South Carolina

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Blue Cross Blue Shield Association.

# AUTHORIZATIONS

# DISCLAIMER

The information included is general and in no event should be deemed as a promise or guarantee of payment. We do not assume and hereby disclaim any liability for loss caused by errors or omissions in preparation and editing of this publication.

# AGENDA

- Overview of Authorizations
- Process of Authorizations
- Authorization Vendors
- Resources

# AUTHORIZATIONS OVERVIEW

# WHAT YOU NEED TO KNOW ABOUT AUTHORIZATIONS

Authorizations are used to determine whether a service is medically necessary.

Authorization requirements can vary per plan and network.

Authorizations do not guarantee payment.

# COMMON SERVICES THAT REQUIRE AUTHORIZATION

- Elective inpatient services (including maternity)
- Skilled nursing facility admission
- Home health and hospice
- Durable medical equipment (DME)*
- Mental health and substance abuse
- High tech imaging**
- Certain medications under the medical benefit

** DME dollar thresholds vary per plan but are typically $500 or $1,000. The threshold amounts can be lower than $500*

*** These services are typically handled by Evolent.*

# GENERAL GUIDELINES FOR AUTHORIZATIONS

Submit elective requests prior to rendering services.

Mark requests as urgent **only** when they are urgent.

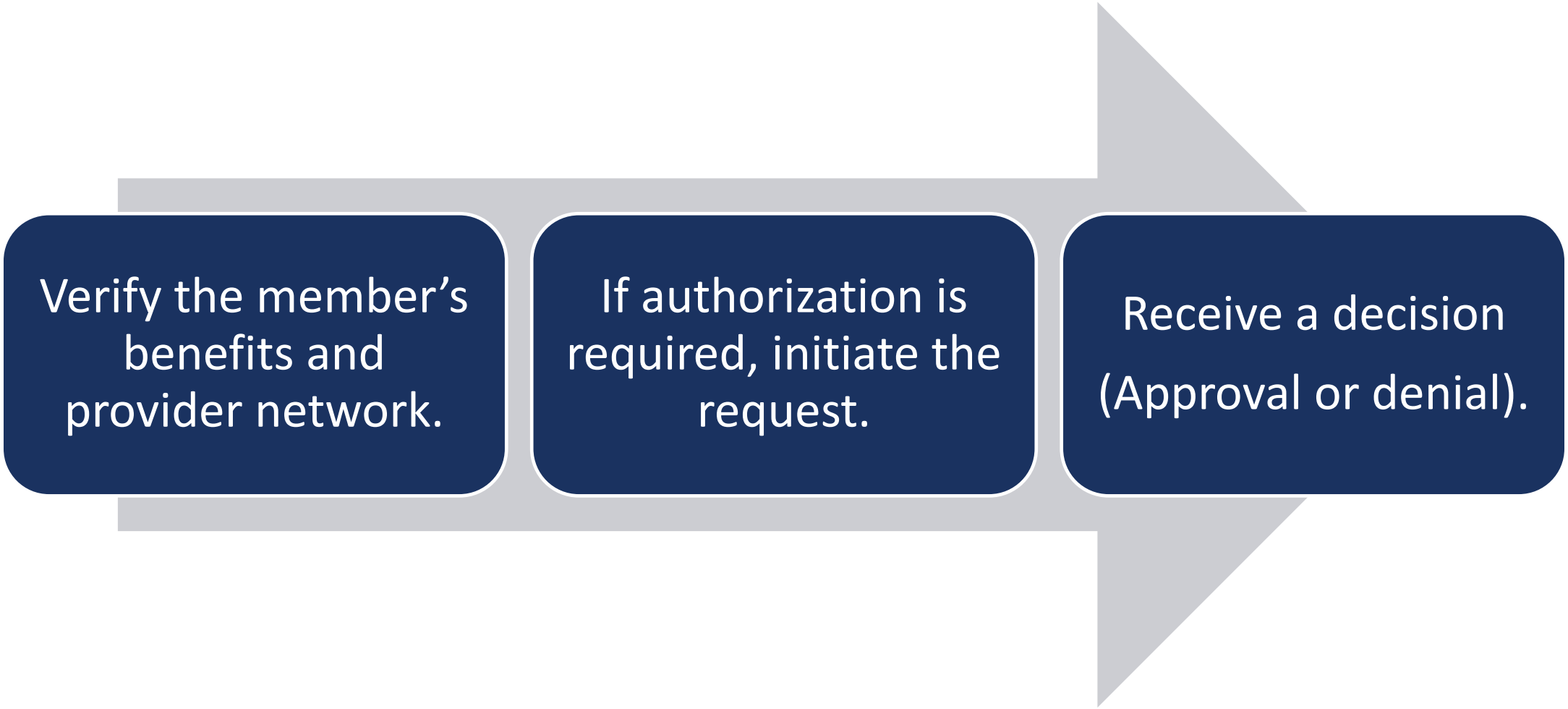
Submit requests once.

Submit a notification of emergency admission within 24-48 hours of admission.

Services must be covered under the member's plan.

Members must have active coverage at the time of request.

# MAIN STEPS IN THE AUTHORIZATION PROCESS



# REQUIRED INFORMATION FOR AUTHORIZATIONS

| Patient Details | Service Details | Location Details | Contact Information | Clinicals |
|---|---|---|---|---|
| • Name<br>• ID number<br>• Date of birth | • CPT or HCPCS codes<br>• Diagnosis codes<br>• Date of service | • Facility<br>  • Name<br>  • Address<br>  • Tax ID or NPI<br>• Rendering<br>  • Name<br>  • Address<br>  • Tax ID or NPI | • Phone number<br>• Fax number<br>• Email | • Length of issue<br>• Attempted treatment<br>• Conservative medications<br>• Studies (i.e., labs, imaging) |

