CHAPTER 5: CARE AND QUALITY MANAGEMENT

UNIT 2: AUTHORIZATIONS

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.

5.2 INTRODUCTION

Overview

Highmark requires authorization of all inpatient admissions, medical and behavioral health. In addition, authorization is required for certain outpatient services, procedures, and durable medical equipment and supplies prior to performing the services or providing the supplies.

Authorization must be requested prior to the initiation of these services in accordance with the member's plan and Highmark administrative requirements. When requesting an authorization, be sure that the member receives care from a provider who participates in the network associated with the member's benefit plan and, when applicable, is in the highest benefit tier.

If a provider fails to obtain authorizations as required, the member cannot be billed for charges for services that are denied for lack of authorization. However, a provider may bill the member if, prior to service or care, the provider informs the member of failure to obtain authorization and the member agrees in writing to pay for such service or care.

Definition

An **authorization** is a determination by Highmark that a health care service proposed for or provided to a member is "medically necessary" as that term is defined by the member's contract. If a service requires authorization, then the provider, and in some cases the member, must contact Highmark to request the medical necessity review. Authorization may also be called precertification, preauthorization, prior authorization, prospective review, preservice review, prior approval, or other similar terms.

Authorization does not guarantee payment. A service or supply will be reimbursed by Highmark only if it is medically necessary, a covered service, and provided to an eligible member.

Products requiring authorization

All Highmark products, including Medicare Advantage, require that certain services be authorized as a condition of coverage. **However, benefits can vary; always confirm authorization requirements under the member's coverage prior to providing services.**

Utilization decision making

Highmark makes utilization review decisions based only on appropriateness of care and service and the existence of coverage. They do not reward practitioners, providers, Highmark employees, or other individuals conducting utilization review for issuing denials of coverage or service, nor do they provide any financial incentives to utilization management decision makers to encourage denials of coverage.

5.2 AUTHORIZATION GUIDELINES

Introduction

Authorization review is the process by which services are evaluated according to benefit availability and criteria for medical necessity and appropriateness. Ordinarily, authorization should be in place before services are rendered; therefore, this process is often called "precertification" or "prior authorization."

Provider-driven process

The authorization process is **provider-driven for all in-network care**. This means that it is the network provider's responsibility to obtain authorization for an inpatient admission or for any outpatient services requiring approval.

If services are delivered and authorization is required but not obtained timely, the corresponding claim may be rejected and the member must be held harmless. In order for such a claim to be considered for payment, the provider will need to request a retrospective review and submit the applicable medical records, if applicable.

For HMO, IPA, and POS products, the PCP is responsible for obtaining authorizations for services needed by the PCP's designated members. If a referral is made to a specialist, the specialist can request an authorization for a service he or she will provide.

What Is My Service Area?

Criteria used

Highmark Medical Policy and Medicare Advantage Medical Policy* are used to assess the medical necessity and appropriateness of health care services.

For inpatient care, Highmark also uses McKesson Health Solution's InterQual® criteria in the processes for assessing medical necessity and appropriateness of services. The InterQual criteria are applied to assessment of acute adult, acute pediatric, acute rehabilitative, long-term acute, skilled nursing, and home health services. These criteria are applied in conjunction with applicable Highmark Medical Policy and Medicare Advantage Medical Policy.

For more information on Highmark's commercial and Medicare Advantage medical policies and criteria used for medical management decisions, please see **Chapter 5.1: Care Management Overview**.

** Medicare Advantage products are available only in Pennsylvania and West Virginia.*

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5.2 AUTHORIZATION GUIDELINES, Continued

Electronic authorization requests

NaviNet® is the preferred method for submitting authorization requests to Highmark. Authorizations may be requested through NaviNet or by submitting a HIPAA 278 electronic transaction. Electronic authorization requests are the preferred method and are quick and easy to perform.

To learn more about how to request authorizations via NaviNet, access the **NaviNet Support** page by clicking on **Help** on the toolbar at the top of the NaviNet screen.

For a HIPAA 278 transaction, refer to the **Provider EDI Reference Guide** accessible from the Provider Resource Center:

- Select **CLAIMS, PAYMENT & REIMBURSEMENT** from the main menu, and then **Electronic Data Interchange (EDI) Services**.
- Select **Resources** from the menu on the Highmark EDI Trading Partner Business Center home page.

IMPORTANT! 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 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.

When Highmark is not primary

Authorization requirements apply if a claim will be submitted to Highmark for any portion of payment. Therefore, if the member's primary insurance is with a commercial carrier other than Highmark, any authorizations required under the member's Highmark benefit plan are required if a claim will be submitted to Highmark for services requiring authorization.

However, if traditional Medicare is primary, an authorization is required only if:

- The member exhausts his/her Medicare benefit and desires to continue the service;
- The service is not covered by Medicare (e.g., home infusion; or
- The member is admitted to a Veteran's Administration (VA) facility.

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5.2 AUTHORIZATION GUIDELINES, Continued

Behavioral health benefits

Behavioral health benefits vary by group. In some instances, a group may purchase medical health care coverage through Highmark, but behavioral health care coverage through another company.

To be sure a member has behavioral health care coverage through Highmark, verify eligibility and benefits through NaviNet® or perform the applicable HIPAA electronic transaction. If you do not have electronic access, call the benefits telephone number on the member's identification card.

The member's benefit program must provide the specific benefit for the service the member is scheduled to receive. **If the member's benefit program does not provide the benefit, the facility will not be reimbursed for the services.**

Disclaimer

An authorization is a determination of medical necessity only and does not guarantee coverage or payment. Payment is based on the member's coverage and eligibility at the time of service.

A service that has been authorized may nonetheless be denied payment if:

- The member is no longer eligible when the service is provided;
- The service is not a covered benefit under the member's contract; or
- The service actually provided is different from the service authorized.

Medical necessity determinations are not a substitute for the medical judgment of the treating provider. They are for reimbursement purposes only. They do not constitute medical advice or treatment or establish any provider/patient relationship.

Providers must exercise their own independent medical judgment regarding the treatment of their patients who are Highmark members. Highmark encourages providers to communicate openly with patients about their treatment options, regardless of benefit coverage limitations. Responsibility for medical treatment and decisions remains with the member and his or her physician.

Medical record review

Highmark reserves the right to request and review medical records for visits whether or not authorization is required. If such review determines that any or all treatments were not medically necessary, were not billed appropriately, or were not performed, a refund will be requested. If a refund is requested, the provider may not bill the member for the services.

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5.2 AUTHORIZATION GUIDELINES, Continued

If the authorization is not in place at the time of service

Ordinarily, the member's attending physician should have requested a required authorization prior to the member receiving the services. However, if a Highmark member arrives for an appointment for non-emergency services and the required authorization does not appear to be in place, the provider should perform and authorization inquiry in NaviNet. If not NaviNet-enabled, call Clinical Services at the phone number for your service area.

Failure to obtain an authorization

Failure to preauthorize or precertify a service or admission may result in a retrospective review. Highmark has the right to review the service retrospectively for medical necessity and appropriateness, and to deny payment when necessary.

If a retrospective review is performed, and Highmark's Medical Management & Quality (MM&Q) department determines that the service was medically necessary and appropriate, the claim will be paid.

If MM&Q determines that the service was not medically necessary and appropriate, no payment will be made for the claim. In this situation, the network provider must write off the entire cost of the claim and may not bill the member (except for any non-covered services).

5.2 SERVICES REQUIRING AUTHORIZATION

Introduction

Highmark products, including Medicare Advantage, require authorization for all inpatient admissions and select outpatient services, drugs, and equipment. The following circumstances are representative of those that require an authorization. **This is not an all-inclusive list.** Benefits can vary; always confirm a member's coverage prior to providing services.

