authorization under the program:

- *Computerized tomography (CT)*
- *Computerized tomography angiography (CTA)*
- *Magnetic resonance angiogram (MRA)*
- *Magnetic resonance imaging (MRI)*
- *Nuclear medicine*
- *Positron emission tomography (PET)*
- *Positron emission tomography-computed tomography (PET-CT)*

Cardiology services component

The following outpatient, non-emergent, elective cardiology services require authorization under the program:

- *Cardiac CT and MRI*
- *Diagnostic heart catheterization*
- *Myocardial perfusion imaging (single-photon emission computerized tomography (SPECT) and PET)*
- *Nuclear cardiac imaging*
- *Stress echocardiogram*
- *Transesophageal echocardiogram*
- *Transthoracic echocardiogram*

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4.5 ADVANCED IMAGING AND CARDIOLOGY SERVICES PROGRAM,
Continued

List of procedure codes requiring authorization

*The **list of all procedure codes that require prior authorization** under the Advanced Imaging and Cardiology Services Program is available on Highmark's Provider Resource Center and also on eviCore's website at **evicore.com/healthplan/highmark**.*

*On the Provider Resource Center, select **CARE MANAGEMENT PROGRAMS** from the menu on the left, and then **Advanced Imaging and Cardiology Services Program**.*

***NOTE:** Please be certain to check this list since additional procedures require prior authorization under this new program than under the previous program.*

Additional reference lists

The following lists are also available on the program page on Highmark's Provider Resource Center to provide you with additional helpful, time-saving information.

- **Allowable Billed Groupings**
- **CPT Code List by Category and Service Type**
- **CPT Codes That Can Be Ordered In the Same Prior Authorization**
- **Nuclear Medicine New CPT Code List**

***Note:** The Nuclear Medicine New CPT Code List contains 85 new procedure codes that do not fall into the six existing categories in NaviNet®. When submitting authorization requests for the nuclear medicine codes in this list via NaviNet, you can select any of the imaging categories and service types.*

Authorization not required

eviCore does not manage prior authorization for advanced imaging or cardiology services that are performed during an inpatient stay, in an emergency room setting, or during an observation stay.

Why blue italics?

Members impacted

eviCore manages the prior authorization process for advanced imaging and cardiology services for the following Highmark members:

- *Fully insured Commercial*
- *Medicare Advantage (in Pennsylvania and West Virginia)*
- *Affordable Care Act (ACA)*
- *Children's Health Insurance Program (CHIP) in Pennsylvania*
- *Select self-insured (Administrative Services Only) groups*

Since some employer groups may choose to opt out of the program, please be sure to always verify a member's eligibility and benefits via NaviNet® to confirm whether the member's coverage requires authorization.

***Note:** The Federal Employee Program (FEP) is excluded from this program.*

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4.5 ADVANCED IMAGING AND CARDIOLOGY SERVICES PROGRAM,
Continued

Highmark Medical Policy and eviCore clinical guidelines

*Highmark Medical Policy applies to services under the program. You can quickly access Highmark Medical Policy by clicking on **MEDICALPOLICY SEARCH** on the Quicklinks Bar at the top of the Provider Resource Center.*

*You can access eviCore's clinical guidelines at **evicore.com/healthplan/highmark**. Scroll down to the **LINKS** category, click on **eviCore Evidenced-Based Clinical Guidelines**, and then select **Radiology & Cardiology** from the **Select Solution** dropdown options.*

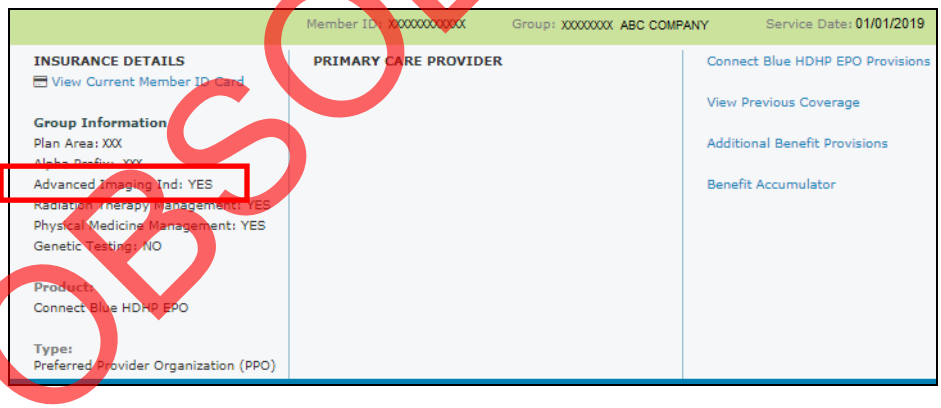
Responsibility for requests

It is the ordering provider's responsibility to request prior authorization from eviCore under the Advanced Imaging and Cardiology Services Program.

Why blue italics?

Verifying prior authorization requirement in NaviNet®

*You can determine if a member's benefit plan requires prior authorization under the Advanced Imaging and Cardiology Services Program via NaviNet. In the **Group Information** section on the **Eligibility and Benefits Details** screen, the Advanced Imaging indicator will display "YES" if the program applies to the member's plan and prior authorization is required.*



Methods for requesting prior authorizations

***NAVINET:** Prior authorization requests for the program can be submitted to eviCore electronically via the **Authorization Submission** transaction in NaviNet, the preferred method for submitting requests. Because the eviCore portal for entering clinical information is integrated into NaviNet, you are able to complete your prior authorization request simply by just logging in to NaviNet.*

***TELEPHONE:** eviCore can accept requests by phone at **1-888-564-5492** from **7a.m. to 7p.m. EST, Monday through Friday**. Outside of these normal business hours, you can leave a message for a return call the next business day.*

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4.5 ADVANCED IMAGING AND CARDIOLOGY SERVICES PROGRAM,
Continued

Methods for requesting prior authorizations *(continued)*

FAX: *To fax your request to eviCore, first obtain the appropriate condition-specific form from the eviCore website at* ***eviCore.com****. From* ***RESOURCES*** *on the menu bar, select* ***Providers****, and then* ***Online Forms & Resources****. Complete the form and fax it to* ***1-800-540-2406****. When the authorization review is completed, eviCore will respond by fax with the decision.*

Prior to submitting your request, please be sure to have all pertinent information at hand, including:

- *Patient's name, address, and current Member ID*
- *Diagnosis and procedure codes*
- *Office notes related to the current diagnosis*
- *Recent clinical information, including imaging studies and prior test results related to the diagnosis*

Why blue italics?

Urgent care requests

An ***urgent care request*** *is any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could result in the following circumstances:*

- *Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment,* ***or***
- *In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.*

When a service is required due to a medically urgent condition, the ordering provider can request authorization by calling eviCore at ***1-888-564-5492****.*

An urgent request can also be submitted online via NaviNet by selecting ***No*** *on the urgency indicator screen in the submission process. However, please note that* ***clinical documentation must be uploaded for urgent requests****. You are able to upload up to five Word or PDF documents. Your case will only be considered urgent if there is a successful upload.*

eviCore will make a good faith effort to render a decision for an urgent request within twenty-four (24) hours and not to exceed seventy-two (72) hours of receipt of all necessary information.

