Blue Essentials℠, Blue Advantage HMO℠ Blue Premier℠, and My Blue Health ℠ Provider Manual - Prior Authorizations & Case Management

Please Note

Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO, Blue Premier** and **MyBlue Health.** These specific requirements will be noted with the plan/network name. If a Plan name is not specifically listed or the "**Plan**" is referenced, the information will apply to **all** HMO products.

In this Section

The following topics are covered in this section:

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Utilization Managment Overview

Utilization management determines whether a benefit is covered under the Blue Cross and Blue Shield of Texas (BCBSTX) health plan using evidence-based clinical standards of care. It can be a prior authorization, prenotification or post service medical review.

Prior Authorization (sometimes referred to as precertification or preauthorization) is a utilization management process that determines whether medical services are:

- Medically Necessary or Experimental/Investigational and covered under the member's plan
- Provided in the appropriate setting or at the appropriate level of care
- Of a quality and frequency generally accepted by the medical community
- Being rendered by a provider in or out of the member's network

  Note: Prior authorization is **not a verification** and does not guarantee payment. Payment will be determined after the claim is filed and is subject to eligibility, contractual limitations and payment of premiums on the date of service.

Predetermination of benefits are voluntary requests for verification of benefits before rendering services. It may be used if you are not sure about coverage or whether we may not consider it medically necessary.

Post-Service Medical Necessity Reviews (PSMNR) occur after the service is rendered. During a post-service utilization management review, we review clinical documentation to determine whether a service or drug was medically necessary and covered under the member’s benefit plan. We may also conduct a post-service utilization management review if you do not obtain a required prior authorization before the services were rendered.

Capitated Medical Group - Important Note

Health care providers who are contracted/affiliated with a capitated Medical Group must contact the Medical Group for instructions regarding referral and prior authorization processes, contracting, and claims-related questions. Additionally, health care providers who are not part of a capitated Medical Group but who provide services to a member whose PCP is contracted/affiliated with a capitated Medical Group must also contact the applicable Medical Group for instructions. Health care providers who are contracted/ affiliated with a capitated Medical Group are subject to that entity’s procedures and requirements for the Plan's provider complaint resolution.

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What Requires Prior Authorization

To determine which services may require prior authorization, prenotification or referrals for Plan members, go to the Utilization Management - Prior Authorizations & Predeterminations page under **Claims and Eligibility** on the provider website and use Availity® or your preferred vendor to check eligibility and benefits, determine if you are in-network for your patient and if prior authorization or prenotification is required, who to contact - BCBSTX Medical Management or AIM Specialty Health (AIM). Availity allows you to determine if prior authorization is required based on the procedure code. Refer to "Eligibility and Benefits" on the provider website for more information on Availity.

AIM Specialty Health Prior Authorizations

BCBSTX has an agreement with AIM to provide certain outpatient prior authorization services. Services requiring prior authorization as well as information on how to prior authorize services with AIM are outlined on the **Utilization Management - Prior Authorizations & Predeterminations** page and on the AIM Specialty Health page on bcbstx.com/provider.

Responsibility for Prior Authorization

Plan Primary care physicians/providers (PCP), specialty care physicians or professional providers with a current referral are responsible for the completion of the prior authorization process.

Note: Failure to meet prior authorization requirements may result in nonpayment and health care providers cannot bill or collect fees from members for services. Out-of-network services require prior authorization.

Renewal of an Existing Prior Authorization

A renewal of an existing authorization issued by BCBSTX or AIM can be requested by a physician or health care provider up to 60 days prior to the expiration of the existing authorization.

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When to Prior Authorize

Prior authorization time frames are listed below.

Type of Service	Time Frame
All elective inpatient admissions	***A minimum of two days before*** admission and preferably seven days in advance
Urgent/Emergent admissions	Within the later of 48 hours or by the next business day of an emergency hospital admission
Extended Care - Home Health	***Prior to*** the delivery of services

Does Observation Require Prior Authorization?

