

Medical Policy & Utilization Management Facility 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



Member Eligibility & Benefits

Prior to requesting an authorization for services, providers and facilities 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



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

www.Availity.com

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

Eligibility of Services

Eligibility of Services is determined by:



Member Benefits



Medical Policy



Medical Necessity



Authorizations

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.

Medical Policy Responsibilities

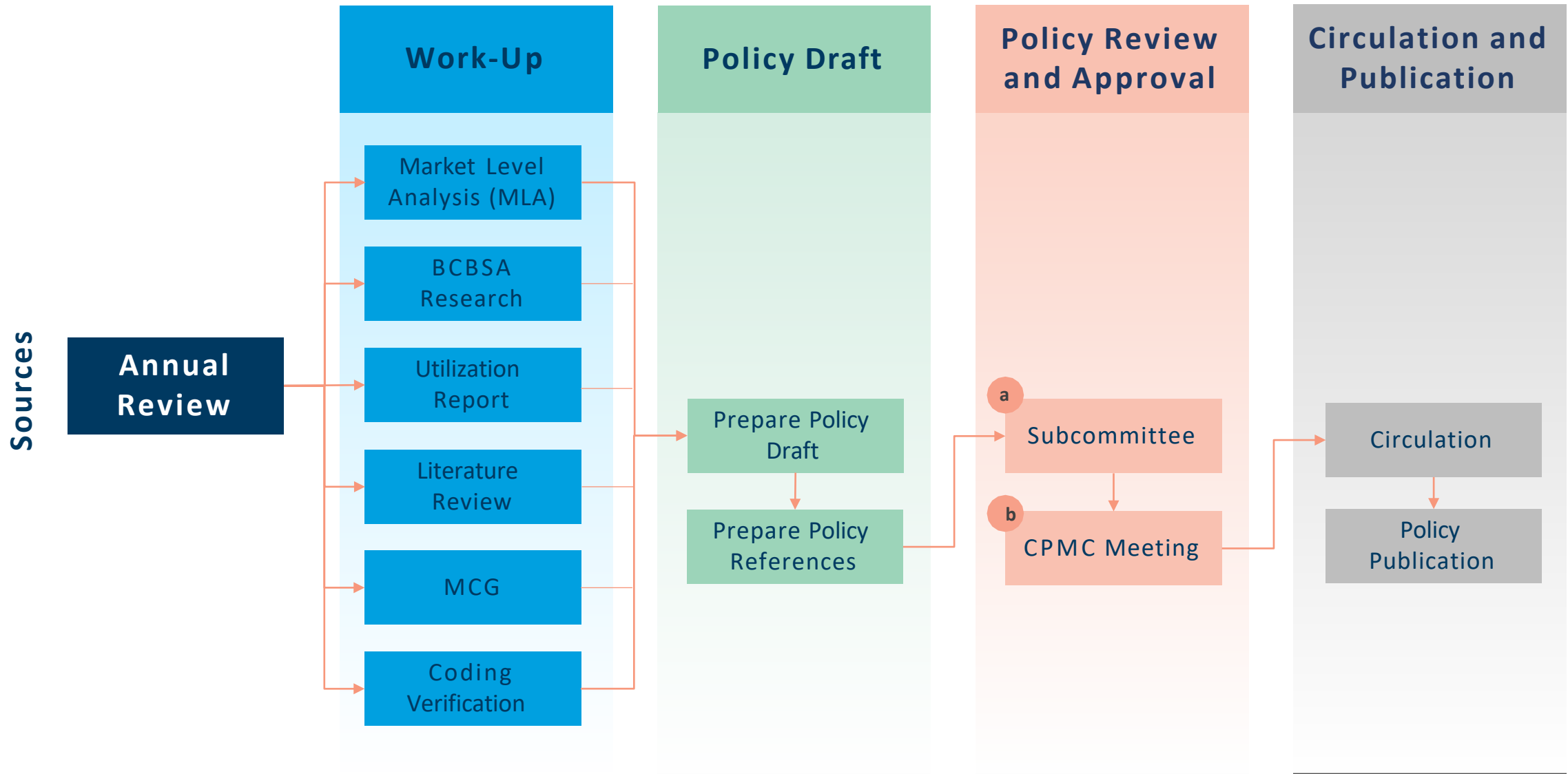
Policy Development

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

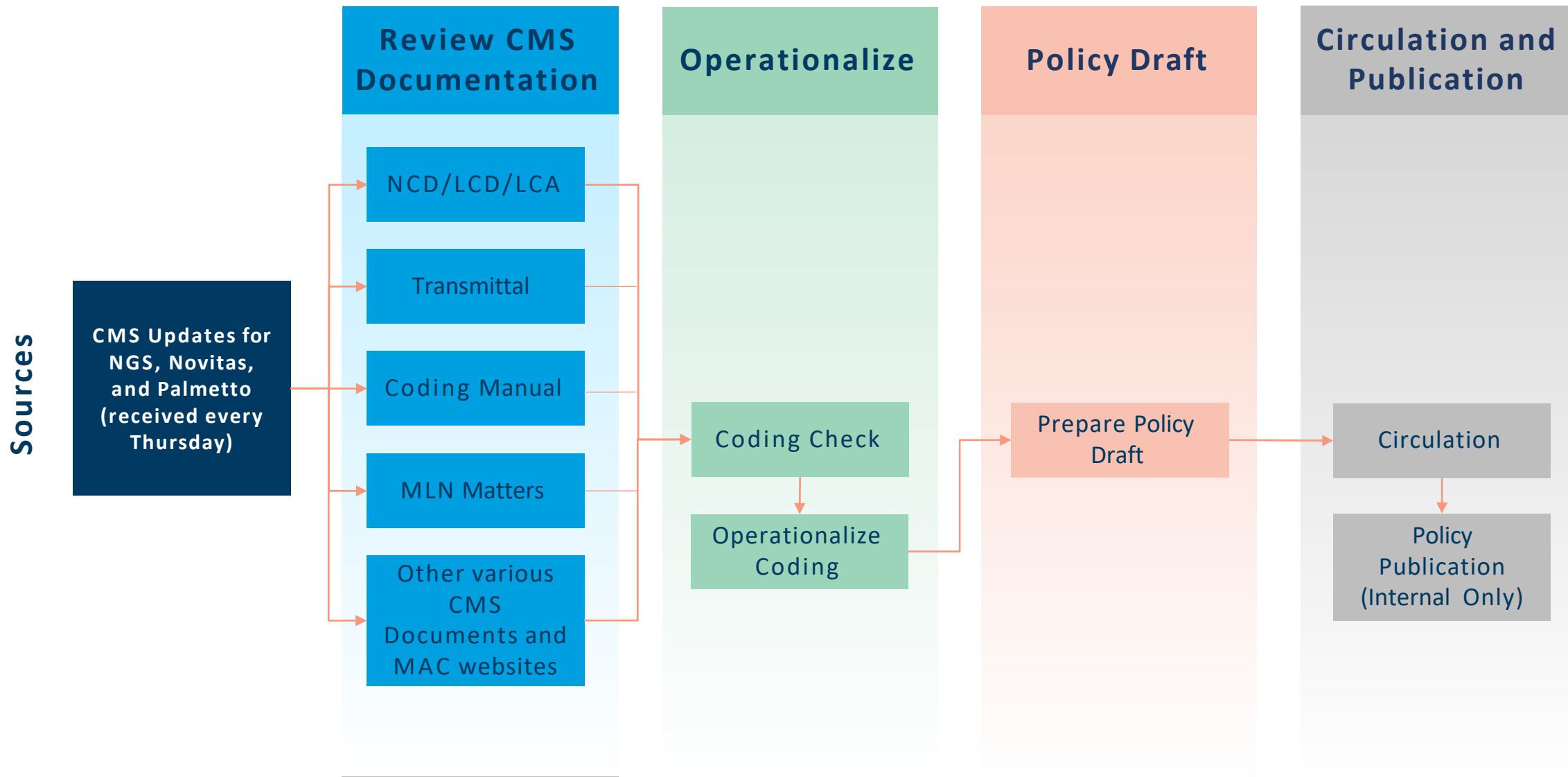
Policy Operationalization

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 Medical Policy criteria**

Medical Policy Annual Review Process - Commercial



Medical Policy Annual Review Process – Medicare Advantage



Innovation & New Technology

Coverage with Evidence Determination (CED)

- Medical Policy Z-103
- Provides opportunity for temporary coverage of new technologies, procedures, or services that are considered experimental/investigational under current Highmark policy
- Must meet CED criteria
- Must be voted on for approval by CED review committee
- Committee meets on a quarterly basis

New Technology Assessment Committee (NTAC)

- Medical Policy Z-105 for digital therapeutics
- Pathway used for review of new technology
- Committee meets monthly to recommend if new technology should be considered for coverage by medical policy

Available Medical Policy Resources

Medical Policy Search

1. Available on the Provider Resource Center
2. Choose “Policies & Programs” then “Medical Policies”
3. You’ll find links to the “MA Policy Search” sites on that page

