Blue Choice PPO℠ and Blue High Performance Network® (BlueHPN)® Provider Manual - Authorization Process

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 Choice PPO and BlueHPN
Provider Manual - Authorization Process

Utilization Management Overview

Utilization management is how we can help Blue Cross and Blue Shield of Texas (BCBSTX) members continue to access the right care, at the right place and at the right time.

A utilization management review determines whether a benefit is covered under the health plan using evidence-based clinical standards of care. The following are types of Utilization Management:

- **Prior Authorizations** are a pre-service medical necessity review. Prior authorization is the process where we review the requested service or drug to see if it is medically necessary and covered under the member's health plan. Not all services and drugs need prior authorization. A prior authorization is not a guarantee of benefits or payment. The terms of the member's plan control the available benefits. Prior authorization may be required through BCBSTX Utilization Management or an external vendor such as Carelon Medical Benefits Management (Carelon).

- **Recommended Clinical Review** are optional reviews for medical necessity submitted before services are completed for a Covered Service that does not require prior authorization and helps limit the situations where a service may be denied based upon medical necessity retrospectively.

- **Post-Service Medical Necessity Reviews (PSMNR)** may occur after the service was rendered. During a PSMNR, we review clinical documentation to determine whether a service or drug was medically necessary and covered under the member's benefit plan. We may ask you for the information we do not have.

What May Require Review

To determine if specific services or categories have required Prior Authorization or the Recommended Clinical Review option:

- Refer to Utilization Management on the provider website for the required Prior Authorization lists, which are updated when new services are added or when services are removed.

- Use Availity® Essentials or your preferred vendor to check eligibility and benefits, determine if you are in-network for your patient and whether prior authorization or prenotification is required and who to contact. Availity allows you to determine if prior authorization is required based on the procedure code. If the provider is eligible for a prior authorization exemption for the healthcare service, per Texas House Bill 3459, Availity will indicate no prior authorization is needed. When prior authorization is required and managed by BCBSTX Utilization Management, providers can enter requests for prior authorization using Availity Authorizations & Referrals or BlueApprovR. Refer to Eligibility and Benefits on the provider website for more information on Availity.

What May Require Review, cont.

- Refer to the Recommended Clinical Review Option page under Utilization Management on the provider website for code lists where outpatient Recommended Clinical Review may be available.
- You can also call Customer Service at the toll-free telephone number on the back of the member's Identification Card.

Get additional information on services requiring prior authorization or prenotification through Carelon on the Carelon page on the provider website.

Refer to the Behavioral Health Section I of this manual for information on behavioral health prior authorizations.

Prior Authorization Exemptions

Under Texas House Bill 3459, providers may qualify for an exemption from submitting prior authorization requests for particular health care service(s) for all fully insured and certain Administrative Services Only (ASO) groups. Only services subject to required prior authorizations are eligible for an exemption. Providers can check Provider Correspondence Viewer via Availity Essentials to determine if they have been issued a PA Exemption for a particular service.

We request you submit a notification to determine the initial length of stay or initial units for service(s) with a PA Exemption. Notification can be submitted via Availity® Authorizations & Referrals or by calling the number on the back of the member's ID card. A Notification Acknowledgement for the specific service(s) allowable per the PA exemption will be provided. Any days/units beyond what is outlined in the Notification Acknowledgement or covered by the initial PA Exemption if a notification is not submitted, will require submission of an extension request (or concurrent review) and may be subject to a medical necessity review.

Refer to the Prior Authorization Exemption page on the website for qualifications for an exemption and other information.

Responsibility for Required 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.

Submitting Required Prior Authorizations (PA), Notifications or Optional Recommended Clinical Review (RCR)

