UTILIZATION MANAGEMENT GUIDE

The UM Department is available at the following phone numbers:
1-800-392-1147 (PA Medicaid); 1-800-685-5209 (PA Medicare)

Updated 10/13/22

Prior Authorization for Specific Services

- Authorizations allow us to verify eligibility, assess medical necessity, establish appropriate location for services and identify members who would benefit from Case Management. It is important for prior authorizations to be accompanied by complete clinical information supporting the specific services being requested.
- The ordering Provider is responsible for obtaining authorization.
- Refer to the **Provider Portal within NaviNet** for a listing of services which require precertification. NOTE: ALL services provided by a non-participating provider require prior authorization.
- Prior authorization is required for potentially experimental, investigational or cosmetic services.
- Non-covered benefits will not be paid unless special circumstances exist. A medical director's review of a request may determine that the item requested is non-covered.

Prior Authorization Timeframe – Medicare Assured℠

- We require that elective inpatient authorizations be submitted in advance. In the event of an emergency, the authorization must be submitted within four business days of the admission.
- Non-urgent precertification decisions and notifications will be made no later than 14 calendar days from receipt of the request.
- Urgent precertification decisions and oral notifications are made as urgently as the member's condition requires.
- Concurrent decisions and oral notifications are made in 1 calendar day from receipt of the request; written notification will follow within 3 calendar days.
- Expedited decisions and oral notifications will be made within 72 hours; written notification will follow within 3 calendar days.
- Failure to prior authorize may result in an administrative denial of the claim with no review of medical necessity.
- Failure to obtain an authorization will result in a claims denial, for untimely authorization. This will necessitate the need for an appeal.

- Prior authorization request is not required for observation.

Prior Authorization Timeframe – Medicaid

- We require that inpatient authorizations be submitted in advance. In the event of an emergency, the authorization must be submitted within four business days of the admission.
- We make non-urgent precertification decisions and oral notification within 2 business days from receipt of the request with complete clinical information.
- Urgent decisions and oral notifications are made as urgently as the member's condition requires, but no later than 3 calendar days from receipt of the request.
- Concurrent decisions and oral notifications are made in 1 calendar day from receipt of the request; written notification will follow within 3 calendar days.
- Failure to obtain an authorization will result in a claims denial for untimely authorization. This will necessitate the need for an appeal.
- Prior authorization request is not required for observation.

Submitting Authorization Requests Electronically Via NaviNet

- Participating providers who currently have access to NaviNet are encouraged to utilize the portal to submit authorization requests electronically.
- Participating provider types who do not have access to NaviNet will have to go through the existing process of submitting authorization requests via phone or fax.
- Failure to prior authorize may result in an administrative denial of a claim with no review of medical necessity.

Tips for Submitting a Prior Authorization Request

- Listen carefully to the voice options on phone message.
- Fax number to request an inpatient authorization from Utilization Management is 1-888-245-2034 (all states) and must include the following clinical documentation:
    - Member demographic information (Name, address, telephone number, date of birth, gender, etc.)
    - Other insurance, if applicable
    - Type of admission (elective versus emergency)
    - Date and time of admission
    - Diagnosis and surgical procedures (applicable only if surgical admission)
    - Admitting physician
    - Past medical history, outpatient treatment tried and failed, including ED visits; recent/current labs, diagnostic testing, medications, etc.
    - Admission orders/treatment plan, consultations, diagnostic testing, lab work, medications, X-rays, etc.

- Psychosocial assessment including any behavioral, economic, environmental, medical, social or spiritual problems. Expectation of discharge needs including home health visits, therapy (PT, OT or Speech) needs, IV infusion setup or enteral feeding requirements, DME, and placement in post-acute care (SNF, LTAC, Rehab)

Criteria for Services

Medicare National and Local Coverage Determinations, McKesson InterQual criteria, and written medical policies are utilized to assist with medical necessity review. Our medical policies are available on the website. If a request for a covered service does not meet the criteria requirements, a Medical Director will review for a medical necessity determination. An opportunity to discuss the request with the Medical Director will also be provided to the ordering physician, when applicable per CMS and NCQA guidelines.

Ambulance

Urgent medically necessary ambulance transports do not require authorization.

Durable Medical Equipment (DME)

- Some DME items require prior authorization. Refer to the Provider Portal within NaviNet for a list of DME items requiring prior authorization.
- All DME supplied by a non-participating DME provider requires prior authorization.
- The following information will be needed in order to submit a prior authorization request: DME order, member info, equipment or medical supply (appropriate codes), cost, rental or purchase, number of items (period of time using) and clinical information to support request.

Therapy Evaluations and Re-Evaluations

- An authorization is not required for initial evaluation or re-evaluation for PT, OT and ST. Additional therapy sessions require authorization.
- Initial evaluations and re-evaluations cannot be done on the same day that the member also received a therapy service, or the claims will deny.
- Therapy services are authorized for a specific timeframe. If the service is unable to be performed within the timeframe, the provider will need to call NIA (Magellan Health) or the claim will deny.

Case Management

- Many factors impact the ability and desire for members to focus on their health. Case Managers intervene with members who have complex medical or social issues.
- Our Case Management Dept. has expertise in the following areas: Oncology, Medically Fragile Children, Medical/Surgical, HIV/AIDS, Obstetrics and MH/MR. Case Management services are available to assist in the care of any member, regardless of diagnosis.

Coordination of Care

- Communication with the PCP is critical for overseeing patients care. Hospitals and specialists must send all records and test results to the member's PCP.

Maternity

- The Maternity Outcome Authorization Form is to be faxed to 1-855-888-8252. The form notifies Highmark Wholecare UM that a woman has delivered and helps to ensure payment for delivery charges. UM responds by faxing the form back to the hospital with an authorization number to cover the delivery.

Letters of Medical Necessity –Medicare Assured

- Discuss the need for a Letter of Medical Necessity (LOMN) with the UM representative
- LOMN can be faxed with any supporting documentation such as progress notes, testing results, or consultations by specialists
- LOMN should be submitted by the appropriate licensed healthcare professional such as MD, DO, CRNP, NP or PA (not all inclusive)
- LOMNs can be submitted for new and ongoing requests for services
- LOMNs should outline the item or service requested, place of service, and quantity/duration of the service requested
- LOMNs may outline the member's overall condition and needs as well as any recent or expected changes to the members overall condition

Letters of Medical Necessity – Medicaid

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- LOMNs may outline the member's overall condition and needs as well as any recent or expected changes to the members overall condition
- Explain why the service or item is medically necessary
    - How the service or item may prevent onset of an illness, condition or disability
    - How the service or item may reduce or ameliorate the physical, mental or developmental effects of the illness, injury or disability
    - How the service will assist the member to achieve or maintain maximum functional capacity in performing activities of daily living

    - The member’s functional capacity and the functional capacities that appropriate for members of the same age
- Members receiving pediatric shift care services should have a new LOMN annually
- Requests for admissions to a skilled facility for members under age 21 should explain why the needed care cannot be provided in the home setting.

NaviNet® is a separate company that provides an internet-based application for providers to streamline data exchanges between their offices and Highmark Wholecare such as, routine eligibility, benefits and claims status inquiries.

Health benefits or health benefit administration may be provided by or through Highmark Wholecare, coverage by Gateway Health Plan, an independent licensee of the Blue Cross Blue Shield Association (“Highmark Wholecare”).