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4.5 ADVANCED IMAGING AND CARDIOLOGY SERVICES PROGRAM,

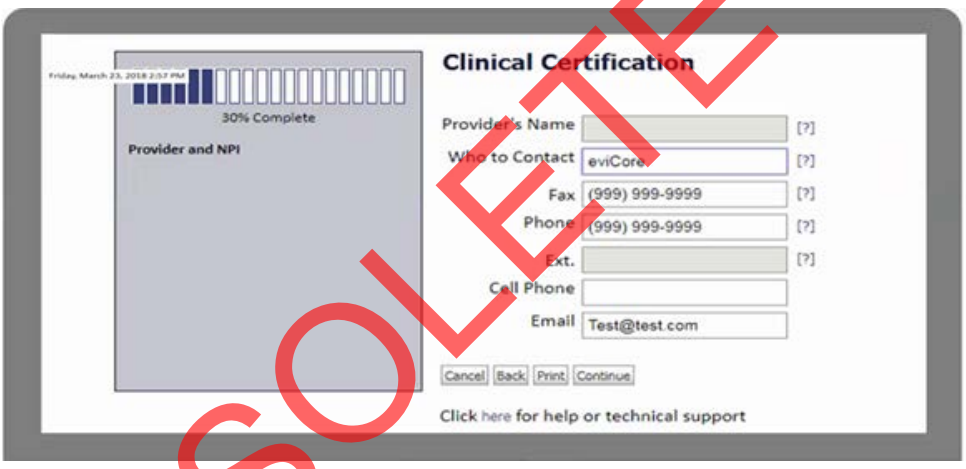
Continued

Why blue italics?

NaviNet submission process

*The NaviNet submission process will be similar to that of Highmark's previous radiology management program. You will log in to NaviNet, select the **Authorization Submission** transaction, and enter the necessary information on the NaviNet screens. Once you complete and submit NaviNet's **Request Form**, the system will seamlessly direct you to eviCore's screens for collecting the necessary clinical information.*

*You will know when you have reached the eviCore portion of the submission since the screen format differs from the NavioNet screens. The first eviCore screen to appear is for entering your contact information.You will enter the required information on each eviCore screen, and then click on the **Continue** button to move on to the next.*



Please note that you will be required to select individual procedure codes during the NaviNet submission process for this program. *Both the CPT Code and Description fields are searchable by drop-down lists - once you select one and click outside the box, the other populates.*

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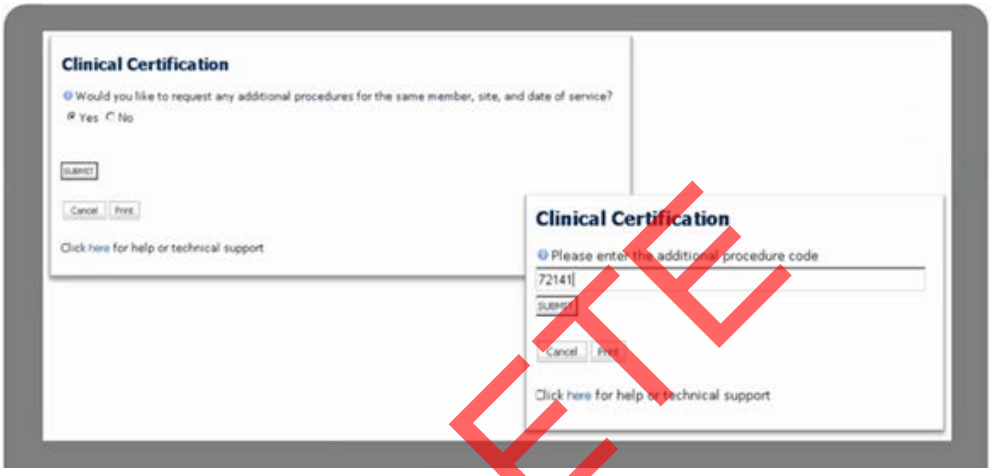
4.5 ADVANCED IMAGING AND CARDIOLOGY SERVICES PROGRAM,
Continued

NaviNet submission process *(continued)*

If you need to request prior authorization for additional procedures for the same member, site, and date of service, you will be given the option to add additional procedure codes:



You will continue through the screens entering the requested information and answering the clinical questions that are presented based on the information you have provided. At the final screen, you will acknowledge the Clinical Certification statement, and then click on ***SUBMIT CASE****.*

Why blue italics?

Approval notification

Once the clinical pathway questions are answered and you have submitted the case, an approval is issued if the answers you have provided have met the clinical criteria. The approval page can be printed for maintaining in the member's file.

An authorization number will be assigned. All authorization numbers will begin with the letter "A" followed by nine digits. The authorization is valid for sixty (60) days.

Please see the next page for an image that illustrates the approval page.

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4.5 ADVANCED IMAGING AND CARDIOLOGY SERVICES PROGRAM,
Continued

Why blue italics?

Approval notification
(continued)

Clinical Certification

Your case has been Approved.

Provider Name: **Contact:**
Provider Address: **Phone Number:**
Fax Number:

Patient Name: **Patient Id:**
Insurance Carrier:

Site Name: **Site ID:**
Site Address:

Primary Diagnosis Code: **Description:**
Secondary Diagnosis Code: **Description:**
CPT Code: **Description:**
Modifier:
Authorization Number:
Review Date:
Expiration Date:
Status: Your case has been Approved.

Print Continue

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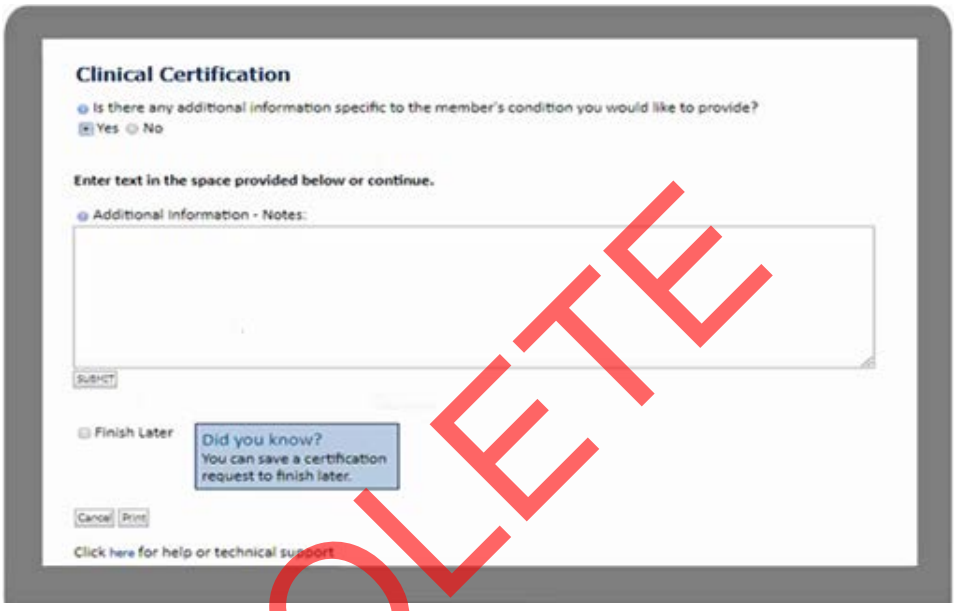
4.5 ADVANCED IMAGING AND CARDIOLOGY SERVICES PROGRAM,

