## Preauthorization

### Please Note
Throughout this provider manual there will be instances when there are references unique to a particular HMO network. These network specific requirements will be noted with the network name.

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Note: Providers who provide services to HMO members whose PCP is contracted/affiliated with a capitated IPA/Medical Group must also contact the applicable IPA/Medical Group for instructions regarding the outpatient service preauthorization requirements. Providers who are contracted/affiliated with a capitated IPA/Medical Group are subject to the entity’s procedures and requirements for complaint resolution.

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Preauthorization, continued

Preauthorization Overview
Preauthorization 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: Preauthorization 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. Providers should leave a detailed message (Provider’s name and phone number, HMO member’s/patient’s name, ID number, group number, and description of illness, etc.).

What Requires Preauthorization
Refer to page E-6 for the Preauthorization Requirements.

Responsibility for Preauthorization
Providers with a current referral are responsible for the completion of the preauthorization process.

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

Does 23 Hour Observation Require Preauthorization
23 hour observation does not require preauthorization. However, if patient converts from 23 hour observation to inpatient, this will require preauthorization.

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Preauthorization, continued

Preauthorization time frames are listed below.

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<thead>
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<th>Type of Service</th>
<th>Time Frame</th>
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<tbody>
<tr>
<td>All elective inpatient admissions</td>
<td>A minimum of two (2) days prior to admission and preferably seven (7) days in advance</td>
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<tr>
<td>Urgent/Emergent admissions</td>
<td>Within the later of 48 hours or by the next business day of an emergency hospital admission</td>
</tr>
<tr>
<td>Extended Care – Home Health</td>
<td>Prior to the delivery of services</td>
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</table>

Preauthorization Telephone Numbers and Hours

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

980-413-0869
bcbstx.com/provider

- Preauthorization may also be performed by calling Utilization Management during business hours. Business hours are:
  - Monday through Friday 6 a.m. – 6 p.m.
  - Saturday, Sunday, and Legal Holidays 9 a.m. – 12 p.m.

**HMO Blue Texas**
Call: 800-441-9188
Fax: 800-252-8815 or 800-462-3272

**Blue Advantage HMO**
Call: 855-462-1785
Fax: 866-589-8253

**Please Note:** Regarding high tech outpatient diagnostic radiology see Section B of the Facility Provider Manual for clarification.

Continued on next page
Preauthorization, continued

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

iExchange is required; however, if iExchange is not available, preauthorization may also be initiated via fax. To FAX, dial:

Toll-free 800-252-8815 or 800-462-3272

Information Necessary to Preauthorized

Please have the following information readily available when initiating Preauthorization:

- Patient’s full name/member’s full name
- HMO 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

Continued on next page
### Out-of-Network/Out-of-Plan Services

Out-of-Network/Out-of-Plan Services always require medical management review. If no preauthorization 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. Network must refer care to HMO Blue Texas physicians and professional providers contracted in the same Limited Provider Network.

**Note:** HMO Blue Texas physicians and professional providers in a Limited Provider Network are required to contract with Magellan Health Services for Network/Out-of-Plan Services, unless services are an exception to this requirement. HMO Blue Texas physicians and professional providers in a Limited Provider Network must refer care to HMO Blue Texas physicians and professional providers contracted in the same Limited Provider Network.

