

CHAPTER 5: CARE AND QUALITY MANAGEMENT

UNIT 4: BEHAVIORAL HEALTH

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[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.

5.4 GENERAL INFORMATION

Objectives

Highmark Behavioral Health Services provides behavioral health medical management services for members enrolled in Highmark programs.

The key objectives of Highmark's Behavioral Health Care Management Program are as follows:

- Ensure timely access to appropriate quality outpatient specialty services
- Encourage adherence to evidence-based treatment standards
- Support behavioral health care needs of members in active treatment with primary care providers
- Increase communication and coordination of care between primary care providers, psychiatrists, and other behavioral health professionals
- Work closely with health care providers to coordinate all aspects of services for its members with both medical and behavioral health needs, especially members with chronic medical conditions complicated by conditions such as depression and anxiety

REMINDER: Verify eligibility

To determine whether a member has behavioral health care coverage through Highmark and if authorization is required, always verify the member's benefits prior to providing services. Eligibility and benefits can be verified via NaviNet® or the applicable HIPAA electronic transaction.

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

NaviNet® Eligibility and Benefits Inquiry

To verify behavioral health benefits via NaviNet, select the **Eligibility and Benefits Inquiry** transaction from the main menu on Highmark Plan Central. Click on the **Additional Benefit Provisions** link on the Eligibility and Benefits Detail page. From the pop-up box, select **Behavioral Health/Substance Abuse** for detailed behavioral health benefits.

Referrals to in-network providers

When recommending inpatient services, be sure that the member is to receive care from a provider who participates in the network associated with the member's program and, when applicable, is in the highest benefit tier.

Timely utilization management determinations

Highmark's Behavioral Health Services department provides timely utilization management determinations for all members and providers. Each utilization management determination is handled in a manner consistent with the clinical urgency of the situation and with legal and regulatory compliance requirements.

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5.4 GENERAL INFORMATION, Continued

Contact information

When NaviNet® is not available and/or for medical management questions/issues that cannot be handled through NaviNet, Highmark Behavioral Health Services can be reached by calling the telephone number for your service area:

- PA Western & Northeastern Regions: **1-800-258-9808**
- PA Central Region: **1-800-628-0816**
- Delaware: **1-800-421-4577**
- West Virginia: **1-800-344-5245**

Hours of availability:

- Monday through Friday – 8:30 a.m. to 7 p.m.
- Saturday and Sunday – 8:30 a.m. to 4:30 p.m. (limited staffing for urgent requests)

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IMPORTANT! Privacy reminder

When calling a behavioral health care manager directly, your call may be answered by voicemail. To uphold a member's right to privacy and in consideration of HIPAA regulations and the importance of documentation, **please do not leave clinical information about members on voicemail.**

Consent required for release of treatment information

Providers are reminded that under federal and state laws, providers of mental health and substance abuse treatment services may be required to obtain members' written authorization in order to release certain mental health and substance abuse treatment information to insurers and/or to other health care providers for the management of patient care.

As a contracted provider, it is your responsibility to obtain appropriate consent for release of information.

Restrictions for substance abuse treatment

Pennsylvania Administrative Code Subsection 255.5(b) limits the information providers can release to insurers and/or other providers about substance abuse treatment, even with member written consent. Providers practicing in Pennsylvania are advised to ensure that the information they communicate to Highmark Behavioral Health Services is compliant with these regulations.

When practicing in any of Highmark's service areas, contracted providers are expected to be compliant with any applicable federal or state regulations.

FOR MORE INFORMATION

For additional information for providing behavioral health services to Highmark members, please see [Chapter 4.2: Behavioral Health Providers](#).

5.4 MEDICAL NECESSITY CRITERIA

Basis of authorization decisions

Highmark Behavioral Health Services bases its decisions to authorize care upon the following:

- Clinical information available to the care manager or physician reviewer at the time of review
- The safety of the patient and, when applicable, the safety of others
- Availability of other effective but less restrictive treatment settings
- Availability to the member of the appropriate behavioral health benefit
- Application of the appropriate medical necessity criteria

Medically necessary definition

Except where any applicable law, regulation, or government body requires a different definition (i.e., the Federal Employees Health Benefits Program, Centers for Medicare & Medicaid Services [CMS] as to the Medicare Advantage program, etc.), Highmark has adopted a universal definition of medical necessity:

The term “Medically Necessary,” “Medical Necessity,” or such other comparable term in any provider contract shall mean health care services (or such similar term as contained in the applicable benefit agreement or plan document to include, but not be limited to, “health services and supplies,” “services and supplies,” and/or “medications and supplies”) that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury, or disease; and
- Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury, or disease.