Continued

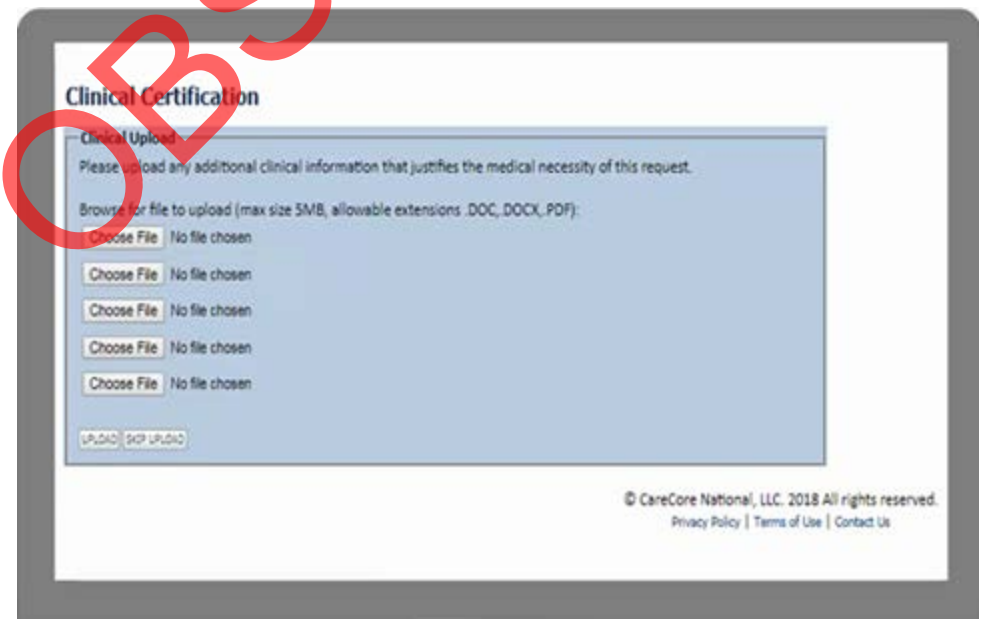
Why blue italics?

Medical review required

If additional information is required for medical review, you will have the option to upload documentation, enter information into the text field, or contact eviCore by phone. ***REMINDER: For urgent care requests, documentation must be uploaded.***



Continue to the next screen to upload documents. You can upload up to five documents (maximum size 5MB; .doc, .docx, .pdf extensions only).



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4.5 ADVANCED IMAGING AND CARDIOLOGY SERVICES PROGRAM,
Continued

Medical review required *(continued)*

Authorization requests are reviewed and processed within two (2) business days of eviCore's receipt of all requested information. Requests are first reviewed by a nurse reviewer who can approve a request if it is determined that criteria is met. If the nurse reviewer is not able to make a determination, the case is reviewed by an eviCore Medical Director. Only an eviCore Medical Director can deny a request.

eviCore will notify the ordering provider of the decision via fax. A determination letter is mailed to the member.

If a request is approved, an authorization number is assigned. An authorization number will begin with the letter "A" followed by nine digits. The authorization is valid for sixty (60) days.

Why blue italics?

Viewing authorization request status in NaviNet

The status of your authorization requests for services under the Advanced Imaging and Cardiology Services program, both approvals and denials, will be available for viewing in NaviNet.

*NaviNet's **Auth Inquiry and Reports**, available under **Workflows for this Plan** menu on Highmark's Plan Central, can be used to view and check the status of authorization requests for the program. You can search by selecting one of these available search options on the fly-out menu: Member ID Search, Member Name Search, and Date of Service Search.*

*The **Referral/Auth Log**, accessed by selecting **Authorization Submission**, makes it easy to review requests you have recently submitted in NaviNet. This function provides numerous search options and is most helpful in accessing incomplete authorizations saved prior to submission. It provides a summary of the original submission with minimal update.*

Reconsiderations and peer-to-peer

Reconsiderations and peer-to-peer discussions will be available for Commercial members only.

For Medicare Advantage members in Pennsylvania and West Virginia, consultations will be made available prior to a decision if requested. Once an authorization request has been denied, the decision cannot be overturned.

Providers rendering services

To avoid any unnecessary delay in payment, those providers rendering the specific advanced imaging or cardiology service should verify that the necessary authorization has been obtained prior to performing the service. Failure to do so may result in non-payment of your claim, and you may not seek reimbursement from the member.

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4.5 ADVANCED IMAGING AND CARDIOLOGY SERVICES PROGRAM,
Continued

Claims adjudication

Under the terms of the agreement between Highmark and eviCore, Highmark will oversee the eviCore program and will continue to be responsible for claims adjudication. All claim inquiries should be directed to Highmark.

Retrospective reviews

*Retrospective requests must be submitted by phone or fax **within 730 business days** following the date of service. Requests submitted after 730 business days will be denied. All retrospective requests are reviewed for medical necessity with determinations made within thirty (30) calendar days.*

***Note:** Retrospective requests for dates of service prior to January 1, 2019, must be submitted to NIA.*

Why blue italics?

Medical necessity appeals

eviCore will process first level provider appeals for Commercial members. Highmark will process first level provider appeals for all other members.

Requests for appeals for Commercial members must be submitted to eviCore within the applicable time frames below:

- *Delaware and West Virginia: **365 days** of the initial determination*
- *Pennsylvania: **180 days** of the initial determination*

The procedure request and all clinical information provided will be reviewed by a physician other than the one who made the initial determination. A written notice of the appeal decision is mailed to the member and faxed to the provider.

***Note:** Appeals for services denied under the previous program for dates of service prior to January 1, 2019, must be submitted to NIA.*

Privileging

All providers who perform imaging services for Highmark members must be privileged. Non-privileged providers are not eligible for reimbursement of imaging services. Any denied services will not be billable to the member.

***Privileging** is a process that assesses the quality of imaging services performed at an imaging center or in a physician's office. Highmark's privileging requirements are intended to promote reasonable and consistent quality and safety standards for the provision of imaging services.*

eviCore will privilege providers that perform diagnostic imaging services based on Highmark's requirements and the same criteria used for the former radiology management program under NIA. The three-year assessment cycle will continue with notification to the provider three (3) months in advance of the expiration date of the provider's privileges.

