SPECIAL eBULLETIN

FOR PROFESSIONAL AND FACILITY PROVIDERS **JULY 16, 2018**

HIGHMARK INTRODUCES UPCOMING CHANGES TO PRIOR AUTHORIZATION PROGRAM

1. **New Musculoskeletal Surgery and Interventional Pain Management Services Prior Authorization Program Being Implemented Oct. 1, 2018 (see Insert 1)**
2. **Prior Authorization List to Be Updated Oct. 1, 2018 (see Insert 2)**

Highmark is committed to partnering with health care providers to guarantee that our members, your patients, receive high-quality, medically necessary care in the most appropriate setting. Although there is no substitute for a physician's professional opinion, the reality of today's health care market is that in some instances nationally accepted evidence-based guidelines are not followed, resulting in inappropriate or unnecessary care delivery. Ensuring patients receive appropriate care based on well-established evidence-based clinical guidelines will result in better outcomes, better experience, and lower costs for our clients and our members. At the same time, Highmark is committed to trying to reduce unnecessary barriers to care and streamlining patient experience.

In line with this approach, we are making updates to our prior authorization program to verify that the elective or planned care our members receive is medically necessary, appropriate, and performed in the optimal setting. In accordance with evidence-based guidelines, we are adding additional procedures to our prior authorization list. Simultaneously, to reduce the administrative burden on our provider partners surrounding less complex cases, and to safeguard timely care and a better patient experience, we are removing other procedures from our prior authorization list.

In addition, in keeping with our commitment of promoting continuous quality improvement for services provided to our members, Highmark has entered into an agreement with eviCore healthcare (eviCore) to implement a musculoskeletal (MSK) surgery and interventional pain management (IPM) services program. The new program incorporates a comprehensive clinical review, including predictive intelligence, clinical decision support, and peer-to-peer discussions. This approach confirms our members receive only medically necessary and appropriate MSK surgical and IPM services in the least intensive setting to promote the best outcomes.

The eviCore MSK surgery and IPM program and prior authorization changes will go into effect on Oct. 1, 2018.

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

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We will provide additional information about our new Musculoskeletal Surgery and Interventional Pain Management program and other changes to our prior authorization program as we get closer to the Oct. 1, 2018, implementation date.

Watch for detailed information on the Highmark Provider Resource Center for everything you'll need to know.

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NEW MUSCULOSKELETAL SURGERY AND INTERVENTIONAL PAIN MANAGEMENT SERVICES PRIOR AUTHORIZATION PROGRAM BEING IMPLEMENTED OCT. 1, 2018

Beginning Oct. 1, 2018, eviCore will manage prior authorizations for Highmark members with non-emergent conditions requiring musculoskeletal (MSK) surgery or interventional pain management (IPM) services. eviCore will perform utilization management for MSK surgical procedures and IPM services for Highmark's fully insured Commercial, Medicare Advantage, and Affordable Care Act members.

Highmark will manage prior authorizations for MSK surgeries or IPM services for all other members according to the member's benefits. Benefits can vary by member contract, so please be sure to check the member's benefits before delivering care to confirm if an authorization is required. NaviNet® is available to help you check member benefits and to verify if an authorization is required.

Beginning Sept. 24, 2018, providers may request prior authorization for procedures or services scheduled for Oct. 1, 2018, and after. If a prior authorization is not requested for a procedure or service planned for Oct. 1, 2018, and later, the claim may be denied.

Prior authorization will apply to elective or non-emergent outpatient and inpatient MSK surgeries and to outpatient IPM services. Prior authorization does not apply to services that are performed in the emergency room or in conjunction with an urgent unplanned observation stay.

The MSK and IPM program includes prior authorization for non-emergent MSK surgeries for Highmark members, including inpatient and outpatient lumbar, cervical, and thoracic spinal surgeries, along with hip, knee and shoulder surgeries and related procedures. Prior authorizations will be required for outpatient IPM services such as spinal injections, spinal denervations, and stimulators or pain pumps. This decision is consistent with industry-wide efforts to ensure clinically appropriate quality of care, and to manage the increasing utilization of these services.

Under the terms of the agreement between Highmark and eviCore healthcare (eviCore), Highmark will oversee the eviCore program and will continue to be responsible for claims adjudication and medical policies. eviCore will manage non-emergent outpatient IPM services, and inpatient and outpatient MSK surgeries through the existing contractual relationships with Highmark.

WHAT PROCEDURES REQUIRE PRIOR AUTHORIZATION THROUGH THIS PROGRAM?

The following outlines the specific procedures requiring the prior authorization components of the MSK and IPM program.

