



Updates Regarding Authorizations for Highmark SelectBlue® and DirectBlue® Patients:

- **Reminder: Authorizations for Outpatient Procedures and Miscellaneous Equipment (e.g., DME Items) Are the Provider's Responsibility**
 - **Effective June 1, 2005, Claims for Unauthorized Procedures/Equipment Will No Longer Pay at Lower Level; They Will Be Denied**
-

Obtaining an authorization for any outpatient procedure or equipment is a provider-driven process for Highmark Blue Shield members with coverage under the following products:

- SelectBlue (Point of Service)
- DirectBlue (Open Access)

Outpatient Procedures

If an outpatient procedure will be performed in a facility or office setting, the ordering or performing provider is responsible for obtaining any necessary authorizations. This can be done quickly and conveniently via NaviNetSM. (See NaviNet instructions on Page 3.)

Providers may submit a request for authorization to Highmark:

- electronically via NaviNet, or
- by calling HMS Care Management at 1-866-731-8080 between 8:30 a.m. and 7 p.m., Monday through Friday. For urgent care, HMS is also available between 8:30 a.m. and 4:30 p.m. on Saturday and Sunday.

Items Ordered by the Physician

Certain pieces of equipment and items ordered by the physician also require authorization. Again, it is the ordering provider's responsibility for obtaining any necessary authorizations, either via NaviNet or telephone.

Which Procedures and Items Require Authorization?

Highmark has eliminated preauthorization requirements for thousands of procedures, and today, procedures that don't require authorization outnumber those that do. To view an all-inclusive listing of procedures requiring authorization, please go to the Provider Resource Center, accessible via NaviNet or at www.highmarkblueshield.com. The list is located under *Administrative Reference Materials*.

Claims Processing and Payment Change, Effective June 1, 2005

Highmark member benefits state that network providers are always responsible for obtaining authorizations for those services requiring them and that the member is to be held harmless if the provider fails to obtain the authorization. The member benefits make no distinction between inpatient and outpatient services in this regard.

Until July 1, 2004, some Highmark products provided for lower-level reimbursement if a member failed to obtain a *referral* from a PCP before receiving services. Although many have come to associate lower-level payment with services received without authorization, this connection doesn't exist in either member benefit or provider contracts. With the elimination of the referral requirement, lower-level reimbursement is no longer applicable for services requiring authorization received from a network provider. Effective June 1, 2005, Highmark will no longer issue lower-level reimbursement to network providers for services requiring authorization. *If a required authorization isn't in place, the professional provider or facility is responsible for obtaining it; otherwise, the claim for the service will be rejected, and the member will be held harmless.*

If a required *authorization* is not obtained, the consequence is a claim denial. No payment can be made, and, contractually, providers cannot seek it from the member under these circumstances. To avoid unnecessary claim denials, please be sure to verify if a service requires authorization and obtain any necessary authorization prior to providing the service.

Note to Providers of Durable Medical Equipment, Orthotics/Prosthetics and Home Infusion Therapy

Please take note of the information detailed above. Although the physician is responsible for obtaining any necessary authorizations, we recommend that you always verify the authorization is in place prior to providing the service or equipment. This will help avoid claim denials.

If you have any questions regarding this information, please contact your Provider Relations representative.

See Page 3 for instructions on using NaviNet to verify/request authorizations.

SelectBlue and DirectBlue are registered marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. Highmark is a registered trademark of Highmark Inc. NaviNet is a registered service mark of NaviMedix Inc.

Using NaviNet to Verify/Request Authorizations

To verify that an authorization is in place for a service or procedure:

1. Go to the plan menu and select *Referral Auth Inquiry*, then click *Member ID Search*, *Member Name Search* or *Date of Service Search*. (Date of birth is required for all name searches.)
2. On the *Referral Auth Inquiry* screen, enter your search criteria. Click *Search*.
3. If you want to see more details on the authorization, click *Select* to see the *Referral/Authorization Detail* screen.
4. To start another inquiry, click *Referral/Auth Inquiry* on the Workflow Tracker, then click the next search type. When you are finished, click *Exit*.

To request an authorization:

1. Select *Referral/Auth Submission* from the plan menu, then click *Auth Submission*.
2. If you are affiliated with more than one office, select a *Referred From Billing Provider* from the Billing Provider list on the *Billing Provider Selection* screen. Otherwise, you are taken directly to the *Selection Form* screen.
3. On the *Selection Form* screen in *Step 1*, choose the *referred from* service provider and enter the proposed date of service, with or without slashes, using the month, day and full year. (A *referred from* provider is the provider who performs the service on the patient.)
4. In *Step 2*, enter the member information. For fastest results, enter the patient's member ID and either the patient's date of birth or first name. (For searches by Last Name/First Name, the date of birth is required.)
5. In *Step 3*, choose the category, then a service for the Authorization you are creating.
6. Click *Submit*.
7. When completing the *Request* screen, you may do any of the following:
 - Enter information directly; enter information and verify entry by clicking the *View Details* button; click *Search* as you proceed to search for any of these: diagnosis code, procedure code, provider number or facility number. (You can use a key word search when looking up a diagnosis code or a procedure code.)
 - Decide whether or not to fax the information. If you wish to send a fax, click on the "Fax to" box.
 - Click *View Details* before finalizing the submission, which allows confirmation and editing of any codes or provider number.
8. Review the *Request* screen. Click *Submit*.
9. View the *Response* screen. If you want to submit another authorization, click *Auth Submission* on the Workflow Tracker.
10. Providers can then inquire about their authorization submissions using the *Referral/Auth Inquiry* transaction.