Observation does not require prior authorization. However, if patient converts from observation to inpatient, the admission will require prior authorization.

How to Prior Authorize Services

For information on behavioral health, refer to Section I of this Provider Manual.

Prior authorizations for services managed by BCBSTX Medical Management can be completed online using the Availity Authorizations & Referrals tool available 24 hours a day, seven days a week.

Prior authorization may also be performed by calling Medical Management

- Call **1-800-441-9188**
- Hours: 7 a.m. – 7 p.m. (CST), M-F and non-legal holidays and 9 a.m. to 1 p.m. (CST), Saturday, Sunday and legal holidays
- Messages may be left in a confidential voice mailbox after business hours.

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After Hours Calls

After hours calls are answered electronically and are returned within 24 hours in the order they are received.

Faxing Prior Authorization Requests

If **Availity Authorization & Referrals** is not available, prior authorization may also be initiated via fax at: **Toll-free 1-800-252-8815** or **1-800-462-3272**

Information Necessary to Prior Authorize

Please have the following information readily available when initiating prior authorization:

- Patient's full name/member's full name
- **Plan** member ID number
- Policy or group number
- Anticipated date of admission or service
- Clinical history
- Diagnosis - International Classification of Diseases (ICD-10) codes
- Procedure(s) or service(s) planned - Current Procedural Terminology (CPT®) codes
- Anticipated length of stay or frequency of services
- Type of admission (elective or emergency)
- Plan of treatment
- Name/phone number of the admitting physician
- Facility
- Comorbid condition(s)
- Results of diagnostic testing and laboratory values, if applicable
- Caller name/phone number will be requested

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Important Information About the Prior Authorization Program

The following outlines important information about the prior authorization program.

- **Clinical Criteria** — Prior authorization requests are reviewed using the MCG Guidelines® which promotes consistent decisions based on nationally accepted, physician-created clinical criteria. The criteria are customized to reflect BCBSTX medical policy and local standards of medical practice. Internally developed criteria for Extended Care are based on established industry standards, scientific medical literature and other broadly accepted criteria, such as Medicare guidelines. Diagnosis, procedure, comorbid conditions and age are considered when assigning the length of stay/service.

Note: Clinical Review Criteria is available upon request for cases resulting in non-authorization.

- **Physician Review** — a case will be referred to a Physician Reviewer if the information received does not meet established criteria. In any instance where there is a question as to medical necessity, experimental/ investigational nature or appropriateness of health care services, the ordering/referring/treating physician or the admitting/attending physician or their delegate shall be afforded a reasonable opportunity to discuss the plan of treatment with the Physician Reviewer ***before*** the issuance of an adverse determination. The Physician Reviewer will attempt to contact the servicing physician or professional provider by telephone ***before*** issuance of an adverse determination. Physician Advisors who are third-parties hired by a facility are not eligible.

®' Registered Mark of MCG Guidelines

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Important Information About the Prior Authorization Program, cont.

- **Notification** — written notification letters are sent to the member, physician or professional provider and facility following approval or denial of benefits. The prior authorized length of stay or service and the prior authorization numbers are included. Letters of notification of adverse determinations include the reason for denial and an explanation of the appeal process.
- **Benefit Decision** — The decision to provide treatment is between the patient and the health care provider. Once the decision has been made, BCBSTX determines what benefits are allowed under the existing health plan.

Note: *Prior authorization is not verification and does not guarantee payment. Prior authorization merely confirms the medical necessity of the service or admission. Payment is subject to, but not limited to eligibility, contractual limitations and payment of premium on the date(s) of service.*

Refer to Section C - Authorization Process for information on appealing adverse determinations and post service medical necessity reviews to determine whether a service or drug was medically necessary and covered under the member's benefit plan.

Payment will be determined after the claim is filed and is subject to the following:

- Eligibility
- Other contractual provisions and limitations, including, but not limited to:
  - Cosmetic procedures
  - Pre-existing conditions
  - Failure to prior authorize
  - Limitations contained in riders, if any
- Claims processing guidelines
- Payment of premium for the date on which services are rendered.