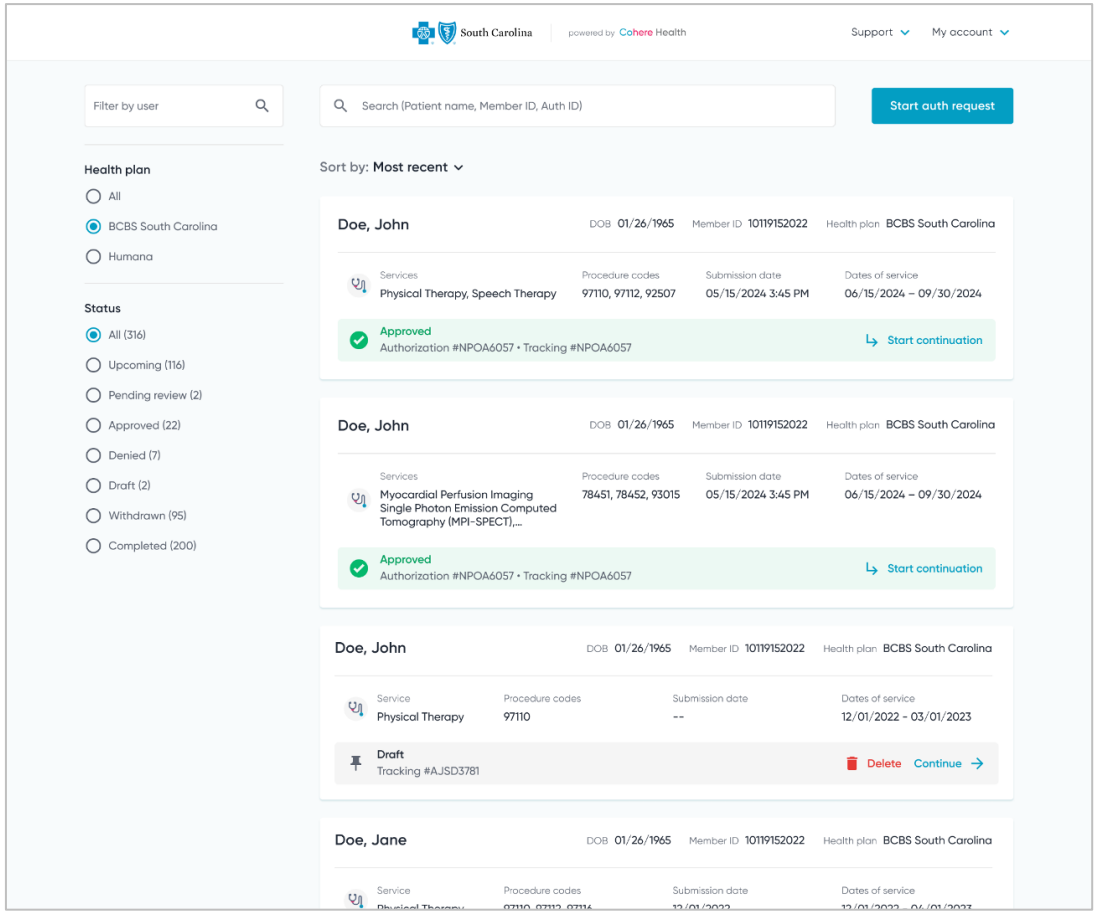
# PROCESS FOR AUTHORIZATIONS

# HOW TO GET AN AUTHORIZATION

- There is a single sign-on through My Insurance Manager℠.
- Under ***Patient Care***, select ***Pre-certification/Referral***.

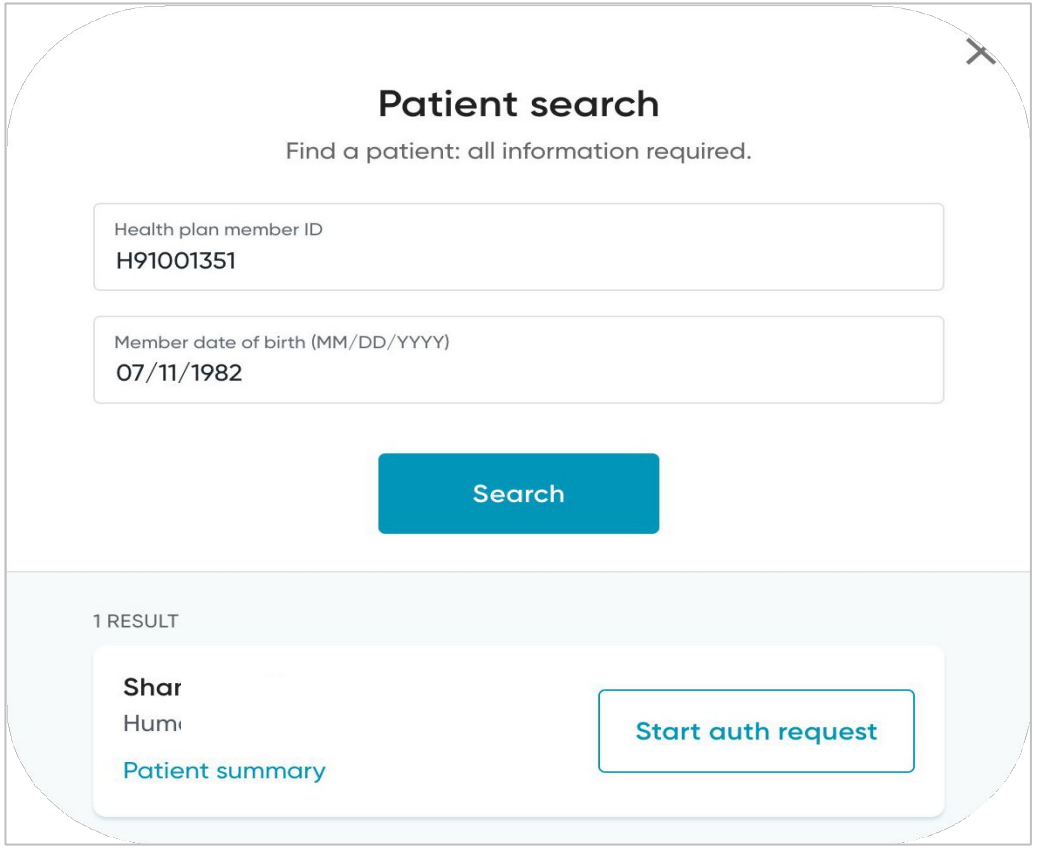
# COHERE HEALTH – LANDING PAGE

- When you reach the landing page of the new platform, you will see a full listing of authorizations under your tax identification number (TIN).
- The authorizations can be filtered by:
  - All
  - Upcoming
  - Pending review
  - Approved
  - Denied
  - Draft
  - Withdrawn
  - Completed
- You can also search for a specific patient or authorization.
- To start a new request, select ***Start auth request***.



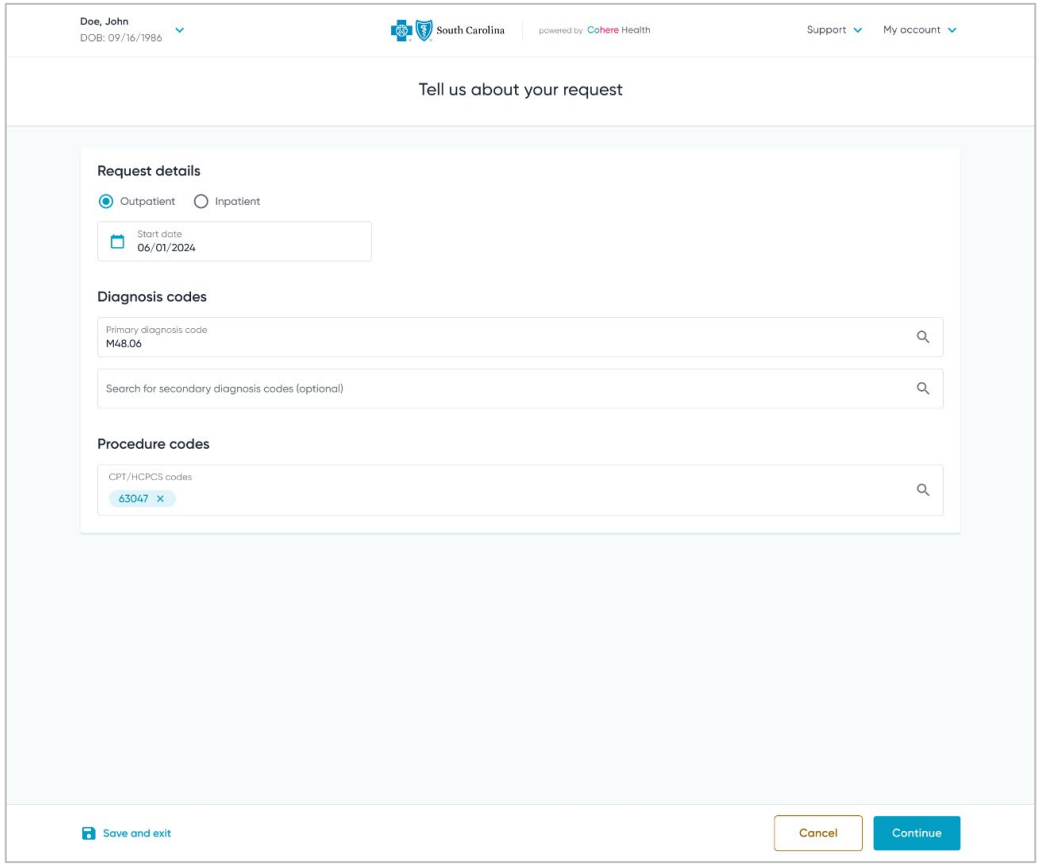
# COHERE HEALTH – PATIENT SEARCH

- Enter the member's ID number.
- Enter the member's date of birth.
- Select ***Start auth request*** next to the appropriate member in the results.



