HIGHMARK®
Delaware
HEALTH OPTIONS

# PROVIDER UPDATE

An Update for Highmark Delaware Health Options Providers and Clinicians

## JULY 2019

## RETRO REVIEW PROCESS CHANGE

After receiving provider feedback, Physical Health Utilization Management (UM) is happy to announce changes related to the concurrent review process **during an inpatient admission** for our Highmark Health Options (HHO) members. Effective **July 1, 2019**, UM will no longer refer member cases **during an inpatient admission** to the Retro Review Appeals Team for a denied claim review when a provider submits a late notification OR cases are impacted by retroactive coverage.

The changes simply mean that while a Highmark Health Options member is **hospitalized**, **Utilization Management** will review the clinical documentation for medical necessity for the inpatient stay under the following scenarios:

- The insurance coverage with Highmark Health Options is **retroactive to the member's date of birth** by DMMA.
- The insurance coverage with Highmark Health Options is **retroactive to the date of admission** by the DMMA.
- The provider submits a notification of admission after 2:30pm on the 3rd business day following the date of admission.

The notification of admission may still be submitted via phone, fax, electronic medical record portal access, or by Secure-email (i.e. a Hospital admission report). For our hospitals that have granted UM access to their portal, the member's medical record will be reviewed via the portal as usual. For hospitals who **have not** granted UM portal access, the provider is responsible for faxing updated clinical information for a timely concurrent review.

## ADDITIONAL INFORMATION

- Provide opportunities for an improved customer service experience with our providers and enable UM to assess ongoing medical services and/or treatments, maintain contact with the facility throughout the stay, impact length of stay, initiate discharge planning, and case manage needs for our members.
- Our providers will **not** have to wait for the member to discharge from the facility to submit claims for a retrospective review. UM will review the case.
- An authorization will be on file for the provider to submit claims for processing from the date of the admission through discharge based on the medical necessity review determination.

***NOTE:** Failure to contact the UM Department for an inpatient authorization (while the member remains inpatient), will result in a claim denial for no authorization. Post-service requests will continue to be reviewed by the Provider Appeals team. If the provider requests a review of the inpatient admission **after** the member is discharged, the provider will need to submit the medical records for a retro appeal review. Post-service requests will be reviewed on an administrative basis.

If you have questions regarding this change, please contact Highmark Health Options Provider Services at 844-325-6251.

*Highmark Health Options is an independent licensee of the Blue Cross and Blue Shield Association*