Accessibility of Utilization Management Criteria

Utilization Management review criteria is available to **Plan** contracted health care providers upon request. To receive MCG Guidelines on a specific condition, please contact the Utilization Management Department for the **Plan** at **1-800-441-9188.**

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Extended Care Prior Authorization Procedure

The prescribing physician or professional provider is responsible for obtaining a prior authorization by contacting the Utilization Management Department by phone or fax.

A prior authorization will be given after verifying medical necessity. For information regarding prior authorization requirements, refer to **"Utilization Management"**, which can be found under **Claims and Eligibility** on the provider website. Providers should obtain eligibility and benefits, determine if the provider is in-network for the member's plan and whether prior authorization is required through Availity or their preferred vendor.

Extended Care Prior Authorization – Home Health Services

The following general guidelines apply to Home Health Services:

- Services ***must*** be ordered by a participating health care provider.
- The patient is certified by the participating health care provider as homebound under Medicare guidelines.
- The needs of the patient can only be met by intermittent skilled care by a licensed nurse, physical, speech or occupational therapist, or medical social worker.
- The care being requested for the patient is not experimental, investigational or custodial in nature.
- All Home Health Services, including nursing services, physical, occupational and speech therapy require prior authorization before services are rendered.

Extended Care Prior Authorization – Hospice

Hospice benefits are available for patients with a life expectancy prognosis of six months or less. Treatment is generally palliative and non-aggressive in nature and is provided in the home. Inpatient admissions for pain management or caregiver respite may also be available depending on current group coverage. Hospice services require prior authorization ***before*** services are rendered.

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Extended Care Prior Authorization – Skilled Nursing Facilities

All admissions to Skilled Nursing Facilities require prior authorization ***before*** receiving services.

Extended Care Prior Authorization - Important Note

When any member needs extended care, the PCP **must** obtain prior authorization to the health care provider of services **before** the delivery of services for the highest level of benefits to be received.

Prior Authorization for Inpatient Care

The **Plan** physician or professional provider, is required to admit the member to a participating facility within his/her Provider Network, except in emergencies or if it is otherwise impossible to do so. The **Plan** Clinical Quality Improvement Committee approve guidelines and standards for review of admissions.

The PCP or a specialty care physician or professional provider with a current referral is responsible for prior authorizing admissions in which he/she is the admitting provider.

A confirmation letter will be mailed to the subscriber, facility and attending physician or professional provider.

When an admission does not meet the clinical screening criteria, the Utilization Management Department will refer the case to a Physician Reviewer. If the referring physician or professional provider disagrees with the Physician Reviewer's decision, he/she may request an appeal.

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Non-Emergency Elective Medical Surgery Admission Guidelines	Elective admissions should be prior authorized at least seven (7) days ***before*** the date of admission by accessing Availity Authorizations & Referrals tool or contacting the Utilization Management Department for the **Plan** at **1-855-896-2701.**
Urgent/ Emergent Admissions Procedure	The admitting physician or professional provider ***must*** access the Availity Authorizations & Referrals or contact the Utilization Management Department for the **Plan** at **1-855-896-2701** within the later of 48 hours or by the next business day of an emergency hospital admission.
Admission on Day of Surgery	Preoperative evaluation, testing, pre-anesthesia assessment and patient education will routinely be performed on an outpatient basis, or on the morning of surgery.
Concurrent Review	Concurrent review is performed when an extension of a previously approved inpatient length of stay is needed, or an extension of a previously approved Extended Care service is required.
Concurrent Review of Inpatient Admissions	Inpatient admissions are reviewed in order to ensure that all services are of sufficient duration and level of care to promote optimal health outcome in the most efficient manner. Hospital admissions will be reviewed in accordance with the screening criteria approved by the Clinical Quality Improvement Committee.
Responsibility for Concurrent Review	The **Plan** PCP, specialty care physician or professional provider with a current referral is responsible for obtaining an extension before the expiration of the previously approved length of stay or service.