# COHERE HEALTH – PRIMARY DETAILS

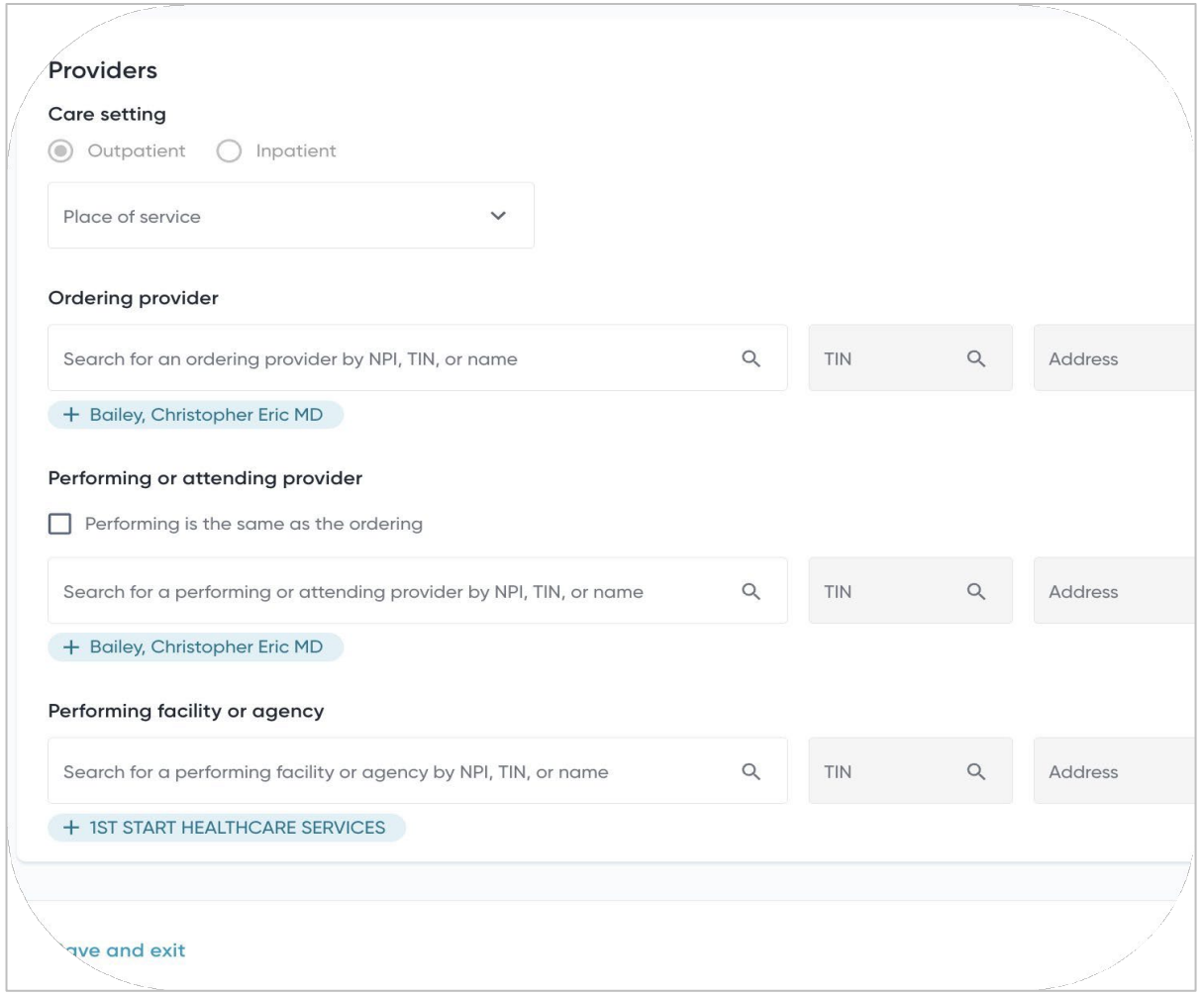
- Select whether the service is outpatient or inpatient.
- Include the diagnosis and procedure code(s).
- Select ***Continue***.




*Note: You have the option to save and exit the request at any time. You can also cancel the request if it's no longer needed.*

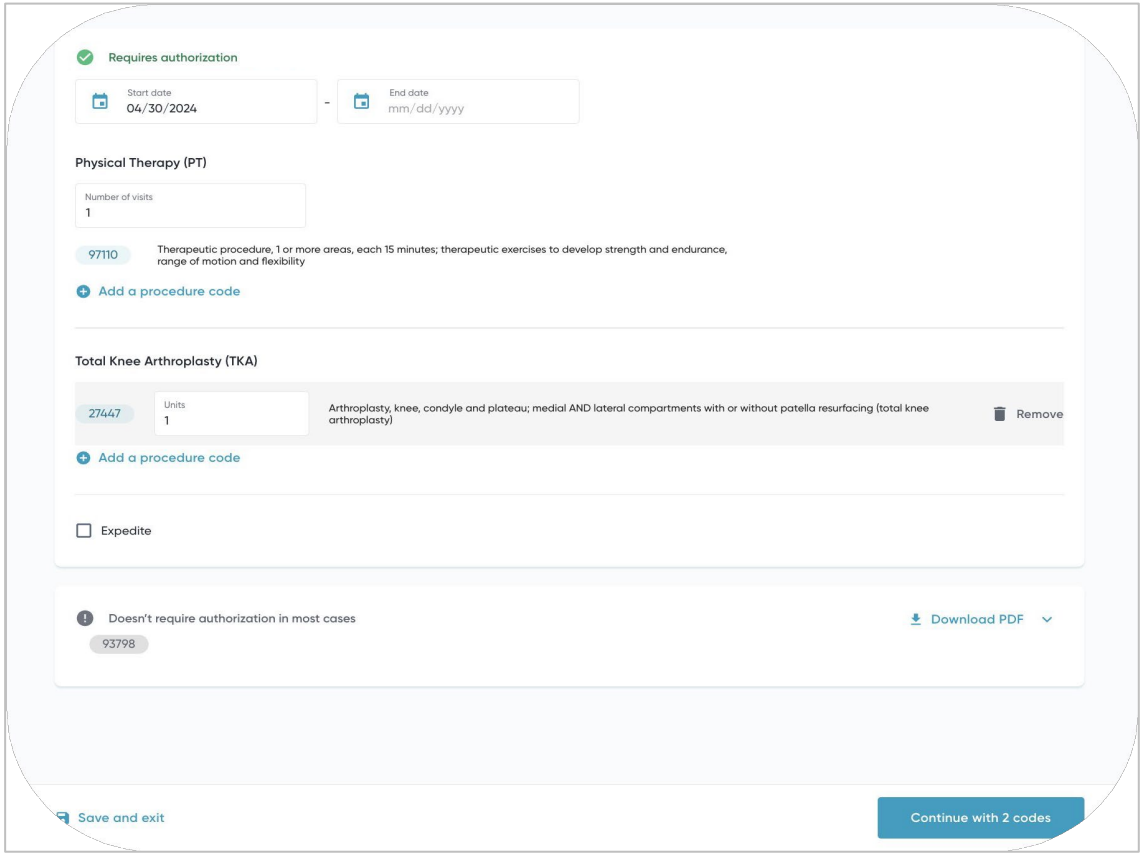
# COHERE HEALTH – PROVIDER DETAILS

- Enter the provider details to include:
  - Ordering provider.
  - Performing or attending provider.
  - Performing facility or agency.
- There is a TIN search feature to make the process easier.
- Select ***Continue***.