- Inpatient hospital admissions
- All other inpatient admissions (e.g., skilled nursing facility, rehabilitation, behavioral health, long-term acute care facility)
- Home health care
- Clinical trials
- Hospice
- Transplantation services
- Highmark's List of Procedures/DME Requiring Authorization

IMPORTANT! Delaware mandate

Delaware legislation, effective January 1, 2018, puts restrictions on imposing authorization and review requirements on drug and alcohol dependency treatment. Please see **Chapter 5.4: Behavioral Health** for information.

For complete details of the Delaware mandate, please see **Chapter 4.2: Behavioral Health Providers**.

What Is My Service Area?

Inpatient admissions

Authorization is required for all in-network inpatient medical services and inpatient levels of behavioral health care.

Authorization is required under all Highmark products whenever a member is admitted as an inpatient to any of the following facilities:

- Acute care hospital
- Long-term acute care hospital (LTAC)
- Rehabilitation hospital
- Skilled nursing facility (SNF)
- Mental health or substance abuse treatment facility

EXCEPTION: Maternity care

An authorization is not required for a normal inpatient delivery for maternity care unless clearly designated in a member's benefit. Normal inpatient delivery in forty-eight (48) hours for vaginal delivery and ninety-six (96) hours for caesarean section.

If the mother and/or baby require an inpatient stay that exceeds these time frames, authorization would be required. In addition, the Clinical Services department should be contacted for any nonroutine or emergency admissions for maternity care, such as admissions for hyperemesis, preterm labor, placenta previa, and preeclampsia.

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5.2 SERVICES REQUIRING AUTHORIZATION, Continued

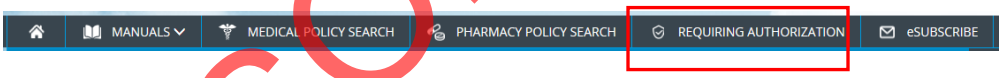
List of Procedures/ DME Requiring Authorization

Highmark maintains a list of outpatient procedures/services that require authorization. Throughout the year, procedures are added and/or deleted and these changes are communicated to the provider community through **Special Bulletins**. The list includes services such as:

- Behavioral health intensive outpatient and partial hospitalization
- Potentially experimental, experimental, and cosmetic procedures
- Select durable medical equipment (DME)
- Select injectable drugs covered under the member's medical plan
- Some oxygen services
- Select Not Otherwise Classified (NOC) procedure codes, i.e., unlisted, miscellaneous, Not Otherwise Specified (NOS)
- Certain outpatient procedures, services, and supplies

To obtain additional information about authorization requirements and to view the all-inclusive and most up-to-date list, please visit the Provider Resource Center. Select **CLAIMS, PAYMENT & REIMBURSEMENT** from the main menu, and then **Procedure/Service Requiring Prior Authorization**.

For quick access to The List of Procedures/DME Requiring Authorization, click on the **REQUIRING AUTHORIZATION** tab on the Quicklinks Bar at the top on the Provider Resource Center:



Note: Certain employer groups may choose to opt out of this requirement. In addition, self-funded accounts, government programs, and other groups with non-standard benefits may have their own lists of services requiring authorization. You must confirm if the requirement is applicable to the member. You can use the NaviNet® **Eligibility and Benefits Inquiry** or the applicable HIPAA electronic transaction for benefit verification.

What Is My Service Area?

Speech therapy

Speech therapy services, including those for Medicare Advantage, require prior authorization. For additional information for Medicare Advantage members, please see **Chapter 5.3: Medicare Advantage Procedures**.

Physical Medicine Management Program

Information about physical medicine services that require prior authorization can be found on the Provider Resource Center. Select **CARE MANAGEMENT PROGRAMS**, and then click on the **Physical Medicine Management Program** link for details on this program. The program applies to physical and occupational therapy and manipulation services in Pennsylvania and West Virginia. In Delaware, the program is for physical and occupational therapy services.

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5.2 SERVICES REQUIRING AUTHORIZATION, Continued

Advanced Imaging and Cardiology Services

*Highmark has required authorization for select advanced outpatient diagnostic imagining procedures under the longstanding Radiology Management Program administered by National Imaging Associates Inc. (NIA). However, the NIA program will end December 31, 2018, and will be replaced by the new **Advanced Imaging and Cardiology Services Program** managed by eviCore healthcare (eviCore) that is effective January, 1, 2019.*

*Information on the transition from the program under NIA to the eviCore program is available in the Highmark Provider Manual's **Chapter 4.5: Outpatient Radiology and Laboratory**. In addition, you can find details of the new program on the Provider Resource Center under **CARE MANAGEMENT PROGRAMS**. The information on the NIA Radiology Management Program will also remain available under **CARE MANAGEMENT PROGRAMS** through the transition.*

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Radiation Therapy Authorization Program

Additional information on radiation therapy services that require prior authorization can be found on the Provider Resource Center. Select **CARE MANAGEMENT PROGRAMS**, and then **Radiation Therapy Authorization Program**.

What Is My Service Area?

Post-acute care management for Medicare Advantage members

Highmark has a partnership with naviHealth, a national post-acute care management company, to bring a personalized approach to support its Medicare Advantage members. According to patient needs, naviHealth will utilize decision-support technology and its post-acute analytics capabilities to coordinate long-term acute care, inpatient rehabilitation, and skilled nursing facility utilization and will oversee proper care transitions to and from these facilities.

For more information, please see the program page on the Provder Resource Center – select **CARE MANAGEMENT PROGRAMS**, and then **Post-Acute Care Management For Medicare Advantage Members**.

Laboratory Management Program for molecular and genomic testing

Highmark contracts with eviCore to manage molecular and genomic testing to ensure that the genetic lab services provided to Highmark's members support clinically appropriate care and are medically necessary, in accordance with their benefit policy.

Additional information on authorization requirements is available on the Provider Resource Center – select **CARE MANAGEMENT PROGRAMS**, and then **Laboratory Management Program**.

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5.2 SERVICES REQUIRING AUTHORIZATION, Continued

MSK and IPM services

*Effective October 1, 2018, musculoskeletal surgical (MSK) procedures and interventional pain management (IPM) services require prior authorization under the **Musculoskeletal Surgery and Interventional Pain Management Services Prior Authorization Program** managed by eviCore. Additional information is available on the Provider Resource Center under **CARE MANAGEMENT PROGRAMS.***

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5.2 FEDERAL EMPLOYEE PROGRAM (FEP) PRIOR AUTHORIZATION REQUIREMENTS

Introduction

The Federal Employee Program (FEP) has precertification and prior authorization requirements for the longstanding Standard and Basic options and also for the new FEP Blue Focus product, which is effective January 1, 2019.

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Inpatient admissions

Precertification is required for inpatient hospital, *residential treatment center (RTC), and skilled nursing facility admissions.* FEP applies a $500 penalty if an authorization is not obtained for inpatient hospital admissions. However, the penalty is imposed on the provider – in the form of reduced payment. The provider may not bill this amount to the member.

Note: *Precertification requirements are not applicable to skilled nursing facility admissions for the Basic Option and for FEP Blue Focus since the plans do not have a benefit for skilled nursing facility.*

TIP SHEET

Other services requiring prior authorization

Prior authorization or notification is also required for certain services for FEP members as indicated in the table below. For a one-page printable version, click on the link in the Tip Sheet icon. This tip sheet can also be quickly accessed from our ***Tip Sheet Index*** *found in* ***ADDITIONAL RESOURCES*** *at the bottom of the manual homepage.*

For the FEP Blue Focus product, FEP applies a $100 penalty if an authorization is not obtained for any of the services listed below. The penalty is imposed on the provider in the form of reduced payment if a claim is received and the service is determined to be covered and medically necessary based on Medical Review. The provider may not bill this amount to the member.

