SPECIAL eBULLETIN

FOR PROFESSIONAL AND FACILITY PROVIDERS

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# UPDATE: CHANGES IN AUTHORIZATION REQUIREMENTS FOR OUT-OF-NETWORK OUTPATIENT SERVICES EFFECTIVE JANUARY 1, 2020

**Please see the "Medicare Advantage" section on the next page for clarification of the impact of this change on Medicare Advantage.**

At Highmark we believe we have to put patients first. To do this, we are continuing to partner with you to provide the most appropriate care possible. Working with health care providers, we're helping to implement nationally accepted, evidenced-based guidelines. Often, these models only require some small changes to the way most practitioners deliver care.

To that end, Highmark requires medical necessity review for all inpatient admissions and for certain outpatient services for commercial products to ensure that our members are receiving the appropriate care in the proper setting. All inpatient admissions, both in-network and out-of-network, require authorization to determine whether the services are medically necessary and appropriate. Currently, our list of outpatient services that require authorization has applied only when our members seek services from a provider within their network as defined by their benefit plan.

Effective January 1, 2020, Highmark's list of outpatient procedures requiring authorization will apply when a Highmark member with **commercial** coverage seeks those services from either an in-network or out-of-network provider.*

***Note:** These authorization requirements will not apply to outpatient services managed by our partner vendors, eviCore and WholeHeath Networks, Inc., a subsidiary of Tivity Health Support, LLC.

Commercial members seeking services from out-of-network providers will be responsible for working with their provider to assure they are obtaining the necessary authorizations. To alleviate claim denials and delays in payment, providers are encouraged to request and obtain the necessary authorizations on behalf of members in advance of any planned services.

As a reminder, an "out-of-network provider" is a provider that is within Highmark's service area but not participating in the member's network OR an out-of-area provider located outside of Highmark's service area who is not participating with the local Blue Plan.

If the covered services are determined to be medically necessary and appropriate, claims will be paid in accordance with the member's benefit plan. If the covered services are not medically necessary or no request for authorization has been made, no payment will be made.

Highmark Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association. NaviNet is a registered trademark of NaviNet, Inc., which is an independent company that provides secure, web-based portal between providers and health insurance companies.

## HIGHMARK'S LIST OF PROCEDURES/DME REQUIRING AUTHORIZATION

The list of outpatient procedures and services that require authorization are available on Highmark's Provider Resource Center. It can be accessed by selecting **REQUIRING AUTHORIZATION** from the Quicklinks bar that spans across the top of the Provider Resource Center.

## APPLICABLE PRODUCTS AND IMPLEMENTATION DATES

The authorization requirements outlined here for out-of-network outpatient services and all inpatient admissions are effective January 1, 2020, for all Affordable Care Act (ACA) individual products. Beginning January 1, 2020, these requirements will also be applied to fully-insured small and large groups upon the group's renewal.

These changes do not apply to self-insured groups (ASO), the Federal Employee Program (FEP), Pennsylvania's Children's Health Insurance Program (CHIP), Medicaid, student health insurance plans (SHIP), indemnity and comprehensive benefit plans, and Medicare Advantage.

## MEDICARE ADVANTAGE

Effective January 1, 2020, Highmark will require that out-of-network inpatient and outpatient services be deemed medically necessary prior to payment. Providers or members are welcome to contact Highmark to request precertification of coverage from the plan prior to performing or receiving a service to determine whether or not it would be considered medically necessary.

## VERIFYING BENEFITS

To obtain eligibility and benefit information, you can contact Highmark by calling the Member Service phone number on the back of the member's identification card.

If you are NaviNet®-enabled, select the member's product provisions link from their Eligibility and Benefits page in NaviNet. The following category under **Product Wide** provisions will be noted as "Yes" if the authorization requirements apply to in-network and out-of-network services:

Inpatient and Certain Outpatient Services…………………………….....Yes  Authorization Required

Inpatient and Outpatient Services……………………………….....Yes  Authorization Required [HMO]

## OBTAINING AUTHORIZATIONS

Please contact Highmark Clinical Services at the Utilization Management phone number on the back of the member's identification card to obtain authorizations for Highmark members with commercial coverage.

If you are NaviNet-enabled, please submit requests through the Authorization Submission function in NaviNet.