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Information Needed When Requesting an Extension

Please have the following information readily available when requesting an extension:

- Change of diagnosis/comorbid conditions
- Deterioration of the patient's condition
- Complication(s)
- Additional surgical intervention, if applicable
- Transfer plans to another facility or to a specialty bed/unit, if applicable
- Treatment plan necessitating inpatient stay

Extension Review Procedure

Review will begin upon request for the extension. The Utilization Management Department may contact the admitting physician or professional provider or hospital Utilization Management Department for additional information. If the criteria are not met, the case will be referred to a Physician Reviewer for a determination. For DRG reimbursed hospitals, all days must be prior authorized in order to be reimbursed for high outlier per diems.

The Plans utilize MCG Guidelines which promotes consistent decisions based on nationally accepted, physician-created, clinical criteria. Diagnosis, procedure, comorbid conditions and age are considered when assigning the inpatient length of stay.

If the information does not satisfy the criteria at any point of the admission, the case is referred to a Physician Reviewer for determination. Only a Physician Reviewer may deny a Prior authorization. When a denial of benefits is determined, the Utilization Management Department notifies the admitting physician or professional provider and the hospital by telephone and letter.

The confirmation letter of the benefit determination will be mailed to the member, facility and attending health care provider *(if other than the PCP).*

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Discharge Planning	Discharge planning is initiated as soon as the need is recognized during the hospital stay. When additional care is medically necessary following a hospital admission, the Utilization Management Department will work with the Hospital Discharge Planning Staff and the admitting physician or professional provider in coordinating necessary services within the same Provider Network.
Case Management Services	Case Management Services help identify appropriate health care providers through a continuum of services while ensuring that available resources are being used in a timely and cost-effective manner.
Case Management Examples	Cases that may be appropriate for referral to Case Management include: • Transplants — solid organ — bone marrow • Infectious Disease • Internal Medicine • Oncology • Pulmonary • High-Risk Obstetrics • Catastrophic Events — closed head injury — spinal cord injury — multi system failure

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Health Care Provider Involvement

Health care providers can assist with the case management process by identifying and referring patients for possible Case Management Services and by providing input to alternative care options identified by the Case Management Department.

Referrals to Case Management

Case Management referrals are accepted by telephone, fax or in writing. Contact the Case Management Department by calling: **1-800-462-3275 or 1-800-252-8815**

When faxing a referral to Case Management, please fax to:

1-800-778-2279

When contacting the Case Management Department in writing, mail to the following address:

Blue Cross and Blue Shield of Texas
Case Management Department
P.O. Box 833874
Richardson, TX 75083-9913

For information on behavioral health case management, call Magellan Behavioral Health Providers of Texas, Inc. at the toll-free number between the hours of 8 a.m. – 5 p.m., CST, **1-800-729-2422**

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Evaluation of New Technology

The Medical Advisory Committee evaluates new technologies, medical procedures, drugs and devices by assessing current clinical literature, appropriate government agency regulatory approvals, medical practice standards and clinical outcomes. The Medical Advisory Committee is composed of participating physicians, professional providers, pharmacists and other related medical personnel. This committee reviews each new are of medical technology and makes a recommendation concerning whether the service should be eligible for coverage. Health care providers may submit new technology requests for evaluation via email to:HCSC_Medical_Policy@bcbstx.com

Emergency Care Services Rendered Inside the Service Area

Emergency care services are services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness or injury is of such a nature that failure to get immediate medical care could result in placing the patient's health in serious jeopardy, cause serious impairment to bodily function, cause serious dysfunction of any organ or part of the body, cause serious disfigurement, or in the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

Note: Services in hospital emergency rooms or comparable facilities do not require prior authorization.

