BlueCross BlueShield of Texas

Blue Choice PPO℠ and Blue High Performance Network® (BlueHPN)® Provider Manual - Prior Authorizations, Recommended Clinical Review & Case Management

Important note:

Throughout this provider manual there will be instances when there are references unique to Blue Choice PPO, Blue High Performance Network, Blue Edge, EPO and the Federal Employee Program. These specific requirements will be noted with the plan/network name. If a Plan/network name is not specifically listed or "Plan" is referenced, the information will apply to all PPO products.

In this Section

The following topics are covered in this section.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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In this Section, cont'd

The following topics are covered in this section:

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Utilization Management Overview

Utilization management determines whether a benefit is covered under the Blue Cross and Blue Shield of Texas health plan using evidence-based clinical standards of care. It can also assist in determining the appropriate site of care for certain services. It can be a prior authorization, prenotification, recommended clinical review 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.

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 and appropriate site of care 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. Refer to the Recommended Clinical Review page on the provider website for more information.

Post-Service Medical Necessity Reviews 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 Services are Applicable to Prior Authorization or RCR

To determine which services may require prior authorization, prenotification or if RCR is applicable 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 or if RCR is applicable and who to contact - Medical Management at BCBSTX, Carelon Medical Benefits Management or Alacura Medical Transportation Management, LLC.

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What Services are Applicable to Prior Authorization or RCR, cont.

Availity allows you to determine if prior authorization is required or RCR is applicable based on the procedure code. Refer to "Eligibility and Benefits" on the provider website for more information on Availity.

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 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 Medical Management at BCBSTX can be submitted via Blue ApprovR℠ or Availity® Authorizations & Referrals or by calling the number on 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, Alacura or Magellan Healthcare to submit notifications for healthcare services managed by them.

Carelon Prior Authorizations or RCR

BCBSTX has an agreement with Carelon to provide certain outpatient prior authorization or RCR services. Services requiring prior authorization or where RCR is applicable as well as information on how to submit requests for services with Carelon are outlined on the Utilization Management page and on the Carelon page on bcbstx.com/provider.

Responsibility for Prior Authorization

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

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

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Renewal of an Existing Prior Authorization or RCR

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

When to Request a Utilization Management Review

Time frames are listed below for contacting the Plan for utilization management review:

Type of Request	Type of Service	Time Frame
Prior Authorization or Required Notifications	• Certain inpatient and outpatient services as designated on Prior Authorization lists on the Utilization Management page. • Submit required notification for services when provider has a prior authorization exemption for the service.	Prior to the delivery of services and preferably seven days in advance
Recommended Clinical Review Option	• For elective inpatient admissions when prior authorization is not required. • Certain outpatient services - refer to list on Recommended Clinical Review page on the provider website.	• Inpatient - minimum of two days prior to admission and preferably seven days in advance • Outpatient - Prior to the delivery of services and preferably seven days in advance
Notifications	Urgent/Emergent admissions	Within the later of 48 hours or by the end of the next business day of an emergency hospital admission.

Recommended Clinical Review Option

Recommended Clinical Review option is available for certain members that do not require **inpatient** prior authorizations. These optional reviews inform the provider of situations where a service will be denied based upon medical necessity and determine the appropriate site of care.

Providers submit an inpatient Recommended Clinical Review utilizing the same submission process as a prior authorization.

Recommended Clinical Review for **outpatient** services is a voluntary, written request by a member or a provider to determine if a proposed treatment or service is covered under a patient's health benefit plan.

Refer to the Recommended Clinical Review page on the provider website for more information.

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Does Observation Require Prior Authorization	Observation does not require prior authorization. However, if patient converts from observation to inpatient, the admission may require prior authorization or maybe applicable to RCR.
How to Request Prior Authorization or RCR	For information on behavioral health, refer to Section I of this provider manual. Refer to Section C Authorization Process in this manual or refer to the Utilization Management page on the provider website.
Information Necessary for a Utilization Management Review	Please have the following information readily available when initiating a utilization management review: • 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 - International Classification of Diseases codes • Procedure(s) or service(s) planned - CPT® or HCPCS 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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Information About Utilization Management Reviews

The following outlines important information about utilization management reviews:

- **Clinical Criteria** — Prior authorization and Recommended Clinical Review requests are reviewed using the our Medical Policy, Carelon Care Guidelines and/or MCG Guidelines® which promotes consistent decisions based on nationally accepted, physician-created clinical criteria. The criteria are customized to reflect our 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 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 ***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. Physician Advisors who are third-parties hired by a facility are not eligible.

- **Notification of Decision**— Written notification letters are sent to the member and health care provider. The approved length of stay or service and the authorization 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 health care provider. Once the decision has been made, BCBSTX determines what benefits are allowed under the existing health plan.

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Important Information About Utilization Management Reviews, cont.

Note: Prior Authorization and Recommended Clinical Review confirms the medical necessity of the service or admission but does not guarantee payment. Prior authorization 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.