HIGHMARK 

Claims & Authorization

Policies & Programs

Provider Network

Resources & Education

Latest Updates

Medical Policies

Medical Policy Search

Frequently Asked

Care Management

Advanced Imaging and Cardiology Services Program

Behavioral Health Resources

Pharmacy Programs

Pharmacy Policy Search

Channel Alignment Program

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

HIGHMARK COMMERCIAL MEDICAL POLICY - PENNSYLVANIA

SEARCH

MISSION

DISCLAIMER

ACKNOWLEDGEMENT

CONTACT US

LICENSED CRITERIA

Submitting a Medical Policy Inquiry

HIGHMARK COMMERCIAL MEDICAL POLICY - PENNSYLVANIA

[SEARCH](#) [MISSION](#) [DISCLAIMER](#) [ACKNOWLEDGEMENT](#) [CONTACT US](#) [LICENSED CRITERIA](#)

Input your Medical Policy search words...

This site works best if viewed with the latest version of Internet Explorer, Firefox, Chrome, or Safari browsers. For the best performance and security, always keep your web browser up-to-date.

[Contact Us](#)

If you have specific questions or comments related to medical policy content, please complete the form at this [LINK](#).

Medical Policy cannot answer individual inquiries about your health coverage, provide confidential personal health information, or give medical advice. Medical Policies are provided here for informational purposes. Please discuss the information contained within the medical policies with your health care provider.

In addition, coverage for services may vary for individual members, based on the terms of your benefit contract, and subject to the applicable laws of your state. If you are a Highmark plan member with questions about your coverage, call the member service number on the back of your insurance card (hours vary depending on plan).

For questions about our company or website, use the mailing address provided or fill out the form found on Highmark's general [Contact Us](#) page.

Medical Policy Inquiry Request

Please complete the fields below and a Medical Policy Analyst will return comments within 72 hours.

Medical Policy cannot answer individual inquiries about your health coverage, provide confidential personal health information, or give medical advice. Medical Policies are provided here for informational purposes. Please discuss the information contained within the medical policies with your health care provider. For anything else, please contact the customer service number on the back of your Member ID card.

****If you have attachments, please correspond with the Medical Policy Analyst who responds to the request.**

PLEASE DO NOT SEND PHI THROUGH THIS FORM.

* Required

1. Name *

2. Email *

3. Inquiry Source *

Internal Highmark

Note: Claims inquiries follow another process

Medical Policy Resources

[Home](#) / [Latest Updates](#) / [Medical Policy Update HBSPA](#)

Medical Policy Update

Medical Policy Update is a monthly newsletter for the health care providers who participate in our networks and submit claims to Highmark using the appropriate HIPAA transactions or claim forms as required by Highmark. This publication focuses only on medical policy and claims administration updates, including coding guidelines and procedure code revisions, and is the sole source for this information. For other important news, information, and updates from Highmark, be sure to read [Provider News](#).

Please [Join Our Mailing List](#) to receive an e-mail notification when the latest issue is available online.

[Join Our Mailing List](#)

Showing 1 - 10 of 30 results

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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 Latest Updates. Scroll down to Medical Policy Update Newsletter.

You can sign up for our Mailing List and receive a monthly email notification when the latest issue of Medical Policy Update is published.

Other Available Resources

Where to find them on the [Provider Resource Center](#).

eviCore

Claims & Authorization	<u>Policies & Programs</u>	Provider Network
Medical Policies Medical Policy Search Frequently Asked Questions Mission Statement	Care Management Advanced Imaging and Cardiology Services Program Behavioral Health Resources Enhanced Community Care Management Laboratory Management Program Musculoskeletal Surgery and Interventional Pain Management Services Oncology Management Pathways Physical Medicine Management Post Acute Care Management For Medicare Advantage Members Radiation Therapy Authorization Program Right Care Program	

Preventive Health Guidelines

work	<u>Resources & Education</u>	Latest Updates
	Educational Programs axialHealthcare Substance Use Risk Mitigation Program Behavioral Health Toolkit Population Health University NY State's End The Epidemic – HIV/AIDS Plan Overview of the Quality Improvement Program	Clinical Quality & Education CAHPS®/QHP EES Results Coding Education/HCC University Educational Resources - Member and Provider HEDIS <u>Practice Site Resources</u> Preventive Health Guidelines Risk Adjustment Programs

Reimbursement Policy & Coding

<u>Claims & Authorization</u>	Policies & Programs	Provider
Authorization Guidance Obtaining Authorization MCG Clinical Criteria Gold Carding Program	<u>Reimbursement Programs</u> Fee Schedule Information Medicare Advantage Stars Quality Blue Hospital Program Reimbursement Policies Specialist Performance Initiative True Performance Programs Value-Based Reimbursement Programs Best Practice NY Incentive Programs	

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).

