

Precertification

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Note:

Physicians and other Professional Providers who are contracted/affiliated with a capitated IPA/Medical Group must contact the IPA/Medical Group for instructions regarding referral and precertification process, contracting and claims related questions. Additionally, Physicians or other Professional Providers who are not part of a capitated IPA/Medical Group but who provide services to a member whose PCP is contracted/affiliated with a capitated IPA/Medical Group must also contact the applicable IPA/Medical Group for instructions. Physicians or other Professional Providers who are contracted/affiliated with a capitated IPA/Medical Group are subject to that entity's procedures and requirements for Physician or other Professional Provider complaint resolution.

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Precertification, continued

Precertification Overview

Precertification determines whether medical services are:

- Medically Necessary or Experimental/Investigational
- Provided in the appropriate setting or at the appropriate level of care
- Generally accepted by the medical community.

Note: Precertification is ***not a verification*** and does not guarantee payment. Payment is subject, but not limited to eligibility, contractual limitations and payment of premiums on date(s) of service.

Note: Calls received after-hours are answered electronically. Physicians or other Professional Providers should leave a detailed message (Physician's or other Professional Provider's name and phone number, HMO Blue Texas member's/ patient's name, ID number, group number and description of illness, etc.).

What Requires Precertification

Refer to page E-6 for the Precertification Requirements.

Responsibility for Precertification

Primary Care Physicians or Specialty Care Physicians or other Professional Providers with a current referral are responsible for the completion of the precertification process.

Note: Failure to meet precertification requirements may result in nonpayment, and Physicians or other Professional Providers cannot bill or collect fees from members for services. Out-of-network services require precertification.

Does 23 Hour Observation Require Precertification?

23 hour observation does not require precertification. However, if patient converts from 23 hour observation to inpatient, this will require precertification.

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Precertification, continued

When to Precertify

Precertification 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 one (1) business day of admission
Extended Care - Home Health	Prior to the delivery of services
High Tech Outpatient Diagnostic Radiology Procedures - MRI/MRA scans, CT/CTA scans, SPECT/Nuclear Cardiology studies and PET scans for members living in the following counties: Bastrop, Bexar, Collin, Comal, Dallas, Denton, Ellis, Grayson, Hays, Johnson, Kaufman, Parker, Rockwall, Tarrant, Travis, Williamson and Wise.	A minimum of two days prior to and preferably seven days in advance

Precertification Telephone Numbers and Hours

- For information on behavioral health, refer to Section I of this Provider Manual.
- Precertifications are completed by accessing iEXCHANGE via the Internet or telephone 24 hours a day, seven days a week.

800-413-0869

bcbstx.com/provider

- Precertification may also be performed by calling Utilization Management at **800-441-9188** 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.
- For High Tech Outpatient Diagnostic Radiology Precertification (*refer to page E-18 for requirements*)

800-859-5299

800-610-0050 (FAX)

americanimaging.net

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Precertification, continued

Utilization Management Department Business Hours

Utilization Management Department business hours are from 6 a.m. - 6 p.m. CST Monday thru Friday and from 9 a.m. - 12 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 Precertification Requests

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

Toll-free 800-252-8815

Information Necessary to Precertify

Please have the following information readily available when initiating Precertification:

- Patient's full name/member's full name
 - HMO Blue Texas member 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
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HMO BLUE® TEXAS PRECERTIFICATION / NOTIFICATION / REFERRAL REQUIREMENTS

Effective November 1, 2007

Out-of-Network/Out-of-Plan Services always require medical management review. If no precertification or referral is obtained for the Out-of-Network/Out-of-Plan Services, no benefits are available and network claims will be denied. Emergency Services are an exception to this requirement.

HMO Blue Texas Physicians and other Professional Providers in a Limited Provider Network **must refer** care to HMO Blue Texas Physicians and other Professional Providers contracted in the same network.