# COHERE HEALTH – RESULTS

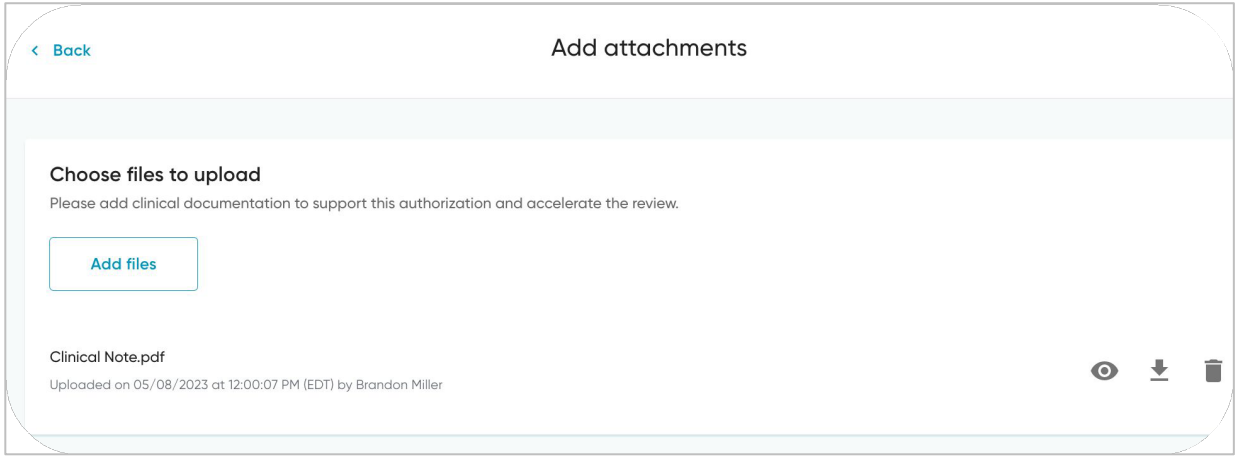
- On this screen, the top portion will tell you which codes you requested require authorization.
- The bottom portion will tell you which codes do not require authorization.
- There's an option to expedite the request if it's an ***urgent matter***.
- Select ***Continue***.




*Note: The continue option will indicate the number of codes being requested for review.*

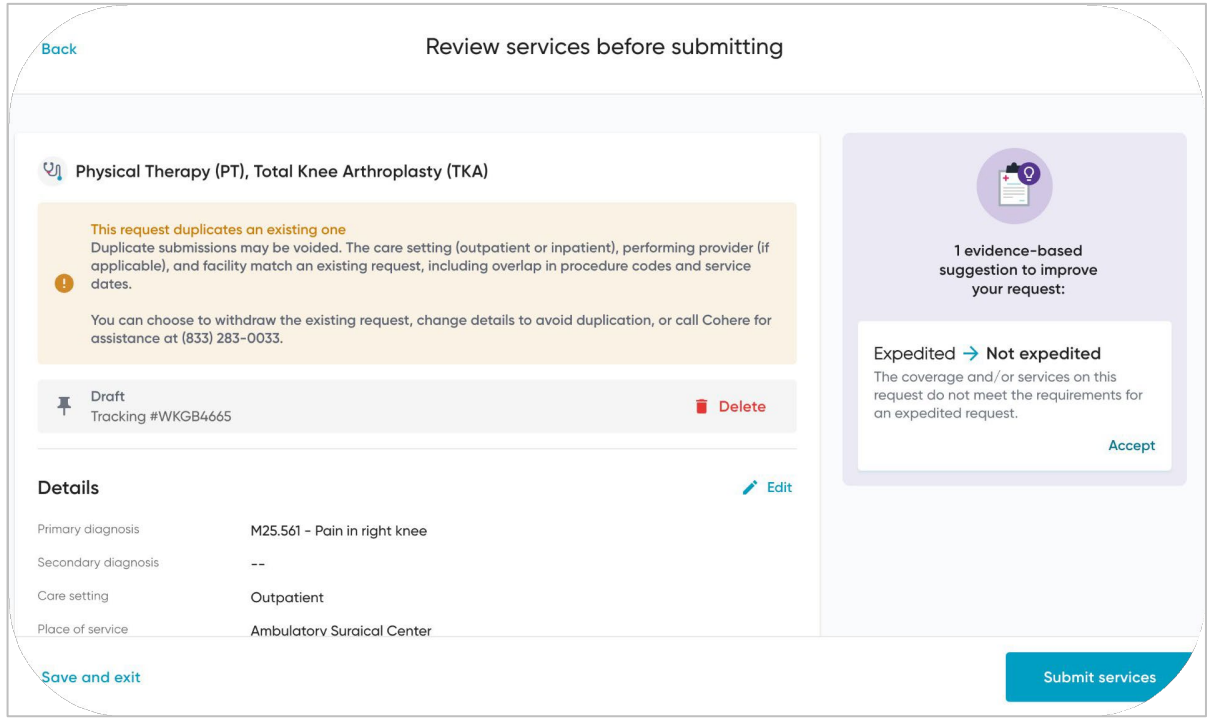
# COHERE HEALTH – CLINICAL DOCUMENTATION

- Upload all relevant clinical documentation for review.
- You will have the option to review the uploaded items or remove them.
- Select ***Continue***.



