Medical Policy & Utilization Management Professional and Ancillary Overview

Agenda

Medical Policy Overview	Member & Service Eligibility
	Introduction to Medical Policy and Mission Statement
	Medical Policy Responsibilities
	Commercial Annual Review Process
	Medicare Advantage Policy Review Process
	Innovation & New Technology
	Available Medical Policy Resources
UM Overview	Authorizations
	Decision Review
	Clinical Quality of Care
	Resources
Pharmacy Formulary	Understanding Formulary Restrictions & Process
	Identifying Needed Medical Information
	Requesting a Drug Authorization
	Utilization Management Pharmacy Policies

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Member Eligibility & Benefits

Prior to requesting an authorization for services, providers should:

1. Validate active coverage for the member
2. Validate member benefits for the proposed service
3. Review the medical policy and medical necessity for the proposed service on the Provider Resource Center
4. If the goods or services require authorization, ensure that you acquire the appropriate authorization

Availity®

All steps can be accomplished by using the **Provider Portal**

www.Availity.com

The **fastest** and **most accurate** means of entering & managing authorizations

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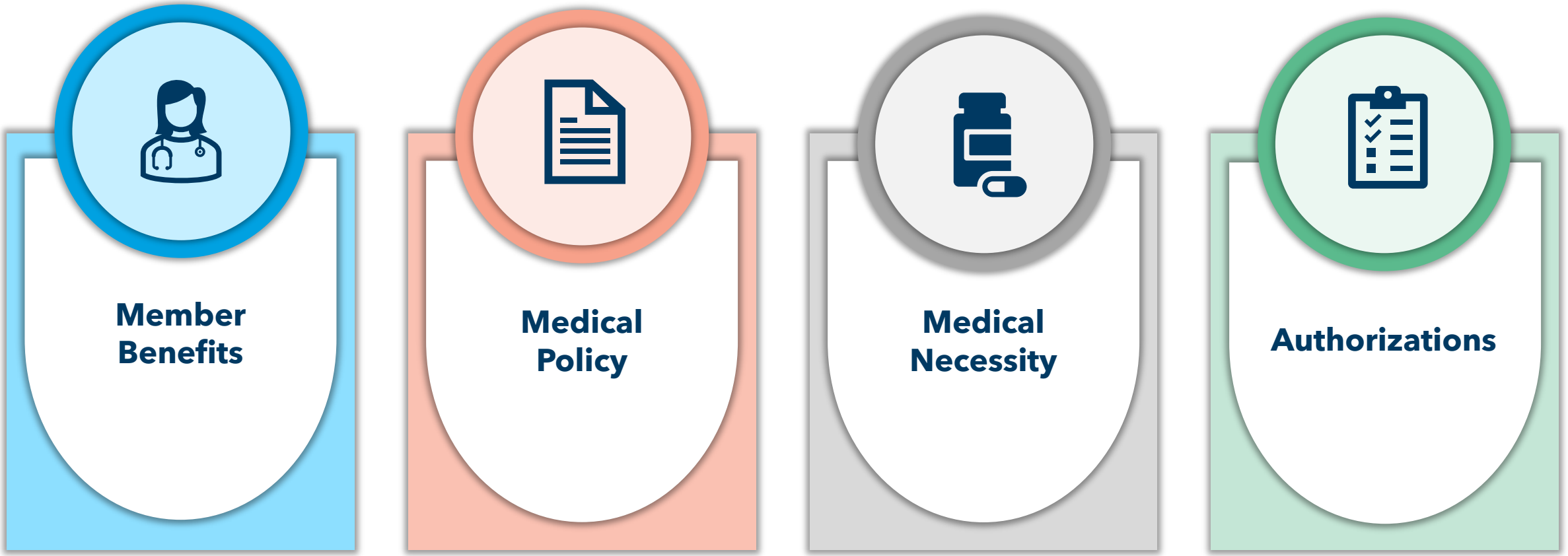
Eligibility of Services

Eligibility of Services is determined by:



Medical Policy

Highmark Medical Policy

Medical Policy Department Mission

To develop and maintain **evidence-based coverage guidelines** and monitor/assess the medical technology* pipeline to anticipate and plan for the evolution of therapies to **ensure appropriate benefit adjudication**, **patient safety** and **optimized therapy** for our customers.

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*Medical technology includes any intervention or service to treat any medical/surgical condition. These technologies may include drugs, devices, procedures and/or gene therapy.

Medical Policy Responsibilities

Policy Development

1. Develop Commercial and Medicare Advantage medical policies **in accordance with national standards such as CMS, NCQA and BCBSA**, outlining medical necessity and coverage guidelines for:
   - Medical
   - Surgical
   - Injectable products

2. Medical Policy is integral to Payor organization and has its own standards and methods including:
   - **Integrating evidence-based practices**
   - Utilizing internal resources
   - Seeking external opinions

Policy Operationalization

1. Commercial and Medicare Advantage policy guidelines are deeply integrated into the claims processing system
2. Implementation of pre-payment edits within the claims processing system through:
   - Applying medical coding to criteria
   - Diagnosis
   - Quantity Level Limits (QLL)
   - Place of Service
   - Provider Class
3. Leading to:
   - **Reduction of administrative work** for post-payment review
   - **Proper claims adjudication**
   - **Cost Avoidance as a result of denials due to claims not meeting MP criteria**

