Blue Choice PPO℠ and Blue High Performance Network℠ (BlueHPN)℠ Provider Manual - Prior Authorizations & Case Management

Important note:

Throughout this provider manual there will be instances when there are references unique to Blue Choice PPO, Blue High Performance Network, Blue Edge, EPO and the Federal Employee Program. These specific requirements will be noted with the plan/network name. If a Plan/network name is not specifically listed or "Plan" is referenced, the information will apply to all PPO products.

The following topics are covered in this section.

In this Section

Blue Choice PPO and Blue High Performance Network (BlueHPN) Provider Manual - Prior Authorizations & Case Management

In this Section, cont'd

The following topics are covered in this section:

Blue Choice PPO and BlueHPN Provider Manual - Prior Authorizations & Case Management

Utilization Management 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, written 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.

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.

Blue Choice PPO and BlueHPN Provider Manual - Prior Authorizations & Case Management

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 physicians and professional providers are responsible for the completion of the prior authorization process**. Plan** facility and ancillary providers are responsible for prior authorization of Extended Care and Home Infusion Therapy services. ***Note: Failure to prior authorize may result in reduced payment and health care providers cannot collect these fees from subscribers. 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.

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 ***prior*** to admission and preferably seven days in advance
Urgent/Emergent admissions	Within the later of 48 hours or by the end of 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.

Blue Choice PPO and BlueHPN Provider Manual - Prior Authorizations & Case Management

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.

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**

Blue Choice PPO and BlueHPN Provider Manual - Prior Authorizations & Case Management

Information Necessary to Prior Authorize

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

- Patient's full name/member's full name
- BCBSTX 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 admitting physician
- Facility
- Comorbid condition(s)
- Results of diagnostic testing and laboratory values, if applicable
- Caller name/phone number will be requested

Information About the Prior Authorization Program

The following outlines important information about the BCBSTX utilization management 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-certification.

- **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 ***prior*** to the issuance of an adverse determination. The Physician Reviewer will attempt to contact the servicing physician or professional provider by telephone ***prior*** to issuance of an adverse determination. Physician Advisors who are third-parties hired by a facility are not eligible

Important Information About the Prior Authorization Program, cont.

- **Notification** — Written notification letters are sent to the member, health care provider. The prior authorized length of stay or service and the prior authorization numbers are included. Letters of notification of benefit denial 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 a 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 *(Federal Employee Participants are not subject to the payment of premium limitation).*

Accessibility of Medical Management Criteria

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

Extended Care Prior Authorization Procedure	The prescribing physician or professional provider is responsible for obtaining a prior authorization by contacting the Medical Management (UM) Department by phone or fax. A prior authorization will be given after verifying medical necessity and network status. If the provider is out-of-network UM will attempt to navigate member to an in-network provider. For detailed information regarding prior authorization requirements, refer to the "What Requires Prior Authorization" section above.
Extended Care Prior Authorization - Home Health Services	The following general guidelines apply to Home Health Services: • Services ***must*** be ordered by a physician and require a physician signed treatment plan. • The patient is certified by the physician 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 needs of the patient are not experimental, investigational or **custodial** in nature. • All Home Health Services require authorization ***prior*** to service being 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 ***prior*** to services being rendered.
Extended Care Prior Authorization – Home Infusion Therapy	**Plan** members requiring Home Infusion Therapy are not required to be homebound to receive services. Home Infusion Therapy requires authorization ***prior*** to services being rendered.
Extended Care Prior Authorization – Skilled Nursing Facilities	All admissions to Skilled Nursing Facilities require prior authorization ***prior*** to receiving services.

Blue Choice PPO and BlueHPN Provider Manual - Prior Authorizations & Case Management

Extended Care Prior Authorization - Important Note	When any **Plan** member needs extended care or home infusion therapy, the **Plan's** health care provider ***must*** obtain authorization of the services ***prior*** to 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, except in emergencies. The Primary Care Physician (PCP) or a Specialty Care Physician or Professional Provider (SCP) is responsible for prior authorizing admissions in which he/she is the admitting provider. A confirmation letter will be mailed to the member, the facility and to the attending physician or professional provider. When an admission does not meet the clinical screening criteria, the Medical 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.
Elective Medical/Surgery Admission Guidelines	Elective (non emergency) admissions should be prior authorized at least seven (7) days ***before*** the date of admission by accessing Availity Authorizations & Referrals or contacting the Medical Management Department at **1-800-441-9188**.
Urgent/ Emergent Admissions Procedure	The admitting physician or provider ***must*** access Availity Authorizations & Referrals or contact the Medical Management Department at **1-800-441-9188** within the later of 48 hours or by the end of 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.

Blue Choice PPO and BlueHPN Provider Manual - Prior Authorizations & Case Management

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.

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

Concurrent Review of Inpatient Admissions

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

Inpatient admissions are reviewed to ensure all services are of a 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** Primary Care physician, Specialty Care health care provider is responsible for obtaining an extension ***prior*** to the expiration of the previously approved length of stay or service.

Extension Review Procedure

Review will begin upon request for the extension. The Medical Management Department may contact the admitting health care provider or hospital Medical Management Department for additional information. If the clinical screening criteria are not met, the case will be referred to a Physician Reviewer for a determination.

BCBSTX utilizes 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 or discontinue benefit certification. When a denial of benefits is determined, the Medical 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 health care provider *(if other than the Primary Care Physician).*

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 Medical Management Department will work with the Hospital Discharge Planning Staff and the admitting health care provider in coordinating necessary services within the **Plan** Network.

Blue Choice PPO and BlueHPN Provider Manual - Prior Authorizations & Case Management

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

Blue Choice PPO and BlueHPN Provider Manual - Prior Authorizations & Case Management

Referrals to Case Management

Case Management referrals are accepted by telephone, fax or in writing. Contact the Case Management Department by calling:

Toll-free 1-800-462-3275

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

Toll-free 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 75083-3874

For information on behavioral health case management, call the number below between the hours of 8 a.m. – 5 p.m. (CT).
1-800-528-7264

Evaluation of New Technology

Following review by the BCBSTX Advisory Panel, the BCBSTX 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 BCSBTX Medical Advisory Committee is composed of participating physicians, professional providers, pharmacists and other related medical personnel. This committee reviews each new area 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

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. ***Emergency room services do not require referral or prior authorization.***

Emergency Inpatient Admissions Rendered Outside the Plan's Service Area

The attending physician/provider or member ***must*** notify BCBSTX Medical 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 health care provider and the Medical Management Department will work together to arrange transportation of the member back to the service area for inpatient care at a participating facility.

Emergency Hospital Admissions

Emergency hospital admissions ***do not require prior*** authorization. The primary care physician ***must*** authorize the admission within the later of 48 hours or by the end of the next business day following the emergency hospital admission. *(Members are required to contact their primary care physician within 48 hours if not admitted by their PCP).*

If the admitting health care provider is not a **Plan** physician or professional provider, the member's primary care physician, in conjunction with the Medical 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's Managed Care Agreement 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 Managed Care 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 BCBSTX 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 the **Plan** while actively receiving health care services by health care providers not in the **Plan** network 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 health care provider leaves the **Plan** network 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 and BCBSTX's obligations will continue until the earlier of the appropriate transfer of the member's care to another **Plan** participating health care provider (whichever is applicable), 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 13th week and beyond

Blue Choice PPO and BlueHPN Provider Manual - Prior Authorizations & Case Management

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