Medical necessity criteria for substance abuse treatment

Highmark's Behavioral Health Services department uses the current version of the American Society of Addiction Medicine (ASAM) criteria when reviewing the medical necessity of substance abuse treatment.

Copies of these criteria can be purchased by visiting the ASAM website at <http://www.asam.org/>, or by contacting ASAM at 1-301-656-3920.

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5.4 MEDICAL NECESSITY CRITERIA, Continued

Medical necessity criteria for all other behavioral health services

Highmark's Behavioral Health Services department applies InterQual Criteria for Behavioral Health when reviewing the medical necessity of behavioral health services.

NaviNet-enabled facilities are able to view the InterQual Criteria via the Automated Care Management (ACM) application. If for any reason NaviNet is not available, facilities can call Highmark Behavioral Health Services for medical necessity criteria applicable to a particular case.

Criteria reviewed annually

All criteria are reviewed, approved, and/or revised at least once annually by the Care Management Committee (CMC). The CMC is comprised of practicing physicians in the community and in hospital administrative positions, including psychiatrists, who are involved in care management functions.

Prudent layperson laws for emergency services

Highmark adheres to state “prudent layperson” laws which require payment of benefits for mental health services in the event of an emergency under prudent layperson laws. An emergency department physician can make a decision regarding admission or physical or chemical restraints.

Highmark agrees that where a physician has not entered into a different agreement with Highmark or the hospital or other mental health care facility where services are rendered, and where Highmark has not entered into a different agreement with such hospital or mental health care facility, in the event of an emergency, Highmark will pay for medically necessary emergency care mental health covered services provided by such physician in accordance with applicable prudent laypersons standards, the definition of medical necessity as defined above, and the terms and conditions of the plan member’s plan and Highmark will pay for medically necessary mental health covered services provided by physicians resulting from the admission in accordance with the definition of medical necessity and the terms and conditions of the member’s plan.

5.4 SERVICES REQUIRING AUTHORIZATION

Behavioral health authorization

Authorization (or “pre-authorization”) is the process whereby the behavioral health provider must contact Highmark Behavioral Health Services to determine the eligibility of coverage for and/or the medical necessity or appropriateness of behavioral health services.

Inpatient services

For most Highmark products, authorization is required to receive coverage for all inpatient behavioral health services, or “higher levels of care.” The term “higher levels of care” applies to the levels listed below:

- Inpatient mental health services
- Inpatient detoxification services
- Inpatient rehabilitation (substance abuse treatment)

Although authorization is not required for emergency services, an authorization is required if an emergency service results in an inpatient admission.

Outpatient services

Traditional outpatient behavioral health treatment does not require authorizations. However, partial hospitalization, intensive outpatient programs, and home health care services for psychiatric care **do require authorization.**

For partial hospitalization and intensive outpatient psychiatric services, the following procedure codes are included on Highmark’s List of Procedures/DME Requiring Authorization:

- S0201 – partial hospitalization services, less than 24 hours, per diem
- S9480 – intensive outpatient psychiatric services, per diem

To quickly access Highmark’s List of Procedures/DME Requiring, select **REQUIRING AUTHORIZATION** from the **Quicklinks** bar at the top of the Provider Resource Center home page.

IMPORTANT! Exceptions



For important changes in Delaware legislation affecting authorization requirements for drug and alcohol dependency treatment in Delaware effective January 1, 2018, please see the next section of this unit.

[What Is My Service Area?](#)

If authorization is not obtained

When the behavioral health provider is required to obtain authorization but provides covered services without obtaining authorization, the member will not be responsible for payment.

5.4 DELAWARE DRUG AND ALCOHOL DEPENDENCY TREATMENT MANDATE

Policy



Effective January 1, 2018, as per Delaware legislation (Del. Code tit. 18 §§ 3343, 3578), Highmark Blue Cross Blue Shield Delaware may not impose precertification, prior authorization, pre-admission screening, or referral requirements for the diagnosis and medically necessary treatment, including inpatient, of drug and alcohol dependencies at a Highmark Delaware network participating facility.