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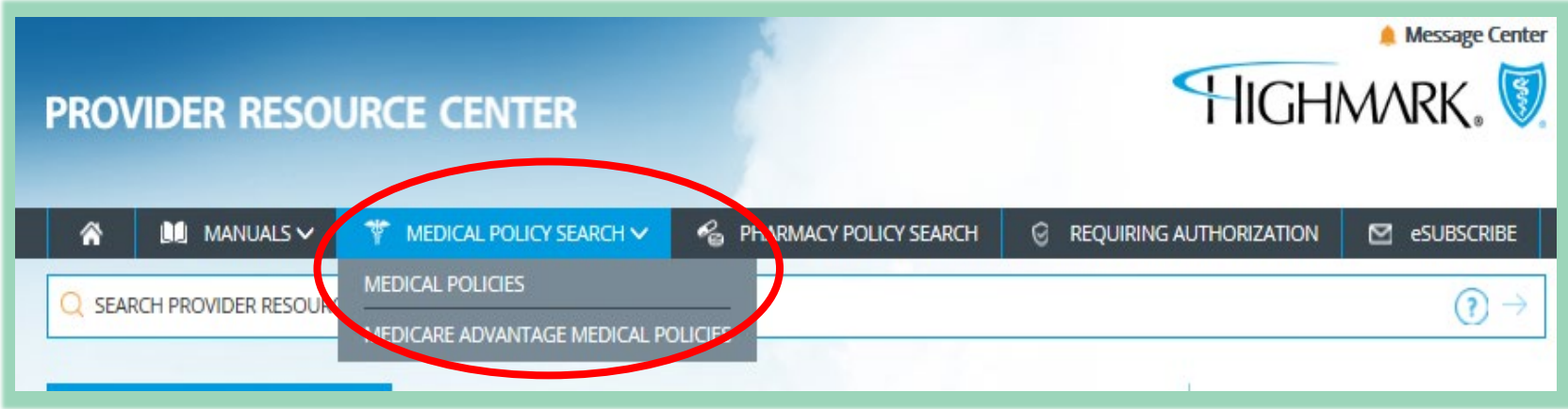
Available Medical Policy Resources

Medical Policy Search



1. Available on the Provider Resource Center on the top navigation bar
2. Choose "Medical Policies" or "Medicare Advantage Medical Policies"