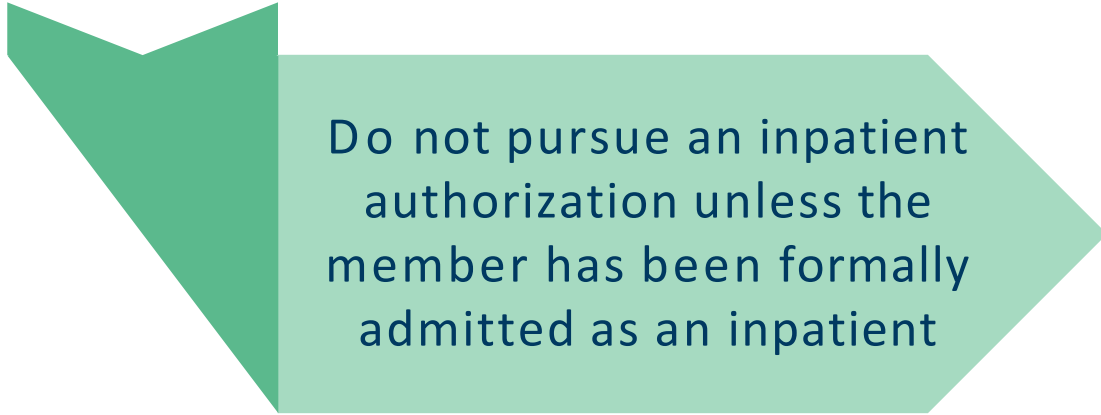
Once an outpatient authorization is on file, service date changes do not need to be communicated to Highmark if they are within the original 60 day time frame.

Authorizations

Observation Services/Emergent Admission:



Observation services do not require authorization



Do not pursue an inpatient authorization unless the member has been formally admitted as an inpatient

Authorizations

Inpatient Urgent/Unplanned Authorizations:

Use **Availity** to request all authorizations.

All inpatient admissions require authorization.

Authorizations need to be pursued as soon as all clinical information is available for urgent / unplanned inpatient admissions, **ideally within 48 hours** of the inpatient admission.

If there is observation time prior to the inpatient admission, please identify this and the reason for converting to inpatient when seeking authorization.

Highmark will provide notification of determination within **24 hours** when all needed clinical is received, but no later than **72 hours** after receipt of the request in cases involving inpatient urgent admissions.

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.



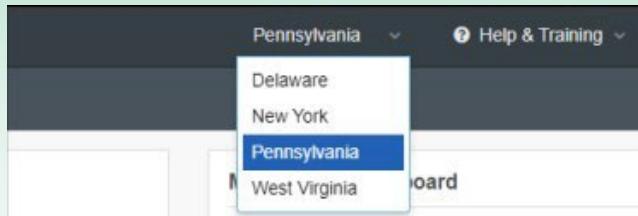
If your service is within the next 72 hours, please submit your request and contact Utilization Management **(800) 452-8507**.

Authorizations

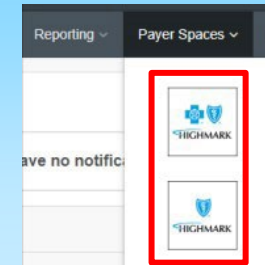
Authorization Self-Service Capabilities

Predictal can be accessed through Avality using the following steps:

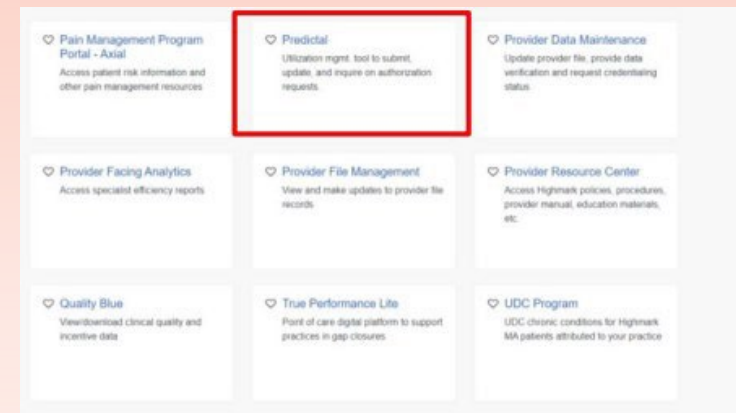
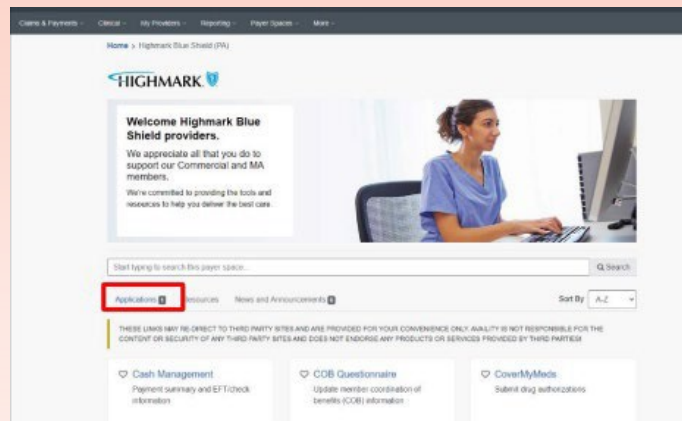
Step 1: After logging in to Avality, select the appropriate **state** for your practice/facility.