Definition



Drug and alcohol dependencies are defined as a substance abuse disorder or the chronic, habitual, regular, or recurrent use of alcohol, inhalants, or controlled substances as identified in Chapter 47 of Title 16 of the Delaware Code.

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Concurrent utilization review



Concurrent utilization review is prohibited during the first fourteen (14) days of medically necessary inpatient and residential treatment by a network participating facility approved by a nationally recognized health care accrediting organization or the Division of Substance Abuse and Mental Health; thirty (30) days of Intensive Outpatient Program treatment; or five (5) days of inpatient withdrawal management, provided that the facility notifies Highmark Delaware of both the admission and the initial treatment plan within forty-eight (48) hours of the admission.

The facility must perform daily clinical review and periodically consult with Highmark Delaware to ensure that the facility is using the evidence-based and peer reviewed clinical review tool used by Highmark Delaware and designated by the American Society of Addiction Medicine (ASAM) or, if applicable, any state-specific ASAM criteria, and appropriate to the age of the patient to ensure that the inpatient treatment is medically necessary for the patient.

Retrospective review



Highmark Delaware may perform retrospective review for medical necessity and appropriateness of all services provided during an inpatient stay or residential treatment, including the initial 14 days of treatment; 30 days of Intensive Outpatient Program treatment; or five days of inpatient withdrawal management.

Highmark Delaware may deny coverage for any portion of the initial 14-day inpatient or residential treatment on the basis that the treatment was not medically necessary only if the treatment was contrary to the evidence-based and peer reviewed clinical review tool used by Highmark Delaware and designated by ASAM or any state-specific ASAM criteria.

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5.4 DELAWARE DRUG AND ALCOHOL DEPENDENCY TREATMENT MANDATE, Continued

Applicability



These statutes are applicable to all Highmark Delaware fully-insured individual and group health benefit plans. Self-insured employer groups will be offered the opportunity to adopt the mandate and may or may not elect to follow the mandate. Medicare supplemental plans are exempt from this law.

Member liability



The Highmark Delaware member does not have any financial obligation to the facility for inpatient and residential treatment other than any applicable copayments, coinsurance, or deductible amounts required under their benefit plan.

[What Is My Service Area?](#)

FOR MORE INFORMATION

For additional information on this mandate, please see [Chapter 4.2: Behavioral Health Providers](#).

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5.4 AUTHORIZATION REQUESTS

Provider-driven process

Authorization of behavioral health services is a provider-driven process. This means that it is the provider's responsibility to obtain the required authorization for all behavioral health services.

In the absence of required authorizations, claims for behavioral health services are not reimbursed and the member must be held harmless.

Complete clinical assessment prior to initiating authorization request

Before initiating the authorization request (either via NaviNet® or through telephone contact with Highmark Behavioral Health Services), please complete the clinical assessment and be prepared to provide the information below:

- The member's name and ID number, including alpha prefix
 - The events precipitating the call
 - The member's symptoms and mental status
 - The degree of impairment in function
 - The potential for harm to self and/or others
 - The degree of distress
 - The member's treatment history, including medications
 - Axis I-III Diagnoses
 - The treatment plan or suggested treatment plan
-

NaviNet® authorization request submission required

Authorization requests must be submitted through Highmark's NaviNet® provider portal for the following behavioral health services:

- Inpatient Admissions
- Inpatient Transfers
- Partial Hospitalization (PHP)
- Intensive Outpatient Services (IOP)

Requests for authorization of inpatient behavioral health services are submitted via NaviNet® by the facility providing services.

Instructional manual for NaviNet® submissions

For assistance with submitting authorization requests through NaviNet, please see the [Behavioral Health Automated Care Management \(ACM\) Authorization Submission Manual](#).

This manual is also available under **EDUCATION/MANUALS** on the Provider Resource Center.

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5.4 AUTHORIZATION REQUESTS, Continued

Time frames for review

Highmark Behavioral Health Services renders authorization decisions within the time frames required by law and the applicable regulatory agencies.

For a routine review, Highmark Behavioral Health Services will render a decision **within two (2) business days** from the receipt of the request.