Use the "Search" function to search by key word, name, number, or procedure code

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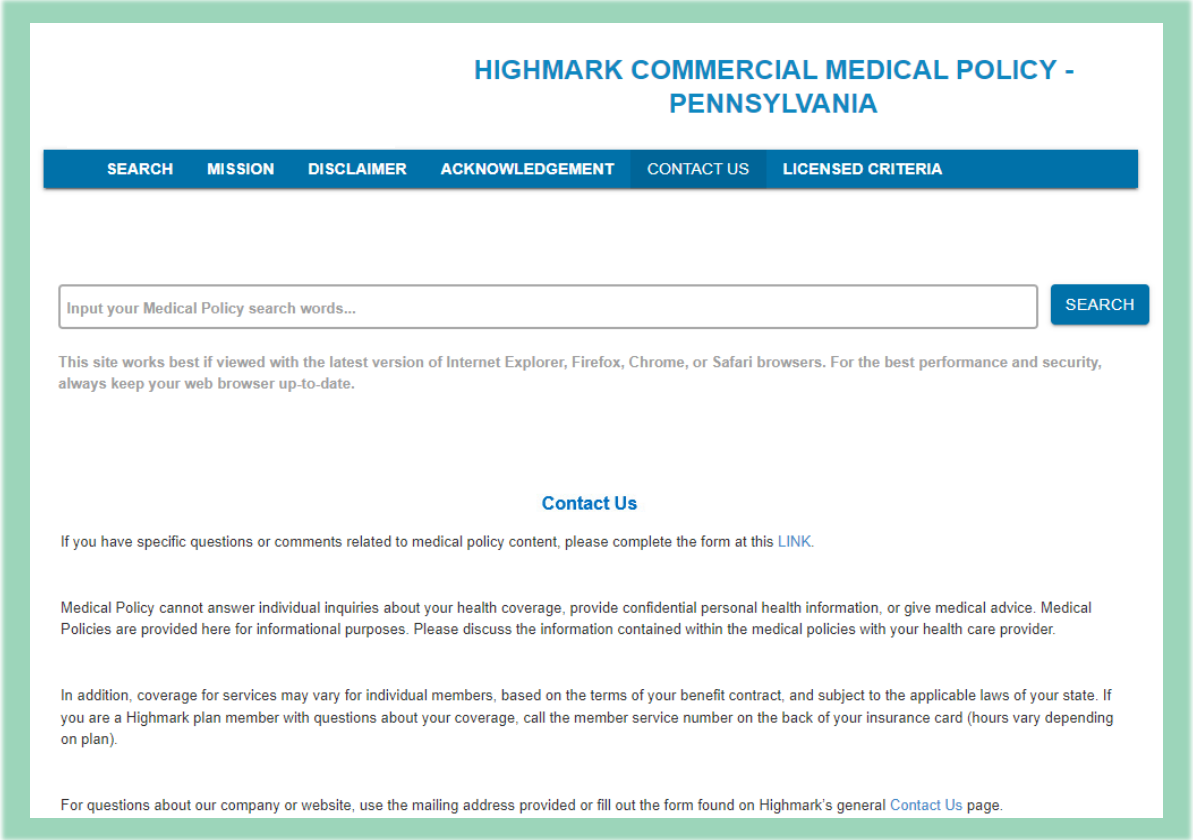
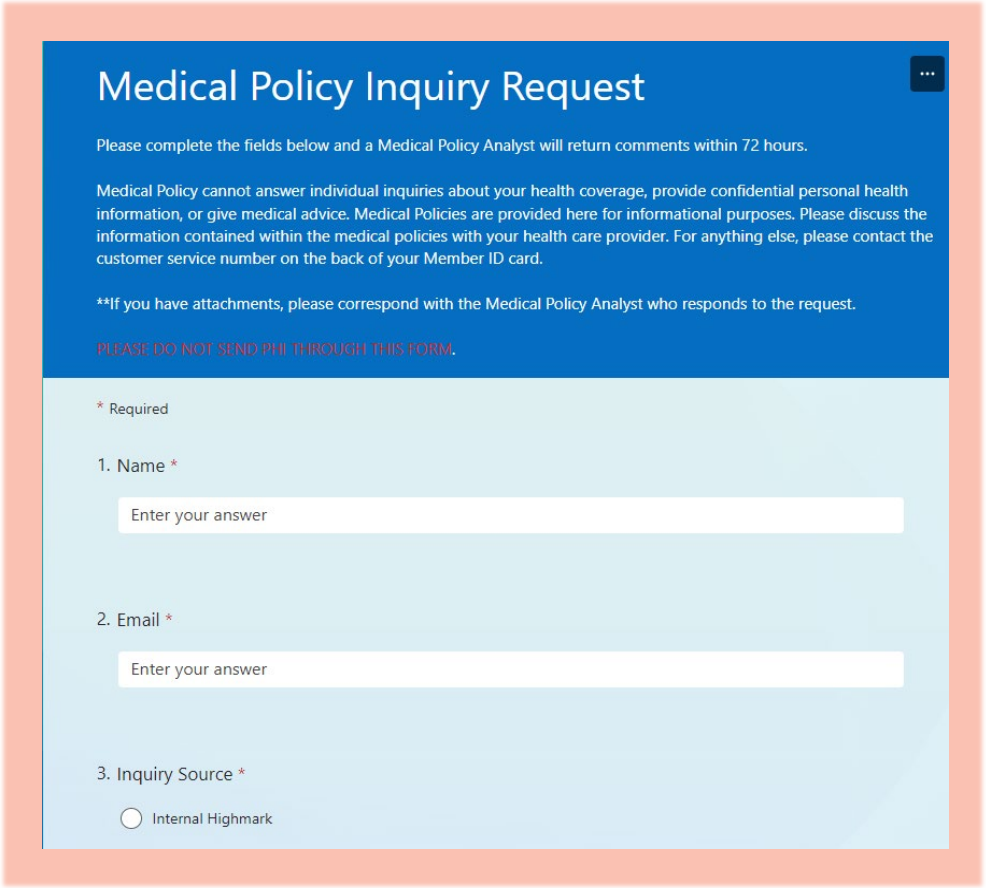
Submitting a Medical Policy Inquiry





