# Preauthorization

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Preauthorization Overview

Preauthorization (sometimes referred to as pre-certification or pre-notification) 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
- Provider's network status in or out network is determined

Note: Preauthorization 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 Preauthorization

To view the Blue Choice PPO Preauthorization/Notification/Referral Requirements List, go to the Clinical Resources page on bcbstx.com/provider.

eviCore Preauthorization Program

BCBSTX has contracted with eviCore healthcare (eviCore) to provide certain utilization management preauthorization services to fully insured Blue Choice PPO members only (eviCore does not apply Administrative Services (ASO) members). Services requiring preauthorization as well as information on how to preauthorize services with eviCore are outlined on the Preauthorizations/Notifications/Referral Requirements Lists and on the eviCore page on bcbstx.com/provider.

Services performed without preauthorization or that do not meet medical necessity criteria may be denied for payment, and the rendering provider may not seek reimbursement from the member.

Responsibility for Preauthorization

Blue Choice PPO physicians and professional providers are responsible for the completion of the preauthorization process. Blue Choice PPO facility and ancillary providers are responsible for preauthorization of Extended Care and Home Infusion Therapy services.

Note: Failure to preauthorize may result in reduced payment, and physicians, professional providers and facility and ancillary providers cannot collect these fees from subscribers. Out-of-network services require preauthorization.

When to Preauthorize

Preauthorization time frames are listed below.

<table>
<thead>
<tr>
<th>Type of Service</th>
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<tr>
<td>All elective inpatient admissions</td>
<td>A minimum of two days prior to admission and preferably seven days in advance</td>
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<tr>
<td>Urgent/Emergent admissions</td>
<td>Within the later of 48 hours or by the end of the next business day of an emergency hospital admission</td>
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<tr>
<td>Extended Care – Home Health</td>
<td>Prior to the delivery of services</td>
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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 Web Access, Telephone Numbers and Hours

- For information on behavioral health, refer to Section I of this Provider Manual.
- Preauthorizations are completed by accessing the iExchange Web application 24 hours a day, seven days a week.
- Preauthorization may also be performed by calling Utilization Management
  - Call 800-441-9188
  - Hours: 7 am – 7 pm (CT), M-F and non-legal holidays and 9 am to 1 pm (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

If the iExchange Web application 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 Preauthorize

Please have the following information readily available when initiating Preauthorization:

- Patient’s full name/member’s full name
- BCBSTX 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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The following outlines important information about the BCBSTX 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-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 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 professional provider by telephone prior to issuance of an adverse determination.

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Important Information About the Preauthorization Program, cont’d

- **Notification** — Written notification letters are sent to the member, physician, professional provider, facility and ancillary provider. The preauthorized length of stay or service and the preauthorization 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, facility or ancillary provider. Once the decision has been made, BCBSTX determines what benefits are allowed under the existing health plan.

**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.

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 the date on which services are rendered (*Federal Employee Participants are not subject to the payment of premium limitation*).

Accessibility of Utilization Management Criteria

Utilization Management review criteria is available to BCBSTX participating physicians, professional providers, facilities or ancillary providers upon request. To receive Milliman Care Guidelines on a specific condition, please contact the Utilization Management Department at 800-441-9188.
## Extended Care Preauthorization Procedure

The prescribing physician or professional 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 and network status. If provider is out-of-network UM will attempt to navigate member to an in-network provider. For detailed information regarding preauthorization requirements, refer to the Blue Choice PPO "Preauthorization/Notification/Referral Requirements List", which can be found on bcbstx.com/provider under General Reimbursement Information section listed under the Standards and Requirements menu.

### Extended Care Preauthorization - 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 preauthorization **prior** to service being rendered.

### 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 - Home Infusion Therapy

Blue Choice PPO members requiring Home Infusion Therapy are not required to be homebound to receive services. Home Infusion Therapy requires preauthorization **prior** to services being rendered.

### Extended Care Preauthorization - Skilled Nursing Facilities

All admissions to Skilled Nursing Facilities require preauthorization **prior** to receiving services.
Extended Care Preauthorization - Important Note

When any Blue Choice PPO member needs extended care or home infusion therapy, the Blue Choice PPO physician, professional provider, facility or ancillary provider must obtain preauthorization of the services prior to the delivery of services for the highest level of benefits to be received.
Blue Choice PPO Provider Manual - Preauthorization

Preauthorization for Inpatient Care

The Blue Choice PPO physician or professional provider is required to admit the subscriber to a participating facility, except in emergencies.

The Primary Care Physician or a Specialty Care Physician or Professional Provider is responsible for preauthorizing admissions in which he/she is the admitting provider.

A confirmation letter will be mailed to the member, the facility and to the 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.

Non-Emergency Elective Medical/Surgery Admission Guidelines

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 800-441-9188.

Urgent/Emergent Admissions Procedure

The admitting physician or provider must access iExchange or contact the Utilization Management Department at 800-441-9188 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**

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 Blue Choice PPO Primary Care physician, Specialty Care physician, professional provider, facility or ancillary provider 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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Extension Review Procedure

Review will begin upon request for the extension. The Utilization Management Department may contact the admitting physician, professional provider, facility or ancillary 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.