Continued stay requests for PHP and IOP

If an authorization expires and continued treatment is necessary, **a new authorization request must be submitted** through NaviNet for outpatient behavioral health services (partial hospitalization and intensive outpatient services). A continued stay request should be submitted on the last covered day of the previous authorization.

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5.4 POTENTIAL OUTCOMES OF AUTHORIZATION REVIEW

Medical necessity criteria used

In making authorization decisions, the Highmark behavioral health care manager reviews the information submitted and makes a determination based on the medical necessity criteria.

If criteria **ARE** met

If the medical necessity criteria **are** met, an internal Highmark system authorization is generated, as well as a notification to the provider.

- If the provider is NaviNet®-enabled, they can retrieve the authorization notice through the NaviNet **Referral/Authorization Inquiry** transaction. (Select the authorization in question in order to view it.)
- If the provider is not NaviNet-enabled, the authorization notice is sent to the provider as a letter through U.S. Mail, with a copy to the member. (The exception to this process is that Medicare Advantage members do not receive a copy of the letter.)

If criteria **ARE NOT** met

If the behavioral health care manager determines that the criteria have **not** been met, he or she may recommend alternative levels of care and treatment options for which the criteria have been met.

If no alternative level of care can be arranged, the case is sent to a Highmark physician reviewer. The physician reviews the clinical information and has the option to contact the attending provider (or designee) to discuss the case. The physician reviewer then renders a decision.

If the decision is made to not authorize the requested care, a verbal non-authorization notice is given to the provider. A written notice follows within one business day after the verbal notice. Information about appeal rights is also communicated.

[Why blue italics?](#)

Peer-to-peer conversation

If the treating or ordering provider did not have an opportunity to discuss a case with the clinical peer reviewer before a utilization management decision was made, he or she may request a peer-to-peer conversation after the decision has been rendered for a commercial member.

To initiate the request, the provider should call the *dedicated peer-to-peer* toll-free phone number: **1-866-634-6468**. *Hours of operation are from 8:30 a.m. to 4:30 p.m. (EST), Monday through Friday. A live agent will take the necessary information and forward the request to a Highmark clinical peer reviewer.*

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5.4 POTENTIAL OUTCOMES OF AUTHORIZATION REVIEW, Continued

Peer-to-peer conversation (continued)

If an emergent need arises before or after business hours, the option to leave a voicemail message is available. The following information will be needed:

- *CASE/REQ# (e.g., REQ-1234).*
- *Patient's name and Member ID.*
- *Name of the treating and/or ordering provider requesting the peer-to-peer conversation and the phone number where a Highmark clinical peer reviewer can reach the provider.*

*The clinical peer reviewer who made the determination (or an appropriate designee) will contact the provider **within one (1) business day** to discuss the case. If the provider still does not agree with the non-authorization decision after the peer-to-peer conversation, an appeal can be initiated.*

Note: The peer-to-peer conversation option is not available for Medicare Advantage members.

[Why blue italics?](#)

Appeal of adverse decisions

Attending providers and facilities can appeal a utilization management decision that results in non-authorization of reimbursement for health care services.

Please see [Chapter 5.5: Denials, Grievances, and Appeals](#) for more information on appeal rights.

5.4 CONCURRENT REVIEW

Definition: Concurrent review	Concurrent review , also known as continued stay review, is an assessment that determines medical necessity and appropriateness for an extension of previously authorized services.
Plan-specific requirements	The need for concurrent review of higher levels of care varies based on the product and the specific benefit plan under which the member has coverage. As for all behavioral health services, always verify plan-specific requirements via NaviNet®, or by contacting Highmark Behavioral Health Services.
When is review completed?	Concurrent reviews for behavioral health services must be completed on or before the "Last Covered Day" (LCD) of the previous authorization.
Time frames	Concurrent review decisions for behavioral health services are communicated to the provider within one (1) business day , or no later than twenty-four (24) hours, from receipt of the request. In view of the short turnaround time imposed by regulating bodies, providers are reminded to forward all relevant clinical information as quickly as possible to avoid denials based on lack of clinical data.
Who initiates?	The provider is ultimately responsible for initiating the concurrent review process; however, it can be initiated by the behavioral health care manager as well.
Initiating the review	Concurrent review requests for inpatient care are normally submitted via NaviNet®. (NaviNet can be used even if the original case was initiated by telephone contact with Highmark Behavioral Health Services.) However, if NaviNet is unavailable or the facility is not NaviNet-enabled, concurrent reviews can be initiated by calling Highmark Behavioral Health Services. When preparing for a concurrent review dialogue with the behavioral health care manager, please plan to provide clinical information that is new or updated since the previous review or authorization.
Continued stay requests for PHP and IOP	If an authorization expires and continued treatment is necessary, a new authorization request must be submitted through NaviNet for outpatient behavioral health services (partial hospitalization and intensive outpatient services). A continued stay request should be submitted on the last covered day of the previous authorization.