PRECERTIFICATION / NOTIFICATION / REFERRAL REQUIREMENTS	PROCESS IN iEXCHANGE	PRECERTIFICATION	REFERRAL
1. Inpatient Facility Admissions - Hospital - Rehab - Skilled Nursing - Long Term Acute Care / Sub-acute	iEXCHANGE Notification for Selected Facility Admissions	Certain Facility Admissions Require Medical Management Review	
2. Obstetrical Care	iEXCHANGE Maternity Notification		
3. Hospice	iEXCHANGE Notification		
4. Pain Management		Precertification Requires Medical Management Review	
5. High Tech Outpatient Diagnostic Radiology Procedures*		Call American Imaging Management (AIM) for precertification at 800-859-5299	
6. In-Network/In-Plan Services	iEXCHANGE Referral for ALL Primary Care Physicians (PCP) Referrals to Specialists Outside of the PCP's Call Group / Back Ups		
7. Out-of-Network/Out-of-Plan Services		Out-of-Network/Out-of-Plan Services always requires Medical Management Review. If no precertification is obtained for the Out-of-Network/Out-of-Plan Services, no benefits are available and network claims will be denied. Emergency Services are an exception to this requirement. HMO Blue Texas Physicians and other Professional Providers in a Limited Provider Network must refer care to HMO Blue Texas Physicians and other Professional Providers contracted in the same network.	Out-of-Network/Out-of-Plan Services always requires Medical Management Review. If no referral is obtained for the Out-of-Network/Out-of-Plan Services, no benefits are available and network claims will be denied. Emergency Services are an exception to this requirement. HMO Blue Texas Physicians and other Professional Providers in a Limited Provider Network must refer care to HMO Blue Texas Physicians and other Professional Providers contracted in the same network.
8. Home Health Services		Precertification Requires Medical Management Review	
9. Hyperbaric Treatment		Precertification Requires Medical Management Review	
10. Drug/Alcohol Treatment		Call Magellan for Precertification	
11. Mental Health Services		Call Magellan for Precertification	
12. Physical Therapy Referral is not required for outpatient facility therapy	iEXCHANGE Referral		
13. Occupational Therapy Referral is not required for outpatient facility therapy	iEXCHANGE Referral		
14. Speech Therapy Referral is not required for outpatient facility therapy	iEXCHANGE Referral		
15. Sleep Studies Precertification is not required for In-Network/ In-Plan outpatient sleep studies.		Out-of-Network/Out-of-Plan Services always require Medical Management Review. If no precertification is obtained for the Out-of-Network/Out-of-Plan Services, no benefits are available and network claims will be denied. Emergency Services are an exception to this requirement. HMO Blue Texas Physicians and other Professional Providers in a Limited Provider Network must refer care to HMO Blue Texas Physicians and other Professional Providers contracted in the same network.	
16. Dental Procedures		Precertification Requires Medical Management Review	

*High tech outpatient diagnostic radiology procedures (CT/CTA scans, MRI/MRA scans, SPECT/Nuclear Cardiology studies & PET scans) in the following Austin, Dallas/Ft. Worth & San Antonio counties require precertification: Bastrop, Bexar Collin, Comal, Dallas, Denton, Ellis, Grayson, Hays, Johnson, Kaufman, Parker, Rockwall, Tarrant, Travis, Williamson and Wise.

For precertification, call American Imaging Management (AIM) at 800-859-5299.

Note: This program does not apply to imaging studies performed in conjunction with any Inpatient, Emergency Room, 23-hour Observation, or Day Surgery admissions.

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Precertification, continued

Important Information About the Precertification Program

The following outlines important information about the HMO Blue Texas 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 or other 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 or other Professional Provider by telephone **prior** to issuance of an adverse determination.

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Precertification, continued

Important Information About the Precertification Program, continued

- **Notification** — Written notification letters are sent to the member, Physician or other Professional Provider and facility following approval or denial of benefits. The precertified length of stay or service and the Precertification numbers are included. Letters of notification of adverse determinations include the reason for denial and an explanation of the appeal process.

Note: Precertification is *not a verification* and does not guarantee payment. Precertification 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.

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.