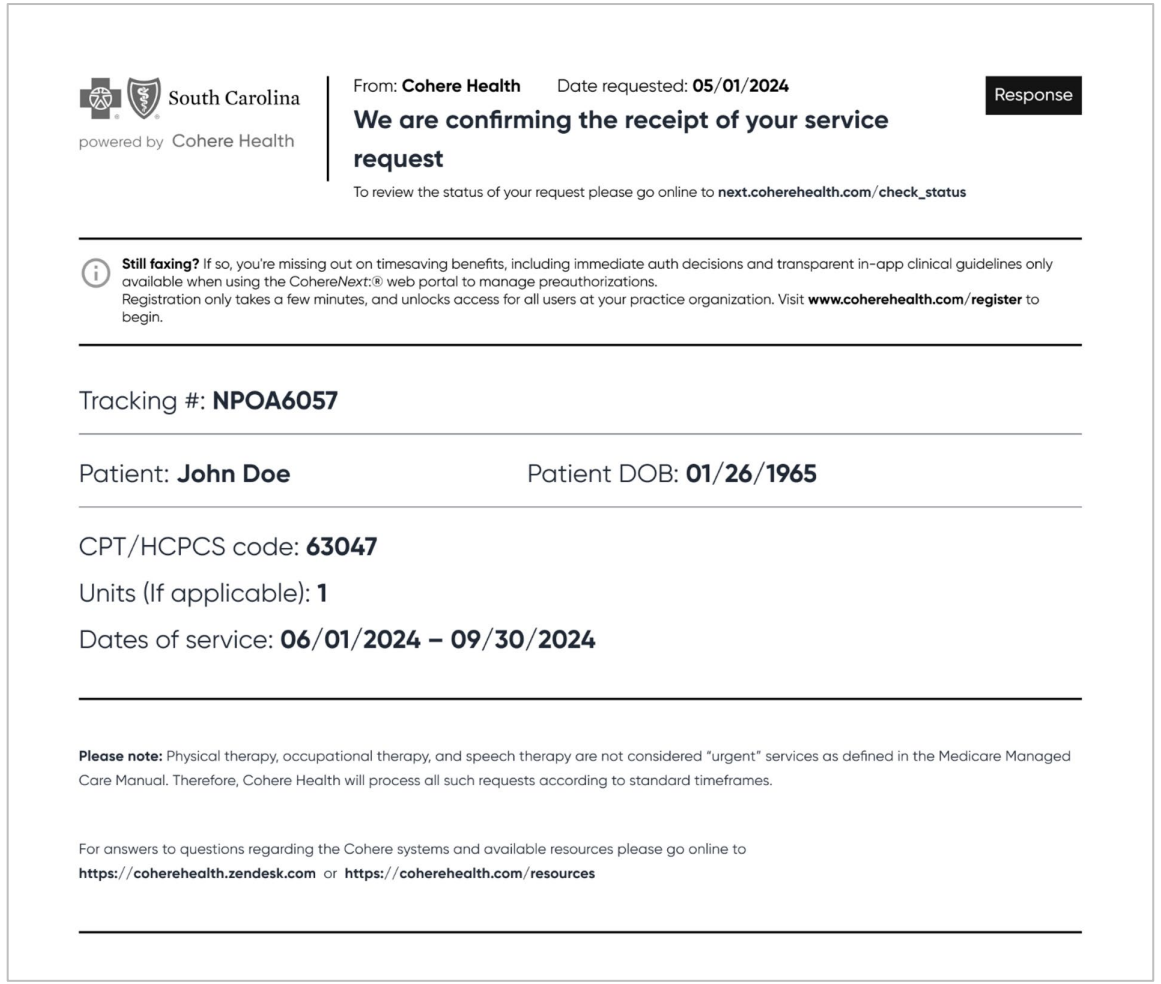
# COHERE HEALTH – SUBMIT REQUEST

- Review all the relevant information.
  - The orange box displays if there is a possible duplicate request on file. Review the current authorizations (whether approved or pending) to avoid submitting an unnecessary duplicate request that would eventually be voided.
  - The purple box displays if there is an expedited request, but based on the services and clinicals, there's no evidence supporting the need for it to be expedited. The provider will be asked to consider changing the request to "not expedited" by selecting Accept. If not, they can continue with the expedited request.
- Select ***Submit services***.



# COHERE HEALTH – CONFIRMATION PAGE

- After submitting the request, you will receive a faxed notification confirming the receipt of your service request.



South Carolina
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From: **Cohere Health** Date requested: **05/01/2024**

Response

**We are confirming the receipt of your service request**

To review the status of your request please go online to **next.coherehealth.com/check_status**

**Still faxing?** If so, you're missing out on timesaving benefits, including immediate auth decisions and transparent in-app clinical guidelines only available when using the Cohere*Next*:® web portal to manage preauthorizations.
Registration only takes a few minutes, and unlocks access for all users at your practice organization. Visit **www.coherehealth.com/register** to begin.

Tracking #: **NPOA6057**

Patient: **John Doe** Patient DOB: **01/26/1965**

CPT/HCPCS code: **63047**

Units (If applicable): **1**

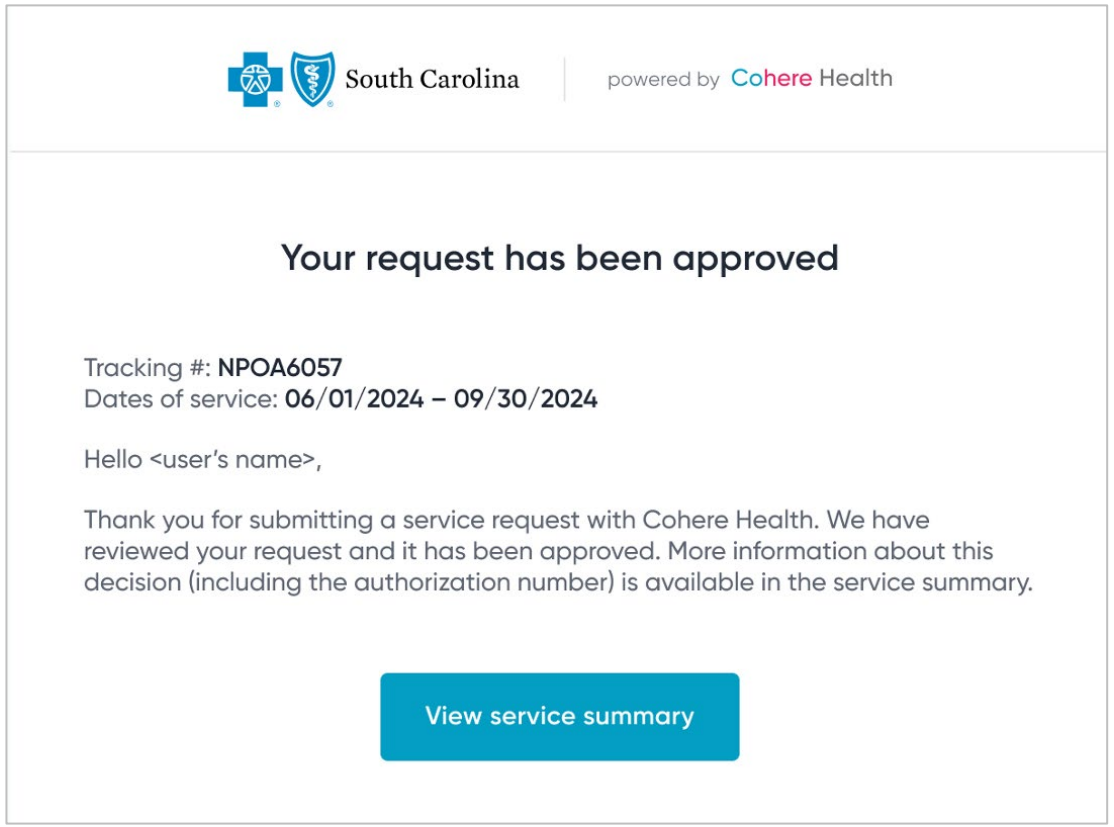
Dates of service: **06/01/2024 – 09/30/2024**

**Please note:** Physical therapy, occupational therapy, and speech therapy are not considered "urgent" services as defined in the Medicare Managed Care Manual. Therefore, Cohere Health will process all such requests according to standard timeframes.