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 (cont.)

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

predictal Auth Automation Hub

Authorization Detail: AUTH-100112

[Concurrent](#) [Discharge](#) [Respond to Request for Additional Information](#)

An authorization means that the requested service has been determined to be medically necessary and/or appropriate. It does not mean that the requested service is covered under the member's benefit plan. Payment is contingent upon benefit coverage for the services rendered and eligibility of the patient.

[Update Start of Care Date](#)

Case Information

Authorization Type	Behavioral-Inpatient
Service Type	Psychiatric
Case Determination	Approved
Discharge Date	
Start Of Care Date	01/11/2023
Last Covered Date	01/12/2023
Place of service	Psychiatric Facility

Communication

Letters

ID	Letter Code	Mail Status	Create Date	Sent Date	Letter Link	Status
TASK-868923	MNDC	Sent	04/04/23 03:14 PM	04/05/23 10:08 AM	View Letter	Resolved-Sent

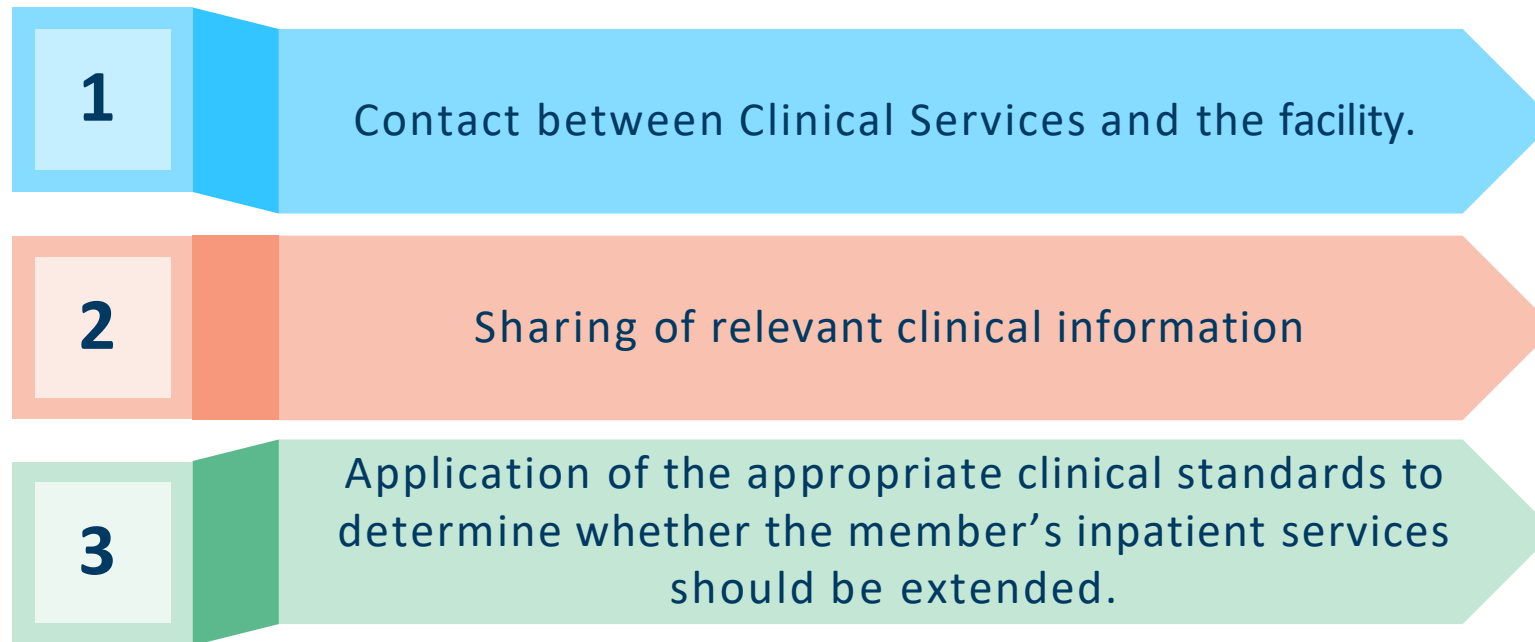
Faxes

Phone Calls

Authorizations

Concurrent Review

The Concurrent Review process for medical services involves three components:



Authorizations

Concurrent Review (cont.)