SERVICES REQUIRING PRIOR AUTHORIZATION	Standard & Basic	FEP Blue Focus
GENETIC TESTING		
BRCA screening or diagnostic testing	X	X
Large genomic rearrangements of the BRCA1 and BRCA2 genes screening or diagnostic testing	X	X
Genetic testing for the diagnosis and/or management of an existing medical condition		X
SURGICAL SERVICES		
Outpatient surgery for morbid obesity	X	X
Outpatient surgical correction of congenital anomalies	X	X
Outpatient surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth	X	X
Gender reassignment surgery	X	X
Breast reduction or augmentation not related to treatment of cancer		X
Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint (TMJ)		X

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5.2 FEDERAL EMPLOYEE PROGRAM (FEP) PRIOR AUTHORIZATION REQUIREMENTS, *Continued*

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SERVICES REQUIRING PRIOR AUTHORIZATION, continued	Standard & Basic	FEP Blue Focus
Orthopedic procedures: hip, knee, ankle, spine, shoulder and all orthopedic procedures using computer-assisted musculoskeletal surgical navigation		X
Reconstructive surgery for conditions other than breast cancer		X
Rhinoplasty		X
Septoplasty		X
Varicose vein treatment		X
OTHER SERVICES		
Outpatient intensity-modulated radiation therapy (IMRT)	X	X
Cardiac rehabilitation		X
Cochlear implants		X
Prosthetic devices (external), including: microprocessor controlled limb prosthesis; electronic and externally powered prosthesis		X
Pulmonary rehabilitation		X
Radiology, high technology including: - Magnetic resonance imaging (MRI) - Computed tomography (CT) scan - Positron emission tomography (PET) scan **Note:** High technology radiology related to immediate care of a medical emergency or accidental injury does not require prior approval.		X
Specialty durable medical equipment (DME), rental or purchase, to include: - Specialty hospital beds - Deluxe wheelchairs, power wheelchairs and mobility devices and related supplies		X
Gene therapy and cellular immunotherapy, for example CAR-T and T-Cell receptor therapy	X	X
Air Ambulance Transport (non-emergent)	X	X
Outpatient sleep studies performed outside the home	X	
Applied behavior analysis (ABA)	X	X
All covered organ/tissue transplants, except kidney and cornea transplants	X	X
Blood or marrow stem cell transplants	X	X
Clinical trials for certain blood or marrow stem cell transplants	X	X
Transplant travel	X	X
SERVICES REQUIRING PRIOR NOTIFICATION	**Standard & Basic**	**FEP Blue Focus**
Maternity Care		X

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5.2 FEDERAL EMPLOYEE PROGRAM (FEP) PRIOR AUTHORIZATION REQUIREMENTS, Continued

Confirming member benefits

*For FEP members located in Pennsylvania, Delaware, and West Virginia, you can confirm their eligibility and benefits, including prior authorization requirements, via NaviNet®. You can also call the **FEP Provider Service Department** for your service area as follows:*

- *Pennsylvania: **1-866-763-3608***
- *Delaware: **1-800-721-8005***
- *West Virginia: **1-800-535-5266***

Why blue italics?

Requesting authorization

Authorization requests for Federal Employee Program (FEP) members cannot be submitted via NaviNet. Please follow the guidance below for calling the FEP Provider Service department for authorizations for FEP members.

- For **outpatient/professional services** that require authorization, please contact your local Highmark plan.
- For **inpatient admissions**, medical and behavioral health, the services should be authorized by the Blue Cross plan where the services are being received as follows:
  - **Pennsylvania's Western & Northeastern Regions, Delaware, and West Virginia** – Highmark participating providers should contact their local Highmark plan for authorization for inpatient admissions.
  - **Pennsylvania's 21-county Central Region** – providers participating with Capitol Blue Cross would request authorization for inpatient admissions from Capitol Blue Cross.

FOR MORE INFORMATION

*You can find a wealth of information to assist you in servicing FEP members at **fepblue.org**.*

Additional information related to the Federal Employee Program is also available in the following units of the Highmark Provider Manual:

- ***Chapter 2.3: Other Government Programs** for background information, FEP products, and membership*
- ***Chapter 5.1: Care Management Overview** for information on accessing FEP Medical Policy(under section titled "Criteria for Medical Management Decisions")*
- ***Chapter 6.4: Professional (1500/837P) Reporting Tips** for special tips on claim submission for FEP members*

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5.2 AUTHORIZATION REQUEST PROCESS

Introduction

Authorization requests should be submitted at least fourteen (14) days in advance prior to a planned admission or service, when possible, or as soon as the intended admission or service is known.

For emergency (urgent, unplanned) admissions and admissions related to childbirth, the provider or member must contact Highmark within forty-eight (48) hours after the emergency admission or for lengths of stay longer than forty-eight (48) hours after a vaginal delivery or ninety-six (96) hours after a cesarean section (C-section) delivery.

REMINDER: Verify eligibility & benefits

Providers are reminded to always verify a member's eligibility and benefits, including the authorization requirements, prior to rendering services. It is the provider's responsibility to confirm that the member's benefit plan provides the appropriate benefits for the anticipated date of service.

You can verify benefits electronically quickly and easily via NaviNet's Eligibility and Benefits Inquiry or by submitting a HIPAA 270 transaction.

Before you begin...

Prior to submitting an authorization request, whether electronically or by telephone, please have the following information available:

- Patient's general information (name, age, gender, etc.)
- Member ID number
- Medical history
- Any comorbidity
- All pertinent medical information (test results, prior treatment, etc.)
- Presenting symptoms
- Acuity
- Diagnosis
- Service to be performed, including admission or procedure dates and location
- Name of any other health care providers involved in the care
- Proposed length of stay and frequency or duration of services
- Treatment plan and goals
- Psycho-social issues impacting care
- Discharge plan

Note: The Highmark reviewer may request additional information. Requests may be denied for lack of information.

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5.2 AUTHORIZATION REQUEST PROCESS, Continued

Electronic submission preferred

Electronic submission is the preferred method for requesting authorization. If NaviNet®-enabled, the request must be submitted via NaviNet.

What Is My Service Area?

Process

The authorization request process is as follows:

STEP	ACTION
1 Submission	Submit the required information via NaviNet or HIPAA 278. • **NaviNet:** The user is guided through the steps. • **HIPAA 278 transaction:** For information about using the transaction, refer to the **Provider EDI Reference Guide**.*
2 Review	The request is reviewed by Highmark's Clinical Services department. The decision-making period begins once Clinical Services has received the request. All decisions are made in accordance with DOL and NCQA requirements.
3 Decision	Following review, Clinical Services either authorizes or denies coverage for the request. • If the request is approved, you will be notified through the **Referral/Authorization Inquiry** in NaviNet or through your practice's software. If you do not have access to NaviNet, you will receive a paper report through the mail. • If the request is denied, you will be advised of your appeal rights and, for Commercial members, the option of requesting a peer-to-peer conversation with the physician advisor who made the decision.

** The EDI Reference Guide is accessible from the Provider Resource Center. Select **CLAIMS, PAYMENT & REIMBURSEMENT**, and then **Electronic Data Interchange (EDI) Services**. Select **Resources** from the EDI Training Partner Business Center home page.*

Home health authorization requests

In Pennsylvania, home health care providers must use NaviNet to submit authorization requests. Please see the next section of this unit -- **NaviNet Home Health Authorization Submission (PA Only)**.

In Delaware and West Virginia, home health care providers can fax requests using the **Home Health Precertification Worksheet** or make their requests by calling Clinical Services.

The worksheet is also accessible from the **Faxable Authorization Request Forms** section of this unit. And it is also available on the Provider Resource Center – select **FORMS** from the main menu, and then **Miscellaneous Forms**.