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4.5 ADVANCED IMAGING AND CARDIOLOGY SERVICES PROGRAM,
Continued

IMPORTANT! Privileging during the transition

During the transition to the new program, eviCore will honor privileging for those providers who are already privileged under NIA until their privileges are set to expire. As their expiration date approaches, providers will need to complete the privileging application through eviCore.

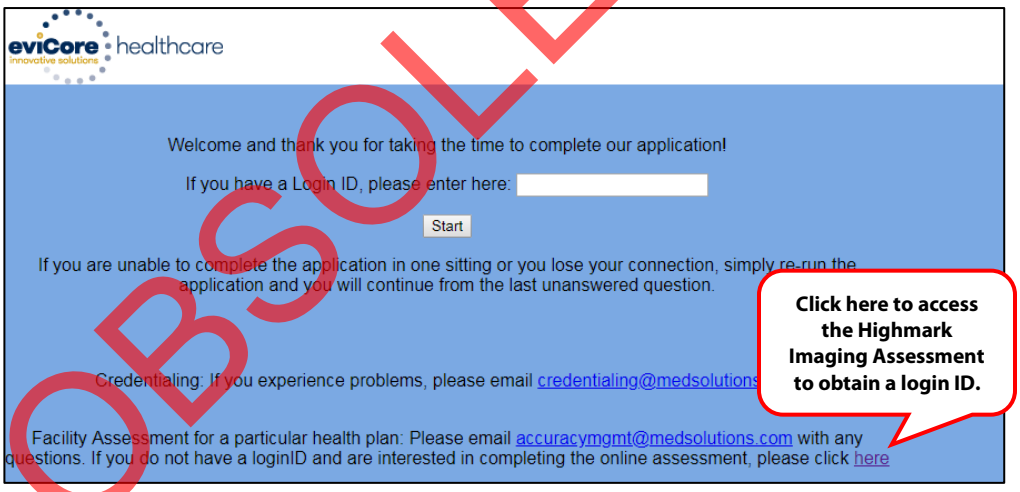
Providers whose privileges expire during the first quarter of 2019 (January, February, or March) will be given a three-month privileging extension. For example, privileges that would have expired on January 2, 2019, will be extended until April 2, 2019.

How to apply for privileging with eviCore

Why blue italics?

OBTAIN LOGIN ID

*To begin the privileging application, the provider must first obtain a secure login ID from eviCore, and then complete the online **Highmark Imaging Assessment**. The Highmark Imaging Assessment is available at **accuracymgmt.com**. Once on the eviCore application screen, click on the **"here"** link at the bottom right to access the assessment.*



Each diagnostic imaging location will require a separate application and, therefore, a separate login ID. In addition, separate login IDs and applications are needed if billing for both global and professional services. The following information will be requested by eviCore to assign a login ID:

- *Provider name*
- *Address of diagnostic imaging location*
- *Tax identification number*
- *Specialty*
- *Highmark Blue Shield number*

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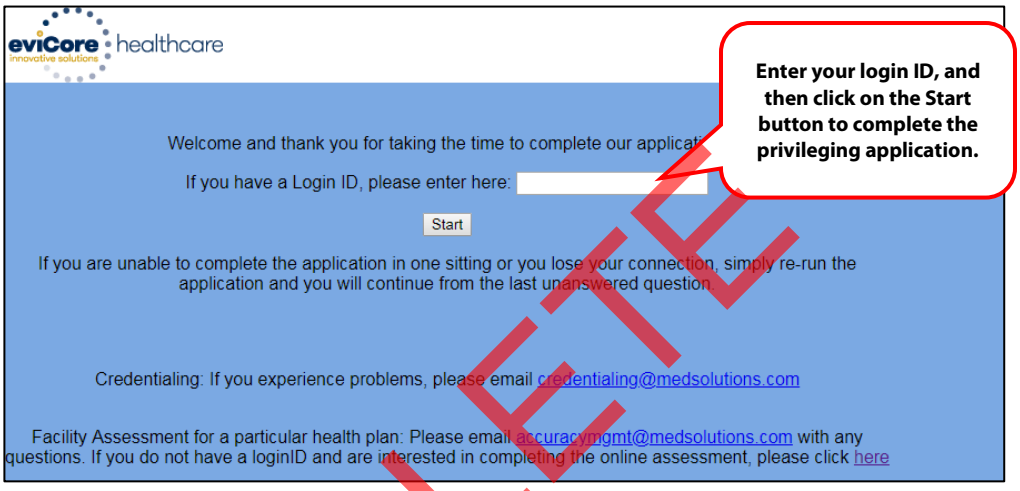
4.5 ADVANCED IMAGING AND CARDIOLOGY SERVICES PROGRAM,
Continued

How to apply for privileging with eviCore *(continued)*

COMPLETE THE PRIVILEGING APPLICATION

Once you receive your login ID, the privileging application is also started from the same page at ***accuracymgmt.com****. Enter your assigned login ID in the box, and then click on the* ***Start*** *button to begin and complete the application.*



If you have a problem logging into the online Highmark Imaging Assessment or with the privileging application, you can contact eviCore's Facility Assessment Department at ***1-800-457-2759*** *or by email at* ***accuracymgmt@evicore.com****.*

Once applications are submitted, any changes must go through eviCore's Facillity Assessment Department. The information for making the change or update will be sent to the provider via email.

FOR MORE INFORMATION

Additional information about the program is available on Highmark's Provider Resource Center. Select ***CARE MANAGEMENT PROGRAMS*** *from the main menu on the left, and then choose* ***Advanced Imaging and Cardiology Services Program****.*

eviCore provides a variety of resources at **evicore.com/healthplan/highmark***. In addition to their clinical guidelines, you will find online forms, educational tools, helpful blogs, and more.*

4.5 RADIOLOGY MANAGEMENT PROGRAM OVERVIEW

IMPORTANT! Program ends December 31, 2018

IMPORTANT! This Radiology Management Program with National Imaging Associates, Inc. (NIA) will end on December 31, 2018.

The new Advanced Imaging and Cardiology Services Program will take effect for dates of January 1, 2019, and beyond. Please refer to the previous section of this unit for program details. These sections for the Radiology Management Program Privileging and Prior Authorization will remain in this unit for a period of time for historical purposes. During the transition from the NIA program to the new program under eviCore, please note the following:

- *NIA will stop taking privileging requests on December 14, 2018.*
- *Appeals for services that were denied by NIA should be submitted to NIA no later than June 30, 2019. NIA will review the appeal using the medical policy guidelines that were applicable on the date the service was performed.*

Why blue italics?

Introduction

Highmark's Radiology Management Program is designed to improve the quality and appropriateness of outpatient advanced imaging services delivered to our members. With the expansion of imaging technology, increasing concern over the levels of radiation exposure, and spiraling health care costs, radiology utilization management programs are common.

