Highmark Blue Cross Blue Shield of Delaware Freedom Blue Medicare Advantage PPO Prior Authorization Overview

Prior authorization is a process Highmark uses to determine if a prescribed medical service or supply is covered by your Highmark Freedom Blue Medicare Advantage PPO plan and is medically necessary. This process helps to make sure you are receiving the most appropriate medical services or supplies for your condition. It also assists your doctors by ensuring you are receiving the service at the right time and place.

If prior authorization is required, your doctor will need to contact Highmark to start the prior authorization process. Highmark's Utilization Management team will work with your doctor to collect the necessary clinical and medical information for review. Highmark nurses currently use nationally standardized criteria and national and local Medicare coverage determinations to review the medical necessity of the requested services. If the nurse is unable to approve the prior authorization request, the case is referred to a medical director (who is a physician) for a secondary review and determination.

The timeframe for rendering a decision is tightly regulated by the Centers for Medicare and Medicaid Services (CMS). For urgent/expedited prior authorization requests for medical services, a determination must be made within 72 hours. Decisions regarding standard/non-urgent requests for medical services or supplies must be made within 14 days. The vast majority of prior authorization requests are approved, but if the request is denied, the doctor, member, or the member's representative has the right to appeal the decision.

The prior authorization process not only ensures you are getting the right care at the right time in the right place, but it also helps curb healthcare costs by limiting duplicative services. The prior authorization process also ensures ongoing or recurrent services are effective in improving or maintaining health.

Frequently asked questions:

1. Q. If my doctor says I need a specific medical service, why do I need a prior authorization approval for service from the State of Delaware Highmark Freedom Blue Medicare Advantage PPO Plan?

    A. While the majority of medical services provided do not require prior authorization, there are some select services that do. Prior authorization is a process to determine if a prescribed product or service is covered by your Highmark Freedom Blue Medicare Advantage PPO plan and is medically necessary based on current evidence-based medicine. This process helps to make sure you are receiving the most appropriate care for your condition. It also assists your doctor to ensure you are receiving the service at the right time and place.

2. Q. What are the most common services that require a prior authorization?

    A. Approval or a prior authorization is required from Highmark Blue Cross Blue Shield (BCBS) Delaware before specific types of services that are non-emergent, such as:

scheduled inpatient hospital care; home health care; home infusion therapy; organ transplants; high-cost or specialized durable medical equipment; non-emergent and air ambulance transportation; outpatient drug and alcohol treatment programs/services; certain high-risk Part B drugs; Physical/Occupational/Speech Therapy; some outpatient hospital/ambulatory surgeries, or those outpatient procedures that may be deemed possibly cosmetic, experimental, or investigational; mental health care; skilled nursing facility care; chiropractic care; respiratory therapy; select outpatient diagnostic tests/labs; and advanced imaging/radiology services (e.g., CT, MRI, MRA, and PET scans).

For services such as home health and Physical, Occupational, or Speech therapy, multiple visits are approved under one authorization request. Within the categories listed above, only those services that are specialized or high-risk, those that may have a potential for misuse or abuse, those that may be considered a comfort or convenience item, and/or those that may be experimental or investigational in nature have prior authorization requirements.

Most medical supplies do not require prior authorization. However, Medicare policies do dictate the limits on certain supplies (e.g., ostomy, wound care supplies). If those limits are exceeded, prior authorization would be required.

3. Q. Do all imaging services (X-ray, MRI, CT, PET scan, etc.) require prior authorizations?

    A. Prior authorization is required for advanced imaging services, which can include MRIs, MRAs, CTs, and PET scans. X-rays, sonograms, and other routine imaging services do **not** require prior authorization.

4. Q. What is the approval rate for prior authorizations?

    A. Highmark's approval rate for Medicare Advantage prior authorization requests is approximately 92% on average for initial prior authorization submissions.

5. Q. Who is responsible to request a prior authorization for services?

    A. For contracted in-network providers in the national Blue Cross Blue Shield Medicare Advantage PPO network, the requesting (ordering) doctor is responsible for obtaining a prior authorization before the delivery of non-urgent services. Providers nationally would submit the prior authorization request directly to Highmark for review. Providers are encouraged to submit prior authorization requests to Highmark electronically through the NaviNet provider system, but also may submit requests via fax or phone.

