Blue Essentials℠, Blue Advantage HMO℠, Blue Premier℠ and MyBlue Health℠ Provider Manual - Authorization Process

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 plan/network 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 HMO products.

In this Section

The following topics are covered in this section:

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Capitated Medical Groups 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.

Utilization Management Overview

Utilization management is how we can help Blue Cross and Blue Shield of Texas (BCBSTX) members continue to access the right care, at the right place and at the right time.

A utilization management review determines whether a benefit is covered under the health plan using evidence-based clinical standards of care. The following are types of Utilization Management:

- **Prior Authorizations** are a pre-service medical necessity review. Prior authorization is the process where we review the requested service or drug to see if it is medically necessary and covered under the member's health plan. Not all services and drugs need prior authorization. A prior authorization is not a guarantee of benefits or payment. The terms of the member's plan control the available benefits. Prior authorization may be required through BCBSTX Utilization Management or an external vendor such as Carelon Medical Benefits Management (Carelon) formerly AIM Specialty Health®.

- **Recommended Clinical Review** are optional reviews for medical necessity submitted before services are completed for a Covered Service that does not require prior authorization and helps limit the situations where a service may be denied based upon medical necessity retrospectively. For outpatient services, this was previously referred to as Predeterminations.

- **Post-Service Medical Necessity Reviews (PSMNR)** may occur after the service was rendered. During a PSMNR, we review clinical documentation to determine whether a service or drug was medically necessary and covered under the member's benefit plan. We may ask you for the information we do not have.

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What May Require Review

To determine if specific services or categories have required Prior Authorization or Recommended Clinical Review managed by BCBSTX Utilization Management, Carelon or Magellan Healthcare®:

- Refer to the Utilization Management page on the provider website for the required Prior Authorization lists, which are updated when new services are added or when services are removed.
- Use Availity®or your preferred vendor to check eligibility and benefits, determine if you are in-network for your patient and whether prior authorization or prenotification is required and who to contact. Availity allows you to determine if prior authorization is required based on the procedure code. In addition, providers can enter requests for prior authorizations managed by BCBSTX Utilization Management using Availity Authorizations & Referrals. Refer to Eligibility and Benefits on the provider website for more information on Availity.
- Refer to the Recommended Clinical Review Option (previously Predeterminations) page under Utilization Management on the provider website for code lists.
- You can also call Customer Service at the toll-free telephone number on the back of the member's Identification Card.

Prior Authorization Exemptions

Under Texas House Bill 3459, providers may qualify for an exemption from submitting prior authorization requests for particular health care service(s) for all fully insured and certain Administrative Services Only (ASO) groups. Only services subject to required prior authorizations are eligible for an exemption.

We request you submit a notification to determine the initial length of stay or initial units for service(s) with a PA Exemption. Notification can be submitted via Availity® Authorizations & Referrals or by calling the number on the back of the member's ID card. A Notification Acknowledgement for the specific service(s) allowable per the PA exemption will be provided. Any days/units beyond what is outlined in the Notification Acknowledgement or covered by the initial PA Exemption if a notification is not submitted, will require submission of an extension request (or concurrent review) and may be subject to a medical necessity review.

Refer to the Prior Authorization Exemption page on the website for qualifications for an exemption and other information.

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Responsibility for Required Prior Authorization

In-network providers are responsible for obtaining Prior Authorization where authorization may be required. If prior authorization is not obtained for the applicable services, the in-network provider could be sanctioned based on the BCBSTX contractual agreement with the provider and the member will be held harmless for the provider sanction.

The member is responsible for prior authorization if they use out-of-network or out-of-state providers. Also, refer to the BlueCard® Provider Manual for more information on prior authorization responsibilities.