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Emergency Inpatient Admissions Rendered Outside the HMO Service Area

The PCP ***must*** notify the **Plan's** Utilization Management Department of an emergency inpatient admission outside the **Plan's** service area within the later of 48 hours or by the end of the next business day.

When appropriate, the PCP and the **Plan's** Utilization Management Department will work together to arrange for the member's care and return to a participating facility within the service area as soon as reasonably possible.

Emergency Hospital Admission

Emergency hospital admissions ***do not require prior*** certification/authorization. The PCP ***must*** contact the **Plan's** Utilization Management Department within the later of 48 hours or by the end of the next business day of the emergency hospital admission. *(Members are required to contact their PCP within 48 hours if not admitted by their PCP).*

If the admitting physician, is not a participating **Plan** physician or professional provider or is not in the same Provider Network as the member's PCP, the PCP, in conjunction with the Plan's Utilization Management Department, is responsible for coordinating the care of the patient upon notification of the admission.

Continuity of Care Program Criteria

Continuity of medical care is considered, based on written criteria and medical necessity, for a limited period when a health care provider contract is discontinued due to reasons other than quality deficiencies. Additionally, such continued care may be available when **Plan** members are required to change health plans based on an employer group change. Termination of the health care provider's agreement shall not release a health care provider from the obligation to continue ongoing treatment of a member of "special circumstance" *(as defined by applicable law and regulation)* or **Blue Essentials, Blue Advantage HMO, Blue Premier** and **MyBlue Health** or **Payer** from its obligation to reimburse the health care provider for such services at the rate set forth in their agreement.

For example:

- A member becomes effective with a **Plan** while actively receiving health care services by health care providers not participating in the member's **Plan** and whose current health care treatment plan cannot be interrupted without disrupting the continuity of care and/or decreasing the quality of the outcome of the care, or
- A member's physician or professional provider leaves the **Plan** and the member's current health care treatment plan cannot be interrupted without disrupting the continuity of care and/or decreasing the quality of the outcome of the care.

Continuity of care **may** extend coverage for care with Out-of-Network health care providers until the course of treatment for a specific condition is completed. The health care providers **Plan** obligations will continue until the earlier of the appropriate transfer of the member's care to another participating **Plan** health care provider, the expiration of 90 days from the effective date of termination of the health care provider or up to nine months in the case of a member who at the time of the termination has been diagnosed with a terminal illness.

If coverage for care with an out-of-network health care provider is certified due to pregnancy, it will be continued through the postpartum checkup within the first six weeks of delivery.

Continuity of care is considered when a member has special circumstances such as:

- acute or disabling conditions
- life-threatening illness
- pregnancy past the 13th week of pregnancy

Continuity of Care Program Criteria Procedure

The procedure for initiating continuity of care is as follows:

- A member or health care provider may initiate a request for continuity of care by calling the **Plan's** Customer Service or the Utilization Management Department.
- A PCP may initiate a request by contacting the **Plan's** Utilization Management Department.
- The **Plan's** Utilization Management Department reviews all requests.
- Cases that do not meet criteria are referred to a Physician Reviewer for determination.
- The **Plan's** Utilization Management Department notifies the **Plan** health care provider and the member of the continuity of care decision via letter.
- If the request for continuity of care is approved, the Utilization Management staff completes an out-of-network referral and a letter is mailed to the servicing physician or professional provider.
- If continuity of care is denied, the member has the following options:
  a. Continue care/treatment with his/her out-of-network physician or professional provider at his/her own expense;
  b. Choose a participating **Plan** physician or professional provider in the member's Provider Network *(whichever is applicable)*;
  c. Receive treatment under the direction of his/her primary care physician; or
  d. File a formal complaint by contacting the **Plan's** Customer Service Department.
- The **Plan** Utilization Management staff and Medical Director review continuity of care criteria at least annually.

Outpatient Diagnostic Imaging

Refer to Section B of the **Blue Essentials, Blue Advantage HMO, Blue Premier and My Blue Health Provider Manual** for information pertaining to outpatient diagnostic imaging.