For answers to questions regarding the Cohere systems and available resources please go online to **https://coherehealth.zendesk.com** or **https://coherehealth.com/resources**

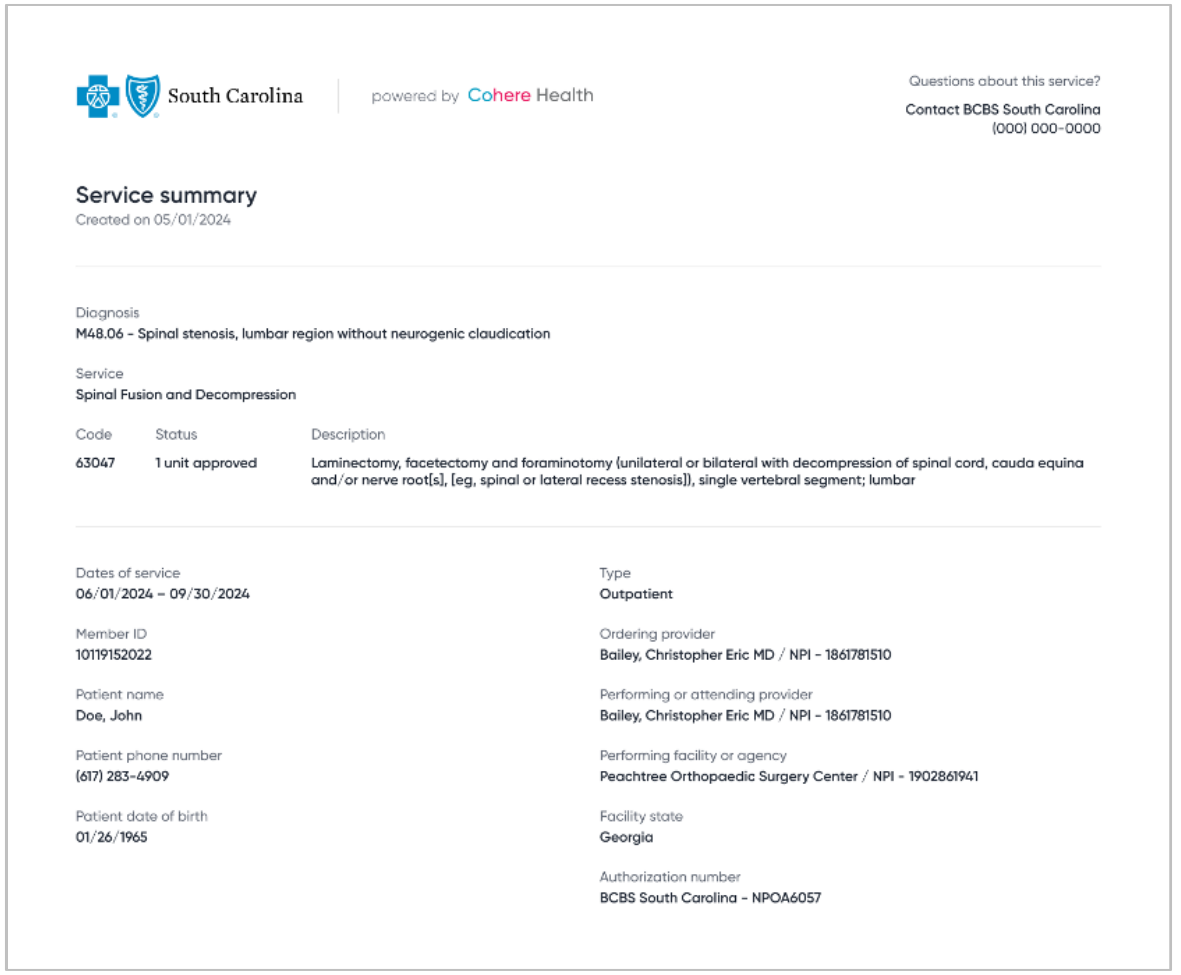
# COHERE HEALTH - NOTIFICATIONS

- You will be notified once the authorization is approved or denied.
- To view additional details, select ***View service summary*** inside the portal.



# COHERE HEALTH – SERVICE SUMMARY

- The ***service summary*** will outline the requested authorization to include:
  - Diagnosis and procedure code(s).
  - Place of service.
  - Ordering provider.
  - Performing or attending provider.
  - Performing facility or agency.
  - Dates of service.



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Questions about this service?
Contact BCBS South Carolina
(000) 000-0000

**Service summary**
Created on 05/01/2024

Diagnosis
M48.06 - Spinal stenosis, lumbar region without neurogenic claudication

Service
Spinal Fusion and Decompression

| Code | Status | Description |
|---|---|---|
| 63047 | 1 unit approved | Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar |

Dates of service
06/01/2024 – 09/30/2024

Member ID
10119152022

Patient name
Doe, John

Patient phone number
(617) 283-4909

Patient date of birth
01/26/1965

Type
Outpatient

Ordering provider
Bailey, Christopher Eric MD / NPI - 1861781510

Performing or attending provider
Bailey, Christopher Eric MD / NPI - 1861781510

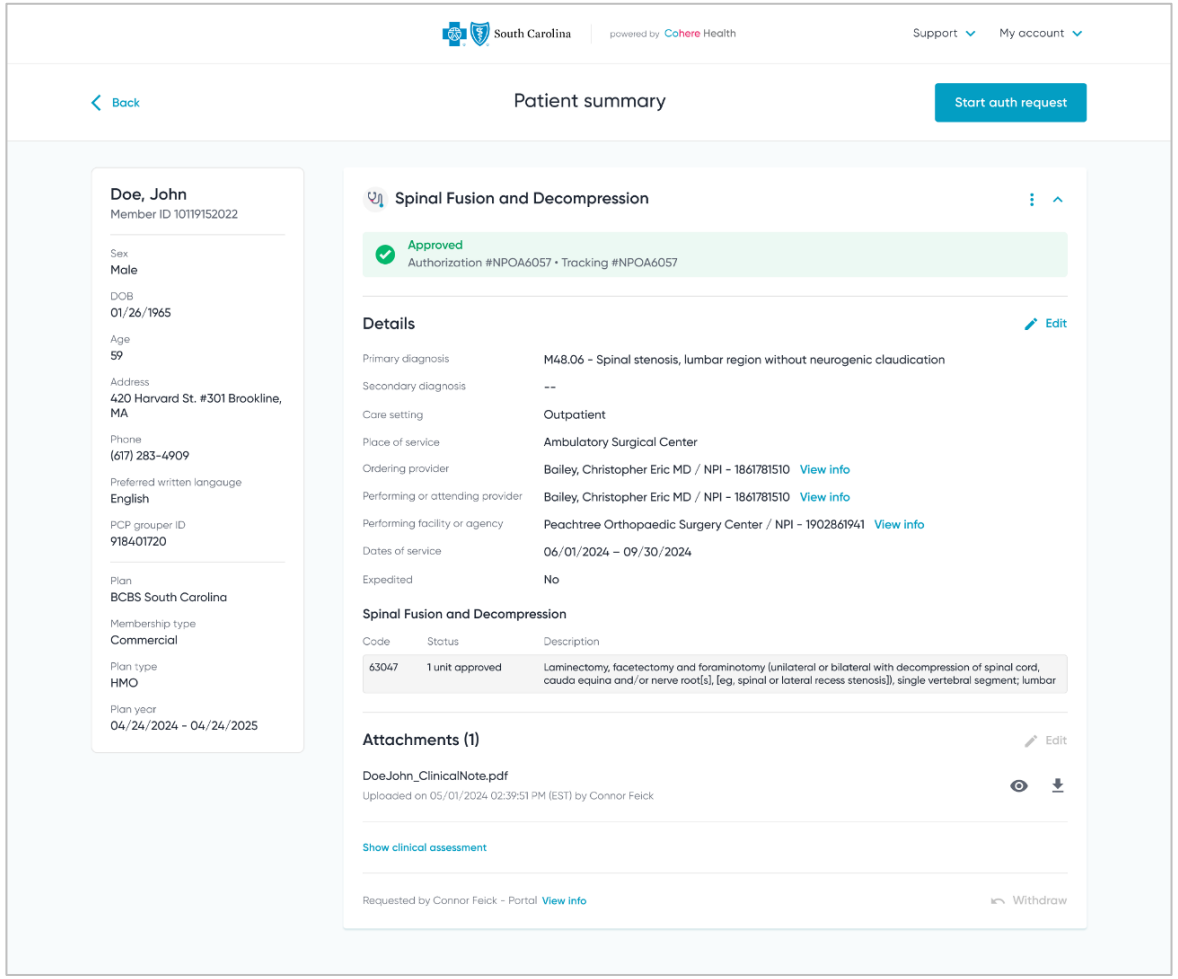
Performing facility or agency
Peachtree Orthopaedic Surgery Center / NPI - 1902861941