Providers can utilize the Medical Policy Inquiry Request form to:

1. Ask a Medical Policy-related question
2. Request the Medical Policy team review a new technology
3. Request the Medical Policy team review the current established coverage of a procedure or service

Do not submit PHI through this form

Medical Policy Resources

Medical Policy Update Newsletter (MPU)

Monthly newsletter for the health care providers who participate in our networks and submit claims to Highmark

Available on the Provider Resource Center at NEWSLETTERS/NOTICES > Medical Policy Update Newsletter

You can sign up for “e-Subscribe” and receive a monthly email notification when the latest issue of Medical Policy Update is published

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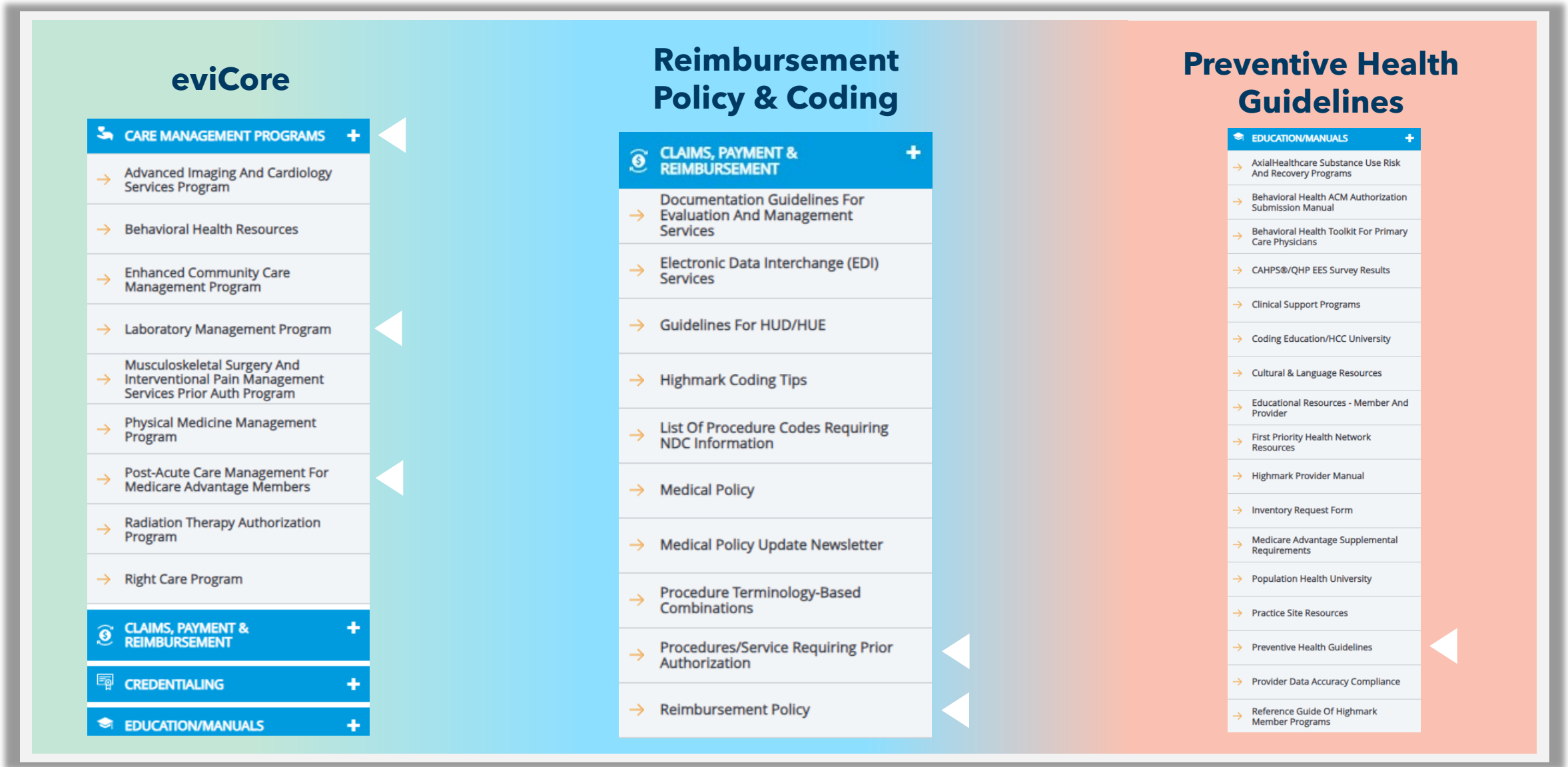
Available Resources



Utilization Management

Authorizations

Outpatient Authorizations:

Use **Availity** to request all authorizations, including eviCore Managed services.

To reduce administrative burden and unnecessary wait time, before submitting an authorization request for outpatient services please confirm that the member's benefit requires one.

Highmark maintains a list of outpatient procedures that generally require an authorization on our Provider Resource Center, however this does not act as an all-inclusive list and the member's benefits should always be reviewed.

For fully insured businesses, outpatient authorization requests will be determined in accordance with the timeframes set forth in Section 2155 of PA Act 146 of 2022 (40 PS § 991.2155).

Once an outpatient authorization is on file, service date changes do not need to be communicated to Highmark if they are within the original 60 day time frame.

Authorizations

Exception: Maternity Care

An authorization is not required for a normal inpatient delivery for maternity care unless clearly designated in a member's benefit. Normal inpatient delivery is 48 hours for vaginal delivery and 96 hours for caesarean section.

Highmark should be contacted for any non-routine or emergency inpatient admissions for maternity care, within 48 hours after admission, such as admissions for hyperemesis, preterm labor, placenta previa, and preeclampsia.

If the mother and/or baby require an inpatient stay that exceeds these time frames post-delivery, authorization would be required.

Use Availity to request all authorizations.

Authorizations

Inpatient Non-Urgent (Planned) Authorizations

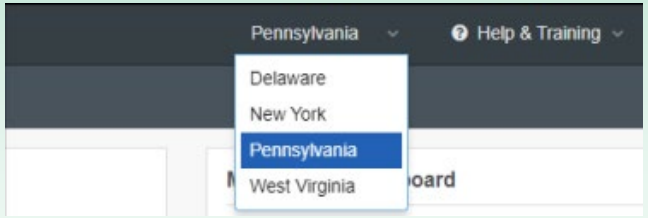
- Use **Availity** to request all authorizations.
- Authorization requests should be submitted at least 14 days in advance prior to a planned admission or service, when possible, or as soon as the intended admission or service is known.
- Highmark will provide notification of determination as soon as possible, but no later than 14 calendar days after receipt of the request in non-urgent cases.
- If your service is within the next 72 hours, please submit your request and contact Utilization Management **(800) 452-8507**.

Authorizations

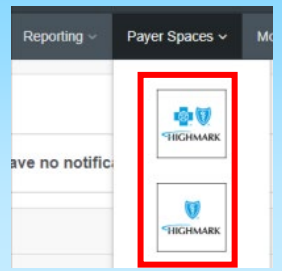
Authorization Self-Service Capabilities

Predictal can be accessed through Availity using the following steps:

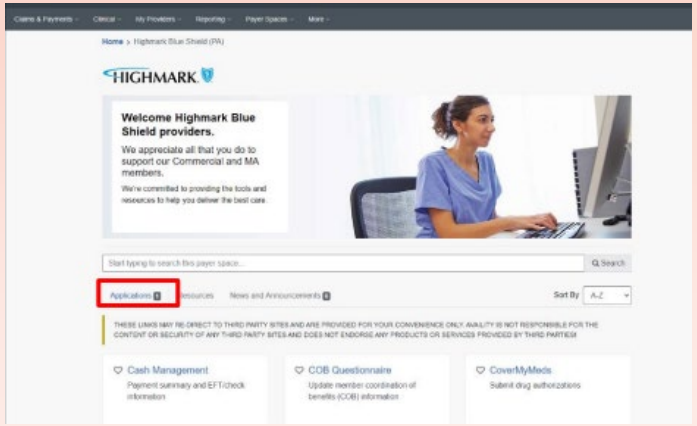
Step 1: After logging in to Availity, select the appropriate **state** for your practice/facility.