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5.2 AUTHORIZATION REQUEST PROCESS, Continued

What Is My Service Area?

Telephone requests

If you are not electronically-enabled, you may contact Clinical Services by calling the applicable phone number for your service area.

PENNSYLVANIA:

- Western Region:
  - Facilities: **1-800-242-0514**
  - Professional Providers: **1-800-547-3627**
- PA Central & Northeastern Regions:
  - Facilities: **1-866-803-3708**
  - Professional Providers: **1-866-731-8080**
- Medicare Advantage:
  - PA Medicare Advantage Freedom Blue PPO: **1-866-588-6967**
  - Community Blue Medicare HMO: **1-888-234-5374**
  - Community Blue Medicare PPO and Plus PPO: **1-866-588-6967**
  - Security Blue HMO (Western Region only): **1-866-517-8585**

DELAWARE: 1-800-572-2872

WEST VIRGINIA: 1-800-344-5245; Freedom Blue PPO: **1-800-269-6389**

BEHAVIORAL HEALTH SERVICES:

- PA Western Region: **1-800-258-9808**
- PA Central, Eastern, & Northeastern Region**: 1-800-628-0816**
- Delaware: **1-800-421-4577**
- West Virginia: **1-800-344-5245**; Freedom Blue PPO: **1-800-269-6389**

IMPORTANT! Federal Employee Program (FEP)

Authorization requests for Federal Employee Program (FEP) members cannot be submitted via NaviNet. *Please see the Federal Employee Program (FEP) Prior Authorization Requirements section of this unit for guidance for calling for authorizations for FEP members.*

Why blue italics?

5.2 HOME HEALTH NAVINET AUTHORIZATION SUBMISSIONS (PA ONLY)

What Is My Service Area?

Overview

Effective August 1, 2016, participating home health care providers in Pennsylvania must use the home health care authorization request submission process through Highmark's NaviNet® provider portal. This process is applicable **for all Pennsylvania commercial and Medicare Advantage products**.

Provider advantages

The advantages of the home health care authorization process in NaviNet include:

- **Automation:** The interactive application allows for more "automation" as compared to the previous home health authorization process.
- **Consistency:** The use of clinical quality outcomes data provides consistency in how criteria are applied across all network home health agencies.
- **Reduced Response Time:** The approval response occurs within minutes rather than days.
- **Efficiencies:** The average submission time has been reduced from a thirty (30) minute average to a five (5) minute average submission time.

Requirements

Using NaviNet, the following is required to be submitted:

- An Outcome and Assessment Information Set (OASIS) File upload
- The CMS-485 form

Note: Highmark no longer requires providers to complete the Home Health Survey.

Helpful resources available

Please review the following webinar and helpful documents for additional information:

- **Home Health Prior Authorization Process Change** - Providers are highly encouraged to view this online webinar.
- **Home Health Process Change Guide**
- **Home Health Authorization FAQs**
- **Home Health Authorization Tips: OASIS File Overview**

These resources are also available on the Provider Resource Center. Select **Provider Training** from the main menu, and then **Provider Training** again. Scroll to the **Informational Training and Documentation** section -- **Home Health Authorizations** is the third bullet in this category.

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5.2 HOME HEALTH NAVINET AUTHORIZATION SUBMISSIONS (PA ONLY), Continued

IMPORTANT! Always verify eligibility and benefits

When an authorization is obtained, it is not a guarantee of payment. The member must have active coverage at the time of service and must also have the benefit for the service to be provided. Therefore, it is important to verify the member's eligibility and benefits through the NaviNet **Eligibility and Benefits Inquiry** or through the applicable HIPAA electronic transactions.

NaviNet Customer Care

For technical process issues pertaining to home health care authorization submissions, please telephone a NaviNet Customer Care Representative at **1-888-482-8057.**

What Is My Service Area?

Provider Service Center

For general questions and inquiries about the new home health care authorization process, please contact the facility Provider Service Center:

- Pennsylvania Western Region: **1-800-242-0514**
- Pennsylvania Central & Northeastern Regions: **1-866-803-3708**

5.2 INPATIENT ADMISSIONS

Introduction

The purpose of the authorization review is to determine whether the services being requested are medically necessary and appropriate and are being delivered in the most appropriate setting. Authorization review assists Care and Case Managers in identifying potential candidates for post-discharge case management or the Blues On Call condition management programs.

Authorization request time frames

Authorization is required for all in-network inpatient medical services and inpatient levels of behavioral health care. Authorization requests should be submitted at least fourteen (14) days in advance prior to a planned admission, when possible, or as soon as the intended admission is known. Authorization for planned admissions must occur no later than the date of admission.

For emergency (urgent, unplanned) admissions, the provider or member must contact Highmark no later than forty-eight (48) hours after admission to be considered timely notification.

Submitting a request for authorization

Facilities should submit authorization requests for medical and behavioral health inpatient admissions via the Automated Care Management (ACM) application in NaviNet®. **Please see the next section of this unit for information on the ACM application in NaviNet.**

If either NaviNet or the authorization request application is unavailable, facilities may make their requests by contacting Clinical Services via telephone at the applicable phone number.

Out-of-network services

Some members have coverage under a benefit plan (e.g., PPO) that provides benefits for services received from a provider outside of the network associated with their Highmark product.

The authorization requirement **does not apply** to such services, except for inpatient admissions to a hospital, skilled nursing facility, rehabilitation hospital, and long-term acute care. These services are reimbursed according to the terms of the member's benefit plan, including any applicable member liability.

REMINDER: Benefit verification required

While not all services require authorization, availability of benefits under the member's benefit plan is required in order for a service to be reimbursed by Highmark. Availability of benefits can be verified through the **Eligibility and Benefits** transaction via NaviNet.

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5.2 INPATIENT ADMISSIONS, Continued

Transfers between hospitals

Transfer of a member from one facility to another requires authorization from Clinical Services. The table below identifies which facility has responsibility for obtaining authorization for transfers between hospitals:

If...	Then...
A member is an inpatient in one hospital and is being transferred to another hospital where he or she will be admitted as an inpatient,	the hospital initiating the transfer would contact Clinical Services for authorization.
A member who has been evaluated in the emergency department of one hospital must be transferred to another hospital for the necessary inpatient services,	the hospital receiving the patient for inpatient services would contact Clinical Services for authorization.

Behavioral health

Some processes vary slightly for behavioral health services. For additional information specific to behavioral health services, please see **Chapter 5.4: Behavioral Health**.

In addition, step-by-step instructions for submitting behavioral health authorization requests via NaviNet are available in the **Behavioral Health ACM Authorization Submission Manual**. This manual is also available on the Provider Resource Center under **EDUCATION/MANUALS**.

What Is My Service Area?

Special process for Medicare Advantage members

The Centers for Medicare & Medicaid Services (CMS) requires that members with coverage under original Medicare or a Medicare Advantage plan are fully aware of their right to appeal a discharge decision. Therefore, a special process will apply to these members. These processes begin when **a Medicare Advantage member is admitted** to an inpatient level of care in an acute care hospital, long-term acute care hospital, skilled nursing facility, inpatient psychiatric hospital/unit, or acute rehabilitation hospital/unit.

For more information on these special processes for Medicare Advantage members, please refer to **Chapter 5.3: Medicare Advantage Procedures**.

5.2 AUTOMATED CARE MANAGEMENT (ACM)

What is Automated Care Management (ACM)?

Automated Care Management (ACM) is an automated process which allows facilities to submit authorization requests for medical and behavioral health inpatient care and inpatient/post-acute transfers via NaviNet® using interactive InterQual® Criteria. NaviNet can also be used for submitting behavioral health intensive outpatient and partial hospitalization authorization requests.

Certain authorization requests for acute inpatient care meeting InterQual criteria may be authorized immediately, via the system. Other inpatient requests will pend for additional review by Clinical Services.