MSK Component

Prior authorization will be required for the following non-emergent inpatient and outpatient surgeries:

- Spine surgery: Fusions, decompressions, disc replacements
- Large joint surgery: Joint replacement, arthroscopy, open procedures

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IPM Component
Prior authorization will be required for the following non-emergent outpatient IPM services:

- Spinal injections
- Spinal denervations
- Stimulators or pain pumps

To review the full list of CPT codes that require prior authorization through eviCore, you may go to the Highmark implementation site at **evicore.com/healthplan/highmark**.

Note: Providers rendering the specific services should verify that the necessary authorization has been obtained before providing the service. Failure to do so may result in non-payment of the claim, and you may not seek reimbursement from the member.

KEY PROVISIONS

It is the responsibility of the provider to obtain prior authorization for all MSK surgeries and IPM services listed above.

eviCore does not manage the prior authorization for emergency MSK surgery cases that are admitted through the emergency room or for MSK surgery procedures outside of those procedures listed above.

For urgent unplanned inpatient admissions, the hospital must notify Highmark within 48 hours of the urgent unplanned admission.

Highmark will honor existing prior authorizations for continuity of care on claims for MSK surgeries or IPM services that overlap during the transition to the new program.

eviCore will not approve prior authorization requests for series-of-three epidural steroid injections (ESIs) for back pain. The provider must request prior authorization for each individual ESI. eviCore will evaluate the medical necessity of subsequent ESIs individually. eviCore will determine the medical necessity of subsequent ESIs based on the patient's response to the previous injection with regard to clinically relevant sustained reductions in pain, decreased need for medication, and improvement in the individual's functional abilities.

Appeals for services that were denied before the new MSK and IPM program goes into effect must be submitted to Highmark. Highmark will review the appeal using the medical policy guidelines that were applicable on the date the service was performed.

eviCore will soon offer web orientation sessions to introduce you and your staff to the new MSK and IPM program. During the sessions, you'll receive information about the prior authorization requirements for Highmark members and will learn how to navigate the eviCore website. We encourage you to attend an orientation session to learn about the new prior authorization process for joint surgery, spine surgery, and interventional pain management. For additional details, please visit eviCore's Highmark implementation site at **evicore.com/healthplan/highmark**.

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PRIOR AUTHORIZATION LIST TO BE UPDATED OCT. 1, 2018

Effective Oct. 1, 2018, we are adding approximately 400 codes in the following categories to the **List of Procedures/DME Requiring Authorization**:

- New Musculoskeletal Surgery and Interventional Pain Management program (202 codes: hip, knee replacements, spinal surgeries, and interventional pain management)
- Durable Medical Equipment (28 codes: electric beds, lifts, assistive listening device, speech generator, electric wheelchairs)
- Potential cosmetic (20 codes: vein ligation, blepharoplasties, nasal septum)
- Morbid obesity/gastric bypass (14 codes)
- Behavioral health/substance abuse (21 codes)
- Gender reassignment (2 codes)
- Medical injectables (90 codes)
- Pediatric obstructive sleep apnea (9 codes)
- Non-emergent transportation (4 codes)
- Transplant (5 codes)

We are also removing approximately 300 codes in medical injectables, common DME items (insulin pumps, oxygen, standard wheelchairs), and orthotics to ensure timely access to care and reduce administrative burden.

We will continue to review and assess our prior authorization list for the safety and quality of care for our members in the future.

Highmark will revise its **List of Procedures/DME Requiring Authorization** on Oct. 1, 2018, by adding the procedure codes that will require authorization. Click here to view a list of these codes.

Note: The codes will not require authorization and will not appear on the all-inclusive authorization list on the Provider Resource Center until the effective date, Oct. 1, 2018.

CODES TO BE DELETED FROM AUTHORIZATION LIST, EFFECTIVE OCT. 1, 2018

Effective Oct. 1, 2018, Highmark will delete approximately 300 codes from its **List of Procedures/DME Requiring Authorization**. Click here to view a list of these codes.

Note: The codes to be deleted will still require authorization and will still appear on the authorization list until the effective date, Oct. 1, 2018.

In order for benefits to be paid, the member must be eligible on the date of service, and the service must be a covered benefit.

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Authorization for services, including those on our list of procedures or DME requiring authorization may not be required for all members. Please be sure to check the member's benefits before delivering care to verify if authorization is required. Providers should use NaviNet® to obtain authorization for services.

Providers who do not have NaviNet should call or fax their request to Clinical Services to obtain authorization for services.

The **List of Procedures/DME Requiring Authorization** for Highmark is subject to change. Remember, during the year, Highmark makes several adjustments to the full list of outpatient procedures, services, durable medical equipment, and drugs requiring authorization.

For more information on obtaining prior authorization or to view the current list of codes that require prior authorization, please visit the Provider Resource Center and look under the **Claims, Payment & Reimbursement** option. The Resource Center is accessible via our Highmark NaviNet system or under **Helpful Links** on our website.