Please Note

Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

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Please Note
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Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Preauthorization

Please Note
Throughout this provider manual there will be instances when there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

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
- 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 the date(s) of service.

Calls received after-hours are answered electronically. Physicians, professional providers, facility and ancillary providers should leave a detailed message including provider’s name and phone number and Blue Essentials Blue Advantage HMO, or Blue Premier member’s/ patient’s name, identification (ID) number, group number and description of the illness, etc.)

Preauthorization/Notification/Referral Requirements
Refer to Preauthorizations/Notifications/Referral Requirements under Clinical Resources on bcbstx.com/provider.

It is imperative that providers obtain eligibility and benefits, determine if the provider is in-network for the member's plan and whether preauthorization/prenotification is required through Availity® or their preferred vendor.

eviCore Preauthorization Program
BCBSTX has contracted with eviCore healthcare (eviCore) to provide certain utilization management preauthorization services. Refer to the Preauthorizations/Notifications/Referral Requirements under Clinical Resources and on the eviCore page on bcbstx.com/provider for a list of services requiring preauthorization through eviCore and information on how to preauthorize services with eviCore for affected plans.

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.

Availity is a trademark of Availity, L.L.C., a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to Blue Cross and Blue Shield of Texas (BCBSTX). BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by independent third-party vendors such as Availity. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.

Please note that verification of eligibility and benefits, and/or the fact that a service or treatment has been preauthorized or predetermined for benefits is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member’s eligibility and the terms of the member’s certificate of coverage applicable on the date services were rendered. If you have questions, contact the number on the member’s ID card.

Updated 05-03-2019
Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Preauthorization

Please Note

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Responsibility for Preauthorization

Primary care physicians/providers (PCP), specialty care physicians or professional providers, facility and ancillary 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 physicians, professional providers, facility and ancillary providers cannot bill or collect fees from members for services. Out-of-network services require preauthorization.

Does Observation Require Preauthorization?

Observation does not require preauthorization. However, if patient converts from observation to inpatient, the admission will require preauthorization.

When to Preauthorize

Preauthorization time frames are listed below.

<table>
<thead>
<tr>
<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 days before admission and preferably seven days in advance</td>
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<td>Urgent/Emergent admissions</td>
<td>Within the later of 48 hours or by the next business day of an emergency hospital admission</td>
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<tr>
<td>Extended Care - Home Health</td>
<td>Before the delivery of services</td>
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# Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Preauthorization

## Please Note

Throughout this provider manual there will be instances where there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These network specific requirements will be noted with the network name.

## Preauthorization 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 which is available 24 hours a day, seven days a week.
- Preauthorization may also be performed by calling the Utilization Management Department for **Blue Essentials, Blue Advantage HMO or Blue Premier** at 855-896-2701.

Business hours are:

- Mon - Fri: 6 a.m. – 6 p.m., CT
- Saturday, Sunday and Legal Holidays: 9 a.m. – noon, CT

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Updated 05-03-2019
# Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Preauthorization

## Please Note
Throughout this provider manual there will be instances where there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These network specific requirements will be noted with the network name.

## Utilization Management Department Business Hours
Utilization Management Department business hours are from 6 a.m. - 6 p.m., CT Monday thru Friday and from 9 a.m. – noon, 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.

**FAX #:** 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
- **Blue Essentials, Blue Advantage HMO and Blue Premier** member ID number
- Policy or group number
- Anticipated date of admission or service
- Clinical history
- Diagnosis - International Classification of Diseases (ICD-10) codes
- Procedure(s) or service(s) planned - Current Procedural Terminology (CPT®) codes
- Anticipated length of stay or frequency of services
- Type of admission (elective or emergency)
- Plan of treatment
- Name/phone number of the 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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iExchange is a trademark of Medecision®, Inc., a separate company that offers collaborative health care management solutions for payers and providers. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by independent third-party vendors such as Medecision. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.
Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Preauthorization

Please Note

Throughout this provider manual there will be instances where there are references unique Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Important Information About the Preauthorization Program

The following outlines important information about the Blue Essentials, Blue Advantage HMO and Blue Premier Preauthorization program.

- **Clinical Criteria** — Preauthorization requests are reviewed using the MCG Guidelines® which promotes consistent decisions based on nationally accepted, physician-created clinical criteria. The criteria are 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 ordering/referring/treating physician or the admitting/attending physician or their delegate shall be afforded a reasonable opportunity to discuss the plan of treatment with the Physician Reviewer before the issuance of an adverse determination. The Physician Reviewer will attempt to contact the servicing physician or professional provider by telephone before issuance of an adverse determination. Physician Advisors who are third-parties hired by a facility are not eligible.

