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SPECIAL BULLETIN

FOR PROFESSIONAL AND FACILITY PROVIDERS

DECEMBER 3, 2013

HIGHMARK DELAWARE'S LIST OF OUTPATIENT PROCEDURES/SERVICES REQUIRING PRIOR AUTHORIZATION CHANGING ON 1/1/14 FEWER CODES FOR IPA/POS PRODUCTS; PRIOR AUTHORIZATION NOW REQUIRED FOR PPO/EPO PRODUCTS

Highmark Blue Cross Blue Shield Delaware (Highmark Delaware) is committed to ensuring that you are aware of important updates to our procedures and policies. In our most recent issue of *Provider News*, we informed you that **effective Jan. 1, 2014, our list of outpatient procedures/services requiring prior authorization would be updated** to align with the list that Highmark uses. This *Special Bulletin* contains important information regarding this change.

The full list of outpatient procedures/services requiring authorization beginning Jan. 1, 2014 is now available online, under *Administrative Reference Materials* on our Provider Resource Center. The Resource Center is accessible via our NaviNet® system or under *Helpful Links* at www.highmarkbcbsde.com. On an ongoing basis, we will make periodic adjustments to this list and will notify you whenever procedure codes are added or deleted.

BACKGROUND

To keep care affordable and accessible to members, Highmark Delaware maintains certain administrative requirements to ensure that the services our members receive are medically necessary, provided in the appropriate setting and cost-effective. One of these requirements is the authorization of certain non-emergent, outpatient products, medications and services. Examples of products, medications and services on our outpatient prior authorization list include DMEPOS; certain outpatient medical-surgical procedures and certain medical injectable drugs.

On Jan. 1, 2014, our list of outpatient procedures/services that require prior authorization will change. For your IPA/POS patients this change means there will be fewer procedure codes requiring prior authorization. Please continue reading to see how this change will impact your patients enrolled in Highmark Delaware PPO or EPO plans. As a reminder, this list does not apply to our indemnity and comprehensive products.

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LIST OF OUTPATIENT PROCEDURES/SERVICES REQUIRING PRIOR AUTHORIZATION NOW APPLIES TO HIGHMARK DELAWARE'S PPO/EPO PRODUCTS

Effective with dates of service of Jan. 1, 2014 and beyond, Highmark Delaware's list of outpatient procedures/services requiring prior authorization will also apply to PPO and EPO products. In most cases, the prescribing or ordering provider will be responsible for obtaining the authorization for PPO and EPO plan members in advance of the anticipated date of service.

HOW DO I VERIFY AUTHORIZATION REQUIREMENTS AND BENEFITS?

Beginning Jan. 1, 2014, authorizations will be required for most PPO/EPO and IPA/POS plan members; however, some employer groups may choose to opt out of this requirement. You must confirm if the requirement is applicable to the member, and you can do so using the NaviNet *Eligibility and Benefits* transaction. From the details page, click on *PPO or EPO Provision* and then scroll down to "In Network" and look for "Authorization."

You can also use the applicable HIPAA electronic transactions to confirm the requirement. Providers who don't have NaviNet should call Medical Management and Policy, toll-free, at 1-866-731-8080, Option 6.

HOW DO I REQUEST A PRIOR AUTHORIZATION?

Please use NaviNet or the applicable HIPAA electronic transactions to obtain authorization for services. Providers who don't have NaviNet or access to the HIPAA transactions should call Medical Management and Policy, toll-free, at 1-866-731-8080, Option 2, to obtain authorization for services for Highmark Delaware members. Please be sure to check members' benefits before delivering care to verify if authorization is required.

Highmark Delaware remains committed to providing authorization approvals within two business days after receipt of a request that contains all of the required information. As a NaviNet user, you can simply watch for the orange flag at the top right of your NaviNet screen to be highlighted (indicating you have a new message from Highmark Delaware) to quickly track the status of your authorization requests. Additionally, the *Referral/Authorization Inquiry* transaction allows you to view authorizations for members for whom you are the "Referred To" or "Referred From Billing Provider."

Please note that claims for services provided without an authorization will be denied and the member will be held harmless unless: a) the provider gives written notice to the member that authorization has been denied; **and** b) the member agrees in writing prior to receipt of the service to assume financial responsibility.

If you have any questions about the information in this *Special Bulletin*, please contact our Provider Services Department at 1-800-346-6262.