

## Managed Care Referrals and Authorizations (Central Region Products)

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## Overview of Referrals and Authorizations

Referrals and authorizations are processes used by health plans to coordinate and evaluate the medical care needs of its members. Highmark Blue Shield also has used the term “precertification” when referring to the authorization process. For simplification, we use the term “authorization” in this manual when addressing authorization or precertification processes.

The table below identifies the coordination activities applicable to each Highmark Blue Shield product:

	<b>ClassicBlue</b>	<b>PPOBlue</b>	<b>DirectBlue</b>	<b>SelectBlue</b>
Inpatient authorization for hospital, skilled nursing, acute rehabilitation, long term acute care and mental/substance abuse	Yes	Yes	Yes	Yes
Outpatient authorization				
<ul style="list-style-type: none"> <li>■ Select surgical procedures</li> <li>■ Manipulation/rehab therapy (physical, occupational or speech)</li> <li>■ Select durable medical equipment</li> <li>■ Home health</li> <li>■ Hospice</li> </ul>	No Yes (MT/PT only) No No No	No Yes (MT/PT only) No No No	Yes Yes Yes Yes Yes	Yes Yes Yes Yes Yes
PCP referrals to specialist	No	No	No	Yes

### Notes:

- Female members of all Highmark Blue Shield programs, including SelectBlue, may receive care from a network obstetrician or gynecologist at any time, for any obstetrical or gynecological condition without a referral.
- Members may receive care from network specialists for outpatient mental health and substance abuse treatment without a referral.
- Emergency care services do not require a referral.

## Referrals

### Referrals: SelectBlue only

Highmark Blue Shield requires referrals only for SelectBlue, our point of service product. Under SelectBlue a member may self-refer to a specialist at any time for any service, but reimbursement will be made at a lower level of benefits.

### Definition of referrals

A referral is issued by the member’s primary care physician to formally direct the member to a particular specialist or facility for care outside the primary care physician’s scope of license or expertise.

### Services not requiring a referral

No referral is needed for the following:

- Emergency care, including any associated ambulance transportation
- Obstetrical/gynecological services
- Outpatient behavioral health services
- Laboratory services, radiology and routine imaging studies

**Who can issue a referral**

The following parties can issue referrals:

- The member's primary care physician
- A specialist authorized by Highmark Blue Shield to act as a member's primary care physician

When referring a member for services by another provider, the primary care physician needs to ensure that the designated provider participates in the PremierBlue Shield network. This will allow the member to receive the highest level of benefit provided by the program. You can view the PremierBlue Shield directory on our Web site, [www.highmarkblueshield.com](http://www.highmarkblueshield.com).

**Services requiring a referral**

A referral is required to initiate any outpatient evaluation, treatment or other service, except as otherwise listed above that will be performed by an individual other than the member's primary care physician. Services requiring a referral include, but are not limited to, the following:

- Specialist office visits
- Certain items of durable medical equipment, orthotics, prosthetics, respiratory equipment and supplies (listed on the back of the *Referral Request Form*) require a referral only, while others also require an authorization.
- Evaluations for home health care, hospice care and rehabilitation therapies (spinal manipulation, occupational, physical and speech therapies)

The Highmark Blue Shield *Referral Request Form*, shown in the appendix, identifies services requiring referral.

**Services included in the referral**

A specialist may evaluate and treat members within the scope of his or her specialty. The services listed below may be performed without preauthorization from Highmark Blue Shield.

- Medically necessary office visits for the evaluation, management and treatment of any condition within the realm of the specialty.
- Any related diagnostic tests or procedures performed in the physician's office.
- Any outpatient tests or surgical procedures not otherwise listed as requiring preauthorization that are performed in a facility other than the physician's office.

For any other services, please refer to Authorizations explained later in this section.

**Services NOT included in the referral**

Specialists must contact the primary care physician to obtain:

- Referrals to other specialists
- Services beyond that specified on the *Referral Request Form* for durable medical equipment supplies, orthotics, prosthetics and home infusion
- Services beyond the initial evaluation visits for therapies, home care and hospice
- Additional treatment beyond the standard or specified treatment period

**60-day treatment period**

If a primary care physician has referred a SelectBlue member to a specialty practitioner, that specialist can treat the member for the referred condition in his or her office for a period of 60 days from the anticipated date of service listed on the referral. (This treatment period does not apply to practitioners such as doctors of chiropractic, rehab therapists, home health care and durable medical equipment providers from whom

authorization of services is required.)