Concurrent Reviews are completed via Availity by accessing the original authorization and selecting the option for Concurrent.

Highmark may conduct concurrent review (AKA continued stay review) for any services as determined by Highmark, including, without limitation, regardless of whether a per diem or DRG reimbursement is in place.

A concurrent review may not be requested unless the patient remains hospitalized beyond the last covered day. Be sure to enter discharge date and disposition to avoid unnecessary concurrent review requests after the last covered day.

The concurrent review process for medical services can be initiated by either the facility or by the Clinical Services Department.

Decisions regarding inpatient concurrent review are made within 24 hours of receipt of the request, in compliance with decision-making time frames as dictated by regulatory/ accreditation standards.

Timely submission of the relevant clinical information will avoid any unnecessary denials due to lack of information.

Authorizations

Discharge Planning

Discharge Planning should be completed via Availity by accessing the original auth and selecting the discharge option.

The purpose of the Discharge Planning Information survey is to assess the need for assistance in discharge planning and to help identify barriers to timely discharge proactively.

Reminder: always complete the discharge survey regardless of the last covered day.

Discharge Planning provides feedback which can help to identify members who may benefit from referrals to Case Management or Condition Management programs.

Acute care facilities are required to complete the Discharge Planning tool for members at the time of the initial inpatient authorization request and with subsequent continued stay reviews.

Discharge Survey is to be completed at or immediately following discharge. The facility should be prepared to provide the following information:

- Discharge date
- Discharge disposition

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

Authorizations

Readmissions

Highmark will not separately reimburse acute care hospitals for a readmission occurring within 15 days of discharge from the same hospital if the members admission is related to the previous admission.

The readmission policy is based on 15 calendar days, not hours.

The hospital must submit relevant medical records and supporting documentation with the inpatient authorization request pertaining to the readmission to determine whether the readmission is related to the most recent inpatient hospital stay. Examples include but are not limited to:

Discharge Summary
from previous
discharge

Admission History &
Physical from
readmission

Physician orders

Emergency records

Progress notes

For additional information, please see Reimbursement Policy RP-50, available on the Provider Resource Center

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.

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

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

Resources

Provider Resource Center (PRC)

<https://providers.highmark.com/>

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.

[Authorization Guides](#)

A variety of training resources for authorizations.

[Provider Training](#)

Additional training guides and resources for providers.

[List of Procedures/DME Requiring Authorization](#)

[Provider Orientation](#)