The Highmark Radiology Management Program consists of two components: privileging diagnostic imaging providers and prior authorization of select procedures. The privileging process helps to ensure that outpatient imaging services are being performed by qualified providers who demonstrate competency in administration of these services, thus improving quality and safety to our members. The prior authorization process ensures that select outpatient advanced diagnostic imaging services are used only when they are clinically appropriate. The program components are discussed in more detail in the next two sections of this unit.

This program applies to all Highmark products, *except* indemnity products.

National Imaging Associates (NIA)

Highmark retains the services of National Imaging Associates, Inc. (NIA), a wholly-owned subsidiary of Magellan Health Services, to assist with the Radiology Management Program. NIA pioneered the radiology benefits management industry and has long-standing experience grounded in clinical research, innovative technology, and proven results. NIA is URAC accredited, NCQA certified in utilization management, and is compliant with all state regulations applicable to their services.

4.5 PRIVILEGING FOR RADIOLOGY SERVICES

What is privileging?

Privileging is a process that assesses the quality of imaging services performed at an imaging center or in a physician's office. All professional providers who perform imaging services must be privileged. Non-privileged providers are not eligible for reimbursement of imaging services.

Privileging Requirements

Highmark's privileging requirements are intended to promote reasonable and consistent quality and safety standards for the provision of imaging services. The *Highmark Radiology Management Program Privileging Requirements* can be accessed from the **Radiology Management Program** page on the Provider Resource Centers via NaviNet® or Highmark's public websites -- select **CARE MANAGEMENT PROGRAMS** from the main menu, and then **Radiology Management Program.**

Highmark will not reimburse providers for imaging services performed for Highmark members if they do not satisfy the privileging requirements. Any denied services will not be billable to the member.

How to become a privileged provider

Any contracted professional provider who performs diagnostic imaging services can apply to become a privileged provider. The online *Highmark Privileging Application* must be completed. A separate privileging application is required for each practice location where diagnostic imaging services are performed as well as for each billing methodology used (global, professional, technical).

To obtain a login for the application, you will need to contact National Imaging Associates, Inc. (NIA) by calling 1-888-972-9642 or by sending an email to RADPrivilege@Magellanhealth.com. NIA will need the following information in order to assign a login:

- Provider name
- Address of diagnostic imaging location
- Tax identification number

Once you obtain your login/MIS number from NIA, you can access the *Highmark Privileging Application* from the Provider Resource Center. From the main menu, select **CARE MANAGEMENT PROGRAMS**, and then **Radiology Management Program**. Next, select **Privileging Application and Requirements**, and then scroll down the page to the link for the **Highmark Privileging Application**.

For questions regarding the application, contact NIA at **1-888-972-9642**.

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4.5 PRIVILEGING FOR RADIOLOGY SERVICES, Continued

IMPORTANT: You may require more than one login & application

A separate login and privileging application will be required for each practice location, each modality, and if more than one billing methodology is used (global, professional or technical).

Providers must complete an application for each addition or expansion of services and also when adding additional sites. Practitioners will not be reimbursed for services provided on transferred or new equipment without being privileged.

4.5 PRIOR AUTHORIZATION FOR DIAGNOSTIC IMAGING SERVICES

Overview

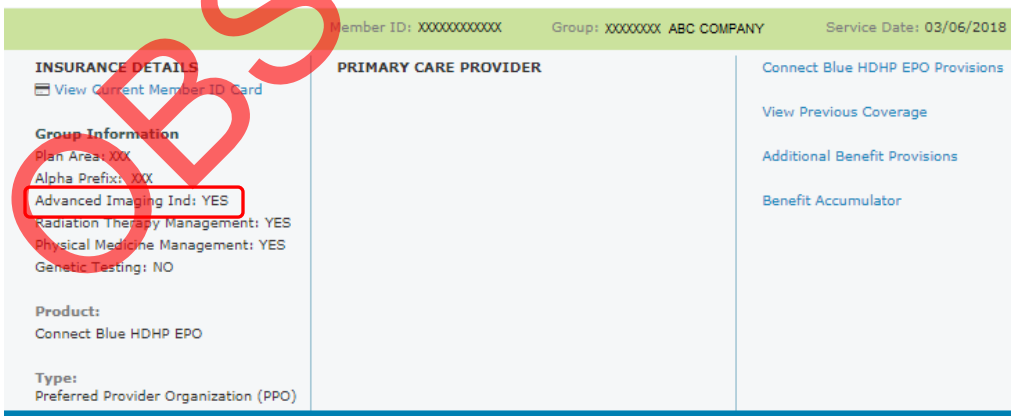
Under the Highmark Radiology Management Program, prior authorization is intended to ensure quality and proper use of diagnostic imaging consistent with clinical guidelines. Providers are required to use NaviNet® to request authorizations from National Imaging Associates, Inc. (NIA) prior to ordering any services on the program's list of procedures requiring authorization.

Using Highmark medical policy and nationally accepted clinical criteria, Highmark and NIA work closely with imaging providers and ordering physicians. This is to ensure our members receive the most appropriate imaging tests, avoid the inconvenience and expense of unnecessary and/or duplicate services, and reduce their exposure to unnecessary radiation. NIA will issue authorization numbers that will be required for reimbursement. Denials may be issued based on medical necessity and/or appropriateness determinations.

Verifying eligibility and benefits

Highmark's Radiology Management Program applies to members enrolled in most Highmark health plans; however, some employer groups may choose to opt out of the program. Prior to ordering or performing any procedures included in the program, providers should always verify the member's eligibility and benefits.

You can determine if a member's benefit plan requires prior authorization on the **Eligibility and Benefits Details** screen in NaviNet. In the **Group Information** section, the **Advanced Imaging Ind** will show "YES" if the Radiology Management Program applies to the member's plan and prior authorization is required:



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4.5 PRIOR AUTHORIZATION FOR DIAGNOSTIC IMAGING SERVICES, Continued

Requesting authorization

The ordering physician's office should use NaviNet's **Authorization Submission** transaction to submit an authorization request to NIA before scheduling the test. NaviNet is the preferred method of submitting NIA authorization requests.

Providers who are not NaviNet-enabled should call the **NIA Call Center**, which can be reached by calling your Highmark Provider Service Center. Listen carefully to the options and select the option for requesting authorization for advanced imaging.

NIA Call Center hours are from 8 a.m. to 8 p.m. EST, Monday through Friday. Saturday hours are from 8 a.m. to 1 p.m. EST. If necessary, NIA can be contacted directly at **1-888-972-9642**.

Quick Reference

Services that require prior authorization

The prior authorization process applies only to certain outpatient, non-emergent advanced diagnostic imaging services. The prior authorization process **does not apply** to imaging services ordered in an emergency room, urgent care centers, ambulatory surgery centers, or during inpatient or observation stays.