® Registered Mark of MCG Guidelines
Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Preauthorization

Please Note
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Important Information About the Preauthorization Program, cont’d

- **Notification** — written notification letters are sent to the member, physician or 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 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.

Accessibility of Utilization Management Criteria
Utilization Management review criteria is available to Blue Essentials, Blue Advantage HMO and Blue Premier contracted physicians, professional providers, facility and hospital providers upon request. To receive MCG Guidelines on a specific condition, please contact the Utilization Management Department for Blue Essentials, Blue Advantage HMO or Blue Premier at 855-896-2701.
## 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. For detailed information regarding preauthorization requirements, refer to "Preauthorization/Notification/Referral Requirements Requirements", which can be found under Clinical Resources on bcbstx.com/provider. Providers should obtain eligibility and benefits, determine if the provider is in-network for the member's plan and whether preauthorization is required through Availity or their preferred vendor.

### Extended Care Preauthorization – Home Health Services

The following general guidelines apply to Home Health Services:

- Services **must** be ordered by a participating physician, professional provider, facility or ancillary provider.
- The patient is certified by the participating physician, professional provider, facility or ancillary 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 before services are 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 **before** services are rendered.
Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Preauthorization

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Extended Care Preauthorization
All admissions to Skilled Nursing Facilities require Preauthorization before receiving services.

Extended Care Preauthorization - Important Note
When any member needs extended care, the PCP must obtain preauthorization to the physician, professional provider, facility or ancillary provider of services before the delivery of services for the highest level of benefits to be received.

Preauthorization for Inpatient Care
The Blue Essentials, Blue Advantage HMO and Blue Premier 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 Blue Essentials, Blue Advantage HMO and Blue Premier 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 preauthorizing admissions in which he/she is the admitting provider.

A confirmation letter will be mailed to the subscriber, 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, professional provider disagrees with the Physician Reviewer’s decision, he/she may request an appeal.
Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Preauthorization

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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</td>
</tr>
<tr>
<td>(7) days before the date of admission by accessing the iExchange Web</td>
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<tr>
<td>application or contacting the Utilization Management Department for Blue</td>
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<tr>
<td>Essentials, Blue Advantage HMO or Blue Premier at 855-896-2701.</td>
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<th>Urgent/Emergent Admissions Procedure</th>
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<td>The admitting physician or professional provider must access the iExchange</td>
</tr>
<tr>
<td>Web application or contact the Utilization Management Department for Blue</td>
</tr>
<tr>
<td>Essentials, Blue Advantage HMO or Blue Premier at 855-896-2701 within the</td>
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<td>later of 48 hours or by the next business day of an emergency hospital</td>
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<td>admission.</td>
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<th>Admission on Day of Surgery</th>
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<td>Preoperative evaluation, testing, pre-anesthesia assessment and patient</td>
</tr>
<tr>
<td>education will routinely be performed on an outpatient basis, or on the</td>
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<tr>
<td>morning of surgery.</td>
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<td>Concurrent review is performed when an extension of a previously approved</td>
</tr>
<tr>
<td>inpatient length of stay is needed, or an extension of a previously approved</td>
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<tr>
<td>Extended Care service is required.</td>
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<td>Inpatient admissions are reviewed in order to ensure that all services are</td>
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<td>of sufficient duration and level of care to promote optimal health outcome in</td>
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<td>the most efficient manner. Hospital admissions will be reviewed in accordance</td>
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<tr>
<td>with the screening criteria approved by the Clinical Quality Improvement</td>
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<td>Committee.</td>
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<tr>
<th>Responsibility for Concurrent Review</th>
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<tr>
<td>The Blue Essentials, Blue Advantage HMO or Blue Premier PCP, specialty care</td>
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<tr>
<td>physician or professional provider with a current referral is responsible for</td>
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<tr>
<td>obtaining an extension before the expiration of the previously approved</td>
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<tr>
<td>length of stay or service.</td>
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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 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.

Blue Essentials, Blue Advantage HMO and Blue Premier utilize MCG 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 the 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 physician, professional provider, facility or ancillary 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, professional provider, facility or ancillary provider (if other than the PCP).

Updated 05-03-2019
## Please Note

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## 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 professional provider in coordinating necessary services within the same Provider Network.