During the 60-day referral period, the SelectBlue member may also need a diagnostic procedure or another procedure that does not require an authorization. When this is the case, the specialist to whom he or she has been referred is permitted to coordinate the care with another provider.

After the treatment period has elapsed, the specialist must contact the member's primary care physician for another referral.

### **Exceptions to the 60-day treatment period**

There are some exceptions to the 60-day treatment period:

- The following providers may only provide services as specified on the referral form and must contact the primary care physician to provide additional services:
  - Durable medical equipment suppliers
  - Home infusion therapy providers
  - Prosthetics and orthotics suppliers
- Standing referral to specialist
- Long-term therapy referrals
- The following providers may provide only an initial evaluation and must obtain authorization from Highmark Blue Shield to provide additional services:
  - Doctors of chiropractic
  - Occupational therapy providers
  - Physical therapy providers
  - Respiratory therapy providers
  - Speech therapy providers
  - Psychiatrists performing physical therapy and/or spinal manipulation
  - Home health care providers
  - Hospice providers

### **Standing referrals to a specialist**

In compliance with regulations of the Pennsylvania Department of Health governing Managed Care Organizations (28 Pa. Code, Chapter 9), SelectBlue members may request a standing referral to a specialist for life-threatening, degenerative or disabling conditions. Examples of diagnoses that may be appropriate for this program include unstable cardiac conditions, AIDS and end-stage liver disease.

If Healthcare Management Services (HMS), Highmark Blue Shield's medical management division, approves the request for a standing referral, the referral will be provided for a period of up to six months. Standing referrals can be continued for a longer period of time pending review of a treatment plan.

If HMS does not approve the referral, the member may appeal the decision according to the rights defined by the regulations of the Pennsylvania Department of Health governing Managed Care Organizations (28 Pa. Code, Chapter 9).

**NOTE:** The primary care physician and/or specialist must agree that a reason exists for the patient to have a standing referral. This type of referral should not be issued solely as a convenience to the member.

**Long-term therapy referral**

Some treatment regimes may require more than 60 days to complete including some that may continue indefinitely. To minimize the administrative burden placed on primary care physicians, the following therapies only require an initial referral for each distinct course of treatment, including those treatments that continue indefinitely.

- Allergy testing and injections
- Chemotherapy
- Fracture care
- Hemodialysis
- Home infusion therapy
- Peritoneal dialysis
- Radiation therapy

**If the referral is not in place at the time of service**

Ordinarily the member's primary care physician should have submitted any required referral prior to the member receiving the services. However, if a SelectBlue member presents him- or herself for non-emergency services and the required referral does not appear to be in place, the provider has the following options:

- Determine if a referral has been issued using the NaviNet inquiry function.
- Call the primary care physician to inquire about the status of the referral and then make a decision based on this conversation. (Please note that with the exception of services not requiring coordination, only the primary care physician can issue a referral.)
- Treat the member on a self-referral basis if no primary care physician can be established.

**How referrals are submitted**

Providers may submit referrals to Highmark Blue Shield:

- Electronically via NaviNet
- By mail to Highmark Blue Shield, P.O. Box 890173, Camp Hill, PA 17089-0073

Follow these steps to issue a referral using NaviNet or the paper *Referral Request Form*.

<b>Step</b>	<b>Action</b>						
<b>1</b>	Complete the referral on NaviNet or the referral portion of the <i>Referral Request Form</i> .						
<b>2</b>	<table border="0"> <tr> <td style="vertical-align: top;">If you are using...</td> <td style="vertical-align: top;"><b>NaviNet</b></td> <td style="vertical-align: top;"><b>Paper Form</b></td> </tr> <tr> <td></td> <td>The referral is automatically transmitted to the required locations via the NaviNet system</td> <td>Distribute copies of the form by mail, fax, or hand delivery to:           <ul style="list-style-type: none"> <li>■ The patient</li> <li>■ The referral physician or facility</li> <li>■ Highmark Blue Shield P.O. Box 890173 Camp Hill, PA 17089-0173</li> </ul> </td> </tr> </table>	If you are using...	<b>NaviNet</b>	<b>Paper Form</b>		The referral is automatically transmitted to the required locations via the NaviNet system	Distribute copies of the form by mail, fax, or hand delivery to: <ul style="list-style-type: none"> <li>■ The patient</li> <li>■ The referral physician or facility</li> <li>■ Highmark Blue Shield P.O. Box 890173 Camp Hill, PA 17089-0173</li> </ul>
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**How referrals are received**

Providers may receive notification of a referral in a number of ways:

- Via NaviNet
- Via the paper *Referral Request Form* from the patient
- Via a faxed *Referral Request Form* from the primary care physician to the specialist

## Authorizations

### Definition

An authorization is the formal agreement between the primary care/attending physician and HMS, that the requested service or admission meets Highmark Blue Shield's criteria for medical necessity and appropriateness.