Prior authorization applies to selected procedures of the following types of imaging tests:

- Computed tomography (CT);
- Magnetic resonance imaging (MRI);
- Magnetic resonance angiography (MRA);
- Positron emission tomography (PET);
- Myocardial perfusion imaging (MPI) scans; and
- Stress echocardiography.*

** Effective with dates of service on or after October 3, 2016, requirements for stress echocardiography under the program changed from prior notification to prior authorization. Please note, however, that stress echocardiography will continue to require prior notification for certain self-funded employer groups.*

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4.5 PRIOR AUTHORIZATION FOR DIAGNOSTIC IMAGING SERVICES,
Continued

Procedures requiring authorization

To access the most current list of specific procedure codes that require authorization, please see the **Prior Authorization Quick Reference Guide for Ordering Providers**.

This Quick Reference Guide is also available on the program's page on the Provider Resource Center. Select **CARE MANAGEMENT PROGRAMS** from the main menu on the Provider Resource Center, and then **Radiology Management Program**. Select **Prior Authorization/ Notification Information** (**Prior Authorization** in Delaware), and then scroll to the **ADDITIONAL RESOURCES** category.

Note: For procedure codes in these categories that are not on the list requiring prior authorization, please refer to Highmark Medical Policy for clinical guidelines to determine coverage based on medical necessity.

Clinical Validation of Records (CVR)

Effective October 3, 2016, NIA implemented a Clinical Validation of Records (CVR) process for all codes that are part of Highmark's Radiology Management Program. As part of the prior authorization process, NIA will **request and review clinical documentation from the member's medical record** to help ensure Highmark members receive the most appropriate and effective care.

If your authorization request is pended for additional clinical information, you will immediately receive a fax specifying clinical documentation from the member's medical record that is needed for review. Providers must fax the requested information to NIA before a final determination can be made.

NIA will validate the clinical criteria within the patient's medical records, ensuring that the clinical criteria support the requested procedure and are clearly documented in the medical records. All reviews are processed under NCQA and regulatory guidelines. Urgent requests can continue to be called into NIA and clinical validation will not be required under those circumstances.

Authorization is not a guarantee of payment

When an authorization number is provided, it serves as a statement about medical necessity and appropriateness; it is **not a guarantee of payment**. Payment is dependent upon the member having coverage at the time the service is rendered and the type of coverage available under the member's benefit plan.

It is the provider's responsibility to verify that the member's benefit plan provides the appropriate benefits for the anticipated date of service prior to rendering the service. Highmark recommends that providers confirm a member's eligibility on

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4.5 PRIOR AUTHORIZATION FOR DIAGNOSTIC IMAGING SERVICES, Continued

Authorization is not a guarantee of payment (continued)

either the anticipated date of service or one business day prior to the anticipated date of service. Some benefit plans may also impose deductibles, coinsurance, copayments, and/or maximums that may impact the payment. Providers may consult NaviNet to obtain benefit information.

Note: Authorization numbers do not need to be entered on a claim. However, Highmark strongly recommends that the provider performing the diagnostic test documents and archives the imaging authorization number in the event it is needed for future reference.

When NIA is contacted post-service

When the ordering physician contacts the National Imaging Associates, Inc. (NIA), an affiliate of Magellan Health, Inc., for authorization **after** one of the select outpatient advanced imaging services was performed but **prior to** claim submission, a retrospective review is necessary.

In such cases, if NIA determines that:

- The service **was medically necessary**, an authorization number is issued. The rendering provider can obtain the authorization number from the **Referral/Authorization Inquiry** transaction in NaviNet®, and then is free to submit a claim to Highmark.
- The service **did not meet medical necessity criteria**, a denial letter is sent to both the ordering physician and the rendering provider. When this is the case, the facility will **not be reimbursed** for the service.

When a claim rejects for lack of NIA authorization

A retrospective review is also necessary when a claim for one of the selected advanced imaging services is received by Highmark and subsequently denied because no NIA authorization is on file. Under these circumstances, the rendering provider can **contact NIA** via telephone to initiate a retrospective review. NIA will then contact the ordering physician to obtain all the necessary information to complete the retrospective review.

Another option for the rendering provider is to **contact the ordering physician directly** to request that he or she initiate the retrospective review process.

If, upon review, NIA determines that the service billed on the rejected claim **did not meet medical necessity criteria**, a denial letter is sent to both the ordering physician and the rendering provider. In this situation, the facility will not be reimbursed and is not permitted to bill the member for the service.

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4.5 PRIOR AUTHORIZATION FOR DIAGNOSTIC IMAGING SERVICES, Continued

When a claim rejects for lack of NIA authorization (continued)

If NIA determines that the service was **medically necessary**, an authorization is issued. The rendering provider can obtain the authorization number from the **Referral/Authorization Inquiry** transaction in NaviNet.

To have the previously denied claim adjusted, the provider can then open a NaviNet Investigation, reporting the newly obtained authorization number. ("NRR-NIA Retrospective Review" should be selected from the NaviNet drop-down selections as the reason for adjustment.)

Providers who are not NaviNet-enabled can call the appropriate Highmark Provider Service Center to request the adjustment with the new NIA authorization number.

FOR MORE INFORMATION

For more detailed information on the components of the Highmark Radiology Management Program, please refer to the documents available on the Provider Resource Center. Select **CARE MANAGEMENT PROGRAMS** from the main menu on the left, and then **Radiology Management Program**.

4.5 OUTPATIENT LABORATORY OVERVIEW

Overview

Providers must refer members to participating laboratory vendors when lab services are needed and are not performed in the provider's office.

Prescription necessary

PCPs and specialists need only give their members a prescription for the necessary lab tests and direct them to a network-participating lab.

Communication between the PCP and specialist

Specialty practitioners should communicate with a member's PCP after a consultation visit so that laboratory services can be appropriately coordinated.

What Is My Service Area?

Pass-through billing not permitted

Pass-through billing occurs when ordering practitioners bill for clinical laboratory tests that were not performed in their offices. In Pennsylvania and Delaware, Highmark does not permit pass-through billing.

Practitioners should bill only for the component of the laboratory service they perform in their offices. Independent laboratories should bill for any clinical lab tests referred to them by practitioners.

Highmark will reimburse practitioners for drawing or handling when the specimen is sent to a laboratory other than the practitioner's office lab and the clinical lab test is billed by the independent laboratory. However, if the clinical lab test is performed in the practitioner's office and the practitioner bills for the test, an additional charge for drawing or handling will not be reimbursed. The handling or drawing of the specimen is considered part of the laboratory procedure.

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4.5 OUTPATIENT LABORATORY OVERVIEW, Continued

Designated outpatient lab providers

Network-participating hospitals provide outpatient lab services. In addition, there are several freestanding labs and specialty labs that are designated outpatient lab providers. NaviNet® is the fastest method for accessing real-time lists of network participating providers.