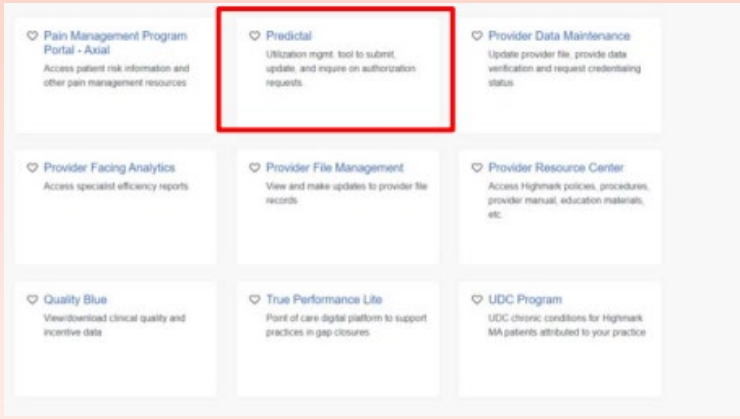


Step 2: Select **Payer Spaces** for the appropriate HealthPlan.



Step 3: Within Payer Spaces, look under **Applications** and select Predictal.





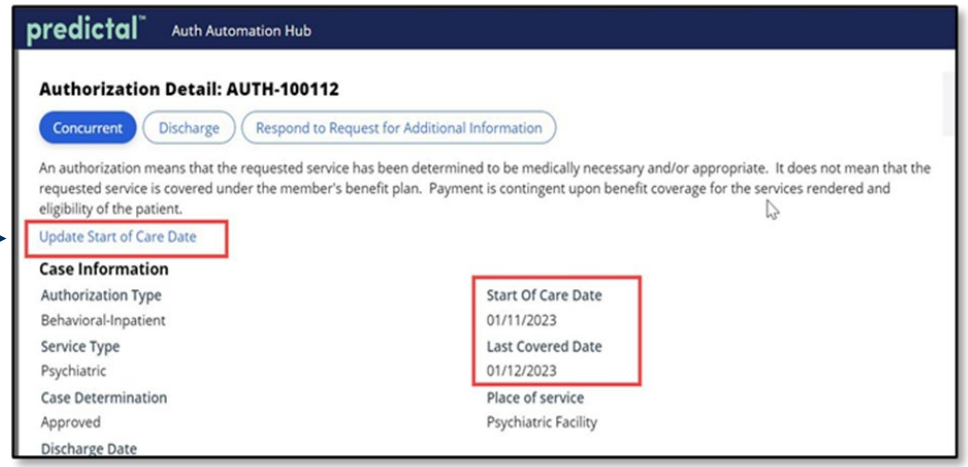
Authorizations

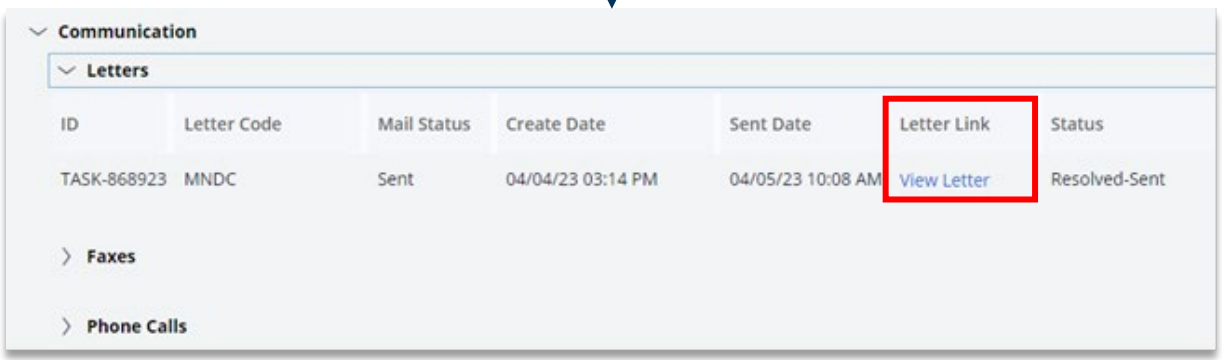
Authorization Self-Service Capabilities

Availity is the fastest means to enter, update, and obtain information on authorizations.

Additional ways to utilize Availity for Authorizations post submission include, but are not limited to:

- Updating the start of care date (the revised date must be a future date of care)
- Discharge Planning
- Concurrent Review
- Review approval and denial letters (once generated these will appear at the bottom of the authorization page)
- Authorization Status or View Letters (Status of authorization can also be obtained via IVR by utilizing the number on the back of the members card)
- Responding to a request for additional information





Authorizations

Post-Acute Admissions

Use **Availity** to request all authorizations.

It is recommended that any request for inpatient post-acute transfers be initiated within 24-48 hours of anticipated discharge.

Escalations for post-acute admissions will be handled on a case-by-case basis to best meet the patient's specified needs. If you need to escalate an authorization for post-acute care, please contact Utilization Management **(800) 452-8507**.