- **To submit services managed by BCBSTX Medical Management:**
  - **Online:**
    - ✓ Use the BlueApprovR tool accessible in the BCBSTX-branded Payer Spaces section via Availity to submit prior authorization and recommended clinical review requests for medical/surgical services. This tool is designed to help simplify the provider submission process by asking for information to support a medical necessity denial. When requests are deemed medically necessary, providers can be granted approvals. The Availity Attachments tool can be used to quickly submit documentation to BCBSTX. For navigation tips, see our user guide.
    - ✓ Use the Availity's Authorizations & Referrals tool (HIPAA-standard 278 transaction) which allows the electronic submission of that require prior authorization, inpatient services to request recommended clinical review, referral requests and notifications for PA exempted services. Additionally, providers can also check the status of previously submitted requests and/or update applicable existing requests. The benefits of using this online functionality:
      - No separate user enrollment needed
      - Direct access within the Availity portal
      - Simplified 5-step process
        1. Log in to Availity
        2. Select Patient Registration menu option, choose Authorizations & Referrals, then Authorizations*
        3. Select Payer BCBSTX, then choose your organization
        4. Select a Request Type and start request
        5. Review and submit your request
      - Choose **Referrals** instead of **Authorizations** if you are submitting a referral request.

If you are not yet registered with Availity, sign up at no charge. If you need registration assistance, contact Availity Client Services at **1-800-282-4548**.

- **For services managed by BCBSTX Medical Management,** cont.**:**
  - **Fax or Mail**
    If online tools are not available, prior authorization may also be initiated via fax at: Toll-free **800-252-8815** or

    1-800-462-3272 and;
    The Recommended Clinical Review Form can be faxed BCBSTX using the appropriate fax number listed on the form or mail to:

    P.O. Box 660044, Dallas, TX
    75266-0044

Blue Choice PPO and BlueHPN Provider Manual - Authorization Process

Submitting Authorizations & Referrals, cont.

- **Phone –** Contact BCBSTX Medical Management using the number on the back of the member's ID card or call **1-800-441-9188.**

Electronic Options are preferred to help expedite your request.

- **For services managed by Carelon:**
  - **Online:** Use the Carelon Provider Portal
  - **Phone:** Contact their call center at **1-800-859-5299.** Please note - do not submit medical records unless requested by Carelon. If a PSMNR is requested, the provider can respond in the Carelon provider portal. Do not submit medical records to BCBSTX for Carelon requests for medical records.

Appeals for Carelon can be submitted:

- **Phone**:**1-800-859-5299**
- **Fax 1-888-583-1005**
- **Mail:** Attention: Prior Authorization Department, HCSC Appeals 540 Lake Cook Road, Deerfield, IL 60015

Renewal of Existing Prior Authorizations

A renewal of an existing prior authorization 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 prior authorization.

BCBSTX Medical Management Appeals

Expedited Appeal Process	BCBSTX has an expedited appeal process for appeals of adverse determinations based on medical necessity, experimental/ investigational or appropriateness of care that involve life-threatening, urgent or emergency services and continued stays for hospitalized patients. Notification of the appeal determination will not exceed one (1) working day from the receipt of all necessary information or seventy-two (72) hours from the appeal request, whichever is sooner. All appeals are reviewed by a physician or professional provider not previously involved in the case, who is in the same or similar specialty as would manage the condition under review.
Standard Appeal Process	BCBSTX has a standard appeal process for appeals of adverse determinations for a denial of service based on medical necessity, experimental/investigational, or appropriateness of care. Written notification of the appeal determination will be provided no later than thirty (30) calendar days after the date BCBSTX received the appeal request. All appeals are reviewed by a physician or professional provider not previously involved in the case who is in the same or similar specialty as would manage the condition under review.
Provider Request for Case Match Review	A health care provider may request a case match review by submitting in writing, within ten (10) working days of an appeal denial, good cause for a specialty physician review. The request will be reviewed and the appealing health care provider shall be notified no later than fifteen (15) working days from the date of the request.

BCBSTX Medical Management Appeals

To Appeal An Adverse Determination for Medical Necessity/ Experimental/ Investigational

To appeal an adverse determination for medical necessity or experimental/investigational, a health care provider may write to:

BCBSTX Medical Management
Attention: Appeals Department
1001 E. Lookout Dr
Richardson, TX 75082-4144

Appeal requests may also be submitted by:

Fax: 1-866-221-3607
Phone: 1-855-896-2701

Appeal Process for Denials of Out-of-Network Requests or Non-Covered Benefits

The appeal of a denial of a service that is not covered per the subscriber's Coverage Documents is considered a "complaint" and is resolved via the BCBSTX Complaint Process.

To request such a review, contact Customer Service at the telephone number shown on the subscriber's ID card.

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.

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

BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by Availity or Carelon. The vendors are solely responsible for the products or services they offer.