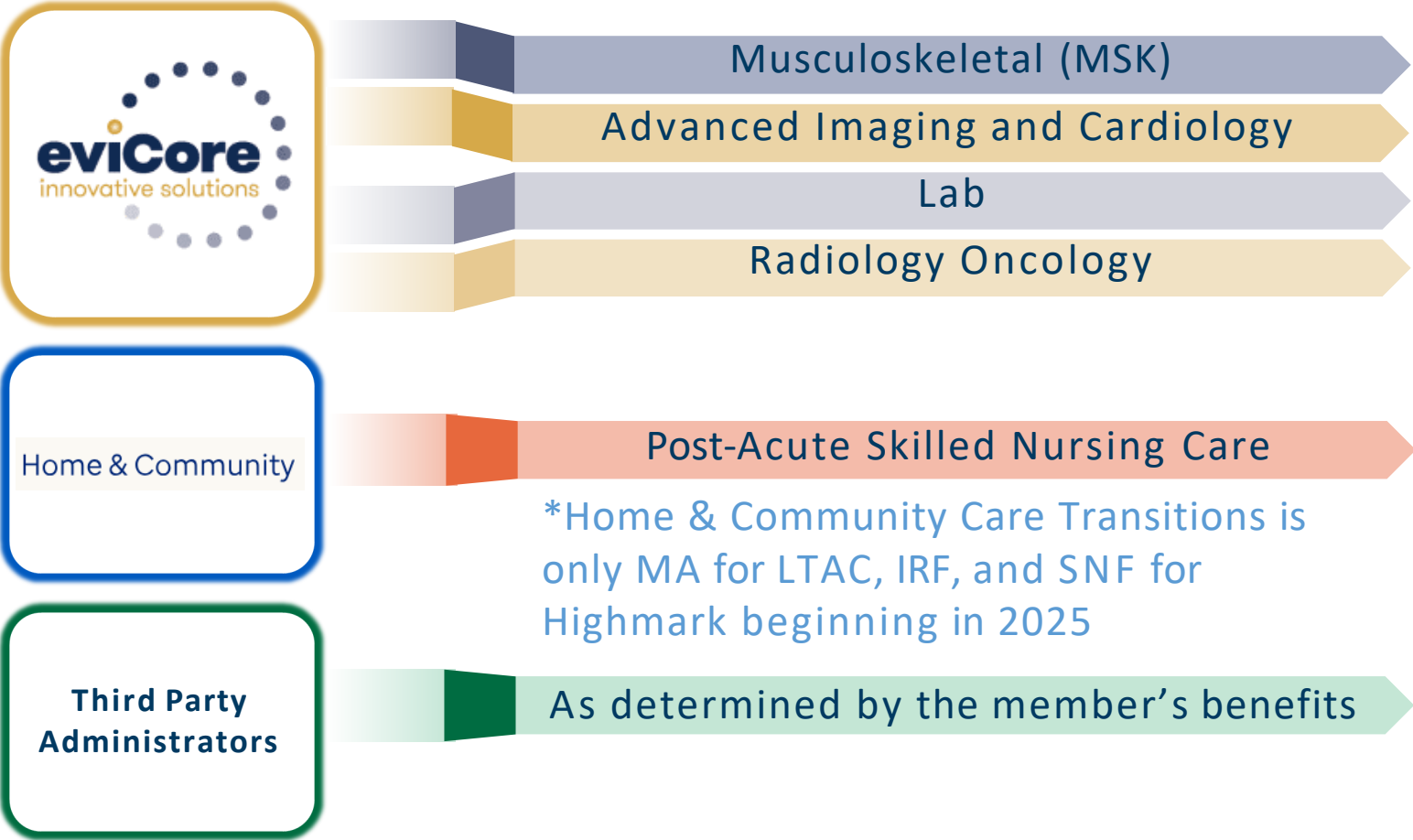
Southeastern region-specific onboarding materials

[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.

Care Management Programs







Our Medical Management Partners in Member Care



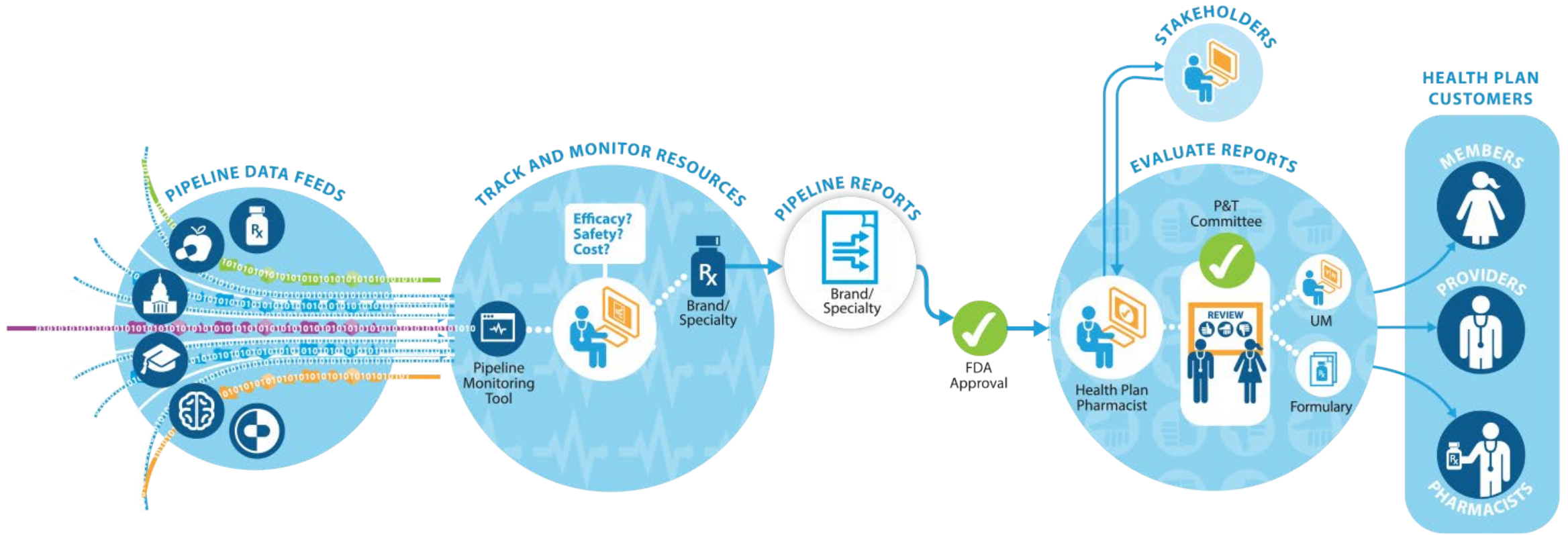
Pharmacy Formulary & Utilization Management

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.