6. Q. Are prior authorizations required for care received from out-of-network, non-contracted providers?

A. You don't need to get a referral or prior authorization when you receive care from out-of-network providers. However, before receiving services from out-of-network providers, you may want to ask for a pre-visit coverage decision to confirm that the services you are receiving are covered and are medically necessary.

   Without a pre-visit coverage decision, if Highmark later determines that the services are not covered or were not medically necessary, we may deny coverage and the member will be responsible for the entire cost. If we say we will not cover the services, the member has the right to appeal our decision not to cover the care.

   Non-contracted, out-of-network providers may request a pre-visit coverage decision directly with Highmark. Members may also request to initiate a pre-visit coverage decision directly by calling the Highmark BCBS Delaware Freedom Blue Medicare Advantage Concierge Service team at **1-888-328-2960 (TTY call 711)**.

7. Q. If a member calls Highmark BCBS for a pre-visit coverage decision of a test or procedure they are planning to have with an out-of-network provider (who is not required to seek prior authorization), is what the member is told over the phone binding on Highmark? That is, if the member is told the test or procedure would likely be deemed medically necessary and appropriate, does that guarantee that the claim cannot be denied?

   A. To confirm the services you are receiving are covered and are medically necessary before receiving services from out-of-network providers, the member (or their provider) should request a pre-visit coverage decision to confirm Highmark will pay the claim for the requested service.

      Without a pre-visit coverage decision, if Highmark later determines the services are not covered or were not medically necessary, we may deny coverage and the member will be responsible for the entire cost. If we say we will not cover the services, the member has the right to appeal our decision not to cover the care.

      Non-contracted, out-of-network providers may request a pre-visit coverage decision directly with Highmark. Members may also request to initiate a pre-visit coverage decision directly by calling the Highmark BCBS Delaware Freedom Blue Medicare Advantage Concierge Service team at **1-888-328-2960 (TTY call 711)**.

8. Q. If a member has an out-of-network test or procedure that is later judged to have been medically unnecessary, and the claim is denied, is there any cap to what the patient would owe? Is there an out-of-pocket maximum or is the provider limited to charging no more than the Medicare-approved amount for that service?

   A. Without a pre-visit coverage decision, if Highmark later determines that the services are not covered or were not medically necessary, we may deny coverage and the member will be responsible for the entire cost. The cost would be limited to the

Medicare-approved amount for the service, assuming the provider is eligible to participate in Medicare and the service was eligible for coverage under Medicare. If we say we will not cover the services, the member has the right to appeal our decision to not cover the care.

9. Q. Who reviews prior authorization requests and what is their training to make medical decisions?

    A. A registered nurse (RN) reviews the prior authorization request and may approve if medical necessity is met according to appropriate use criteria. If the nurse is not able to approve the request, the request is sent to a medical director (a physician) for a secondary review.

10. Q. What information is required to be included as part of a prior authorization request?

    A. The doctor should provide all pertinent clinical information to support medical necessity of the request. For example, if you need an MRI of your shoulder, your doctor should include any part of your medical record that pertains to the particular shoulder problem (i.e., X-rays, physical therapy, the cause of the pain and how long it has lasted). If Highmark does not receive this information, Highmark will contact the doctor to obtain the missing clinical information needed to make a decision on the request.

11. Q. How much time does it take to review a prior authorization request?

    A. After Highmark receives all the needed medical information pertaining to your specific request, the average turnaround time for urgent/expedited requests is 1.57 days and for non-urgent requests, 4.05 days. CMS guidelines require decisions for urgent/expedited medical service or item requests to be made within 72 hours. Standard/non-urgent medical request decisions must be made within 14 days.

12. Q. Is there an expedited review for urgent prior authorization requests and, if so, what is the timing?

    A. Yes, decisions for expedited/urgent medical service or supply requests must be made no later than 72 hours after the receipt of the request. For Part B drugs, the decision must be made within 24 hours.

13. Q. Are prior authorizations required in emergency care situations?

    A. No, emergency services do not require prior authorization. Emergency care should not be delayed or impeded waiting for an authorization.

