

SPECIAL eBULLETIN

FOR PROFESSIONAL AND FACILITY PROVIDERS

SEPTEMBER 1, 2020

PRIOR AUTHORIZATION TO BE REQUIRED FOR OUTPATIENT SERVICES WHEN PROVIDED BY AN OUT-OF-AREA BLUE PLAN PROVIDER REQUIREMENTS EFFECTIVE NOVEMBER 1, 2020

Highmark requires medical necessity review for certain outpatient services to ensure that our members are receiving the appropriate care in the proper setting. Currently, our list of outpatient procedures and services requiring prior authorization applies to our network participating providers in our service areas and also to out-of-network providers in and outside our service areas.

As a reminder, in-network providers are Highmark network participating providers who participate in the member's network as per their benefit plan. An "out-of-network provider" is a provider that is within Highmark's service area but not participating in the member's network OR an out-of-area provider located outside of Highmark's service area who is not participating with their local Blue Plan.

Effective November 1, 2020, Highmark is expanding our prior authorization requirements for outpatient services to include those services provided by out-of-area providers participating with their local Blue Plan. This will assure that the care our members receive while living and traveling outside of the Highmark service areas is medically necessary and managed consistently as it is throughout our service areas. Beginning November 1, 2020, claims for services on the prior authorization list received without authorization will deny and a request for medical records will be sent to the provider's local Blue Plan.

To accommodate electronic submission of authorization requests, Highmark is enabling our NaviNet® portal functionality to accept authorization requests for outpatient services from out-of-area Blue Plan providers when submitted via their local portals.

HIGHMARK'S LIST OF PROCEDURES/DME REQUIRING AUTHORIZATION

Highmark provides a list of outpatient procedures and services that require authorization that is updated regularly with notice of additions or deletions communicated on Highmark's Provider Resource Center. This list is also available on the Provider Resource Center by selecting **REQUIRING AUTHORIZATION** from the Quicklinks bar that spans across the top of the Provider Resource Center.



APPLICABLE PRODUCTS AND IMPLEMENTATION DATES

Effective November 1, 2020, this requirement will apply to Commercial fully-insured and Affordable Care Act (ACA) plans. Self-insured groups will be offered the option upon renewal in 2021.

This change does not apply to the Federal Employee Program (FEP), Medicaid, and indemnity and comprehensive benefit plans. In addition, these authorization requirements will not apply to outpatient services managed by our partner vendors, eviCore and WholeHeath Networks, Inc., a subsidiary of Tivity Health Support, LLC.

MEDICARE ADVANTAGE

Highmark Medicare Advantage members are not affected by this change since medical management for outpatient services is already in place for our Medicare Advantage members seeking care from out-of-area Blue Plan providers.

VERIFYING ELIGIBILITY AND BENEFITS

Providers participating with out-of-area Blue Plans are able to obtain eligibility and benefit information for Highmark members using Blue Exchange[®], which is the Blue Cross and Blue Shield Association's inter-Plan system for select HIPAA transactions. Other options include submitting a HIPAA 270/271 electronic eligibility inquiry or calling the BlueCard Eligibility line at **1-800-676-BLUE** (2583).

For those members requiring prior authorization for medical and behavioral health outpatient services when provided by an out-of-area Blue Plan participating provider, **Authorization for Outpatient Services** will indicate "Yes" for Out of Area. The provision for authorization for outpatient services will display as one of two options if authorization is required for out of area services:

Authorization for Outpatient Services.....	Yes for In Area Out of Area and Out of Network Services
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Or, if the group has not adopted out-of-network management:

Authorization for Outpatient Services.....	Yes for In Area and Out of Area Services
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Prior authorization indicators for specialty drugs will be displayed on the member's **Eligibility & Benefits Details** page in NaviNet. If prior authorization is required for Site of Care Specialty Drugs, Oncology Specialty Drugs, and/or Other Specialty Drugs, it will be noted as "YES" after the specialty drug category. See image below for example.