BCBSTX 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 or discontinue benefit certification. When a denial of benefits is determined, the Utilization Management Department notifies the admitting physician or 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, facility or ancillary 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, professional provider, facility or ancillary provider in coordinating necessary services within the Blue Choice PPO Network.
### Blue Choice PPO Provider Manual - Preauthorization

#### Case Management Services

Case Management Services help identify appropriate physicians, professional providers, facilities and ancillary 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

#### Physicians, Professional Providers, Facility or Ancillary Providers Involvement

Physicians, professional providers, facility and ancillary providers can assist the case management process by identifying and referring patients for possible Case Management Services and by providing input to alternative care recommendations identified by the Case Management Department.
Blue Choice PPO Provider Manual - Preauthorization

**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 the number below between the hours of 8 am – 5 pm (CT).

**800-528-7264**

**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, 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, professional providers, facilities and ancillary providers may submit new technology requests for evaluation via email to:

**HCSC_Medical_Policy@bcbstx.com**
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**Emergency Care Services**
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. *Emergency room services do not require referral or preauthorization.*

**Emergency Inpatient Admissions Rendered Outside the Blue Choice PPO Service Area**
The attending physician/provider or member must notify BCBSTX Utilization Management Department of an emergency inpatient admission outside the Blue Choice PPO service area within the later of 48 hours or by the end of the next business day.

When appropriate, the physician, professional provider, facility or ancillary provider and the Utilization 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. The primary care physician must preauthorize the admission within the later of 48 hours or by the end of the next business day following the emergency hospital admission. *(Subscribers are required to contact their primary care physician within 48 hours if not admitted by their PCP).*

For Blue Choice PPO - If the admitting physician, professional provider, facility or ancillary provider is not a Blue Choice PPO physician, professional provider, the member’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.
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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 physician’s, professional provider’s, facility’s or ancillary provider’s Managed Care Agreement is discontinued due to reasons other than quality deficiencies. Additionally, such continued care may be available when Blue Choice PPO members are required to change health plans based on an employer group change. Termination of the physician’s, professional provider’s, facility’s or ancillary provider’s Managed Care Agreement shall not release a physician, professional provider, facility or ancillary provider from the obligation to continue ongoing treatment of a member of “special circumstance” (as defined by applicable law and regulation) or BCBSTX or Payer from its obligation to reimburse the physician, professional provider, facility or ancillary provider for such services at the rate set forth in their agreement.

For example:

- A member becomes effective with Blue Choice PPO while actively receiving health care services by physicians, professional providers, facility and ancillary providers not in the Blue Choice PPO 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, professional provider, facility or ancillary provider leaves the Blue Choice PPO network 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, facility and ancillary providers until the course of treatment for a specific condition is completed. The physician’s, professional provider’s, facility and ancillary providers and BCBSTX’s obligations will continue until the earlier of the appropriate transfer of the subscriber’s care to another Blue Choice PPO physician, professional provider, facility or ancillary provider (whichever is applicable), the expiration of 90 days from the effective date of termination of the physician, professional provider, facility or ancillary 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, professional provider, facility or ancillary provider is certified due to pregnancy, it will be continued through the postpartum check-up within the first six weeks of delivery.
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<td>Continuity of care is considered when a member has special circumstances such as:</td>
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<td>• acute or disabling conditions</td>
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<td>• life threatening illness</td>
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<td>• pregnancy 13th week and beyond</td>
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<td>The procedure for initiating continuity of care is as follows:</td>
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<td>• A member, physician, professional provider, facility or ancillary provider may initiate a request for continuity of care by calling Customer Service or the Utilization Management Department.</td>
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<tr>
<td>• A physician, professional provider, facility of ancillary provider may initiate a request by contacting the Utilization Management Department.</td>
</tr>
<tr>
<td>• The Utilization Management Department reviews all requests.</td>
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<tr>
<td>• Cases that do not meet criteria are referred to a Physician Reviewer for determination.</td>
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<tr>
<td>• The Utilization Management Department notifies the physician, professional provider, facility or ancillary provider and member of the continuity of care decision via letter.</td>
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<tr>
<td>• 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, professional provider, facility or ancillary provider.</td>
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<tr>
<td>• If continuity of care is denied, the member has the following options:</td>
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<tr>
<td>a. Continue care/treatment with his/her out-of-network physician, professional provider, facility or ancillary provider at the out-of-network benefit level;</td>
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<tr>
<td>b. Choose a Blue Choice PPO physician, professional provider, facility or ancillary provider (whichever is applicable);</td>
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<tr>
<td>c. Receive treatment under the direction of his/her Primary Care Physician (if applicable); or</td>
</tr>
<tr>
<td>d. File a formal complaint by contacting the Customer Service Department.</td>
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<tr>
<td>• The Utilization Management staff and Medical Director review continuity of care criteria at least annually.</td>
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