STEP	ACTION
1	Log in to NaviNet by accessing https://navinet.navimedix.com/sign-in?ReturnUrl=/Main.asp .
2	From Plan Central, select **Network Facility Inquiry**.
3	Use the descriptive fields to narrow your search requirements by network, facility number, specialty description, etc. **Note:** Laboratories can be found by selecting **Laboratory Medicine** in the specialty description field.
4	Click **Search** to return requested information.

What Is My Service Area?

Participating independent laboratory lists

NaviNet is the preferred Highmark tool for inquiring about participating providers; however, if you are not NaviNet-enabled, please click the links below for a list of designated independent lab providers. Please select the appropriate region-specific link below:

- Pennsylvania Western Region Independent Labs
- Pennsylvania Central Region Independent Labs
- Pennsylvania Northeastern Region Independent Labs
- Delaware Independent Labs
- West Virginia Independent Labs

If you are a provider who participates with Highmark and are interested or want more information about NaviNet, call the Provider Service Center for your service area.

Quick Reference

4.5 LABORATORY MANAGEMENT PROGRAM

Overview

Highmark has partnered with eviCore healthcare ("eviCore") to ensure our members are receiving the most clinically appropriate genetic laboratory testing. eviCore has a team of genetic counselors and medical geneticists with national experience in genetic testing utilization management using evidence-based policies developed with trained genetic experts.

Under Highmark's Laboratory Management Program, eviCore will perform medical necessity reviews for select molecular and genomic tests performed in an outpatient setting. In addition, all claims associated with molecular and genetic procedure codes will be reviewed for accuracy and medical necessity, based on eviCore's policies.

Procedures requiring authorization

Effective for dates of service beginning August 1, 2016, prior authorization is required for certain outpatient, non-emergent molecular and genomic testing, such as:

- Hereditary cancer screening
- Carrier screening
- Tumor marker/molecular profiling
- Hereditary cardiac disorders testing
- Cardiovascular disease and thrombosis risk variant testing
- Pharmacogenomics testing
- Neurologic disorders testing
- Mitochondrial disease testing
- Intellectual disability/developmental disorders testing

A complete list of impacted procedure codes is available at **eviCore.com**, under **Online Forms and Resources**.

Any services performed without prior authorization may be denied, and providers may not seek reimbursement from members.

Exclusions

Prior authorization is not required for the following:

- Inpatient genetic testing;
- General lab testing; or
- Genetic testing for CPT codes not included on eviCore's prior authorization list.

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4.5 LABORATORY MANAGEMENT PROGRAM, Continued

Applicable products

Highmark's Laboratory Management Program applies to Highmark members with fully-insured commercial, Affordable Care Act (ACA), and Medicare Advantage products.

The program is not applicable to traditional indemnity products, ASO (Administrative Services Only) accounts, National accounts, the Federal Employee Program (FEP), and BlueCard.

If you are uncertain whether a member's benefits require authorization for genetic testing under the Laboratory Management Program, you can call eviCore at **1-888-564-5492** for confirmation of prior authorization requirements for the member.

Requesting authorizations

Highmark recommends that ordering physicians secure authorizations and pass the authorization numbers to rendering facilities at the time of scheduling. Authorizations contain authorization numbers and one or more CPT codes specific to the services authorized. If the service requested is different from what is authorized, contact eviCore for review.

NaviNet-enabled providers should use the NaviNet Authorization Submission transaction to submit authorization requests. If you attempt to submit a request and receive a message to call eviCore, authorization may not be required under the member's benefit plan; the eviCore representative will assist in identifying the member and determining if authorization is needed.

If you are not NaviNet-enabled for authorization submission, you may use the eviCore Web Portal, available 24/7 at **evicore.com**, to request authorizations.

Authorizations are valid for sixty (60) days. If the approved procedure is not completed by the Last Assigned Covered Day, a new request must be submitted.

Urgent requests

If services are required in less than forty-eight (48) hours due to medically urgent conditions, please call eviCore at **1-888-564-5492** for authorization. Be sure to tell the representative that the authorization is for medically urgent care.

eviCore will make every effort to render a decision within one (1) business day of receipt of all necessary information.

Claim submission & reimbursement

Claims are submitted to Highmark following normal claim submission procedures, and you will receive reimbursement for eligible services from Highmark.

Continued on next page

4.5 LABORATORY MANAGEMENT PROGRAM, Continued

Claims review requirements

Beginning August 1, 2016, all claims associated with molecular and genomic procedure codes will be reviewed prior to payment for accuracy and medical necessity, based on eviCore's policies, and matched against the authorization, if applicable. **This review is not limited to those codes for which authorization is required.** A list of codes subject to claims review is available at **eviCore.com**.

FOR MORE INFORMATION

For complete program information, please see the Laboratory Management Program page on the Provider Resource Center – select **CARE MANAGEMENT PROGRAMS**, and then **Laboratory Management Program**.

4.5 SPECIAL PROGRAMS IN LUZERNE AND LACKAWANNA COUNTIES (PA ONLY)

What Is My Service Area?

Introduction

Highmark recognizes the need to address regional community needs while maintaining provider network continuity and balance. The goal is to meet the needs of members through innovative programming within the network.

For members with HMO plans serviced by providers in the First Priority Health (FPH) network in Pennsylvania's Luzerne and Lackawanna counties, special programs for outpatient laboratory and radiology services meet their needs for access to high quality, cost-effective services.

For all other counties in the 13-county Northeastern Region service area, radiology and laboratory services for members with HMO plans serviced by the FPH provider network can be performed at any participating facility with a script from the ordering physician.

Outpatient Laboratory Program

The outpatient laboratory program with Commonwealth Health Laboratory Services is for members whose FPH network primary care physician (PCP) is located within Lackawanna or Luzerne counties. Care must be coordinated with the member's FPH network PCP. The member needs only to take a physician's orders to a Commonwealth Health Laboratory for services.

Services included in this program are:

- Pre-admission testing;
- House calls; and
- Services associated with skilled nursing/personal care facilities.

Please see the **Commonwealth Health Laboratory Services** listing of laboratory sites, which includes addresses, hours, and telephone and fax numbers. This list is also available on the **Highmark Blue Shield Provider Resource Center** – select **EDUCATION/MANUALS**, and then **First Priority Health Network Resources**.

Outpatient Radiology Program

For members with HMO coverage whose FPH network PCP is located within Luzerne County (excluding the Berwick and Hazelton areas), an outpatient radiology program provided in conjunction with Wilkes-Barre General Hospital renders integrated, high quality, and cost-effective care.

Care must be coordinated with the member's FPH network PCP. The member needs only to take a physician's orders to Wilkes-Barre General Hospital or one of

Continued on next page

4.5 SPECIAL PROGRAMS IN LUZERNE AND LACKAWANNA COUNTIES (PA ONLY), Continued

Outpatient Radiology Program (continued)

its affiliated sites for services. For site locations, hours, and telephone numbers, please see the **Wilkes-Barre General Radiology Sites** list. This list is also available on the **Highmark Blue Shield Provider Resource Center** – select **EDUCATION/MANUALS**, and then **First Priority Health Network Resources**. Services for members in the remaining Luzerne County region can be obtained from any participating hospital facility.

Magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), and positron emission tomography (PET) scans are excluded from the capitated radiology program; however, they do require prior authorization. For a complete listing of radiology procedures that require authorization, please refer to the **Wilkes-Barre General Radiology Sites** list.

What Is My Service Area?

4.5 REPORTING PLACE OF SERVICE

Inpatient vs. outpatient

When you submit claims to Highmark for diagnostic or therapeutic radiology services or diagnostic medical services provided to hospital inpatients or outpatients, you must report the place of service as inpatient hospital or outpatient hospital, as appropriate. In these cases, you will be reimbursed only the professional component of the service.

- **Inpatient** – a patient who is an inpatient of a facility, such as a hospital or skilled nursing facility, at the time the procedure is performed. When an inpatient is taken outside the hospital setting, such as to a physician's office, and is then returned to the hospital, the physician must report services according to the patient's status, in this case, inpatient. Therefore, you must report only "inpatient" as the place of service, rather than the place, such as "office" or "outpatient hospital," where the service actually was performed.

- **Outpatient** – a patient, other than an inpatient, who is treated in a hospital, on hospital grounds, or in a hospital-owned or controlled satellite, when it has been determined that the satellite is an outpatient department of the hospital. This definition does not apply when a treating physician's sole practice is located in a hospital or hospital owned building, if the practice is not affiliated or controlled, in any way, by the hospital or a related entity; or, if the practice has been approved to be recognized as an office practice.

For example, if a mobile ultrasound, MRI, or CT unit locates on hospital grounds one day each week, all services provided to patients on that day must be reported with inpatient or outpatient, but not office, as the place of service.

4.5 COST SHARING ON OUTPATIENT DIAGNOSTIC SERVICES

Overview

Highmark offers optional benefit designs that include cost-sharing provisions specific to outpatient diagnostic services.

Services affected

Cost sharing on outpatient diagnostic services will be applied to:

- Routine/preventive diagnostic services (with the exception of all mammograms and the annual routine Pap test), and
- Non-routine diagnostic services, including pre-admission testing.

Impacted products

Products that may have a cost-sharing benefit design include Exclusive Provider Organization (EPO) and Preferred Provider Organization (PPO) plans, including Medicare Advantage PPO.

Note: Cost-sharing provisions will not be noted on Member ID cards. Please review member benefits accordingly through NaviNet® or by contacting Provider Service if you are not a NaviNet-enabled provider.

Five categories of outpatient diagnostic services

ADVANCED IMAGING SERVICES:	
1	Advanced Imaging Services – include, but are not limited to, computed tomography (CT), computed tomography angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET scan), and positron emission tomography/computed tomography (PET/CT scan).
BASIC DIAGNOSTIC SERVICES:	
2	Standard Imaging Services – procedures such as skeletal X-rays, ultrasound, and fluoroscopy.
3	Diagnostic Medical Services – procedures such as stress echocardiography, myocardial perfusion imaging (MPI), electrocardiograms (ECG), pulmonary studies, echocardiograms, electroencephalograms (EEG), regular treadmill stress tests, and audiology tests.
4	Laboratory and Pathology Services – procedures such as non-routine Papanicolaou (Pap) smears, blood tests, urinalysis, biopsies, and cultures.
5	Allergy Testing Services - allergy testing procedures such as percutaneous tests, intracutaneous tests, and patch tests.

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4.5 COST SHARING ON OUTPATIENT DIAGNOSTIC SERVICES,
Continued

How coinsurance is applied

If a member has coinsurance, it is applied to all line items identified as outpatient diagnostic services either on Advanced Imaging only or also on the four categories of Basic Diagnostic Services depending on the benefit design selected. The coinsurance amount (e.g., 80%) for the four categories of Basic Diagnostic Services is the same. Coinsurance for outpatient diagnostic services is applicable to the total component, technical component, and/or professional component only.

The member may be responsible for both a copayment and coinsurance when a service, such as an office visit or therapy service, and an outpatient diagnostic service are performed on the same date of service.

How copayments are applied

If a member has copayments on outpatient diagnostic services, they are applied per date of service and per type of diagnostic service. If services fall in more than one of the five diagnostic service categories (see previous page), multiple copayments can be applied. Please review the member's benefit program to determine if a copayment is owed on multiple services.

Copayments may be applicable to only the advanced imaging services or also to all four categories of basic diagnostic services. The copayment amount for the advanced imaging services would usually be a higher amount (e.g., $100). The copayment amount for the four categories of basic diagnostic services is the same (e.g., $25 for each type of service).

Copayments are applied to the total component or technical component claims for outpatient diagnostic services. Copayments are not applied to professional component only claims (26 modifier).

Please Note: For Medicare Advantage products with outpatient diagnostic copayments, copayments are applied per date of service, per type of diagnostic service, and also per provider.

Examples of multiple copayments and/or coinsurance

- If a PPO member sees his cardiologist and receives an EKG during the visit, he would be responsible for two copayments: an office visit copayment and an outpatient diagnostic service copayment for the EKG (diagnostic medical service).
- If a PPO member receives an MRI (advanced imaging service), then has a spinal X-ray (standard imaging service) and lab work (laboratory/pathology service) on the same day – all as outpatient services – she would be responsible for three outpatient diagnostic copayments.

Continued on next page

4.5 COST SHARING ON OUTPATIENT DIAGNOSTIC SERVICES,
Continued

Examples of multiple copayments and/or coinsurance (continued)

- If an EPO member sees his cardiologist and receives a regular treadmill stress test (basic diagnostic medical service) while there, he would pay an office visit copayment, and then would be responsible for any applicable coinsurance when the stress test claim is processed.
- If a Medicare Advantage member with outpatient diagnostic copayments sees his cardiologist and receives an EKG (basic diagnostic medical service) while there and on the same day goes to another physician and receives a regular treadmill stress test (also a basic diagnostic medical service), he would be responsible for two copayments, one for each provider.

Cost sharing exceptions

- All mammograms (routine and medically necessary) and the annual routine Pap tests are generally unaffected by the cost sharing benefit designs.
- Diagnostic services performed in conjunction with an emergency room visit would not be impacted in most cases.
- There may be situations where cost sharing may apply in the first two situations, especially for self-insured employer groups. Please be sure to review each service on a case-by-case basis.

Quick Reference

Determining if members have cost sharing

More information on outpatient radiology and other diagnostic services cost sharing can be easily accessed through NaviNet, or by contacting the Provider Service Center if you are not a NaviNet-enabled provider.

To verify outpatient diagnostic benefits in NaviNet, select **Additional Benefit Provisions** from the Eligibility and Benefits detail page, and then **Outpatient Facility Services** from the pop-up box.