

Precertification: Overview

Introduction

Precertification determines whether medical services are:

- Medically Necessary or Experimental/Investigational
- Provided in the appropriate setting or at the appropriate level of care
- Of a quality and frequency generally accepted by the medical community

Note: Precertification 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 date of service.

What Requires Precertification and Concurrent Review?

Refer to Section C, pages C – 3 and C - 4 for Precertification Requirements.

Responsibility for Precertification

BlueChoice Primary Care Physicians or designated Specialty Care Physicians/Professional Providers are responsible for the completion of the precertification process. BlueChoice ancillary providers are responsible for precertification of Extended Care and Home Infusion Therapy services.

BlueChoice facilities are responsible for notifying the Utilization Management Department of an elective admission prior to admission and an urgent/emergency admission within the later of 48 hours or by the end of the next business day.

Note: Failure to precertify may result in reduced payment, and Providers cannot collect these fees from subscribers. Out-of-network services require precertification.

Continued on next page

Precertification: Overview

**In this
Section**

The precertification section covers the following topics:

Topic	Page
Precertification Procedure	D — 3
Extended Care Precertification	D — 5
Important Notes: Precertification	D — 6
Inpatient Care	D — 8
Concurrent Review	D — 9
Case Management Referrals	D — 11
Emergency Care	D — 13
Continuity of Care	D — 14

Precertification Procedure

When to Precertify

Precertification time frames are listed below.

Type of Service	Time Frame
All elective inpatient admissions	A minimum of two days <i>prior</i> 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	<i>Prior</i> to the delivery of services

Precertification Telephone Numbers and Hours

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

Precertifications are completed by accessing iEXCHANGE via the Internet or telephone 24 hours a day, seven days a week.

1-800-413-0869

www.bcbstx.com/provider

Precertification may also be performed by calling Utilization Management at 1-800-441-9188, select 1, then select 3, during business hours. Business hours are:

Monday through Friday 6 a.m. – 6p.m.

Saturday, Sunday and Legal Holidays 9 a.m. – 12 p.m.

After Hours Calls

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

Faxing Precertification Requests

iEXCHANGE is *required*; however, if iEXCHANGE is not available, precertification may also be initiated via fax. To FAX, dial:

Toll-free 1-800-252-8815

Continued on next page

Precertification Procedure, Continued

**Information
Necessary
to
Precertify**

Please have the following information readily available when initiating Precertification:

- Patient's full name/subscriber's full name
 - BCBSTX subscriber ID number
 - Policy or group number
 - Anticipated date of admission or service
 - Clinical history
 - Diagnosis (ICD-9 codes)
 - Procedure(s) or service(s) planned (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
-

Extended Care Precertification

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 precertification **prior** to service being rendered.
-

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 precertification **prior** to services being rendered.

Home Infusion Therapy

BlueChoice subscribers requiring Home Infusion Therapy are not required to be homebound to receive services. Home Infusion Therapy requires precertification **prior** to services being rendered.

Skilled Nursing Facilities

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

Important Note

When any subscriber needs extended care or home infusion therapy, the Primary Care Physician **must** obtain referral certification to the Physician/Professional Provider of services **prior** to the delivery of services for the highest level of benefits to be received.

Important Notes: Precertification

Precertification Program

The following outlines important information about the BCBSTX precertification program.

- **Clinical Criteria** — Precertification requests are reviewed using the Milliman Care Guidelines[®] which promotes consistent decisions based on nationally accepted, physician-created clinical criteria. The criteria is 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 health care Physician/ Professional Provider who ordered the services 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/Professional Provider by telephone *prior* to issuance of an adverse determination.

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, 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. Physicians/Professional Providers may submit new technology requests for evaluation to the attention of the Medical Director at the appropriate address listed on page B-23 of this Provider Manual.

Continued on next page

[®] Registered Mark of Milliman Care Guidelines

Important Notes: Precertification, Continued

Precertification Program, Continued

- **Notification** — All written letters of notification are sent to the subscriber, Physician/Professional Provider and facility. The **precertified** length of stay or service and the precertification 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 Physician/Professional Provider. Once the decision has been made, BCBSTX determines what benefits are allowed under the existing health plan.

Note: Precertification is ***not a verification*** and merely confirms the medical necessity of the service or admission, but does not guarantee payment. 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 precertify
 - 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*).
-

Inpatient Care

Precertification for Inpatient Care

The BlueChoice Physician/Professional Provider (whichever is applicable) is required to admit the subscriber to a participating facility, except in emergencies.

The Primary Care Physician or a Specialty Care Physician/Professional Provider with a current referral is responsible for precertifying admissions in which he/she is the admitting physician/professional provider. In the event no precertification has been obtained, the facility is responsible for providing the information necessary to complete the precertification to ensure the member receives their maximum benefits.

A confirmation letter will be mailed to the subscriber, facility and attending Physician/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/Professional Provider disagrees with the Physician Reviewer's decision, he/she may request an appeal.