Accessibility of Utilization Management Criteria

Utilization Management review criteria is available to HMO Blue Texas network Physicians or other Professional Providers upon request. To receive Milliman Care Guidelines on a specific condition, please contact the Utilization Management Department.

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Precertification, continued

Extended Care Precertification Procedure

The prescribing Physician or other Professional Provider is responsible for obtaining a Precertification by contacting the Utilization Management Department by phone or fax.

A Precertification will be given after verifying medical necessity. For detailed information regarding Precertification requirements, refer to the HMO Blue Texas Precertification/Notification/Referral Requirements List on page E-6 of this section.

Extended Care Precertification – Home Health Services

The following general guidelines apply to Home Health Services:

- Services **must** be ordered by a participating Physician or other Professional Provider.
 - The patient is certified by the Physician or other Professional 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 Precertification **prior** to services being rendered.
-

Extended Care Precertification – 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.

Extended Care Precertification – Skilled Nursing Facilities

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

Important Note

When any subscriber needs extended care, the Primary Care Physician **must** obtain precertification to the Physician or other Professional Provider of services **prior** to the delivery of services for the highest level of benefits to be received.

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Precertification, continued

Precertification for Inpatient Care

The HMO Blue Texas Physician or other 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 HMO Blue Texas Clinical Quality Improvement Committee approves guidelines and standards for review of admissions.

The Primary Care Physician or a Specialty Care Physician or other Professional Provider with a current referral is responsible for precertifying admissions in which he/she is the admitting Physician or other Professional Provider.

A confirmation letter will be mailed to the subscriber, facility and attending Physician or other 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 other 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 or other Professional Provider *must* access iEXCHANGE or contact the Utilization Management Department 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.

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Precertification, continued

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 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 HMO Blue Texas Primary Care Physician or Specialty Care Physician or other Professional 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 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
-

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Precertification, continued

Extension Review Procedure

Review will begin upon request for the extension. The Utilization Management Department may contact the admitting physician or other 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.

HMO Blue Texas utilizes Milliman Care 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 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 Precertification. When a denial of benefits is determined, the Utilization Management Department notifies the admitting Physician or other 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 Physician or other Professional 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 Utilization Management Department will work with the Hospital Discharge Planning Staff and the admitting Physician or other Professional Provider in coordinating necessary services within the same Provider Network.

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Precertification, continued

Case Management Services

Case Management Services help identify appropriate Physicians or other 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 or other Professional Provider Involvement

Physicians or other Professional 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.

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Precertification, continued

Referrals to Case Management

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

Toll-free 800-462-3275

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

Toll-free 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 Magellan Behavioral Health Providers of Texas, Inc. at the toll-free number below between the hours of 8:00 a.m. and 5:00 p.m. (*Central Time*):

800-729-2422

Evaluation of New Technology

The HMO Blue Texas 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 HMO Blue Texas Medical Advisory Committee is composed of participating Physicians or other 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. Physicians or other Professional Providers may submit new technology requests for evaluation via e-mail to the attention of the appropriate Medical Director at bcbstx.com/provider/training/reference_guide.html.

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Precertification, continued

Emergency Care Services Rendered Inside the HMO Blue Texas 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.

Services in hospital emergency rooms or comparable facilities do not require Precertification.

Emergency Inpatient Admissions Rendered Outside the HMO Blue Texas Service Area

The Primary Care Physician **must** notify HMO Blue Texas Utilization Management Department of an emergency inpatient admission outside the HMO Blue Texas 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 for the member's care and return to a participating facility within the service area as soon as reasonably possible.

Services in hospital emergency rooms or comparable facilities do not require Precertification.

Emergency Hospital Admission

Emergency hospital admissions **do not require prior** certification. The Primary Care Physician **must** contact the HMO Blue Texas 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 Primary Care Physician within 48 hours if not admitted by their PCP).*

If the admitting physician or other professional provider is not an HMO Blue Texas network Physician or other Professional Provider, or is not in the same Provider Network as the member's Primary Care Physician, the Primary Care Physician, in conjunction with the Utilization Management Department, is responsible for coordinating the care of the patient upon notification of the admission.