Facility state
Georgia

Authorization number
BCBS South Carolina - NPOA6057

# COHERE HEALTH – PATIENT SUMMARY

- The ***patient summary*** will outline the same details as the service summary but will give you the option to view the clinical documentation that was provided.



# AUTHORIZATION PARTNERS

# ORGANIZATIONS THAT MANAGE SELECT AUTHORIZATIONS

- Evolent
- Avalon Healthcare Solutions
- Specialty Pharmacy Manager (MBMNow)
- Companion Benefit Alternatives (CBA)
- Integrated Home Care Services (IHCS)

*Note: These are independent organizations that offer utilization management on behalf of BlueCross and BlueChoice.*

# EVOLENT

- Manages the following types of authorization for most plans:
  - Radiation oncology
  - Advanced radiology
  - Musculoskeletal care (MSK)
- To request an authorization:
  - Use: My Insurance Manager or visit www.RadMD.com
  - Call: 866-500-7664 for BlueCross members
  - Call: 888-642-9181 for BlueChoice® members

# AVALON HEALTHCARE SOLUTIONS

- Manages authorizations for lab services in the following settings:
  - Office
  - Outpatient facility
  - Independent laboratory
- To request an authorization:
  - My Insurance Manager
    - Use the Prior Authorization System (PAS)
  - Call: 844-227-5769
  - Fax: 813-751-3760
    - Fax form located on www.SouthCarolinaBlues.com:
      - Providers>Policies and Authorizations>Prior Authorization>Laboratory Medical Benefits

*Note: Avalon does not review requests in an emergency room, ambulatory surgery center or inpatient hospital setting.*

# MBMNOW (SPECIALTY PHARMACY)

- Manages authorizations for certain specialty medications.
  - View the available lists on www.SouthCarolinaBlues.com.
    - Providers>Specialty and Pharmacy Drugs>Specialty Medical Medications
- To request an authorization:
  - Access MBMNow through My Insurance Manager
  - Call: 877-440-0089
  - Fax: 612-367-0742

OPTUM BlueCross BlueShield of South Carolina

# COMPANION BENEFIT ALTERNATIVES

- Manages authorizations for behavioral health services.
  - Examples of services include:
    - Psychological testing
    - Behavioral health program admissions
    - Repetitive transcranial magnetic stimulation (rTMS)
- To request an authorization:
  - Visit www.CompanionBenefitAlternatives.com.
  - Call: 800-868-1032

Companion
BENEFIT ALTERNATIVES

# INTEGRATED HOME CARE SERVICES

- Manages certain authorizations for Medicare Advantage and Group and Individual plans.
- For Medicare Advantage:
  - DME in the home setting
  - Home health
  - Home infusion services
- For Group and Individual
  - DME
  - Home health
- To request an authorization:
  - Call: 844-215-4264
  - Fax: 844-215-4265
    - Include the appropriate fax form

# AUTHORIZATION RESOURCES

# STANDARD PRIOR AUTHORIZATION LIST

- BlueCross developed a standard prior authorization list.
  - www.SouthCarolinaBlues.com
    - Providers>Policies and Authorizations>Prior Authorization
- The list only applies to the following lines of business:
  - National Alliance
  - Major Group
  - Small Group and Individual
  - Planned Administrators Inc.
  - State Health Plan
- **The list is not all inclusive and is subject to change. It's a guide that includes the most requested services that require medical review for prior authorizations.**

South Carolina

SERVICES THAT REQUIRE PRIOR AUTHORIZATION
STANDARD LIST EFFECTIVE OCTOBER 2025

Many of our plans require prior authorization for certain procedures and services. This process allows us to check ahead of time whether services meet criteria for coverage by a member's health plan. Some services on this list may not be covered by the benefit plan. **Always verify benefits prior to services being rendered.**

Prior authorization is not a guarantee of payment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied.

**This list is not all inclusive and is subject to change. It is a guide that includes the most commonly requested services requiring a medical review.** Other services may require review based on our medical policies, guidelines or the employer group's plan of benefits. **Please review specific contract verbiage for exclusions, limitations and/or maximums.**

List does not apply to medical specialty drugs. To find out which medical specialty drugs require prior authorization under the medical plan or the Specialty Medical Benefit Management (SMBM) program, refer to My Insurance Manager℠.

Some plans may require prior authorization for mental health services. Contact Companion Benefit Alternatives (CBA) to verify by calling 800-868-1032. CBA is a wholly owned subsidiary of Blue Cross Blue Shield.

**Online Resources and Tools**

www.CompanionBenefitAlternatives.com
- Medical Policies
- Prior Authorization Forms and Information
- Clinical Form Resource Center

https://www.bcbs.com/blue-distinction-center/facility
- Blue Distinction Center Facility Finder

