SPECIAL eBULLETIN

FOR FACILITY PROVIDERS **OCTOBER 1, 2019**

CHANGES TO UNPLANNED INPATIENT HOSPITALIZATION REQUESTS SUBMITTED THROUGH NAVINET EFFECTIVE 12/1/2019

At Highmark, we put the patient at the center of everything we do and we continue to partner with you to provide the most appropriate care possible.

Working with health care providers, we're helping to implement nationally accepted, evidence-based guidelines. Often, these models only require some changes to current practices. Importantly, these changes are proven to add up to better patient outcomes and more affordable care.

To that end, effective **12/1/2019**, Highmark will make changes to the urgent / unplanned inpatient hospitalization process for authorizations submitted via NaviNet.

- Consistent with the review process already in place today for all urgent and unplanned inpatient hospital admission requests that come in through other channels (i.e., phone, fax), Highmark will complete an enhanced inpatient review for all authorizations submitted via NaviNet.
- Additionally, the goal length of stay will be based on clinical diagnosis, vs. InterQual criteria.

DETAILS: CHANGES TO URGENT / UNPLANNED INPATIENT REQUESTS

Consistent with our processes outside of NaviNet submissions, Highmark will implement enhanced medical necessity review for all urgent unplanned inpatient admission requests, which will pend for additional review regardless of the diagnosis when the green "Criteria Met" indicator is received and displayed in InterQual as it appears below. Urgent unplanned requests will no longer auto-approve, in order to ensure our members, your patients, are receiving medically necessary care in the most appropriate setting.

The InterQual criteria are used as a guide to determine inpatient appropriateness, also taking into consideration the CMS 2-Midnight Rule, Ambulatory Care Sensitive Conditions, and the medical complexities of the member. Members may always be converted from an observation to inpatient level of care if symptoms do not improve or the condition worsens during the observation period.

CHANGES TO GOAL LENGTH OF STAY BASED ON CLINICAL DIAGNOSIS

In addition, Highmark will apply condition-specific guidelines to determine when the next clinical update is due based on the goal length of stay for the diagnoses.

This will result in the last covered day moving away from an initial 5-day approval to a more clinically appropriate initial approval.

This change will:

- Allow for proactive discharge planning,
- Help ensure members are connected to case management earlier,
- Identify care needs sooner in the hospital, and
- Avoid delays in transitioning the member to the most appropriate care setting at the most appropriate time.

Highmark's appeals process for both Medical Advantage and Commercial members will remain the same with the implementation of this change. As a reminder, our current processes are as follows:

MEDICARE ADVANTAGE APPEALS

To remain in compliance with CMS requirements, providers may request either an expedited or standard appeal, which is also known as a standard org determination, for authorization denials for Highmark's Medicare Advantage members. An expedited appeal is suggested when the patient remains hospitalized, while a standard appeal is typical if the patient has already been discharged. CMS does not recognize a peer-to-peer appeal type, nor does Highmark for its Medicare Advantage members.

For any appeal requested, please be able to provide the patient's name, identification number, date of birth, type of service denied, and REQ or Case number referenced in the denial notice.

COMMERCIAL APPEALS

Peer-to-peer reconsiderations are available for Highmark Commercial members to offer providers the opportunity to discuss an adverse determination of an authorization request with a Highmark Medical Director. Providers may also request an expedited or standard appeal after, or in lieu of, a peer-to-peer reconsideration for Commercial authorization denials.

For more information about the appeals process, please refer to the Highmark Provider Manual's Chapter 5.5, Denials, Grievances, and Appeals. The Highmark Provider Manual is available under **EDUCATION/MANUALS** on the Provider Resource Center. It can also be accessed quickly by selecting **MANUALS** on the **Quicklinks Bar**.

Thank you for your support and the high-quality, cost-effective care you provide to our members. We look forward to your continued collaboration to ensure that Highmark members receive medically necessary services in a high-quality, clinically appropriate fashion.