Eligibility and Benefits for [Redacted] Male born on 02/17/1958 [View Patient Details](#)

Highmark Blue Shield No additional payer information on file

INSURANCE DETAILS
 View Current Member ID Card

Group Information
 Plan Area: 363
 Alpha Prefix: [Redacted]
 Advanced Imaging Ind: YES
 Radiation Therapy Management: YES
 Physical Medicine Management: NO
 Genetic Testing: NO
 Musculoskeletal Interventional Pain Management: Yes - Highmark

Site of Care Specialty Drugs: YES
Oncology Specialty Drugs: YES
Other Specialty Drugs: YES

Product: PPO BLUE

PRIMARY CARE PROVIDER

PPO BLUE Provisions
 Pharmacy Product Wide Provi
 View Previous Coverage
 Additional Benefit Provisions
 Benefit Accumulator

PRIOR AUTHORIZATION SUBMISSIONS

Beginning November 1, 2020, out-of-area providers participating with their local Blue Plans will be able to use their local Plan’s portal to conduct pre-service review for outpatient services for Highmark members. Providers can utilize the pre-service review for out-of-area members in their local Plan’s portal, enter the Highmark member’s 3-character prefix, and then will be routed to the pre-service review capabilities available to Highmark’s local providers.

Once you are directed to Highmark’s NaviNet portal, you will first see a welcome screen. Click on **Authorization Submission** to begin the authorization request.

NantHealth NaviNet [Home](#) | [Help](#) | [Contact Support](#) [Feedback](#)

Workflows Action Items Activity

NaviNet Home

HIGHMARK.

Pre-Service Review for Out-of-Area Members

Highmark Blue Shield
 Welcomes [Redacted]

[Log Off](#)

You have been routed from Highmark BCBS WV to Highmark Blue Cross Blue Shield to conduct pre-service review for a Highmark Blue Cross Blue Shield member.

Please choose from the following options:

- [Authorization Submission](#)

At the present time, Highmark only requires authorizations for inpatient services for out of area members.

For assistance, please see a help guide below:

- [Help Guide for Out of Area Prior Authorization](#)

Please be advised that referrals do not substitute for pre-certification and are not a guarantee of benefits as benefits are contingent upon the services being covered by the member’s health plan as well as the member being insured at the time services are rendered.

You will first complete the **Selection Form**:

- Your information will be pre-populated in Step 1. You are required to enter the **Proposed Date of Service**.
- Member information is entered in Step 2.
- Select **Outpatient** from the **Category** dropdown in Step 3, and then select the applicable **Service**.
- Click on **Submit** to continue through the screens to complete your request.

The screenshot shows the 'Selection Form' interface for Highmark. At the top, there is a navigation bar with 'NantHealth | NaviNet' and links for 'Home | Help | Contact Support | Feedback'. Below this is a 'Workflows' dropdown menu and a breadcrumb trail: 'Highmark Blue Shield | Authorization Submission | Selection Form'. The main content area is titled 'Selection Form' and includes a Highmark logo. It contains three steps: Step 1: 'Please enter the address and telephone number where you would like to receive your authorization determination. Step 1. Please confirm a Referred From Facility / Group and enter the proposed Date of Service (both are required):'. This step includes input fields for Facility/Group Name, Last Name, First Name, Middle Initial, NPI, Specialty, Proposed Date of Service, Address 1, Address 2, City, State, ZIP Code, Phone, Fax, and E-mail. Step 2: 'For faster results, enter Member ID with Date of Birth and/or Member First Name:'. This step includes input fields for Member ID, Member Date of Birth, Member First Name, and Member Last Name. Step 3: 'Please select a Category and then a Service from the selection below:'. This step includes dropdown menus for 'Category' and 'Service', both currently set to 'Please choose one.'. Below these are 'Add Category/Service' and 'Submit' buttons. At the bottom, there is a table titled 'Category and Services Added:' with columns for 'Category' and 'Service'. The 'Submit' button is highlighted in green.