In addition to acute care hospitals, authorization is also required for the following admissions:

- Long-term acute care hospital (LTAC)
- Inpatient Rehabilitation facility (IRF)
- Skilled nursing facility (SNF)
- Mental health or substance abuse treatment facility

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Decision Review

Peer-to-Peer Conversation

The request for a Peer-to-Peer for a commercial, ACA, or CHIP member can be made after an initial adverse determination by following the steps below:

- To initiate the request, the provider should call the Peer-to-Peer tollfree phone number:
  1-866-634-6468.
- Hours of operation are standard business hours.
- If an emergent need arises before or after business hours, the option to leave a voicemail message is available.
- Peer-to-Peer is available until an internal appeal is initiated, or for a time limit of 180 days, whichever comes first.

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Decision Review

Provider Appeals

There are 2 paths for provider appeals:

1. The provider is acting as the member's authorized representative under Act 146, and therefore must follow the Act 146 requirements for the member appeal.
2. The provider is appealing on its own and NOT acting as the member's authorized representative under Act 146.

The type of appeal available to the provider following a medical necessity denial is determined by the urgency of the situation, as well as the physician's assessment of the situation:

a. **Expedited appeal**: treating provider believes that a delay in service will adversely affect the member's health.
b. **Standard appeal**: pre-service denials in non-urgent situations and for appeals of a post-service denial decision.

- Requests for appeals may be **submitted either by telephone or in writing**.
- Unless specified differently in the member's contract, a provider has **180 days** from the date of the initial denial of coverage in which to file an appeal.
- For the Highmark Healthy Kids/Children's Health Insurance Program (**CHIP**) in Pennsylvania, a provider has **60 days** from the date of the initial denial of coverage in which to file an appeal.

Decision Review

Retrospective Review

- If a claim has not been submitted, a retrospective authorization can be requested via Availity within **7 days** of the date of service.
- If a Retrospective Review is greater than 7 days, Retrospective Reviews can only be requested when the claim has been filed and is denied for no authorization.
- Highmark's claims processing system will automatically reject the claim when no authorization is on file but required under the member's agreement.
- Claims can also reject for no authorization when the service on the submitted claim does not match the authorization. This can include procedure code, diagnosis code or place of service differences.

- When the claim denial notification is received (via the remittance advice), submit pertinent clinical information with a cover letter explaining the circumstances to the applicable address below:

  Highmark Medical Review
  P.O. Box 890392 Camp Hill, PA 17089-0392

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Clinical Quality of Care Review Process

Standard of Care

All member QOC complaints and internal quality flag referrals (including accompanying clinical information) are initially reviewed by a registered nurse to determine a potential deviation in the standard of care

If additional clinical information is needed to determine a potential deviation, the QOC team will contact the provider/facility via email or fax requesting specific clinical information relevant to the QOC issue

The ultimate determination of a deviation in the standard of care is made by a Highmark medical director

If a deviation in the standard of care has been identified, the QOC team will correspond directly with the provider/facility regarding the specific issue

If a QOC concern arises for HH, SNF, IRF, LTAC, Hospice, or OPT, the Helion team will reach out to complete a root-cause analysis and gather additional information

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All clinical quality of care reviews must be completed within 30 days of receipt, therefore, a prompt response for all requested information is required

Resources

Provider Resource Center (PRC)

https://hbs.highmarkprc.com/Southeastern-PA-Providers/SEPA-Provider-Information

Highmark offers additional resources and trainings on our PRC. You can obtain this information by accessing the Claims Payment Reimbursement/Procedure Service Requiring Prior Authorization via the PRC.

Inpatient Authorizations Guides
Including step-by-step Helion Arc authorizations guide.

Outpatient Authorization Guide
Including step-by-step Helion Arc authorizations guide.

List of Procedures/DME Requiring Authorization

Provider Orientation
Southeastern region-specific onboarding materials

MCG Guidelines Product Acronym List

MCG Clinical Criteria: Information on Highmark's incorporation of MCG Health evidence-based clinical guidelines into HMK's criteria of clinical decision support.

Medical Management Partners

Our partners in Member Care

eviCore innovative solutions	Musculoskeletal (MSK)
	Advanced Imaging and Cardiology
	Lab
	Radiology Oncology
naviHealth	Post-Acute Skilled Nursing Care
Third Party Administrators	As determined by the member's benefits
Helion ARC	Physical Medicine Management & Home Health