### PREAUTHORIZATION / NOTIFICATION / REFERRAL REQUIREMENTS

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<th>Service Type</th>
<th>Process In Exchange</th>
<th>Preauthorization Requirements</th>
<th>Referral</th>
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<tr>
<td>1. Inpatient Facility Admissions - Hospital - Rehab - Skilled Nursing - Long Term Acute Care / Sub-acute</td>
<td>iExchange Notification for Selected Facility Admissions</td>
<td>Certain Facility Admissions Require Medical Management Review</td>
<td></td>
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<tr>
<td>2. Obstetrical Care</td>
<td>iExchange Maternity Notification</td>
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<tr>
<td>3. Hospice</td>
<td>iExchange Notification</td>
<td></td>
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<tr>
<td>4. Pain Management</td>
<td>Preauthorization Requires Medical Management</td>
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<tr>
<td>5. High Tech Outpatient Diagnostic Radiology Procedures (Includes HMO Blue Texas and Blue Advantage HMO)</td>
<td>Call AIM Specialty Health, (AIM) for a Radiology Quality Initiative (RQI)</td>
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<tr>
<td>6. Blue Advantage HMO – Outpatient Renal Dialysis</td>
<td>Preauthorization Requires Medical Management Review</td>
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<tr>
<td>7. Blue Advantage HMO – Outpatient Lumbar Fusions</td>
<td>Preauthorization Requires Medical Management Review</td>
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<tr>
<td>8. Blue Advantage HMO – Durable Medical Equipment (DME)</td>
<td>DME greater than $2500.00 requires preauthorization. DME less than $2500.00 requires either: (1) a preauthorization or (2) a referral from the Primary Care Physician (PCP) or rendering physician</td>
<td></td>
<td></td>
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<tr>
<td>9. In-Network/In-Plan Services</td>
<td>iExchange Referral for ALL Primary Care Physicians (PCP) Referrals to Specialists Outside of the PCP’s Call Group / Back Ups</td>
<td></td>
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<tr>
<td>10. Out-of-Network/Out-of-Plan Services</td>
<td>Out-of-Network/Out-of-Plan Services always require Medical Management Review. If no preauthorization 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 professional providers in a Limited Provider Network must refer care to HMO Blue Texas physicians and professional providers contracted in the same Limited Provider Network.</td>
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<td>11. Home Health Services</td>
<td>Preauthorization Requires Medical Management Review</td>
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<td>12. Hyperbaric Treatment</td>
<td>Preauthorization Requires Medical Management Review</td>
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<td>13. Drug/AlcoholTreatment</td>
<td>Call Magellan for Preauthorization</td>
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<td>14. Mental Health Services</td>
<td>Call Magellan for Preauthorization</td>
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<tr>
<td>15. Physical Therapy</td>
<td>Referral is not required for outpatient facility therapy</td>
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<td>16. Occupational Therapy</td>
<td>Referral is not required for outpatient facility therapy</td>
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<td>17. Speech Therapy</td>
<td>Referral is not required for outpatient facility therapy</td>
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<tr>
<td>18. Sleep Studies</td>
<td>Out-of-Network/Out-of-Plan Services always require Medical Management Review. If no preauthorization 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 professional providers in a Limited Provider Network must refer care to HMO Blue Texas physicians and professional providers contracted in the same Limited Provider Network.</td>
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<tr>
<td>19. Oral Dental Surgery Procedures</td>
<td>Preauthorization Requires Medical Management Review</td>
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*High Tech Outpatient Diagnostic Radiology Procedures (CT/CTA scans, MRI/CTA scans, SPECT/Nuclear Cardiology studies & PET Scans) require a Radiology Quality Initiative (RQI) number prior to services. View List of CPT Codes Requiring a RQI.

Physicians and professional providers should contact AIM at 800-859-5299 to obtain a RQI number.

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

The following outlines important information about the HMO Preauthorization program.

Clinical Criteria — Preauthorization 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-authorization.

• 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 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 Provider by telephone prior to issuance of an adverse determination.

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

Note: Preauthorization is not a verification and does not guarantee payment. Preauthorization 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.

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Preauthorization, continued

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 preauthorize
  - Limitations contained in riders, if any
- Claims processing guidelines
- Payment of premium for date on which services are rendered.

Accessibility of Utilization Management Criteria

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

Extended Care Preauthorization Procedure

The prescribing Provider is responsible for obtaining a Preauthorization by contacting the Utilization Management Department by phone or fax.

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

Extended Care Preauthorization – Home Health Services

The following general guidelines apply to Home Health Services:

- Services must be ordered by a participating Provider.
- The patient is certified by the 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 Preauthorization prior to services being rendered.

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Preauthorization, continued

Extended Care Preauthorization – 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 Preauthorization prior to services being rendered.

Extended Care Preauthorization – Skilled Nursing Facilities

All admissions to Skilled Nursing Facilities require Preauthorization prior to receiving services.