Refer to **Section C - Authorization Process** for information on appealing adverse determinations and post service medical necessity reviews to determine whether a service or drug was medically necessary and covered under the member's benefit plan.

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 prior authorize
  - 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 Medical Management Criteria

Medical Management review criteria is available to BCBSTX participating health care providers upon request. Links to our Medical Policy and Carelon Care Guidelines are also available on the provider website. To receive MCG Guidelines on a specific condition, please contact the Medical Management Department at **800-441-9188**.

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Extension of Care Procedure

The prescribing physician or professional provider is responsible for obtaining a required prior authorization or recommended clinical reviews by contacting the Medical Management Department by phone or fax or submission through the Availity Authorizations & Referrals tool.

An approval will be given after verifying medical necessity and network status. If the provider is out-of- network UM will attempt to navigate member to an in- network provider. For detailed information regarding prior authorization requirements, refer to the "What Services are Applicable to Prior Authorization or RCR" section above.

Extension of Care - 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 authorization ***prior*** to service being rendered.

Extension of Care - 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. When prior authorization is required, submit requests for Hospice services prior to services being rendered.

Extension of Care - Home Infusion Therapy

Plan members requiring Home Infusion Therapy are not required to be homebound to receive services. When prior authorization is required, submit requests for Home Infusion Therapy services prior to services being rendered.

Extension of Care Prior Authorization - Important Note

When any **Plan** member needs extension of care, the **Plan's** health care provider ***must*** obtain authorization of the services ***prior*** to the delivery of services for the highest level of benefits to be received when prior authorization is required.

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Prior Authorization or Recommended Clinical Review for Inpatient Care

The **Plan** health care provider is required to admit the member to a participating facility, except in emergencies.

The healthcare provider 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.

When an admission does not meet the clinical screening criteria, the Medical 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 **800-441-9188**.

Note: When a provider has a Prior Authorization Exemption, a Notification to BCBSTX should be submitted to determine the initial length of stay or initial units exempted for service(s). Services beyond the initial length of stay or units covered by the PA exemption will be reviewed for medical necessity. Any days/units beyond what is outlined in the initial Notification Acknowledgement letter will need an extension (or concurrent review)
request submitted. Extension (concurrent review) requests may be subject to a medical necessity review.

Urgent/ Emergent Admissions Procedure

Notification is encouraged within 2 business days of an urgent/emergent 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.

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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.

Concurrent Review of Inpatient Admissions

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

Inpatient admissions are reviewed to ensure 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 **Plan** health care provider is responsible for obtaining an extension ***prior*** to the expiration of the previously approved length of stay or service.

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Extension Review Procedure

Review will begin upon request for the extension. The Medical Management Department may contact the admitting health care provider or hospital Medical 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 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 prior authorization or discontinue benefit certification. When a denial of benefits is determined, the Medical 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 member, facility and health care 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 Medical Management Department will work with the Hospital Discharge Planning Staff and the admitting health care provider in coordinating necessary services within the **Plan** Network.

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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 Providers Involvement	Health care 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.

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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:

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
PO Box 833874
Richardson, TX 75083-3874

For information on behavioral health case management, call the number below between the hours of 8 a.m. – 5 p.m. (CT).
800-528-7264

Evaluation of New Technology

Following review by the our Advisory Panel, 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. 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	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 prior authorization.***
Emergency Inpatient Admissions Rendered Outside the Plan's Service Area	The attending physician/provider or member ***must*** notify our 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.

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's Managed Care Agreement 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 Managed Care 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 BCBSTX 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 the **Plan** while actively receiving health care services by health care providers not in the **Plan** 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 health care provider leaves the **Plan** network 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 and BCBSTX's obligations will continue until the earlier of the appropriate transfer of the member's care to another **Plan** participating health care provider (whichever is applicable), 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 13th week and beyond

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Continuity of Care 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 Customer Service or the Medical Management Department.
- A health care provider may initiate a request by contacting the Medical Management Department.
- The Medical Management Department reviews all requests.
- Cases that do not meet criteria are referred to a Physician Reviewer for determination.
- The Medical Management Department notifies the health care provider and member of the continuity of care decision via letter.
- If the request for continuity of care is approved, the Medical Management staff completes an out-of-network referral and a letter is mailed to the servicing health care provider.
- If continuity of care is denied, the member has the following options:
    a. Continue care/treatment with his/her out-of-network health care provider at the out-of-network benefit level;
    b. Choose a **Plan** participating health care provider *(whichever is applicable)*;
    c. Receive treatment under the direction of his/her Primary Care Physician *(if applicable)*; or
    d. File a formal complaint by contacting the Customer Service Department.
- The Medical Management staff and Medical Director review continuity of care criteria at least annually.

Registered Mark of MCG Guidelines

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Carelon Medical Benefits Management is an independent company that has contracted with BCBSTX to provide utilization management services for members with coverage through BCBSTX.

Alacura Medical Transportation Management, LLC. is an independent company that has contracted with Blue Cross and Blue Shield of Texas to provide utilization management services for members with coverage through BCBSTX.

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSTX

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