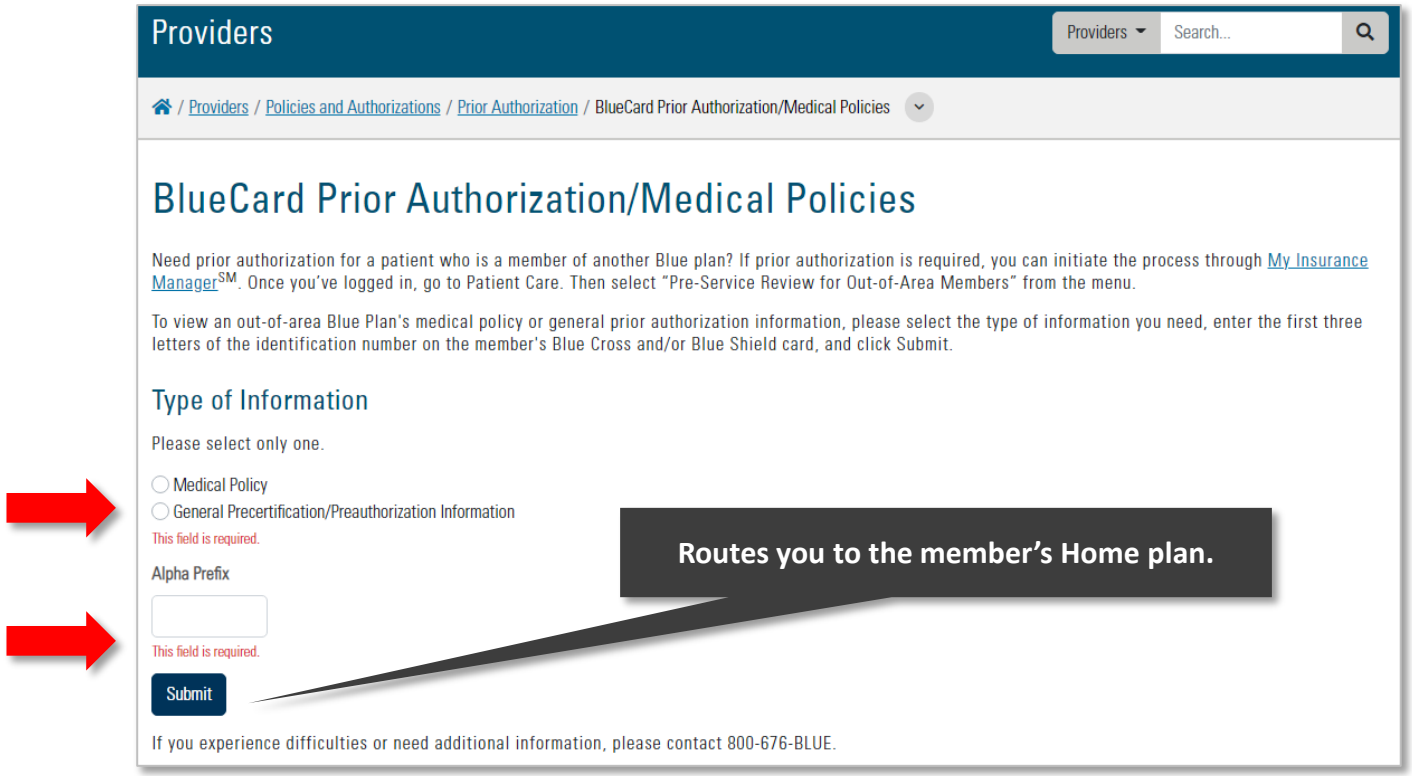
**Inpatient**
- Elective, nonemergent inpatient (surgical or nonsurgical) hospital admissions (medical and behavioral health)
- Acute rehabilitation admissions
- Hospice
- Long term acute care (LTAC) facility admissions
- Skilled nursing facility (SNF) admissions
- Residential Treatment Center (RTC) admissions

# AUTHORIZATION RESOURCES

| Plan or Vendor | Authorization Service | Web-based Requests | Telephone Requests | Fax Requests |
|---|---|---|---|---|
| BlueCross | [various] | My Insurance Manager | 800-334-7287 | |
| BlueChoice | [various] | My Insurance Manager | 800-950-5387 | |
| FEP | [various] | My Insurance Manager | 800-327-3238 | |
| State Health Plan | [various] | My Insurance Manager | 800-925-9724 | |
| Avalon | Laboratory | My Insurance Manager | 844-227-5769 | 813-751-3760 |
| CBA | • Behavioral health<br>• Substance abuse | My Insurance Manager<br>or<br>www.CompanionBenefitAlternatives.com | 800-868-1032 | |
| Evolent | • Advanced Radiology<br>• Musculoskeletal Care<br>• Radiation Oncology | My Insurance Manager<br>or<br>www.RadMD.com | BlueCross:<br>866-500-7664<br>BlueChoice:<br>888-642-9181 | 888-656-1321 |
| MBMNow | Specialty Medical Drug | My Insurance Manager | 877-440-0089 | 612-367-0742 |
| IHCS | • DME, home health and home infusion | | 844-215-4264 | 844-215-4265 |
| Cohere Health | *Platform for medical authorization requests. | My Insurance Manager | 888-787-0309 | |

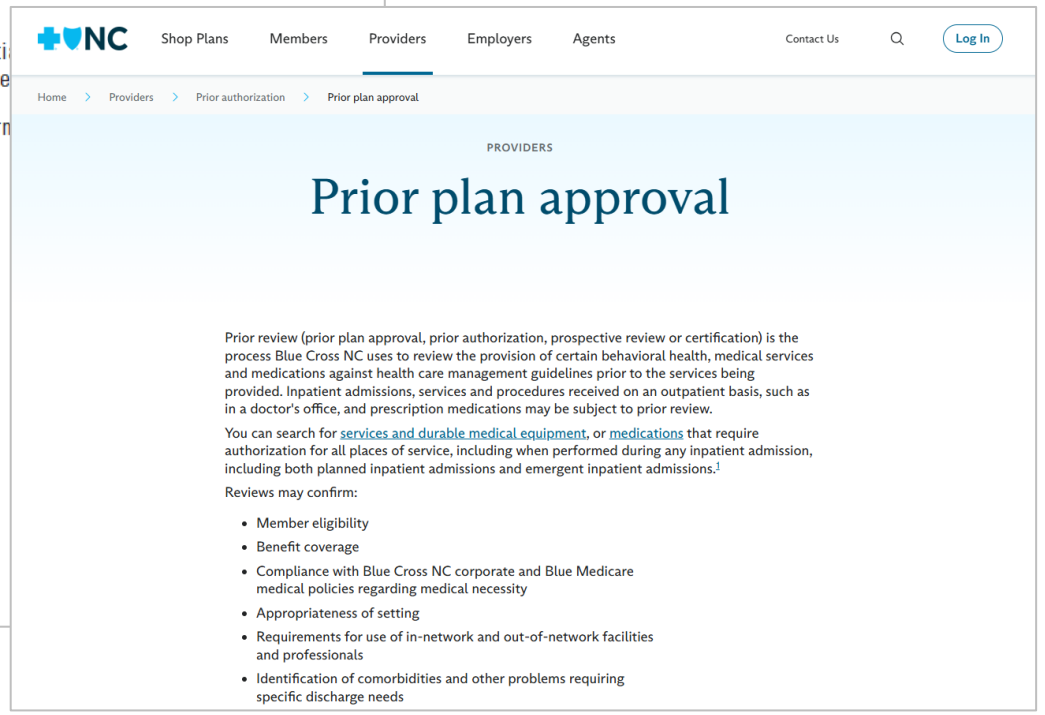
# OUT-OF-STATE MEMBER AUTHORIZATIONS

Use the BlueCard Authorization/Medical Policy tool to verify authorization requirements for out-of-state members.



# OUT-OF-STATE MEMBER AUTHORIZATIONS (CONTINUED)

Example

# PEER-TO-PEER REQUESTS

- Process to review and discuss denied prior authorizations.
  - Must be requested before submitting claims.
- Required criteria:
  - Medical necessity adverse decision was received, along with health plan denial
  - Requested within two business days of the denial for inpatient or continued stay requests OR five business days for all other denials
  - Requested prior to an authorization
- Clinical discussion:
  - Facilitated within one business day of receipt of request
  - Our medical doctor makes two attempt to contact the rendering provider
  - A decision is rendered at the end of the call

# HOW TO REQUEST A PEER-TO-PEER

## Initiating Requests and Checking Statuses

**South Carolina Website**

- Visit www.SouthCarolinaBlues.com

  Providers>Forms>Other Forms>Peer-to-Peer Request

- Enter all pertinent details (and save the document)
- Email the form to Peer.Medical@bcbssc.com or fax to 803-264-9175

**Phone (for statuses and eligibility only)**

- Call 803-264-8114

  Available Monday - Friday

  8:30 a.m. – 5:00 p.m. EST

# UTILIZATION MANAGEMENT COURTESY RE-EVALUATIONS

- Utilization management courtesy re-evaluations are permitted for denials that are due to the following:
  - No clinical information submitted
  - Insufficient clinical information submitted
- To request a courtesy review, you must:
  - Specify the request is for a re-evaluation upon submission (via fax)
  - Submit clinical documentation within five business days of the denial notice

# THANK YOU