Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual - Prior Authorization & Case Management

In this Section, cont.

The following topics are covered in this section:

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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.

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.

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Utilization Management Overview, cont.

Notifications can submitted for inpatient services that are not subject to prior authorizations. By submitting a notification, the plan in turn will let the provider know what days or units are covered initially so that concurrent review is submitted when required for additional days or units. When a provider submits a notification for a service that is exempt from required prior authorizations, no review is conducted on that service.

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. Submitting the request prior to the service is optional and helps limit the situations where a service may be denied based upon medical necessity retrospectively. For outpatient services recommended clinical reviews were previously referred to as predetermination of benefits.

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 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 Carelon Medical Benefits Management (Carelon) formerly AIM Specialty Health®. 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.

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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. Refer to the Prior Authorizations Exemptions page on the provider website for the current applicable ASO groups and additional information.

We request you submit a notification to determine the initial length of stay or initial units for service(s) with a PA Exemption. Notification for services managed by BCBSTX Utilization Management 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. Contact Carelon or Magellan Healthcare to submit notifications for healthcare services managed by them.

Carelon Prior Authorizations

BCBSTX has an agreement with Carelon to provide certain outpatient prior authorization services. Services requiring prior authorization as well as information on how to prior authorize services with Carelon are outlined on the Utilization Management - page and on the Carelon 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.

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Extension of 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 or Recommended Clinical Review 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 submitting required prior authorizations or when no prior authorization is required has the option to request a Recommended Clinical Review for an elective inpatient admission including:

- Elective Acute (Medical, Hospice, Maternity, Surgical, Transplant)
- Elective Post-Acute (LTAC, Rehab, SNF)

The health care provider must also notify BCBSTX of extensions of care.

A confirmation letter will be mailed to the member, 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.

Submit required prior authorizations or optional Recommended Clinical Reviews for elective (non emergency) admissions 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**.

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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 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.

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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**

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

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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.***
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 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.

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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

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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.