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5.4 CONCURRENT REVIEW, Continued

Types of information to be provided

The information below should be provided to the behavioral health care manager for a concurrent review whether through a telephone dialogue or a “Note” on the NaviNet screen:

- Presenting problem/proximal event
- Current mental status
- Progress since the last review
- Barriers to progress and modifications to the treatment plan
- Psychiatric and substance abuse history and response
- Current substance abuse
- Vital signs, withdrawal, blood alcohol level
- Axis I-V diagnosis
- Family/social support involvement since last review
- Risk related to functional impairment/inadequate support system
- Risk related to self and/or others
- Medications, including start date, dosage, and frequency, as well as PRN medications ordered and given
- Current medical status, complications, consultations, medications, plans of care
- Treatment plan addressing targeted symptoms
- Treatment plan changes based on progress or newly identified problems
- Patient response to and compliance with treatment
- Coordination of care for patients with co-existing medical and/or substance-related disorders
- Discharge planning, including scheduling of appointments
- Any additional assistance needed
- Any other information which may be useful in assessing the medical necessity of the patient’s continuing to remain at this level of care

IMPORTANT! Privacy reminder

When working directly with a particular behavioral health care manager, it is possible that a provider may occasionally reach a voicemail line. In consideration of the member’s right to privacy and the importance of documentation, you are asked to **never leave clinical information about your patient on the voicemail system.**

Compliance

Information for concurrent review should be provided in accordance with the limits imposed by federal or state law, including but not limited to Pennsylvania Administrative Code Subsection 255.5(b).

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5.4 CONCURRENT REVIEW, Continued

Outcomes of the decision process

After all the relevant clinical information has been gathered, the behavioral health care manager will make a clinical determination based on the appropriate medical necessity criteria.

- If **criteria are still met**, the continued stay may be authorized.
- If **criteria are not met**, an alternative level of care may be discussed.
- If **criteria are not met and an alternative level of care is not accepted**, the case is referred to the physician reviewer. The physician reviewer then contacts the attending provider. A decision will be rendered within the appropriate time frame based on the urgency of the request

Medicare Advantage: When continued stay is not approved



The Centers for Medicare & Medicaid Services (CMS) requires the issuance of the *Important Message From Medicare* (“*Important Message*”) to the Medicare Advantage patient **within two (2) days of admission** as well as a follow-up notice again prior to discharge. This *Important Message* explains the member’s rights as an inpatient as well as his or her right to appeal a discharge decision.

When a concurrent review results in a denial and a Medicare Advantage member **disagrees with the decision to discharge** him or her from inpatient care, the member may request a review as instructed in the *Important Message*. Highmark delegates responsibility to the facility to then issue the required *Detailed Notice of Discharge* (“*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 about the *Important Message* and *Detailed Notice* requirements for Medicare Advantage members, please see [Chapter 5.3: Medicare Advantage Procedures](#).

[What Is My Service Area?](#)

Late notice cases

Normally, authorization is in place before behavioral health services are rendered. However, if for some reason services were initiated without authorization and the member remains in treatment, the behavioral health care manager initiates an **immediate review of the services going forward** from the point at which Highmark Behavioral Health Services was notified. Although there was no initial authorization process, **this is considered a concurrent review**.

In addition to performing a concurrent review of the services provided from the point of notification on, Highmark Behavioral Health Services will also initiate a **retrospective review** of the services rendered prior to notification in late notice cases.

5.4 RETROSPECTIVE REVIEW

Definition A **retrospective review**, also known as post-service review, is an evaluation of the medical necessity and appropriateness of services *after* they have been provided.

Late notice initiates review for medical necessity When a facility provides late notice that a member has been admitted as an inpatient for behavioral health services, Highmark Behavioral Health Services will initiate both a concurrent review for services going forward as well as a retrospective medical necessity review of the services rendered to the point of notification.