14. Q. If I am traveling outside the country, are prior authorizations required for services?

A. For emergency services, prior authorizations would not be required when outside the United States. For routine services or elective care, service would have to be eligible for coverage under Original Medicare and be medically necessary to be a covered benefit outside of the United States.

15. Q. What clinical and other criteria are used to review and determine approval of prior authorizations?

    A. If a prior authorization is required, your doctor will usually contact Highmark to initiate the prior authorization process. Highmark's Utilization Management team will work with your doctor to collect the necessary clinical/medical information for review of the prior authorization request. Highmark nurses currently use nationally standardized criteria and national and local Medicare coverage determinations to review the medical necessity of the requested services.

16. Q. Does a doctor review and make a decision on each prior authorization request?

    A. A Highmark physician only reviews the prior authorization request if the nurse cannot approve it.

17. Q. Why would my provider's prior authorization request be denied?

    A. The number one reason prior authorization requests are not approved is that there was insufficient clinical information submitted for review with the initial request, and no additional information was provided to support an approval. Other reasons a prior authorization request could be denied are that the requested service is not considered medically necessary by current medical evidence or if the service is not covered by Highmark Freedom Blue Medicare Advantage PPO plan, which covers all benefits covered under the Original Medicare program as well as additional benefits provided by the State of Delaware Highmark Medicare Advantage plan.

18. Q. How are approvals and denials for prior authorization requests communicated to both the provider and to the member?

    A. Members are notified of the prior authorization approval or denial by phone and letter. Providers receive a notification of the prior authorization approval or denial via the NaviNet system when submitting requests to Highmark electronically as well as by fax, phone, and letter (a copy of what is sent to the member).

19. Q. When receiving care from in-network providers, what happens if a medical service (that requires a prior authorization) was received without a prior authorization approval? Who is responsible for the cost of the service, the provider or the member?

A. If a service that requires prior authorization was provided prior to obtaining the prior authorization, the provider will need to submit the authorization request retrospectively (post-service). If a post-service authorization request is denied, the contracted network provider is responsible for the cost of the service (this is not a member liability).

20. Q. For members who are currently receiving services under the Special Medicfill plan that would require prior authorization when the member transitions to the Freedom Blue PPO plan on January 1, 2023, does the member or doctor need to take any action? Is there a grace period if a member is currently receiving care for services that would be subject to prior authorization under the new plan? Will there be any outreach by Highmark to providers about the plan transition?

A. To help transition members from the Special Medicfill plan to the new Freedom Blue Medicare Advantage PPO plan, Highmark has a Transition of Care process to ensure new members can continue in their current course of treatment for a transitional period (typically up to 90 days) from the effective date of enrolling in the Freedom Blue Medicare Advantage PPO plan.

All that is needed to assure a seamless transition is completion of the Transition of Care request form. This form can be completed by your doctor or the member for services that may otherwise require ongoing prior authorization. This process is only necessary during the transitional period so that medically necessary services are not subject to prior authorization during the active/ongoing course of treatment as defined above.

Highmark will be actively communicating to providers across Delaware through the remainder of 2022 on the transition of the State of Delaware retirees into the Freedom Blue Medicare Advantage PPO plan.

21. Q. What happens if a prior authorization request is denied?

A. CMS mandates the appeals process for Medicare Advantage plans. All Medicare Advantage plans must follow a five-level appeals process. A State of Delaware pensioner, their provider, or the pensioner's "appointed representative" can request an appeal of a prior authorization denial as well as appeal any payment decision on a service provided to a Medicare Advantage member. Highmark follows the CMS prescribed five-level appeals process for Medicare Advantage plans as outlined below. Details of the Highmark Medicare Advantage appeals process and how to request assistance are outlined in the Medicare Advantage Evidence of Coverage document that will be available in early October for all State of Delaware pensioners.

- 1st level of Appeal is a Health Plan Reconsideration by Highmark from a different reviewer than made the initial coverage decision

- 2nd level of Appeal is with an Independent Review organization (IRE) hired by CMS for Medicare Advantage appeals
- 3rd level of Appeal is an Administrative Law Judge Hearing with the Office of Medicare Hearings and Appeals (Required amount in controversy >$180)
- 4th level of Appeal is with the Medicare Appeals Council
- 5th level of Appeal is in Federal District Court (Required amount in controversy >$1,760)