HIGHMARK’S LABORATORY MANAGEMENT PROGRAM ADMINISTRATIVE GUIDE

Guidelines and Requirements for Facility and Professional Providers

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INTRODUCTION

Purpose	Highmark has partnered with eviCore to ensure our members are receiving the most clinically appropriate laboratory testing. eviCore manages molecular, genomic, and *non-molecular* testing within the Laboratory Management Program.
Program overview	Effective with dates of service beginning on Aug. 1, 2016, Highmark requires prior authorization and claims review for several molecular and genomic tests when performed in an outpatient setting for fully insured Commercial, Affordable Care Act and Medicare Advantage members. *Effective for dates of service beginning on Aug. 1, 2021, Highmark requires claims review for several non-molecular tests when performed in an outpatient setting for fully insured Commercial, Affordable Care Act and Medicare Advantage members. A prior authorization is **not** required for these tests.*

PROGRAM GUIDELINES

eviCore's molecular and genomic testing policies	A complete list of eviCore's procedure codes and policies are available here.

REQUESTING PRIOR AUTHORIZATION

Outpatient molecular and genomic tests requiring authorization

Prior authorization is required through eviCore for the following outpatient, non-emergent molecular and genomic testing:

- Hereditary cancer screening
- Carrier screening
- Tumor marker/molecular profiling
- Hereditary cardiac disorders testing
- Cardiovascular disease and thrombosis risk variant testing
- Pharmacogenomic testing
- Neurologic disorders testing
- Mitochondrial disease testing
- Intellectual disability/developmental disorders testing

Note: A complete list of eviCore's procedure codes and policies are available here.

Authorization requirements

To ensure the authorization process is quick and efficient, physicians are required to submit the following:

- Specimen collection date (if applicable)
- Type or test name (if known)
- CPT code(s) and units
- ICD-10-CM code(s) relevant to requested test
- Test indication (personal history of condition being tested, age at initial diagnosis, relevant signs and symptoms, if applicable)
- Relevant past test results
- Member's or patient's ethnicity
- Relevant family history, if applicable, (maternal or paternal relationship, medical history including ages at diagnosis, genetic testing)
- If there is a known familial mutation, what is the specific mutation?
- How will the test results be used in the member's or patient's care?

Continued on next page

REQUESTING PRIOR AUTHORIZATION, Continued

Authorization requirements (continued)

- Any pertinent clinical documentation that will support the test request
- Patient's name, date of birth, and address
- Member identification
- Referring physician NPI, phone, and fax

Requesting authorizations

The preferred method for requesting an authorization is an electronic submission through NaviNet®. Providers who do not have access to Highmark's NaviNet system should use eviCore's preferred method of contact, eviCore.com.
The website is available 24/7, 365 days a year.

As a second option, providers can use eviCore's toll-free number, 1-888-564-5492, between 7 a.m. and 7 p.m. EST. Outside of business hours, providers can leave a message to receive a return call the next business day.

Note: eviCore's call center will be closed in observance of New Year's Day, Labor Day, Thanksgiving and the day after, and Christmas Day.

Urgent request

When an authorization request is urgent due to a medically urgent condition and an authorization is needed in less than 48 hours, the referring physician's office must call eviCore healthcare at 1-888-564-5492. eviCore will make a good faith effort to render a decision within one business day.

Expired authorizations

Authorizations for genetic testing procedures are given for 60 days. If the approved procedure is not completed by the assigned Last Covered Day, providers must contact eviCore for a new request.

Post service review request

Contact Highmark Provider Services to request a post service review. Post service review requests will be considered when a claim rejects for no authorization.

Note: Be prepared to fax the appropriate medical clinical information to Highmark.

eviCore will send notification when the decision has been rendered. In the event of an approval, you must resubmit the claim to Highmark.

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REQUESTING PRIOR AUTHORIZATION, Continued

New category and drop-down selection in NaviNet

The Lab Management Program will have a new selection in the **Category** drop-down box. Use **Lab Management** in the **Category** section and type in **Genetic Testing** in the **Service** section.

NantHealth NaviNet Home | Help | Contact Support Feedback Welcome
Workflows
Highmark Blue Shield | Auth Submission | Selection Form
HIGHMARK.
Selection Form
Step 1. Please select a Referred from Service Provider and enter the Proposed Date of Service (both are required):
Service Provider:
Proposed Date of Service:
Step 2. For faster results, enter Member ID with Date of Birth and/or Member First Name:
Member ID:
Member Date of Birth:
Member First Name:
Member Last Name:
Step 3. Please select a Category and then a Service from the selections below:
Category: Lab Management
Service: Genetic Testing
Add Category/Service
Category and Services Added:

Category	Service

AUTHORIZATION DETERMINATION

Authorization determination

Determination of an authorization may require further review before approval or denial. All authorization determinations will be available for viewing in NaviNet through the **Referral/Authorization Inquiry** transaction. The provider is notified by phone and in writing for all cases. The member is only notified in writing for all cases except for Medicare Advantage members with urgent cases that are notified in both phone and writing.

Authorization information

All authorizations will include the following:

- Authorization ID number that consists of one alpha and nine numeric characters (e.g., A123456789)
- Time period for which the authorization is valid
- Service/procedure approved
- Description
- Units requested
- Units approved
- Modifier

Authorization denials

eviCore will notify the physician, rendering laboratory site, and member in writing of a denial and will provide a rationale for the determination within one working day of a decision.

Note: Appeal information will be provided with the denial communication.

Peer-to-peer consultation

If Commercial members receive a denial, the ordering physician can consult with an eviCore medical director or certified genetic counselor on a peer-to-peer basis.

For Medicare Advantage members, if further clinical discussion is needed for approval, the ordering physician can request a pre-decision consultation.

For peer-to-peer or pre-decision consultations, the ordering physician can contact eviCore Healthcare at 1-888-564-5492, Option 4. Fax: 1-866-699-8128.
Email: **appealsfax@evicore.com**.

CLAIMS REVIEW REQUIREMENTS

Claims review Claims associated with molecular, genomic, and *non-molecular* procedure codes will be reviewed for accuracy and medical necessity prior to payment, based on eviCore's policies. This review is not limited to only those codes for which authorization is required.

NOTE: Claims review is prepayment.

The following procedure codes will be subject to claims review, as part of our Laboratory Management Program.

PROCEDURE TYPE	PROCEDURE CODES
AMA Pathology and Laboratory Procedures	*80400 – 89398**
Proprietary Laboratory Analyses (PLA)	*CPT codes ending in U (e.g. 0001U)**
Administrative Codes for Multianalyte Assays with Algorithmic Analyses (MAAA)	*CPT codes ending in M (e.g., 0002M)*
CPT Category III Codes Representing Laboratory Testing	*0423T, 0500T, 0546T*
HCPCS Codes Representing Laboratory Tests	*Various HCPCS codes beginning with G, P, Q, S, or U that represent laboratory testing*

*Generally defined as codes that include "DNA," "RNA," "nucleic acid," and "genotype."

Claim reconsideration reviews

When eviCore reviews claims and more information is needed to make a determination eviCore will deny the claim. The provider should submit any additional information to Highmark Provider Services. Highmark will coordinate the submission to eviCore. No appeals will be accepted if the claim remains denied.

Claim denials

Inquiries and appeals for claim denials should be directed to Highmark.

Note: If your claim is denied due to no authorization, see "Post service review request" on page 6.

Claim review requirements

To review detailed information on the process for claim review requirements, check eviCore Healthcare's Clinical Guidelines.

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