Information needed To demonstrate that the treatment that had been provided was medically necessary, Highmark Behavioral Health Services will need the same type of information as that required for a concurrent review.

Note: For a list of the specific types of information needed for both the concurrent and retrospective reviews, please see the preceding content regarding concurrent review.

[What Is My Service Area?](#)

Compliance When requesting a retrospective review of substance abuse treatment services, please provide information regarding the member's substance abuse history in a manner compliant with **Pennsylvania Administrative Code 255.5**.



Mailing address Information for retrospective reviews of mental health or substance abuse treatment services can be mailed to the address below:

Highmark Behavioral Health Services
 120 Fifth Avenue, Suite P4205
 Pittsburgh, PA 15222-3099
 Attention: Benefit Analyst

Outcomes of the decision process After all the relevant clinical information has been gathered, the behavioral health care manager will make a clinical determination, based on the appropriate medical necessity criteria, on the services provided prior to notification or without authorization.

- If **criteria are met**, an authorization is issued.
- If **criteria are not met**, the case is referred to a physician reviewer.

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5.4 RETROSPECTIVE REVIEW, Continued

Review results in approval

If an authorization is issued, the rendering provider can obtain the authorization number from the **Referral/Authorization Inquiry** transaction via NaviNet®.

To have a previously denied claim adjusted, the provider can then open a NaviNet Investigation, reporting the newly obtained authorization number. Providers who are not NaviNet-enabled can call the Highmark Provider Service Center for your service area to request the adjustment with the new authorization number.



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5.4 PROVIDER APPEAL PROCESS

Non-authorization decision

When it is determined that a member's case does **not** meet medical necessity criteria, alternative levels of care may be discussed. If these suggestions are not acceptable to the provider or facility, the case is sent to a physician reviewer.

If the physician reviewer makes a decision to not authorize the requested services, a verbal non-authorization notice is given to the provider or facility, and a written notice follows within the required time frames. The applicable appeal rights are provided both verbally and in writing.

Why blue italics?

Peer-to-peer conversation

If the treating or ordering provider did not have an opportunity to discuss the case with the clinical peer reviewer before a utilization management decision was made, he or she may request a peer-to-peer conversation for commercial members (the peer-to-peer option is not available for Medicare Advantage members).

To initiate the request, the provider should call the *dedicated peer-to-peer phone line: 1-866-634-6468. Hours of operation are from 8:30 a.m. to 4:30 p.m. (EST), Monday through Friday. A live agent will take the necessary information and forward the request to a Highmark clinical peer reviewer.*

If an emergent need arises before or after business hours, the option to leave a voicemail message is available. The following information will be needed:

- *CASE/REQ# (e.g., REQ-1234).*
- *Patient's name and Member ID.*
- *Name of the treating and/or ordering provider requesting the peer-to-peer conversation and the phone number where a Highmark clinical peer reviewer can reach the provider.*

*The clinical peer reviewer who made the determination (or an appropriate designee) will contact the provider **within one (1) business day** to discuss the case. If the provider still does not agree with the non-authorization decision after the peer-to-peer conversation, an appeal can be initiated.*

Note: *If the provider chooses to proceed with an appeal, the peer-to-peer option is forfeited and no longer available to the provider.*

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5.4 PROVIDER APPEAL PROCESS, Continued

Initiating an appeal

Either the attending provider or the facility may initiate an appeal either verbally or in writing at the time of the initial non-authorization decision.

When requesting a provider appeal, the provider or facility should provide the name and telephone number of the individual who will be able to discuss the clinical aspects of the case with the physician reviewer.

Two types of appeals are available for providers of behavioral health services -- **expedited appeals** and **standard appeals**.

Expedited appeals

An expedited behavioral health provider appeal is a formal appeal of a decision denying one of the following on the basis of medical necessity:

- An imminent or ongoing service; or
- The admission or continued stay of a patient who has received emergency services but has not been discharged from a facility.

Time frame: Expedited appeals

For an expedited appeal, a decision is rendered **within one (1) business day** of receipt of complete information, not to exceed seventy-two (72) hours of receipt of the request.

