SPECIAL eBULLETIN

FOR PROFESSIONAL AND FACILITY PROVIDERS **SEPTEMBER 1, 2020**

PRIOR AUTHORIZATION TO BE REQUIRED FOR OUTPATIENT SERVICES WHEN PROVIDED BY AN OUT-OF-AREA BLUE PLAN PROVIDER

REQUIREMENTS EFFECTIVE NOVEMBER 1, 2020

Highmark requires medical necessity review for certain outpatient services to ensure that our members are receiving the appropriate care in the proper setting. Currently, our list of outpatient procedures and services requiring prior authorization applies to our network participating providers in our service areas and also to out-of-network providers in and outside our service areas.

As a reminder, in-network providers are Highmark network participating providers who participate in the member's network as per their benefit plan. 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 their local Blue Plan.

Effective November 1, 2020, Highmark is expanding our prior authorization requirements for outpatient services to include those services provided by out-of-area providers participating with their local Blue Plan. This will assure that the care our members receive while living and traveling outside of the Highmark service areas is medically necessary and managed consistently as it is throughout our service areas. Beginning November 1, 2020, claims for services on the prior authorization list received without authorization will deny and a request for medical records will be sent to the provider's local Blue Plan.

To accommodate electronic submission of authorization requests, Highmark is enabling our NaviNet® portal functionality to accept authorization requests for outpatient services from out-of-area Blue Plan providers when submitted via their local portals.

HIGHMARK'S LIST OF PROCEDURES/DME REQUIRING AUTHORIZATION

Highmark provides a **list of outpatient procedures and services that require authorization** that is updated regularly with notice of additions or deletions communicated on Highmark's Provider Resource Center. This list is also available on the Provider Resource Center by selecting **REQUIRING AUTHORIZATION** from the Quicklinks bar that spans across the top of the Provider Resource Center.

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APPLICABLE PRODUCTS AND IMPLEMENTATION DATES

Effective November 1, 2020, this requirement will apply to Commercial fully-insured and Affordable Care Act (ACA) plans. Self-insured groups will be offered the option upon renewal in 2021.

This change does not apply to the Federal Employee Program (FEP), Medicaid, and indemnity and comprehensive benefit plans. In addition, 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.

MEDICARE ADVANTAGE

Highmark Medicare Advantage members are not affected by this change since medical management for outpatient services is already in place for our Medicare Advantage members seeking care from out-of-area Blue Plan providers.

VERIFYING ELIGIBILITY AND BENEFITS

Providers participating with out-of-area Blue Plans are able to obtain eligibility and benefit information for Highmark members using Blue Exchange®, which is the Blue Cross and Blue Shield Association's inter-Plan system for select HIPAA transactions. Other options include submitting a HIPAA 270/271 electronic eligibility inquiry or calling the BlueCard Eligibility line at **1-800-676-BLUE** (2583).

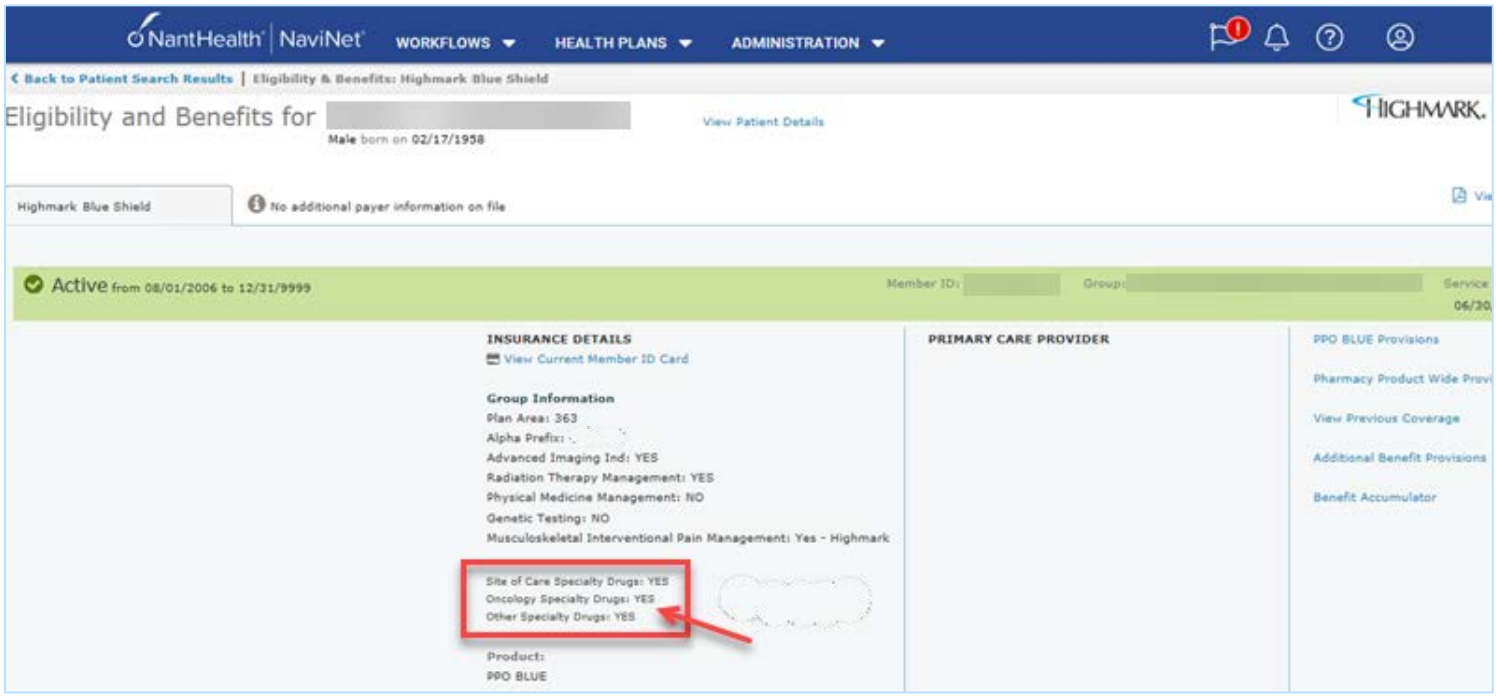
For those members requiring prior authorization for medical and behavioral health outpatient services when provided by an out-of-area Blue Plan participating provider, **Authorization for Outpatient Services** will indicate "Yes" for Out of Area. The provision for authorization for outpatient services will display as one of two options if authorization is required for out of area services:

Authorization for Outpatient Services.....	Yes for In Area Out of Area and Out of Network Services

Or, if the group has not adopted out-of-network management:

Authorization for Outpatient Services.....	Yes for In Area and Out of Area Services

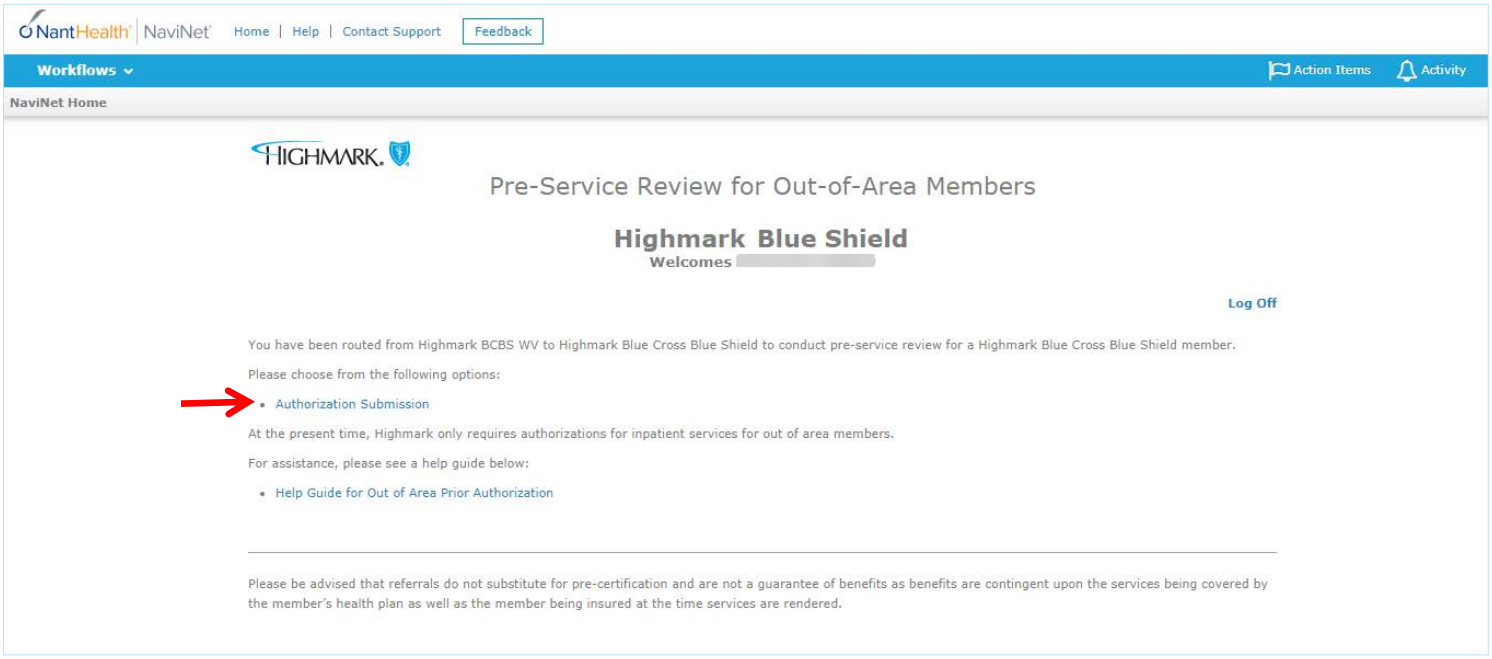
Prior authorization indicators for specialty drugs will be displayed on the member's **Eligibility & Benefits Details** page in NaviNet. If prior authorization is required for Site of Care Specialty Drugs, Oncology Specialty Drugs, and/or Other Specialty Drugs, it will be noted as "YES" after the specialty drug category. See image below for example.



PRIOR AUTHORIZATION SUBMISSIONS

Beginning November 1, 2020, out-of-area providers participating with their local Blue Plans will be able to use their local Plan's portal to conduct pre-service review for outpatient services for Highmark members. Providers can utilize the pre-service review for out-of-area members in their local Plan's portal, enter the Highmark member's 3-character prefix, and then will be routed to the pre-service review capabilities available to Highmark's local providers.

Once you are directed to Highmark's NaviNet portal, you will first see a welcome screen. Click on **Authorization Submission** to begin the authorization request.



You will first complete the **Selection Form**:

- Your information will be pre-populated in Step 1. You are required to enter the **Proposed Date of Service**.
- Member information is entered in Step 2.
- Select **Outpatient** from the **Category** dropdown in Step 3, and then select the applicable **Service**.
- Click on **Submit** to continue through the screens to complete your request.