## Case Management Services

Case Management Services help identify appropriate physicians, professional providers or facility 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
Please Note

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Physician, Professional Provider, Facility and Ancillary Provider Involvement

Physicians, professional providers, facility and ancillary 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.

Referrals to Case Management

Case Management referrals are accepted by telephone, fax or in writing. Contact the Case Management Department by calling: **800-462-3275 or 800-252-8815**

When faxing a referral to Case Management, please fax to: **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., CT, **800-729-2422**
Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Preauthorization

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| 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 area of medical technology and makes a recommendation concerning whether the service should be eligible for coverage. Physicians, professional providers, facility and ancillary providers may submit new technology requests for evaluation via email to: HCSC_Medical_Policy@bcbstx.com |

| 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 preauthorization. |
Please Note

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Blue Essentials Only

Emergency Inpatient Admissions Rendered Outside the HMO Service Area

The PCP must notify the Blue Essentials, Blue Advantage HMO and/or Blue Premier Utilization Management Department of an emergency inpatient admission outside the Blue Essentials, Blue Advantage HMO and/or Blue Premier service area within the later of 48 hours or by the end of the next business day.

When appropriate, the PCP and the Blue Essentials, Blue Advantage HMO and/or Blue Premier 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.

Emergency Hospital Admission

Emergency hospital admissions do not require prior certification/authorization. The PCP must contact the Blue Essentials, Blue Advantage HMO and Blue Premier 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 Blue Essentials, Blue Advantage HMO or Blue Premier physician or professional provider, or is not in the same Provider Network as the member’s PCP, the PCP, in conjunction with the Blue Essentials, Blue Advantage HMO and Blue Premier Utilization Management Department, is responsible for coordinating the care of the patient upon notification of the admission.
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 or ancillary provider contract is discontinued due to reasons other than quality deficiencies. Additionally, such continued care may be available when Blue Essentials, Blue Advantage HMO and Blue Premier members are required to change health plans based on an employer group change. Termination of the physician’s, professional provider’s, facility or ancillary provider’s 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 Blue Essentials, Blue Advantage HMO and Blue Premier 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 Essentials, Blue Advantage HMO or Blue Premier while actively receiving health care services by physicians, professional providers, facility and ancillary providers not in the Blue Essentials, Blue Advantage HMO or Blue Premier 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 Blue Essentials, Blue Advantage HMO or Blue Premier 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, professional providers and facility or ancillary providers until the course of treatment for a specific condition is completed. The physician’s, professional provider’s and facility and ancillary providers Blue Essentials, Blue Advantage HMO or Blue Premier obligations will continue until the earlier of the appropriate transfer of the member’s care to another Blue Essentials, Blue Advantage HMO or Blue Premier physician, professional provider or facility or ancillary provider, 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.
Please Note

Throughout this provider manual there will be instances where there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

Continuity of Care Program Criteria, cont’d

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 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

Continuity of Care Program Criteria Procedure

The procedure for initiating continuity of care is as follows:
- A member, physician, professional or facility or ancillary provider may initiate a request for continuity of care by calling the Blue Essentials, Blue Advantage HMO or Blue Premier Customer Service or the Utilization Management Department.
- A PCP may initiate a request by contacting the Blue Essentials, Blue Advantage HMO or Blue Premier Utilization Management Department.
- The Blue Essentials, Blue Advantage HMO or Blue Premier Utilization Management Department reviews all requests.
- Cases that do not meet criteria are referred to a Physician Reviewer for determination.
- The Blue Essentials, Blue Advantage HMO or Blue Premier Utilization Management Department notifies the Blue Essentials, Blue Advantage HMO or Blue Premier physician, professional provider or facility and ancillary provider and the Blue Essentials, Blue Advantage HMO or Blue Premier member of the continuity of care decision via letter.
- If the request for continuity of care is approved, the Blue Essentials, Blue Advantage HMO or Blue Premier Utilization Management staff completes an out-of-network referral and a letter is mailed to the servicing physician or professional provider.
### Please Note

Throughout this provider manual there will be instances where there are references unique to Blue Essentials, Blue Advantage HMO and Blue Premier. These network specific requirements will be noted with the network name.

### Continuity of Care Program Criteria Procedure, cont’d

- 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 Blue Essentials, Blue Advantage HMO or Blue Premier physician or 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 Blue Essentials, Blue Advantage HMO or Blue Premier Customer Service Departments.

- The Blue Essentials, Blue Advantage HMO or Blue Premier 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 Provider Manual for information pertaining to outpatient diagnostic imaging.

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