Important Note

When any member needs extended care, the Primary Care Physician must obtain preauthorization to the Provider of services prior to the delivery of services for the highest level of benefits to be received.

Preauthorization for Inpatient Care

The HMO 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 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 or the Hospital is responsible for preauthorizing admissions in which he/she is the admitting Provider.

A confirmation letter will be mailed to the Member, 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 Provider disagrees with the Physician Reviewer’s decision, he/she may request an appeal.

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<th>Non-Emergency Elective Medical/Surgery Admission Guidelines</th>
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<tr>
<td>Elective admissions should be preauthorized at least seven (7) days prior to the date of admission by accessing iExchange or contacting the Utilization Management Department at</td>
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**HMO Blue Texas**  
**800-441-9188**  
**Blue Advantage HMO**  
**855-462-1785**

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<thead>
<tr>
<th>Urgent/Emergent Admissions Procedure</th>
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<tbody>
<tr>
<td>The admitting 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.</td>
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</table>

**HMO Blue Texas**  
**800-441-9188**  
**Blue Advantage HMO**  
**855-462-1785**

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<thead>
<tr>
<th>Admission on Day of Surgery</th>
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<tr>
<td>Preoperative evaluation, testing, pre-anesthesia assessment and patient education will routinely be performed on an outpatient basis, or on the morning of surgery.</td>
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<thead>
<tr>
<th>Concurrent Review</th>
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<tbody>
<tr>
<td>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.</td>
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<thead>
<tr>
<th>Concurrent Review of Inpatient Admissions</th>
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<tbody>
<tr>
<td>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.</td>
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<tr>
<th>Responsibility for Concurrent Review</th>
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<tbody>
<tr>
<td>The HMO Primary Care Physician or Specialty Care Physician or other Professional Provider with a current referral or the Hospital is responsible for obtaining an extension prior to the expiration of the previously approved length of stay or service.</td>
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**Preauthorization, continued**

**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

**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. For DRG reimbursed hospitals, all days must be preauthorized in order to be reimbursed for high outlier per diems.

HMO 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 Preauthorization. When a denial of benefits is determined, the Utilization Management Department notifies the admitting 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 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 Provider in coordinating necessary services within the same Provider Network.

Case Management Services help identify appropriate Physicians and 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.

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

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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Preauthorization, 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 or 800-252-8815**

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 75083-9913**

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 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 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. 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](http://bcbstx.com/provider/training/reference_guide.html).

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Preauthorization, continued

Emergency Care Services Rendered Inside the HMO 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 Preauthorization.*

Emergency Inpatient Admissions Rendered Outside the HMO Service Area

The Provider **must** notify HMO Utilization Management Department of an emergency inpatient admission outside the HMO service area within the later of 48 hours or by the end of the next business day.

When appropriate, the Provider 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 Preauthorization.*

Emergency Hospital Admission

Emergency hospital admissions **do not require prior** authorization. However, the Provider **must** contact the HMO 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 provider is not an HMO network Provider, or is not in the same Provider Network as the member’s Primary Care Physician, the Provider, 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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Continuity of medical care is considered, based on written criteria and medical necessity, for a limited period when a Provider’s contract is discontinued due to reasons other than quality deficiencies. Additionally, such continued care may be available when HMO members are required to change health plans based on an employer group change. Termination of the Provider agreement shall not release a Provider from the obligation to continue ongoing treatment of a member of “special circumstance” (as defined by applicable law and regulation) or HMO or Payer from its obligation to reimburse the Provider for such services at the rate set forth in their agreement.

For example:
- A member becomes effective with HMO while actively receiving health care services by Providers not in the HMO 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 Provider leaves the HMO 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 providers until the course of treatment for a specific condition is completed. The provider’s and HMO obligations will continue until the earlier of the appropriate transfer of the member’s care to another HMO Provider, the expiration of 90 days from the effective date of termination of the 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 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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Preauthorization, continued

The procedure for initiating continuity of care is as follows:

- A member or 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 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 provider.
- If continuity of care is denied, the member has the following options:
  a. Continue care/treatment with his/her out-of-network provider at his/her own expense;
  b. Choose an HMO 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.

See Section B of the Facility Provider Manual.

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