Important: Observation services

ACM is not to be used for observation services. Do not submit admission requests until it is clear that the patient requires inpatient admission.

ACM exclusions

ACM cannot be used to submit authorization requests for members with coverage under the Federal Employee Program (FEP), or members from another Blue Plan (BlueCard).

Highmark's expectation of facilities

Highmark expects that NaviNet-enabled facilities will submit all medical and behavioral health inpatient authorization requests, inpatient/post-acute transfer requests, and behavioral health intensive outpatient and partial hospitalization authorization requests for Highmark members via ACM.

Facilities are also expected to provide consistent and timely completion of the admission and discharge surveys, including entry of the discharge date.

Monitoring the process

Based on monitoring patterns of the facility's use and submissions, Highmark has the right to perform on-site educational audits and discuss findings with the appropriate hospital staff.

Interventions triggered by the ACM surveys

ACM is designed to simplify the administrative process while continuing to collect relevant clinical data for post-discharge and case management activities. Some of the interventions triggered by the survey information include referrals to Health Coaches.

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5.2 AUTOMATED CARE MANAGEMENT (ACM), Continued

Admission Survey

The Admission Survey is presented immediately following the InterQual section of the ACM application on NaviNet during the initial request for authorization of an acute inpatient admission. At that time, the facility should be prepared to provide the following information:

- Patient history and any co-morbid conditions
- Re-admissions within thirty (30) days
- Social situation
- Any special needs
- Any assistance needed from Clinical Services in discharge planning

Accessing the Admission Survey

After submission, the Admission Survey can be viewed through the NaviNet **Referral/Authorization Inquiry** application. Identify the admission in question, and then click on the **Survey** button.

Important benefit reminder

An authorization means that the requested service has been determined to be medically necessary and/or appropriate.

It does **not** mean that the requested service is covered under the member's benefit plan. Payment is contingent on the availability of benefit coverage for the services rendered and the eligibility of the patient.

Discharge Planning Information Survey

Hospitals are also responsible for completing the Discharge Planning Information Survey during an inpatient admission of five (5) or more days, and also at or immediately following discharge.

For more information, please see the "Discharge Planning" section of this unit.

Post-acute transfers

Acute care facilities also submit authorization requests through ACM via NaviNet for **post-acute transfers** to long-term acute care hospitals, acute rehabilitation hospitals, and skilled nursing facilities.

Submitting authorization requests through NaviNet for these transfers follows a similar process to the steps which are used for acute inpatient hospital admissions. There are two main differences:

1. The Clinical Comments section on the NaviNet screen **must** be completed for post-acute transfers.
2. All authorization requests for post-acute transfers will pend for review by a Highmark Care Manager, regardless of whether or not post-acute InterQual criteria have been met.

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5.2 AUTOMATED CARE MANAGEMENT (ACM), Continued

Discharge survey

The Discharge Planning Information survey for the acute care stay **must** be completed at discharge.

Time frames for post-acute transfer requests

Post-acute transfer requests may be entered according to the following schedule:

If transferring to…	Then the time frame will be…
Skilled Nursing Facilities	From the current date through 2 days in the future
Acute Rehabilitation Hospitals	From the current date through 2 days in the future
Long-Term Acute Care Hospitals	From the current date through 2 days in the future

Continuity of care

To ensure continuity of care, facilities are asked to notify the member's primary care or preferred physician about any services that he or she receives during the inpatient stay.

This step taken by the facility enables the primary care or preferred physician to make any subsequent treatment decisions on a more fully informed basis.

What Is My Service Area?

Special procedures for Medicare Advantage members

The Centers for Medicare & Medicaid Services (CMS) has established procedures to ensure any member with coverage under original Medicare or Medicare Advantage plans has the opportunity to appeal a discharge decision with which he or she disagrees. This process begins when a Medicare Advantage member is admitted to an inpatient level of care and requires additional action prior to discharge.

Note: For more information on these special processes for Medicare Advantage members, please see **Chapter 5.3: Medicare Advantage Procedures**.

Additional resource for Behavioral Health

The **Behavioral Health ACM Authorization Submission Manual** provides instruction for submitting authorization requests through NaviNet for behavioral health inpatient, intensive outpatient, and partial hospitalization services. This manual is available under **EDUCATION/MANUALS** on the Provider Resource Center in all service areas.

5.2 DISCHARGE PLANNING

Definition: Discharge planning

Highmark initiates discharge planning at the beginning of an admission in order to facilitate a coordinated transition to the next level of care. Discharge planning involves coordination and collaboration among providers, the health plan, the member, and/or the member's family.

When discharge planning begins

The discharge planning process ideally begins prior to a scheduled admission or at the time of an emergency admission. The initial discharge plan is reassessed throughout the member's stay.

Objectives of discharge planning

The objectives of discharge planning are to:

- Promote a safe and effective transition of care, especially when the transition is to home
- Promote, when appropriate, the use of alternative levels of care
- Direct members within the participating provider network
- Arrange for the provision of care in an appropriate alternative cost-effective setting (e.g., skilled nursing or inpatient rehabilitation facility, home care, outpatient services) with an ongoing assessment of continued need
- Provide early identification of members who may be candidates for case management or condition management programs
- Collaboratively develop and implement appropriate discharge plans with the treating provider

Discharge planning tool

The Discharge Planning Information survey is available through the Automated Care Management (ACM) function via NaviNet®. Acute care facilities are required to complete the tool for members at the time of the initial inpatient authorization request and with subsequent continued stay reviews.

The purpose of the Discharge Planning Information survey is to assess the need for assistance in discharge planning. It also provides feedback which can help to identify members who may benefit from referrals to Case Management or Condition Management programs.

Completing the Discharge Survey

The ACM Discharge Survey is to be completed at or immediately following discharge. The facility should be prepared to provide the following information:

- Discharge date
- Discharge Disposition

Continued on next page

5.2 DISCHARGE PLANNING, Continued

Coordinating the discharge plan

The hospital is normally responsible for coordinating the discharge plan for the member. Facilities are encouraged to contact Clinical Services for assistance whenever complex cases are identified.

Clinical Services can assist in: coordinating services, including transfers to other facilities; referrals to Case Management and Condition Management programs; and evaluation of available community resources, as appropriate.

When Clinical Services assists

When Clinical Services is asked to assist in the discharge planning process, the facility should be able to provide and discuss the following information as it pertains to the member:

- Level of function, pre- and post-service
- Ability to perform self-care activities
- Primary caregiver and support system
- Living arrangements, pre- and post-service
- Psychosocial needs of the member and the member's caregiver
- Special equipment, medication, dietary needs, safety needs, and/or obstacles to care
- Needs requiring referral to Case Management or Condition Management

Behavioral health

For additional information on discharge planning for behavioral health, please see **Chapter 5.4: Behavioral Health**.

What Is My Service Area?

Additional requirements for Medicare Advantage members

The Centers for Medicare & Medicaid Services (CMS) requires that members with coverage under original Medicare or a Medicare Advantage plan are fully aware of their right to appeal a discharge decision. Therefore, a special process will apply to these members. These processes **begin when a Medicare Advantage member is admitted** to an inpatient level of care in an acute care hospital, long-term acute care hospital, skilled nursing facility, inpatient psychiatric hospital/unit, or acute rehabilitation hospital/unit.

Note: For more information on these special processes for Medicare Advantage members, please refer to **Chapter 5.3: Medicare Advantage Procedures**.

5.2 CONCURRENT REVIEW

When is concurrent (continued stay) review conducted?

Highmark may conduct **concurrent review**, also known as **continued stay review**, for any services as determined by Highmark, including, without limitation, all behavioral health services and medical care at hospitals, skilled nursing facilities, long-term acute care facilities, rehabilitation facilities, and any other facilities as noted by Highmark regardless of whether a per diem or DRG facility.