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Precertification, continued

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 or other Professional Provider's contract is discontinued due to reasons other than quality deficiencies. Additionally, such continued care may be available when HMO Blue Texas members are required to change health plans based on an employer group change. Termination of the Physician or other Professional Provider agreement shall not release a Physician or other Professional Provider from the obligation to continue ongoing treatment of a member of "special circumstance" (as defined by applicable law and regulation) or HMO Blue Texas or Payer from its obligation to reimburse the Physician or other Professional Provider for such services at the rate set forth in their agreement.

For example:

- A member becomes effective with HMO Blue Texas while actively receiving health care services by Physicians or other Professional Providers not in the HMO Blue Texas 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 Physician or other Professional Provider leaves the HMO Blue Texas 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 physicians or other professional providers until the course of treatment for a specific condition is completed. The physician's or other professional provider's and HMO Blue Texas' obligations will continue until the earlier of the appropriate transfer of the member's care to another HMO Blue Texas Physician or other Professional Provider, the expiration of 90 days from the effective date of termination of the Physician or other Professional 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 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 member has special circumstances such as:

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

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Precertification, continued

Procedure

The procedure for initiating continuity of care is as follows:

- A member, Physician or other 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 Physician or other Professional Provider and 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 other 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 other professional provider at his/her own expense;
 - b. Choose an HMO Blue Texas Physician or other Professional Provider (*whichever is applicable*);
 - c. Receive treatment under the direction of his/her Primary Care Physician; 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.

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Precertification, continued

Outpatient Diagnostic Imaging

- **Precertification Required** – High tech outpatient diagnostic radiology procedures - CT/CTA scans, MRI/MRA scans, SPECT/Nuclear Cardiology studies and PET scans (*excludes radiology services provided during emergency room visits, in-patient admissions, out-patient surgeries and 23 hour observation*) for members living in the following counties: Bastrop, Bexar, Collin, Comal, Dallas, Denton, Ellis, Grayson, Hays, Johnson, Kaufman, Parker, Rockwall, Tarrant, Travis, Williamson and Wise

Please note: Physicians or other Professional Providers participating in capitated Limited Provider Networks should contact the Limited Provider Network for any additional certification requirements.

- **For Precertification**, contact American Imaging Management (AIM) at 800-859-5299. Requests for these procedures cannot be processed in the iEXCHANGE System.
- **Clinical Criteria** – Precertification requests are reviewed using American Imaging Management’s (AIM) proprietary criteria. The criteria are based upon the literature and policies from major medical specialty organizations and are consistent with the American College of Radiology’s appropriateness criteria for imaging.
- **Notification** – Notification of the determination is provided to the Referring Physician or other Professional Providers within the sooner of, 2 working days after receipt of necessary information to complete the review or 3 calendar days of receipt of the request.

Physician Review – A case will be referred to an AIM 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 network Physician or other 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 or other Professional Provider by telephone **prior** to issuance of an adverse determination. Physician Reviewers can be contacted by calling **800-859-5299** and select option 2.

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Precertification, continued

Outpatient Diagnostic Imaging, continued

Note: For Outpatient Radiology Services **Not** Requiring Referral/Precertification:

- If not performed in the Physician's or other Professional Provider's office, the Physician or other Professional Provider **must** send the member to a contracted imaging location within the member's Provider Network.
 - Refer to the HMO Blue Texas Provider Directory for contracted imaging locations for each Provider Network. Physicians or other Professional Providers who are contracted/affiliated with an IPA/Medical Group may need to use a specified imaging location depending on the requirements of the IPA/Medical Group.
-

Accessibility of Outpatient Diagnostic Imaging Utilization Management Criteria

Outpatient Diagnostic Imaging Utilization Management review criteria is available to HMO Blue Texas network Physicians or other Professional Providers upon request. To receive criteria on a specific condition please contact the AIM Utilization Management Department at 800-859-5299. A listing of the most common indications is displayed on the AIM website at americanimaging.net under Physician Education.