Non-Emergency Elective Medical/Surgery Admission Guidelines

Elective admissions should be precertified at least seven (7) days *prior* to the date of admission by accessing iEXCHANGE or contacting the Utilization Management Department.

Urgent/Emergent Admissions Procedure

The admitting Physician/Professional Provider should access iEXCHANGE or contact the Utilization Management Department at the time of admission during business hours or 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.

Concurrent Review

Description 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 a sufficient duration and level of care to promote optimal health outcome in the most efficient manner.

Responsibility for Concurrent Review The Provider with a current referral is responsible for obtaining an extension *prior* to the expiration of the previously approved length of stay or service.

Information Needed 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.
-

Procedure Review will begin upon request for the extension. The Utilization Management Department may contact the admitting physician/professional provider or hospital Utilization 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.

Only a Physician Reviewer may deny a precertification or discontinue benefit certification. When a denial of benefits is determined, the Utilization Management Department notifies the admitting physician/professional provider and the hospital by telephone and letter.

The confirmation letter of the benefit determination will be mailed to the subscriber, facility and attending physician/professional provider (*if other than the Primary Care Physician*).

Continued on next page

Concurrent Review, continued

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/ Professional Provider in coordinating necessary services within the BlueChoice Network.

Case Management Referrals

Introduction Case Management Services help identify appropriate Physicians/Professional Providers and facilities 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

Physician/Professional Provider Involvement Physicians/Professional Providers can assist this process by identifying and referring patients for possible Case Management Services and by providing input to alternative care recommendations.

Continued on next page

Case Management Referrals, Continued

**Referrals to
Case
Management,**
Continued

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 8:00 a.m. and 5:00 p.m. (*Central Time*):

1-800-528-7264



Emergency Care

Emergency Room Services

Emergency room 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 precertification.***

Emergency Admissions Rendered Outside the BlueChoice Service Area

The Primary Care Physician ***must*** notify BCBSTX Utilization Management Department of an emergency inpatient admission outside the BlueChoice service area within the later of 48 hours or by the end of the next business day.

When appropriate, the Primary Care Physician and the Utilization Management Department will work together to arrange transportation of the subscriber back to the service area for inpatient care at a participating facility.

Emergency Hospital Admission

Emergency admissions ***do not require prior*** certification. The Primary Care Physician ***must*** precertify the admission within the later of 48 hours or by the end of the next business day following the emergency hospital admission. *(Subscribers should contact their Primary Care Physician within 24 hours if not admitted by their PCP).*

For BlueChoice - If the admitting physician/professional provider is not a BlueChoice Physician/Professional Provider, the Subscriber's Primary Care Physician, in conjunction with the Utilization Management Department, is responsible for coordinating the care of the patient upon notification of the admission.

Continuity of Care

Continuity of Care Program Criteria

Continuity of medical care is considered, based on written criteria and medical necessity, for a limited period when a Physician's/Professional Provider's Managed Care Agreement is discontinued due to reasons other than quality deficiencies. Additionally, such continued care may be available when BlueChoice subscribers are required to change health plans based on an employer group change. Termination of the Physician's/Professional Provider's Managed Care Agreement shall not release a Physician/Professional Provider from the obligation to continue ongoing treatment of a subscriber of "special circumstance" (as defined by applicable law and regulation) or BCBSTX or Payer from its obligation to reimburse the physician for such services at the rate set forth in their agreement. For example:

- A subscriber becomes effective with BlueChoice while actively receiving health care services by Physicians/Professional Providers not in the BlueChoice 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 subscriber's Physician/Professional Provider leaves the BlueChoice plan and the subscriber'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 physicians/professional providers until the course of treatment for a specific condition is completed. The physician's/professional provider's and BCBSTX' obligations will continue until the earlier of the appropriate transfer of the subscriber's care to another BlueChoice Physician/ Professional Provider (whichever is applicable), the expiration of 90 days from the effective date of termination of the Physician/ Professional Provider, or up to nine months in the case of a subscriber who at the time of the termination has been diagnosed with a terminal illness. If coverage for care with an out-of-network physician or other professional provider is certified due to pregnancy, it will be continued through the postpartum check-up within the first six weeks of delivery.

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

- acute or disabling conditions
- life threatening illness
- pregnancy 3rd trimester and beyond

Continued on next page

Continuity of Care, Continued

Procedure

The procedure for initiating continuity of care is as follows:

- A subscriber or Physician/Professional Provider may initiate a request for continuity of care by calling Customer Service or the Utilization Management Department.
 - A Primary Care Physician may initiate a request by contacting the Utilization Management Department.
 - The Utilization Management Department reviews all requests.
 - Cases that do not meet criteria are referred to a Physician Reviewer for determination.
 - The Utilization Management Department notifies the subscriber 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 physician or professional provider.
 - If continuity of care is denied, the subscriber has the following options:
 - a. Continue care/treatment with his/her out-of-network physician/professional provider at the out-of-network benefit level;
 - b. Choose a BlueChoice Physician/Professional 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 Utilization Management staff and Medical Director review continuity of care criteria at least annually.
-