Components of concurrent review

The concurrent review process for medical services can be initiated by either the facility or by the Clinical Services department. The process for medical services involves three components:

1. Contact between Clinical Services and the facility
2. Sharing of relevant clinical information
3. Application of the appropriate clinical standards to determine whether the member's inpatient services should be extended

During the concurrent review conversation, the facility should be prepared to provide relevant information about the member's clinical signs and symptoms, continuing treatment, and discharge plans.

The decision process

Based on the information provided by the facility, the Clinical Services nurse reviewer applies the relevant criteria and determines whether to extend the member's care or to offer an alternative level of care. Concurrent review cases that meet criteria will be approved.

If the clinical staff cannot approve the case, it is referred to a physician reviewer to determine the need for the continuation of services.

Approval notification

The requesting entity is notified verbally of the approval decision by the care manager or physician reviewer within designated regulatory time frames.

In addition, approval notifications are provided electronically to all NaviNet®-enabled providers. Approval letters are sent to commercial and indemnity members as well as providers without electronic connectivity.

Denial notification

If the member does not meet the criteria for continued stay, the Clinical Services staff will contact the entity requesting the review to explore and facilitate alternative care as appropriate. The member's needs, as well as the local delivery system, will be considered in making a determination.

In accordance with legal and regulatory requirements, the member and/or facility will be notified of a denial both verbally and in writing. The verbal notification will include information about the right to appeal the decision. The written notification will also include the member's appeal rights.

Continued on next page

5.2 CONCURRENT REVIEW, Continued

Medicare Advantage: When continued stay is not approved

When a concurrent review results in a denial and a Medicare Advantage member **disagrees with the decision to be discharged** from inpatient care, the member may request a review. Highmark delegates responsibility to the facility to issue the ***Detailed Notice of Discharge*** (or "*Detailed Notice*") form to the member. This form gives a detailed explanation of the discharge decision as well as a description of any applicable Medicare and/or Medicare Advantage coverage rules, policies, or rationales which support the decision.

Note: For more information, please refer to **Chapter 5.3: Medicare Advantage Procedures**.

What Is My Service Area?

Time frame

Decisions regarding inpatient concurrent review are made **within twenty-four (24) hours** of receipt of the request in order to comply with strict decision-making time frames imposed by regulatory/accreditation standards.

All relevant information **must** be provided by the facility at the time of the request. Timely submission of the relevant clinical information will avoid any unnecessary denials due to lack of information.

Additional components of concurrent review

Medical necessity, quality, utilization review, and utilization management requirements, as well as all other applicable administrative requirements as determined by Highmark, as applicable to all payment methodologies including, without limitation, DRG-based payments, are also applicable to all outlier determinations and outlier payments.

If the member does not meet the applicable criteria as determined by Highmark for a continued stay based on such aforementioned criteria, then those days not meeting the concurrent review requirements for a continued stay will not be included:

- in the count for day outlier status.
- in the calculation for cost outlier status for charges related to tests, procedures, room and board, etc.

Also, is the admission is determined by Highmark to not be medically necessary and appropriate for acute care, the admission will be downgraded and paid at the observation rate or the outpatient methodology , as applicable.

Note: Highmark will apply the applicable criteria as determined by Highmark for a continued stay against review of the entire length of stay to ensure outlier payments are not made for care that is not medically necessary and appropriate, and/or at the appropriate level of care.

Continued on next page

5.2 CONCURRENT REVIEW, Continued

Retrospective review	Facilities are reminded that Medical Management & Quality (MM&Q) may conduct a retrospective review whenever authorization or continued stay certification was required but not obtained. A retrospective review may also be conducted when Highmark receives a claim that includes outlier days.
Behavioral health	For more information on concurrent review for behavioral health, please see **Chapter 5.4: Behavioral Health**.

5.2 RETROSPECTIVE REVIEW

Introduction

Retrospective review is the assessment of the appropriateness of health care services after the services have been rendered to a member and completed without prior authorization from Medical Management & Quality (MM&Q). Retrospective review is also known as "post-service review."

How to request

To request a retrospective review of an inpatient admission or an outpatient medical service provided without the appropriate authorization, a facility should follow these steps:

What Is My Service Area?

STEP	ACTION
1	Submit a claim for the service, according to normal procedures. Because no authorization is on file for the service, Highmark's claims processing system **will reject** this claim.
2	When the claim denial notification is received (via the remittance advice), submit pertinent clinical information with a cover letter explaining the circumstances to the following address: **PENNSYLVANIA:** Highmark Medical Review P.O. Box 890392 Camp Hill, PA 17089-0392 PA Central Region outpatient claims only: Medical Review P.O. Box 890035 Camp Hill, PA 17089-0035 **DELAWARE:** Highmark BCBSDE, Inc. Medical Management Retrospective Reviews P.O. Box 1991 Del Code 1-8-40 Wilmington, DE 19899-1991 **WEST VIRGINIA:** Highmark West Virginia Attn.: Medical Review P.O. Box 1948 Parkersburg, WV 26102 **Behavioral Health** (all service areas): Highmark Clinical Services Attn.: Behavioral Health 120 Fifth Ave., Suite P4205 Pittsburgh, PA 15222

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5.2 RETROSPECTIVE REVIEW, Continued

Time frame	Retrospective reviews are completed **within thirty (30) calendar days** of receipt of the facility's request. If MM&Q requires additional information, the request will be made within forty-eight (48) hours after receiving the request for retrospective review.
Behavioral health	For more information on retrospective review specific to behavioral health services, please refer to **Chapter 5.4: Behavioral Health**.

5.2 TIME FRAMES FOR AUTHORIZATIONS

Preservice determinations

For preservice authorization requests, Highmark will provide notification of our determination as soon as possible, taking into account the member's health condition, but no later than:

- Seventy-two (72) hours after receipt of the request in cases involving urgent care; or
- Fourteen (14) calendar days after receipt of the request in non-urgent cases.

A case involving urgent care is one in which making a determination under standard time frames could seriously jeopardize the member's life, health, or ability to regain maximum function; or, in the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that could not be adequately managed without the care or treatment that is the subject of the request. If a physician indicates a case is one involving urgent care, it would be handled as such.

For non-urgent cases, Highmark may extend the time frame one time by up to fourteen (14) days. For products other than Medicare Advantage, if the extension is necessary because the member failed to submit information needed to make the determination, we will afford the member at least forty-five (45) days to provide the specified information.

Concurrent review determinations

For requests to extend a current course of treatment previously authorized, Highmark will provide notification of our determination as soon as possible, taking into account the member's health condition, but no later than:

- Twenty-four (24) hours after receipt of the request in cases involving urgent care, provided that the request was received at least 24 hours before the expiration of the currently authorized period or treatments; or
- Seventy-two (72) hours after receipt of the request if it is a case involving urgent care and the request was received fewer than 24 hours before the expiration of the currently authorized period or treatments; or
- Within the time frames for preservice determinations in non-urgent cases.

If Highmark reduces or terminates authorization for a previously authorized course of treatment before the end of the period or number of treatments originally authorized, we will issue the determination early enough to allow the member to appeal and receive a decision before the reduction or termination occurs.

Continued on next page

5.2 TIME FRAMES FOR AUTHORIZATIONS, Continued

Retrospective review determinations

For retrospective reviews, Highmark will provide notification of our determination within thirty (30) calendar days of receipt of the request. If Medical Management & Quality (MM&Q) requires additional information, the request will be made within forty-eight (48) hours after receiving the request for retrospective review.

This 30-day time frame may be extended one time for up to fifteen (15) days. If this extension is necessary because the member failed to submit information needed to make the determination, we will afford the member at least forty-five (45) calendar days to provide the specified information.