When a member's primary care or attending physician requests an authorization, HMS evaluates whether the particular service or admission meets Highmark Blue Shield's criteria for medical necessity and appropriateness. When a request has been approved, an authorization number is provided.

### Authorization is not a guarantee of payment

When an authorization number is provided, it serves as a statement about medical necessity and appropriateness; it is not a guarantee of payment. Payment is dependent upon the member's having coverage at the time the service is rendered and the type of coverage available under the member's benefit plan. Some benefit plans may also impose deductibles, coinsurance, co-payments and/or maximums that may impact the payment.

### Products requiring authorization

All products have authorization requirements:

- ClassicBlue – limited authorization requirements: generally, only for inpatient care depending on the benefit design.
- PPOBlue – limited authorization requirements: generally, only for inpatient care depending on the benefit design.
- DirectBlue – inpatient and outpatient authorization requirements. (see below)
- SelectBlue – inpatient and outpatient authorization requirements. (see below)

### Services requiring authorization

The following circumstances are representative of those that require an authorization.

- All inpatient admissions, including acute hospital, acute rehabilitation, skilled nursing facility, psychiatric, substance abuse and long term acute admissions
- Select surgical procedures that are performed in a facility other than the physician's office. (Please refer to the appendix for a list of outpatient surgical procedures that require preauthorization.)
- Procedures that may be considered cosmetic
- Non-standard issue durable medical equipment
- Procedures or treatments that may be considered experimental or investigational
- Home health care
- Hospice
- Physical, occupational, speech, and spinal manipulation therapies
- Diabetic education
- Enteral formula
- Neuropsychiatric testing
- Therapeutic drugs—Herceptin, Hyalgan, Infliximab (Remicade) and Synvisc

**Responsibility for requesting authorization**

The following parties can request an authorization:

- The member's primary care or attending physician
- The specialist to whom a member has been referred
- The specialist authorized by Highmark Blue Shield to act as a member's primary care physician
- The facility to which the member has been referred/admitted

**Failure to obtain authorization**

Failure to secure the required authorization for a health care service may result in a claim denial following a retrospective review. In the event of a claim denial, the network provider may not bill the patient.

**Review criteria**

If you would like more information about the criteria used for the authorization determination, please contact HMS at 1-866-731-8080. Highmark Blue Shield medical policy can be accessed electronically through the Web site at [www.highmarkblueshield.com](http://www.highmarkblueshield.com).

**Provider-driven care management**

It is the network provider's responsibility to obtain an authorization from HMS prior to rendering a non-emergent service that requires authorization. This is known as provider-driven care management.

**If the authorization is not in place at the time of service**

Ordinarily, the member's primary care or attending physician should have requested any required authorization prior to the member receiving the services. However, if a Highmark Blue Shield member presents him- or herself for non-emergency services and the required authorization does not appear to be in place, the provider has the following options:

- Perform an authorization inquiry in NaviNet
- Call the ordering physician or primary care physician to inquire about the status of the authorization and then make a decision based on this conversation
- Contact HMS to request an authorization at 1-866-731-8080 between the hours of 8:30 a.m. and 7:00 p.m. Monday through Friday. For urgent care, HMS is also available between the hours of 8:30 a.m. and 4:30 p.m. on Saturday and Sunday.

**How authorizations are submitted**

Providers may submit a request for authorization to Highmark Blue Shield:

- Electronically, via NaviNet
- By calling HMS at 1-866-731-8080 between the hours of 8:30 a.m. and 7:00 p.m. Monday through Friday. For urgent care, HMS is also available between the hours of 8:30 a.m. and 4:30 p.m. on Saturday and Sunday.



## How to Request an Authorization

Follow these steps to request an authorization.