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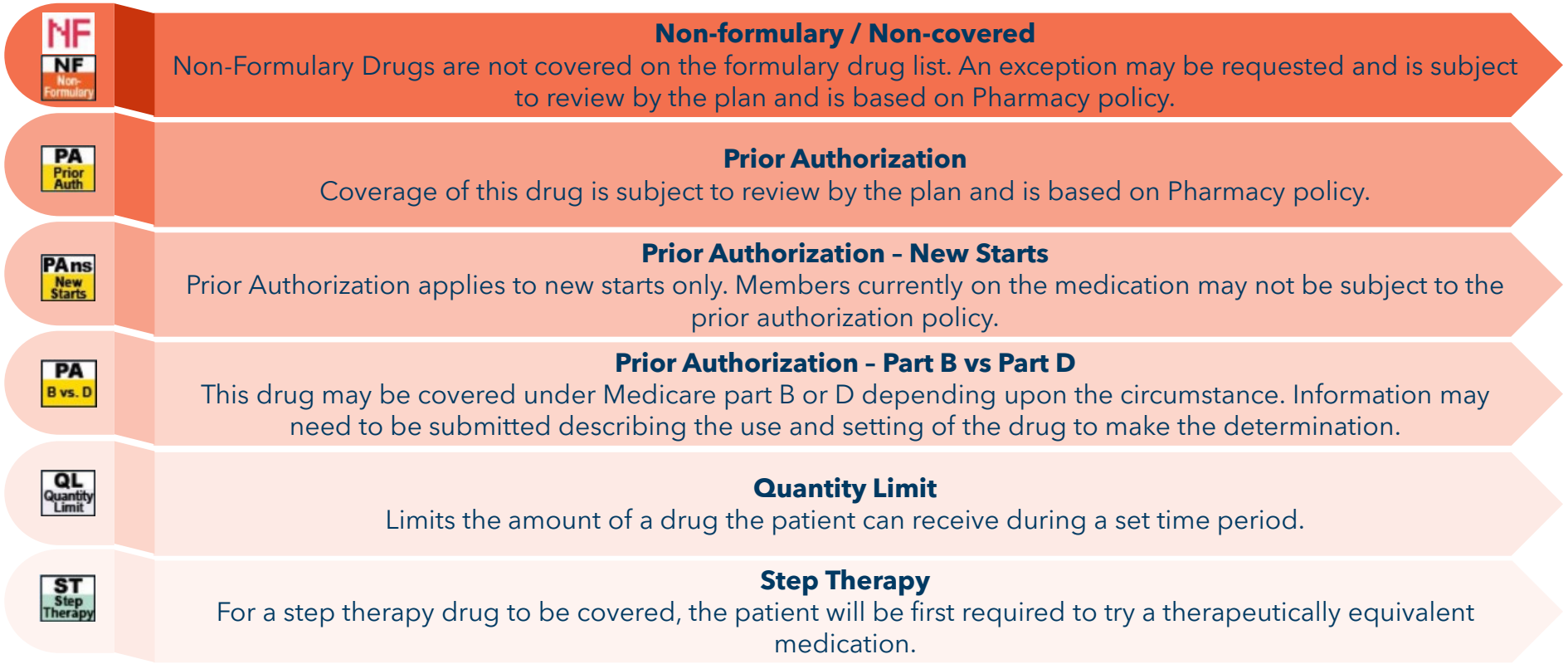
* naviHealth is only MA for LTAC, IRF, and SNF for Highmark beginning in 2025

Pharmacy Formulary & Utilization Management

Understanding Formulary Restrictions

Before prescribing medications, check to see if there are coverage restrictions.
These restrictions are in place to ensure patient safety and meet FDA Requirements.
It will also help minimize delays in getting medications to your patients.



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Identifying Needed Medical Information

When searching within the formularies, click on the icons that appear next to the medication name to view more details on what is needed for authorization.

Brand Name *Generic Name*	Therapeutic Class *Sub-class*	Dose/ Strength	Status	Notes & Restrictions
Humira 40 Mg/0.8Ml Subcutaneous Syringe Kit	MUSCULOSKELETAL / RHEUMATOLOGY *OTHER RHEUMATOLOGICALS*	SYRINGE KIT 40 mg/0.8 mL	SP Specialty Product	QL Quantity Limit PA Prior Auth

Use the Pharmacy Policy Search on the Provider Resource Center

Search by using the medication name. You will then be able to view details on restrictions and the medical information needed when requesting an authorization.

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Requesting a Drug Authorization

Electronic submissions through Cover My Meds are the most efficient way to request an authorization.

Or you can fill out a Pharmacy Prior Authorization form and fax or mail it to Highmark. It will speed up the process so there is little delay in helping your patients.
Here is how it works:

1	Use the applicable **Pharmacy Prior Authorization Form** found under the *Forms* section on the Provider Resource Center.
2	Include only one patient and one prescription per request.
3	Include all supporting clinical documentation.
4	Double check the form to make sure everything is filled out and accurate.
5	Fax form to 1-866-240-8123 or mail to: Clinical Services, 120 Fifth Ave, MC P4207 Pittsburgh, PA 15222

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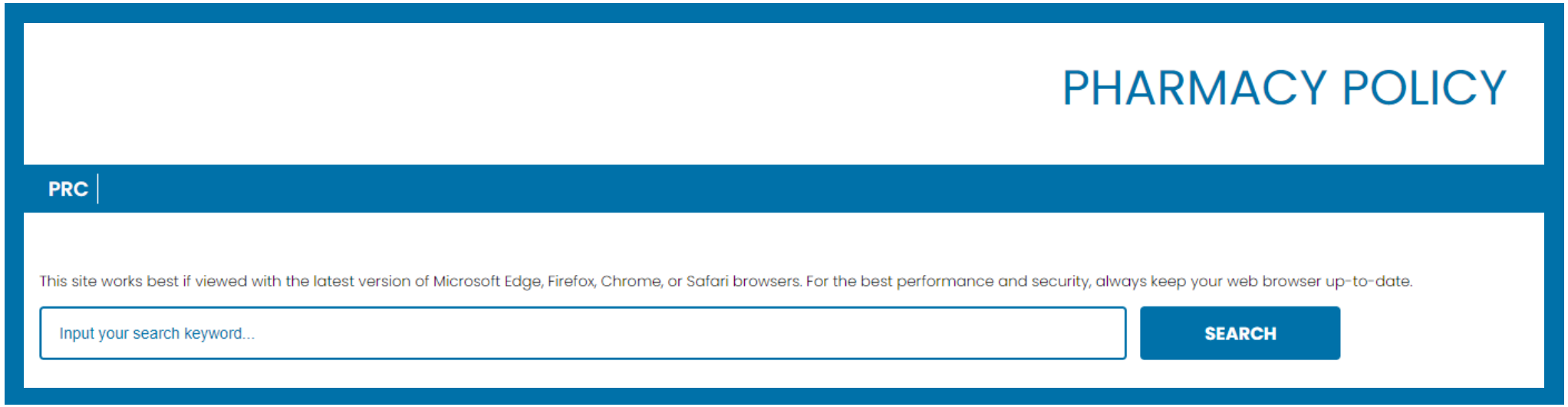
Utilization Management Policies