Notification

If an authorization is granted, Highmark will notify the member and requesting provider within the required time frame for the type of review requested. The notification will include a reference number that the provider can use in referencing the authorization.

In concurrent review cases, notification of the authorization to extend services will include the number of extended days or units of service, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services.

If the authorization is denied, Highmark will issue written notification to the member and requesting provider. The notification will include:

- The principal reason(s) for the denial;
- Reference to the plan provision on which the determination is based;
- In the case of denials for lack of information, a description of any additional information necessary to make the determination and an explanation of why it is necessary;
- A description of procedures and time frames for appealing the denial;
- A statement that a copy of the clinical review criteria relied upon will be provided free of charge upon request; and
- A statement that an explanation of the scientific or clinical basis for the determination as it relates to the member's medical condition (clinical rationale) will be provided free of charge upon request.

5.2 FAXABLE AUTHORIZATION REQUEST FORMS

Overview

Highmark is continuously taking steps to improve our internal processes to provide quick and efficient service when processing authorization requests.

While the preferred method to submit authorization requests continues to be through NaviNet®, there are certain instances when Highmark allows requests to be made via fax.

Forms

The following faxable precertification/authorization forms are available:

- **Bariatric Surgery Precertification Worksheet**
- **Discharge Notification Form**
- **Discharge Summary Fax Template (Behavioral health)**
- **Home Health Precertification Worksheet**
- **Inpatient Authorization Request Form** (Hospital)
- **Long-Term Acute Care Facility Precertification Worksheet**
- **Outpatient Authorization Request Form**
- **Rehabilitation Precertification Worksheet** (Inpatient)
- **Skilled Nursing Facility Precertification Worksheet**

Completed authorization request forms should be **faxed** to the fax numbers designated on the forms. Please take note that some forms have designated fax numbers for specific service areas – be careful to fax to the correct number to avoid any delays.

These forms are also available on the Provider Resource Center – select **FORMS**, and then **Miscellaneous Forms**. For the Behavioral Health fax template, select **FORMS**, and then **Behavioral Health Forms**.

Fax forms <u>one</u> time

An authorization request form should be faxed to Highmark only once. Because of the high volume of requests being submitted into Highmark, the request form may not be immediately loaded and viewable in our system. Re-faxing an original authorization request form will only add to the overall volume of requests being received, which can result in longer overall response times.

Use the appropriate form

If you are faxing an authorization request to Highmark, please be sure to use the appropriate authorization request form. The forms vary based on the type of clinical services being requested.

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5.2 FAXABLE AUTHORIZATION REQUEST FORMS, Continued

Time frames: Urgent vs. non-urgent

Highmark remains committed to handling authorization requests within the required regulatory time frames. It is important for providers to submit timely requests well **in advance of the patient's anticipated date of service** to allow for adherence to the following regulatory time frames:

- **Urgent** requests are completed within seventy-two (72) hours of receipt.
- **Urgent concurrent** requests are completed within twenty-four (24) hours of receipt.
- **Non-urgent** requests are completed within fourteen (14) days of receipt.

Tips

Wait times for authorization requests can either be eliminated or reduced by adhering to the following guidelines:

- Always ensure that the authorization submission includes **all** required information, including applicable diagnoses and procedure codes.
- When calling Highmark, please have all necessary member and clinical information available to allow for the fastest completion of the call.
- Authorization requirements have been suspended for certain procedure codes. Before submitting an authorization request, check NaviNet first to see if an authorization is still required.
- Outpatient authorization requests have a sixty (60) day window. Service date changes do not need to be communicated to Highmark as long as they are within the original 60-day time frame.

Use NaviNet for status updates!

Please use NaviNet to check on the status of your authorization request, as the most up-to-date status will be viewable in NaviNet.

If you are not yet NaviNet-enabled, visit **https://nanthealth.com/navinet-contact-us/** to learn more about obtaining access to the system.

5.2 PRESERVICE DENIALS

Introduction

At times, providers may encounter situations in which a claim for services provided to a Highmark member is denied because medical necessity criteria were not met. Guidelines have been developed to identify when a Highmark commercial member can be billed for services rendered in such situations.

Guidelines

When services are denied in advance of being rendered, the member must be notified and given the option to cancel the services or proceed with the services as planned.

The Highmark member cannot be billed for the denied services unless the provider has given advance written notification informing the member that the specific service may be deemed not medically necessary or not covered by the member's benefit plan and providing an estimate of the cost. The member must agree in writing to assume financial responsibility before receiving the service.

Note: Medical policy allows a provider to bill the member for services that are deemed to be experimental or investigational. In these cases, providers need to ensure that the member understands that he or she is personally liable for the cost of services that are considered to be experimental or investigational.

Preservice denial defined

A **preservice denial** occurs when a provider informs a member that a specific requested service cannot be provided or continued due to lack of medical necessity or because the service is a non-covered benefit.

If the member accepts the provider's decision, a preservice denial is not necessary. If the member continues to request the service after being informed that is it non-covered, a preservice denial notification is needed.

This conversation must occur before the service is provided and the claim is submitted. A preservice denial notification cannot be issued for services already received.

Specific to service to be provided

The preservice denial notification is **specific to the service** to be provided and may not be used to secure a routine or "blanket" acceptance of financial responsibility by the Highmark member.

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5.2 PRESERVICE DENIALS, Continued

Requirements

The member must agree in writing to assume financial responsibility in advance of receiving the service. Each of the following conditions must be met:

- Written notification was provided to the member **before the service was rendered**, indicating the specific service to be received may be denied
- The notification included an estimate of the cost
- The member agreed in writing, **before the service was rendered**, to assume financial liability for the services
- The signed agreement is maintained in the provider's records

No specific form required

No specific form is required or recommended for documenting such a conversation with a member. However, the form must do all of the following:

- Identify the proposed services **specifically**;
- Inform the member that the services are not deemed to be medically necessary or are experimental/investigational;
- Provide an estimate of the cost; and
- Require the member to agree in writing, in advance of receiving a service, to assume financial responsibility for the service.

Purpose of the preservice denial notification

The purpose of a signed agreement is to document that: (a) a provider has had a conversation with the member regarding lack of coverage and the estimated out-of-pocket expense the member will incur; and (2) the member agrees in writing to be financially responsible for the cost of the service.

Appealing preservice denials

If the Highmark member has questions about the preservice denial notification or questions about his or her appeal rights, please tell them to call Highmark Member Services at the telephone number listed on their Member ID card.

Member later reconsiders

If the member agrees with the provider's decision not to supply the service at the time of the visit **but later reconsiders** and decides that he or she wants to have the service, this is a preservice denial.

What Is My Service Area?

IMPORTANT! Medicare Advantage requirements

The preservice denial requirements for Highmark's Medicare Advantage members differ from the requirements for Highmark commercial members.

For information specific to Medicare Advantage members, please refer to the section on "Preservice Organization Determinations" in **Chapter 5.3: Medicare Advantage Procedures**.

5.2 EMERGENCY SERVICES

Emergency medical care defined

Emergency medical care is the treatment of bodily injuries resulting from an accident, following the sudden onset of a medical condition or following, in the case of a chronic condition, a sudden or unexpected medical event that manifests itself with acute symptoms of sufficient severity or severe pain such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention to result in one or more of the following:

a. placing the health of the member or, with respect to a pregnant woman, the health of the woman or the unborn child, in serious jeopardy;
b. causing other serious medical consequences;
c. causing serious impairment to bodily functions; or
d. causing serious dysfunction of any bodily organ or part.

Definition: Prudent layperson

A **prudent layperson** is one who is without medical training and who draws on his or her practical experience when deciding whether emergency medical treatment is needed.