Step	Action
1	Provider completes a request for authorization either through NaviNet or by calling HMS at 1-866-731-8080. If you are using NaviNet, skip to step 4.
2	Be prepared to provide HMS with the following information about the member: <ul style="list-style-type: none"> <li>■ Relevant demographic information (name, age, sex, etc.)</li> <li>■ Member identification number</li> <li>■ Pertinent medical history</li> <li>■ Any comorbidity</li> <li>■ All pertinent medical information: test results, prior treatment, etc.</li> <li>■ Diagnosis</li> <li>■ Symptoms of present illness or condition</li> <li>■ Service to be performed, including admission or procedure date and provider(s) involved in care</li> <li>■ Proposed length of stay and frequency/duration of services</li> <li>■ Treatment plan and goals</li> <li>■ Psycho-social issues impacting care</li> <li>■ Discharge planning information (i.e., anticipated plan across the continuum of care)</li> </ul> <p><b>Note:</b> HMS clinical staff may request additional information.</p>
3	HMS staff reviews the information and issues either an authorization number or an adverse determination (denial). If the request is denied, you may appeal the decision. Note: If you would like more information about the criteria used for determinations, please contact HMS at 1-866-731-8080.
4	HMS communicates the authorization reference number to the relevant health care provider.
5	An electronic (NaviNet) authorization will be automatically transmitted to the primary care physician, specialist or facility as required, if they also have NaviNet.

## Denials and Appeals

### Introduction

Any Highmark Blue Shield member has the right to appeal if they are not satisfied with decisions made by Highmark Blue Shield regarding the coverage of service. There are specific managed care regulations in place for handling appeals of managed care members.

With the implementation of our managed care product, SelectBlue, Highmark Blue Shield must follow the regulations of the Pennsylvania Department of Health governing Managed Care Organizations (28 Pa. Code, Chapter 9). This contains provisions for managed care members to appeal previous decisions made by Highmark Blue Shield regarding the coverage of services.

### Denial decisions

The decision to deny a service, admission or item on the basis of medical necessity is one that can only be made by a physician reviewer. The decision not to authorize an admission, service or item because the benefit is not available can be made by a care or case manager.

**Types of member appeals**

Appeals are classified into two categories: complaints and grievances.

- Complaint – this is related to the member’s program benefits or the operation or management policies of Highmark Blue Shield. Only the member may request a review of this type of denial of coverage. Members must contact Customer Service by calling the number on their identification card to initiate the review.
- Grievance – this is related to medical necessity and/or appropriateness of health care services. A provider, on behalf of a member, or a member’s representative, may request a review of this type of denial of coverage.

**Provider-initiated grievances on the member’s behalf**

Here’s what you need to know if a SelectBlue member asks you to file a grievance on his/her behalf:

1. The grievance must be submitted in writing with detailed information regarding the concern.
2. To avoid delays, make sure you obtain the member’s signature when filing the grievance. Grievances filed on a member’s behalf that do not include a signed member consent form are returned to the provider. For your convenience, a member consent form can be found in the appendix.
3. Mail the grievance and information to Highmark Blue Shield, P.O. Box 890174, Camp Hill, PA 17089-0174.
4. Managed care members waive their right to file a grievance on the same matter, if the provider files on their behalf.
5. You have 180 days from the date of the initial denial of coverage to file the grievance.
6. Standard grievances are addressed within 30 calendar days of receipt.
7. Expedited grievances are addressed within 72 hours of receipt.

More information about the standard and expedited grievance procedures can be found later in this Section.

**Services that are potentially cosmetic or experimental/investigational**

A Highmark Blue Shield physician evaluates the medical necessity of services that may potentially be cosmetic or experimental/investigational. If review indicates that medical necessity or appropriateness does not exist for the service, an experimental/investigational/cosmetic denial will be issued. Providers have the opportunity to appeal all denials related to cosmetic or experimental/investigational services.

**Types of provider appeals**

There are two types of provider appeals:

- An expedited appeal is used when a member is receiving an ongoing service or is scheduled to receive a service for which coverage has been denied and the seriousness of the circumstances require that the appeal be reviewed quickly because the physician believes that the lack of service will adversely affect the member’s health. This process may be used when any of the following circumstances exist:
  - When a delay in decision-making might seriously jeopardize the life or health of the member or the member’s ability to regain maximum function is in jeopardy.
  - The denial concerns an admission, continued stay or other health care service for a member who has received emergency services but has not been discharged from the facility.
  - The denial is related to ongoing or imminent services.

- A standard appeal is used under all other circumstances, including denials resulting from retrospective reviews of services rendered without the required authorization.