Other more cost-effective medications first

Ensure appropriate use (e.g., confirm patient diagnosis, age)



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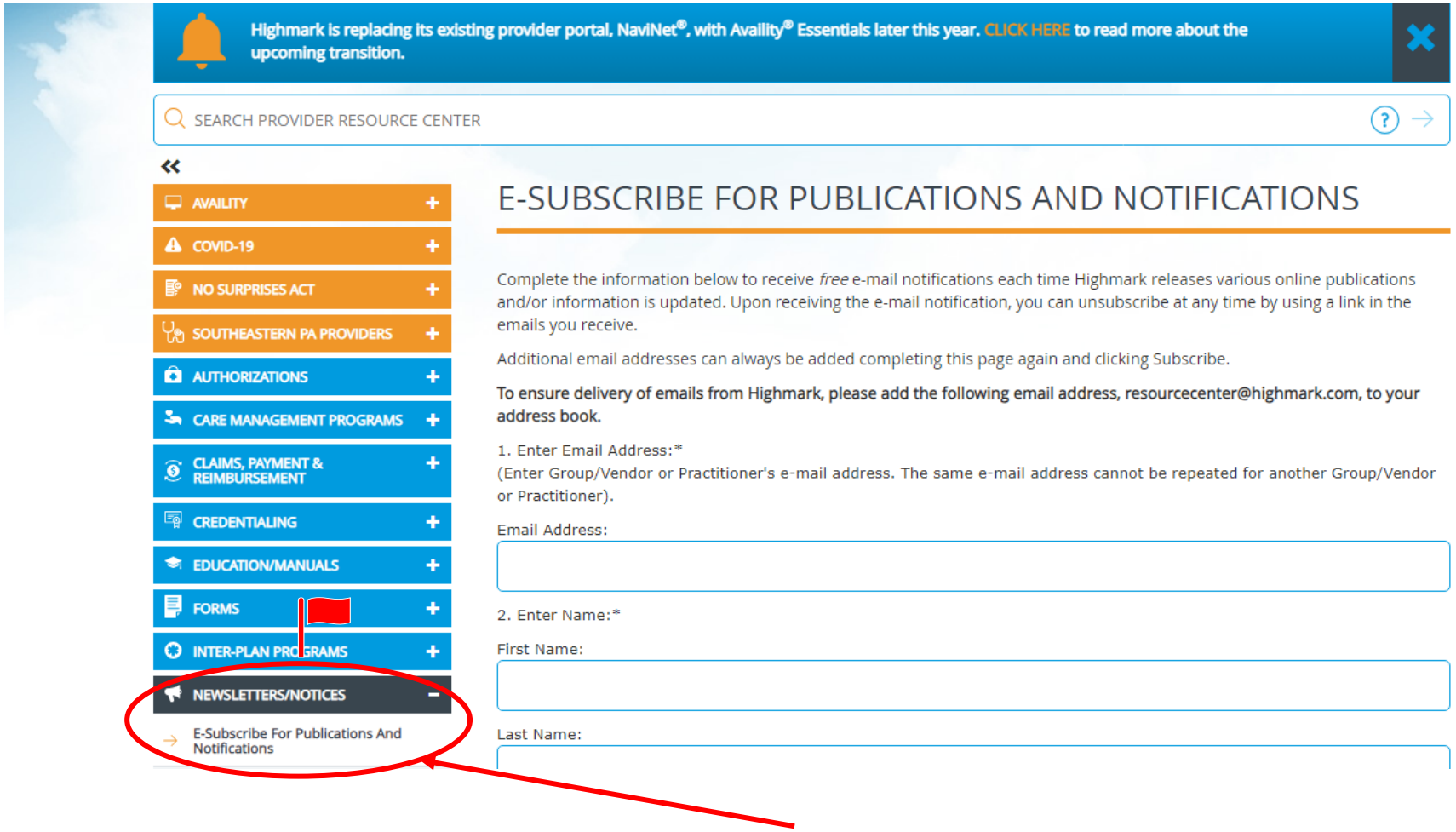
Questions?

Appendix

How to e-Subscribe



Go to "Newsletters/Notices"

Authorizations

Availity®

www.Availity.com

The **fastest** and **most accurate** means of entering & managing authorizations

Always use Availity first. If your issue cannot be resolved using Availity, you can utilize the following alternate forms of communication:

(800) 452-8507

UM Team (for clinical issue resolution)

Availity provides all status information on authorizations

Inpatient Faxes*

(800) 416-9195

PA Highmark members

(877) 650-6069

Highmark DE members

Outpatient Faxes*

(888) 236-6321

PA Highmark members

(800) 670-4862

Highmark DE members

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*Faxing should be utilized ONLY when electronic submissions are not available.
Please indicate proper return fax numbers in all fax submissions.

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