Submitting Referrals, Required Prior Authorizations (PA), Notifications, and Optional Recommended Clinical Review (RCR)

- **For services managed by BCBSTX Medical Management:**
  - **Online:** Use the Availity's Authorizations & Referrals tool (HIPAA-standard 278 transaction) which allows the electronic submission of inpatient admissions, select outpatient services and referral requests. Additionally, providers can also check the status of previously submitted requests and/or update applicable existing requests. The benefits of using this online functionality:
    - ✓ No separate user enrollment needed
    - ✓ Direct access within the Availity portal
    - ✓ Simplified 5-step process

      1. Log in to Availity
      2. Select **Patient Registration** menu option, choose **Authorizations & Referrals**, then **Authorizations***
      3. Select **Payer BCBSTX**, then choose your organization
      4. Select a **Request Type** and start request
      5. Review and submit your request

      * Choose **Referrals** instead of **Authorizations** if you are submitting a referral request.

    If you are not yet registered with Availity, sign up at no charge. If you need registration assistance, contact Availity Client Services at **1-800-282-4548**.

    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.**

Submitting Authorizations & Referrals, cont.

- **For services managed by BCBSTX Medical Management,** cont.**:**
  - **Phone –** Contact BCBSTX Medical Management using the number on the back of the member's ID card or call **1-800-441-9188.**

Note: For ***outpatient*** recommended clinical review, refer to section B(b) **Provider Roles and Responsibilities - Eligibility and Benefits** in this provider manual.

- **For services managed by Carelon:**
  - **Online:** Use the Carelon ProviderPortal
  - **Phone:** Contact their call center at **1-800-859-5299.** Please note - do not submit medical records unless requested by Carelon. If a PSMNR is requested, the provider can respond in the Carelon provider portal. Do not submit medical records to BCBSTX for Carelon requests for medical records.

Appeals for Carelon can be submitted:

- **Phone**:1-800-859-5299
- **Fax** 1-888-583-1005 Carelon
- **Mail:** Attention: Preauthorization Department
  HCSC Appeals
  540 Lake Cook Road,
  Deerfield, IL 60015

Renewal of Existing Prior Authorization

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

BCBSTX Medical Management Appeals

Expedited Appeal Process

The **Plan** has an expedited appeal process for appeals of adverse determinations based on medical necessity, experimental/ investigational or appropriateness of care that involve life-threatening, urgent or emergency services and continued stays for hospitalized patients. Notification of the appeal determination will not exceed one (1) working day from the receipt of all necessary information or 72 hours from the appeal request, whichever is sooner. All appeals are reviewed by a Physician not previously involved in the case who is in the same or similar specialty as would manage the condition under review.

Appeal Process

The **Plan** has a standard appeal process for appeals of adverse determinations based on medical necessity, experimental/ investigational, or appropriateness of care. Written notification of the appeal determination will be provided no later than 30 calendar days after the date the **Plan** received the appeal request. All appeals are reviewed by a physician not previously involved in the case who is in the same or similar specialty as would manage the condition under review.

Provider Request for Case Match Review

A physician or professional provider may request a specialty match review by submitting in writing, within ten (10) working days of receipt of a standard appeal denial, good cause for a specialty physician review.

The review shall be completed and the appealing physician or professional provider shall be notified of the determination no later than 15 working days from the date of the request.

To Appeal an Adverse Determination for Medical Necessity or Experimental/ Investigational

To appeal an adverse determination for medical necessity or experimental/investigational, a health care provider may write to:

Blue Essentials, **Blue Advantage HMO, Blue Premier** or **MyBlue Health**
Utilization Management Department
Attn: Appeals Department
P.O. Box 833874
Richardson, TX 75083-3874

Call: **1-855-462-1785**
Fax: **1-866-589-8253**

BCBSTX Medical Management Appeals

Appeal Process for Denials of Out-of-Network Requests or Non-Covered Benefits

The appeal of a denial of a request for a referral to an out-of-network health care provider or a service that is not covered per the member's Coverage Documents is considered a "complaint" and is resolved via the HMO Complaint Process. To request such a review, a health care provider may write or call:

Blue Essentials, Blue Advantage HMO,
Blue Premier and My Blue Health
P O Box 660044
Dallas, TX 75266-0044

- Blue Essentials: **1-877-299-2377**
- Blue Advantage HMO:**1-800-451-0287**
- Blue Premier: **1-877-299-2377**
- MyBlue Health: **1-800-451-0287**