Note: For Pennsylvania Act 68 expedited appeals, the decision time frame is not to exceed forty-eight (48) hours. Please refer to the [Chapter 5.5: Denials, Grievances, and Appeals](#), section titled "Expedited Grievance: Filing On Behalf of a Member (PA Act 68)," for additional information.

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Potential outcomes of the expedited appeal

Either of the following could occur as the outcome of an **expedited** appeal:

If ...	Then ...
the denial is overturned upon expedited appeal,	an authorization is provided for the service.
the denial is upheld upon expedited appeal,	a statement of appeal rights is provided, both verbally and in writing. The provider can request a standard appeal.

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5.4 PROVIDER APPEAL PROCESS, Continued

Standard provider appeals

A standard behavioral health provider appeal is a formal appeal of a denial decision that does not meet the criteria for an expedited appeal.

It is also used as a secondary appeal level when a denial is upheld under the expedited appeal process.

As is necessary for an expedited appeal, the facility must provide the name and telephone number of the facility contact who will be prepared to discuss the clinical aspects of the case with a physician reviewer for a standard provider appeal.

Time frame: Standard provider appeals

For a standard provider appeal, a decision is rendered and communicated in writing **within thirty (30) days** of receipt of the request.

Potential outcomes of standard appeal process

Either of the following could occur as a result of the standard appeal process:

If ...	Then ...
the denial is overturned at standard appeal,	an authorization is provided.
the denial is upheld at standard appeal,	the decision is final, no further appeals can be initiated.

Appealing on behalf of a member

Upon request by the member or the member’s family, a facility may file an appeal on behalf of a member as his or her representative.

If appealing on behalf of the member, the facility must provide Highmark with the name and address of the facility and a written consent form signed by the member, which specifies the services to be performed. A copy of the appropriate form is attached to every denial letter.

Note: For more detailed information about appealing on behalf of a member, please see [Chapter 5.5: Denials, Grievances, and Appeals](#).

5.4 DISCHARGE PLANNING AND POST-DISCHARGE FOLLOW-UP CARE

Discharge planning	Discharge planning should begin prior to or upon admission to an inpatient facility. At the time of precertification, the behavioral health care manager discusses discharge planning barriers and assists with any discharge needs.
Encourage follow-up appointment	To increase the likelihood that a member being discharged from inpatient behavioral health services will receive appropriate aftercare, it is very important that the member leave the hospital with a follow-up outpatient appointment.
Contact following discharge	<p>Upon a mental health inpatient discharge, a Highmark behavioral health specialist will attempt to make a post-discharge call to the member. When post-discharge contact is made, the behavioral health specialist will verify that a follow-up appointment has been made or, if necessary, assist the member in obtaining an appointment.</p> <p>The behavioral health specialist will provide education about the importance of adhering to scheduled appointments and will work with the member to resolve any barriers. They will also discuss any questions the member may have regarding discharge instructions, medication changes, and/or any other issues of concern to the member.</p>
Continuing care coordination	<p>Highmark Behavioral Health Services is committed to working with providers to support members in maintaining the gains achieved during inpatient treatment.</p> <p>It is very important that the member leaves the facility having scheduled a follow-up appointment with a psychiatrist or other behavioral health provider within seven (7) days post discharge. If the appointment was not kept, the behavioral health specialist will work with the member to resolve any barriers and assist in rescheduling the appointment.</p>
When medication is prescribed	The follow-up appointment is particularly important when a patient is discharged with a prescription for psychotropic medication. Follow-up care should be arranged with a behavioral health provider.

Continued on next page

5.4 DISCHARGE PLANNING AND POST-DISCHARGE FOLLOW-UP CARE, Continued

Discharge Summary

Facilities are reminded to complete the [Discharge Summary Fax Template](#) at, or immediately following, discharge of a Highmark member from inpatient behavioral health care admission.

This form is also available on the Provider Resource Center – select **FORMS**, and then **Behavioral Health Forms**.

[What Is My Service Area?](#)

Special requirements for Medicare Advantage members



The Centers for Medicare & Medicaid Services (CMS) requires that people with coverage under traditional Medicare or a Medicare Advantage plan are fully aware of their right to appeal a discharge decision. Therefore, a special process applies to these members. 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 information on these special requirements for Medicare Advantage members, please see [Chapter 5.3: Medicare Advantage Procedures](#).

OBSOLETE