Reimbursement of emergency services

Emergency services are reimbursed without authorization in cases where a prudent layperson believed that an emergency medical condition existed. If the emergency condition results in an inpatient admission, authorization is required within forty-eight (48) hours of the admission.

Emergency transportation

Emergency transportation and the related medical emergency services provided by a licensed ambulance service are considered to be emergency care and, therefore, are covered without authorization.

5.2 EXPERIMENTAL/INVESTIGATIONAL AND COSMETIC SERVICES

Introduction

Highmark maintains policies and procedures to ensure that all services identified as or potentially considered experimental/investigational or cosmetic are reviewed and analyzed on an individual basis.

Definition: Experimental/ investigational

The term **experimental/investigational** applies to the use of any treatment, service, procedure, facility, equipment, drug, device, or supply (intervention) which is determined by Highmark or its designated agent not to be medically effective for the condition being treated.

Highmark Medical Policy

Highmark determines an intervention to be experimental/investigational based on one or more of the following reasons:

- The service does not have FDA approval;
- Based on scientific evidence, the service does not impact or improve health outcomes;
- Scientific evidence does not demonstrate the efficacy of the service; and/or
- The service is still being performed in a clinical trial setting with no long-term outcomes available.

Note: Providers need to always follow Highmark Medical Policy. To access medical policies, select **CLAIMS, PAYMENT & REIMBURSEMENT** from the main menu on the Resource Center, and then **Medical Policy**.

Definition: Cosmetic

The term **cosmetic** applies to procedures performed to improve an individual's appearance and not to improve or restore bodily function.

Precertification requirements

All services or procedures identified as or potentially considered as experimental/investigational or cosmetic are to be sent to Clinical Services for review. This should occur prior to beginning the treatment.

Physician review

The care managers refer all requests for potentially experimental/investigational or cosmetic services to the Physician Advisor Office. This step is undertaken to ensure individualized clinical analysis of the requested service and to ensure that every case is reviewed by a physician reviewer.

Questions regarding these services or this process can be directed to Clinical Services by calling the Provider Service Center phone number for your service area.

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5.2 EXPERIMENTAL/INVESTIGATIONAL AND COSMETIC SERVICES, Continued

Appeal rights

If the physician reviewer determines that a request is either cosmetic or experimental/investigational, a care manager will verbally or electronically notify the provider of the determination and the availability of appeal rights. A denial letter is sent to the member (or the member's representative), the provider and/or facility. The denial letter will include the member and provider appeal rights.

Both the member and the provider can appeal a denial decision regarding services which are determined to be experimental/investigational or cosmetic in nature.

Note: For information about appeals, please see **Chapter 5.5: Denials, Grievances, and Appeals**.

5.2 CLINICAL TRIALS

Definition

Clinical trials are research studies designed to evaluate the safety and effectiveness of medical care. They are key to understanding the appropriate use of medical interventions of all types.

Verify benefits

Certain clinical trials may be covered under a member's benefit plan. Others are covered under the Medicare program.

To determine if benefits are available for a particular clinical trial, providers should check the member's benefits through NaviNet. If NaviNet is unavailable, facilities should contact the Provider Service Center.

Quick Reference

Provider responsibility

When requesting services connected to a clinical trial, it is the responsibility of the provider participating in the trial to furnish Clinical Services with all the necessary information concerning the clinical trial itself as well as the clinical status of the member.

If appropriate, the Clinical Services reviewer will notify the provider about whether the service should be billed to Highmark (i.e., when the member's benefit plan covers it) or to the Medicare program (i.e., the member's benefit plan does not cover it).

5.2 PCP REFERRAL AUTHORIZATIONS IN DELAWARE

Overview

Under Highmark's Independent Practice Association (IPA) and Point of Service (POS) plans in Delaware, members are required to select a PCP who will work with them to coordinate their health care needs.

When the PCP or treating specialist determines that a referral to another provider is medically necessary, he or she initiates the referral authorization process. Referrals should be made only to network participating providers.

Process

Requests for referral authorizations must be submitted to Highmark's Medical Clinical Services department.

- Telephone: **1-800-572-2872**
- Fax: **1-800-670-4862**

When Highmark authorizes a referral to a network provider, the medical management staff will enter the authorization into Highmark's system. Payment for claims received for services requiring a referral authorization will be denied without the required authorization.

What Is My Service Area?

Non-network referral authorization

In rare, extenuating circumstances, if a referral must be made to a non-network provider, Highmark may grant authorizations.

- PCPs or referral specialists generally initiate non-network referral authorizations.
- These requests usually involve special or unique circumstances where the most appropriate course of action may be to authorize patient care from a non-network provider.

If a member with a plan requiring referral authorization sees a non-network provider without a non-network referral authorization, Highmark will deny payment for services.

To obtain a non-network authorization, the provider must call Highmark's Clinical Services department and provide the following information:

- The details concerning the patient and his or her condition;
- The non-network provider's name, address, phone number, and specialty; and
- The reasons why a network provider is not adequate.

The Highmark Medical Director will review the request and notify the requesting provider as soon as the review is completed.

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5.2 PCP REFERRAL AUTHORIZATIONS IN DELAWARE, Continued

Additional services

If the referral provider determines that additional services are required, the following guidelines apply:

- If the original authorization from the referring PCP was for consultation only, the referral provider must request additional services from the PCP or contact Highmark's Clinical Services department directly.
- If the original authorization from the referring PCP was for consultation and treatment, the referral provider is approved to render limited services without requiring additional authorization from the PCP. Any changes or additional requests for services require authorization by Highmark. The referral provider must contact Highmark's Clinical Services department directly to request the authorization. Examples of such services include:
  - Surgery, diagnostic testing, or other treatment for the same condition as the original referral.
  - Treatment, such as physical therapy, that is for the same condition as the original referral.
  - Referral to another specialist for the same or related condition.

If the original authorization from the referring PCP was for consultation and treatment, the referral provider is **not** approved to render the following services without going back to the PCP for additional authorization:

- Surgery, diagnostic testing, or other treatments that is not for the same condition as the original referral.
- Referral provider identifies new or different condition requiring consultation by another specialist.

What Is My Service Area?

5.2 PRIOR AUTHORIZATIONS FOR NON-PARTICIPATING PROVIDERS (PA-FPH)

What Is My Service Area?

Overview

There may be occasions when an HMO member in the 13-county Northeastern Region in Pennsylvania requires services that cannot be provided by a specialist or facility within the First Priority Health (FPH) network. If services are not available through a FPH network participating provider, prior authorization must be obtained for any services provided by a non-participating specialist or facility.

General information

The following guidelines apply to non-participating provider prior authorizations for services not available from a FPH network participating specialist or facility:

- If a member receives care without a prior authorization from his/her referring participating provider and approval from Highmark, the member may be responsible for payment for all services rendered.
- All prior authorizations for services by non-participating providers should be issued prior to the member receiving the services.
- Covering PCPs may request prior authorizations for another PCP's patient(s).
- Prior authorizations are not a guarantee of payment by Highmark. The non-participating prior authorization is void for services that are not medically necessary or not covered.
- Non-participating provider prior authorization guidelines apply to all products using the FPH network (i.e., fully-insured, Plus, self-funded, CHIP).
- Prior authorizations for elective services by non-participating providers are required at least two (2) weeks prior to the member's target service date.

Requesting prior authorization

Prior authorization for all non-participating outpatient physician and/or outpatient facility services may be requested by completing the **Outpatient Non-Participating Provider Request Form** and faxing it to the fax number for migrated business for Highmark indicated on the form. This form is also available on the Highmark Blue Shield Provider Resource Center – select **EDUCATION/MANUALS**, and then click on **First Priority Health Network Resources**.

Prior authorization/precertification can also be requested for non-participating provider services by contacting the Clinical Services Department by calling the Provider Service Center phone line for your service area.

Quick Reference