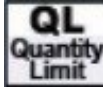

	Non-formulary / Non-covered Non-Formulary Drugs are not covered on the formulary drug list. An exception may be requested and is subject to review by the plan and is based on Pharmacy policy.
	Prior Authorization Coverage of this drug is subject to review by the plan and is based on Pharmacy policy.
	Prior Authorization – New Starts Prior Authorization applies to new starts only. Members currently on the medication may not be subject to the prior authorization policy.
	Prior Authorization – Part B vs Part D This drug may be covered under Medicare part B or D depending upon the circumstance. Information may need to be submitted describing the use and setting of the drug to make the determination.
	Quantity Limit Limits the amount of a drug the patient can receive during a set time period.
	Step Therapy For a step therapy drug to be covered, the patient will be first required to try a therapeutically equivalent medication.

Formulary Development Process



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.

<u>Brand Name</u> <i>Generic Name</i>	Therapeutic Class <i>Sub-class</i>	Dose/ Strength	<u>Status</u>	Notes & Restrictions
Humira 40 Mg/0.8MI Subcutaneous Syringe Kit	MUSCULOSKELETAL / RHEUMATOLOGY <i>OTHER</i> <i>RHEUMATOLOGICALS</i>	SYRINGE KIT 40 mg/0.8 mL		 

Click the icons for more information

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.

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

Utilization Management Policies

Other more cost-effective medications first

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

PHARMACY POLICY

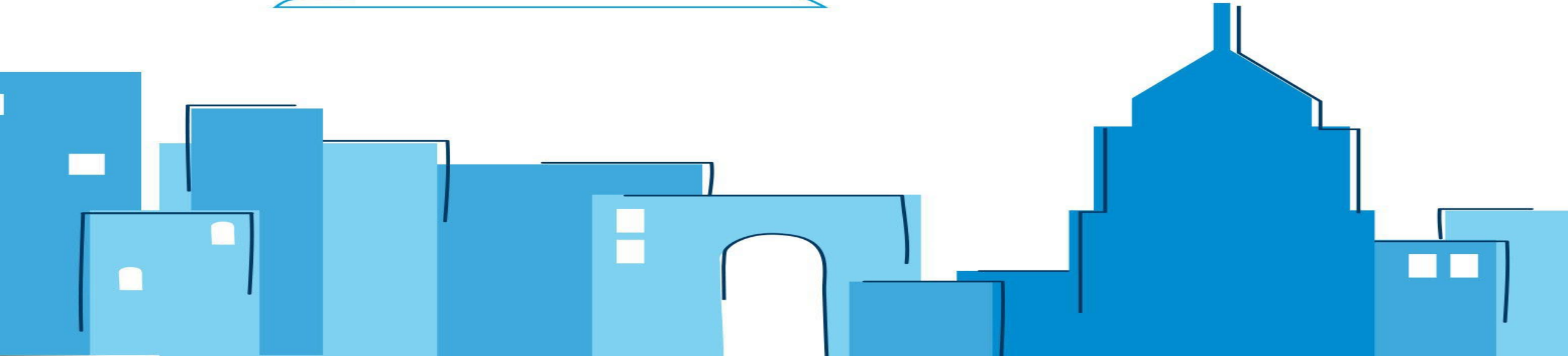
PRC |

This site works best if viewed with the latest version of Microsoft Edge, Firefox, Chrome, or Safari browsers. For the best performance and security, always keep your web browser up-to-date.

Input your search keyword...


SEARCH

Questions?



Appendix

How to Join our Mailing List

HIGHMARK 

[Contact Us](#) [Join Our Mailing List](#) [All Regions](#) [Login via Availity](#)

[Claims & Authorization](#) [Policies & Programs](#) [Provider Network](#) [Resources & Education](#) [Latest Updates](#)

Search Keyword or Code [SEARCH](#)

Welcome to the Highmark Provider Resource Center

Join our network - get credentialed to serve our members.

[GET STARTED](#)

[AVAILITY](#) [FEE SCHEDULE](#) [FIND A FORM](#) [PRIOR AUTH LISTS](#) [PROVIDER MANUAL](#) [SELF-SERVICE HUB](#)


Authorizations




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**
DE Highmark members

Outpatient Faxes*

 **(888) 236-6321**
PA Highmark members

 **(800) 670-4862**
DE Highmark members

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

Legal Disclaimers

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