Explicit directions for filing appeals appear in the written denial notification, which is sent to the member or the member's representative, the physician and the facility, when appropriate. This process involves a telephonic or written request initiated by the provider to review a determination that denied payment of a health care service. A clinical peer reviewer who was not involved in the original denial must conduct the review.

### **Peer-to-peer contact**

Peer-to-peer contact is a process that offers the member's primary care or attending physician the opportunity to present additional pertinent clinical information to support the authorization of a requested service. It is provided when a medical necessity denial has been rendered without a peer-to-peer conversation about the request or when additional information has become available. The physician who made the initial denial decision, or a designee, will be available within one Highmark Blue Shield business day to discuss the determination with the requesting physician. To request a Peer-to-peer contact, call 1-866-634-6468.

### **Highmark Blue Shield's requirements in processing appeals**

Highmark Blue Shield's process for reviewing appeals follows all applicable regulatory requirements. These include the following components:

- Review by a clinical peer reviewer or physician advisor who was not involved in the original denial decision.
- Review by a clinical peer reviewer or physician advisor who is board certified and holds an unrestricted license and is in the same or similar specialty that typically manages the medical condition, procedure or treatment under review.
- Review of the appeal within timeframes established by the applicable regulations and standards
- Verbal (as applicable) and written communication of the decision within timeframes established by the applicable regulations and standards.

### **Responsibility for medical treatment and decisions**

Under all circumstances, the member and the primary care physician bear ultimate responsibility for the medical treatment and the decisions made regarding medical care.

Providers and Highmark Blue Shield employees involved in utilization management decisions are not compensated for denying coverage, nor are there any financial incentives to encourage denials of coverage.

## The Expedited Provider Appeal Process

Follow these steps to request an expedited appeal:

<b>Step</b>	<b>Action</b>
<b>1</b>	Contact HMS by calling 1-866-731-8080
<b>2</b>	An HMS care or case manager will inform the practitioner if additional information is necessary for review. The practitioner gathers the information and forwards it to the HMS care or case manager.
<b>3</b>	Within 72 hours of receipt of the appeal request, a clinical peer reviewer who was not involved in the original decision reviews the case and renders a decision to uphold or reverse the original denial.
<b>4</b>	The appropriate parties will be notified of the determination by telephone. The notification will include, but not be limited to, the following information: <ul style="list-style-type: none"><li>■ The reason/clinical rationale for the adverse determination.</li><li>■ The source of the screening criteria used to make the determination, if applicable.</li><li>■ The right to file a standard appeal.</li><li>■ The procedure to initiate a standard appeal.</li></ul>
<b>5</b>	Within one working day of the decision, a letter containing the information in step 4 will be sent to the: <ul style="list-style-type: none"><li>■ Member, member's representative</li><li>■ Primary care physician and/or specialist</li><li>■ Facility or ancillary provider, if appropriate</li></ul>

## The Standard Appeal Process

Follow these steps to request a standard appeal:

Step	Action
1	<p>Request an appeal by mailing or calling as shown below.</p> <p><b>Mail to:</b></p> <p>For: <b>ClassicBlue and PPOBlue</b>            Highmark Blue Shield            P.O. Box 890177            Camp Hill, PA 17089-0177            Attn: Appeals</p> <p>For: <b>SelectBlue and DirectBlue - Inpatient</b>            Highmark Blue Shield            P.O. Box 890177            Camp Hill, PA 17089-0177            Attn: Appeals</p> <p>For: <b>SelectBlue and DirectBlue - Outpatient</b>            Highmark Blue Shield            P.O. Box 890174            Camp Hill, PA 17089-0174            Attn: Grievance Review Committee</p>
<p><b>In all other cases call: 1-866-731-8080</b></p>	
2	<p>HMS care or case manager communicates any additional information necessary for additional review. The provider gathers the information and forwards it to the HMS care or case manager.</p>
3	<p>Within 30 days of receipt of all pertinent information, a clinical peer reviewer who was not involved in the original decision reviews the case and communicates the decision to the care or case manager by telephone.</p>
4	<p>HMS sends written notification of the decision to the:</p> <ul style="list-style-type: none"> <li>■ Appealing physician or provider</li> <li>■ Primary care physician, if appropriate</li> <li>■ Facility, if appropriate</li> <li>■ Member, member's representative</li> </ul> <p>The communication includes:</p> <ul style="list-style-type: none"> <li>■ The decision on the case</li> <li>■ Principal reasons and clinical rationale</li> <li>■ If applicable, a description of the source of screening criteria used to make the decision</li> </ul>

