

AUTHORIZATIONS



South Carolina

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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

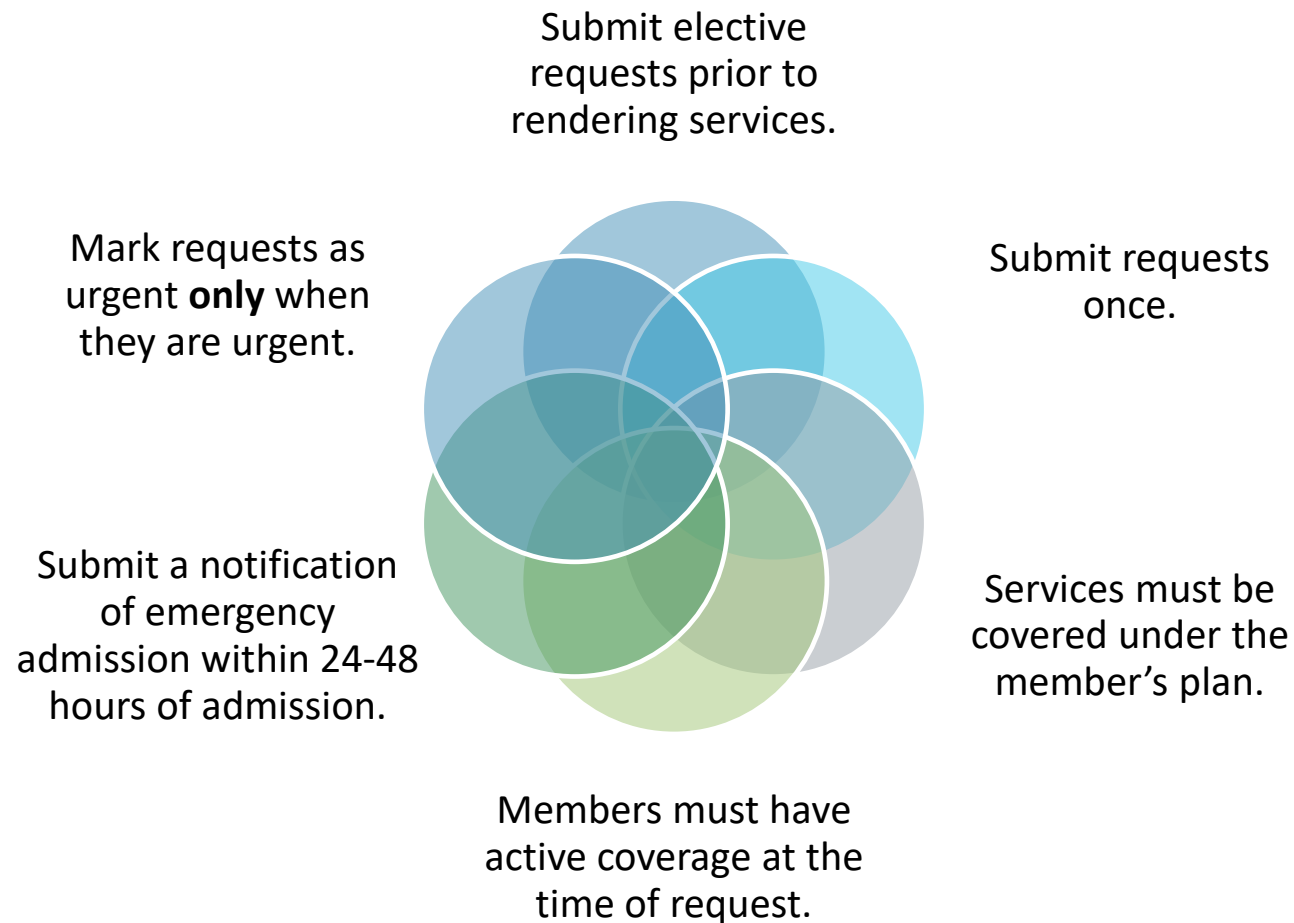
High tech imaging**

Certain medications under the medical benefit

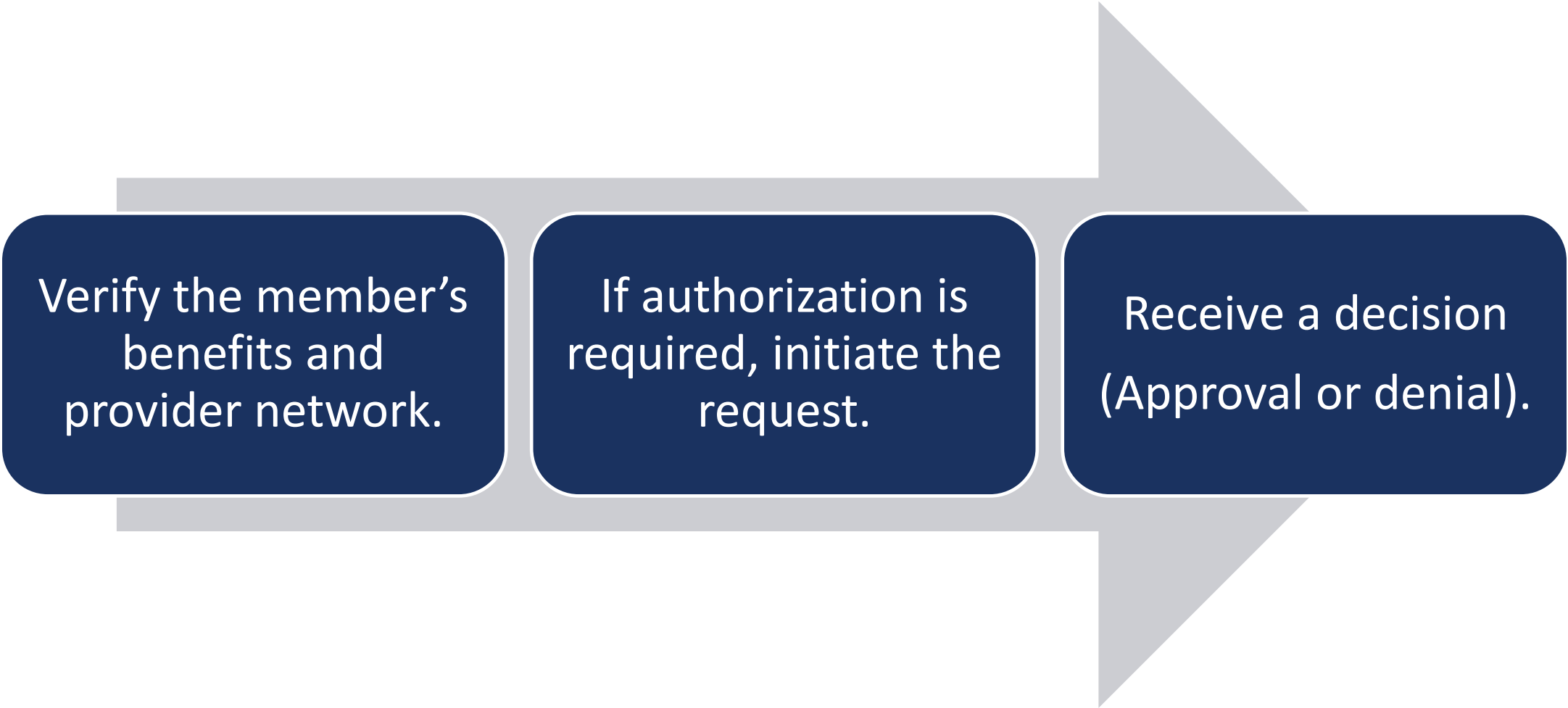
** DME dollar thresholds vary per plan but are typically \$500 or \$1,000. The threshold amounts can be lower than \$500*

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

GENERAL GUIDELINES FOR AUTHORIZATIONS



MAIN STEPS IN THE AUTHORIZATION PROCESS



Verify the member's
benefits and
provider network.

If authorization is
required, initiate the
request.

Receive a decision
(Approval or denial).

REQUIRED INFORMATION FOR AUTHORIZATIONS

Patient Details

- Name
- ID number
- Date of birth

Service Details

- CPT or HCPCS codes
- Diagnosis codes
- Date of service

Location Details

- Facility
 - Name
 - Address
 - Tax ID or NPI
- Rendering
 - Name
 - Address
 - Tax ID or NPI

Contact Information

- Phone number
- Fax number
- Email

Clinicals

- Length of issue
- Attempted treatment
- Conservative medications
- Studies (i.e., labs, imaging)



PROCESS FOR AUTHORIZATIONS



NEW PROCESS COMING SOON

- Coming soon, we will implement a new process for requesting an authorization.
- My Insurance Manager will route you to a new web-based application, powered by Cohere Health, to enhance the efficiency of prior authorization decisions.
- Benefits of the new process include:
 - Accelerates and expands real-time approvals.
 - More seamless provider experience.
 - Decreases administrative efforts.
- The authorizations process for our third-party vendors will remain the same. This includes:
 - HealthHelp
 - Evolent
 - Avalon Healthcare Solutions
 - MBMNow
- **All clinical decisions are made by BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan.**

HOW TO GET AN AUTHORIZATION

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

Health

- | | |
|-----------------------------|--|
| ▶ Authorization Extension | ▶ Patient Directory |
| ▶ Authorization Status | ▶ Pre-Certification/Referral |
| ▶ Claims Status | ▶ Superbill Maintenance |
| ▶ Eligibility and Benefits | ▶ Pre-Service Review for Out-of-Area Members |
| ▶ Institutional Claim Entry | ▶ Professional Claim Entry |
| ▶ Other Health Insurance | ▶ Verify Primary Care Physician |

Dental

- | | |
|----------------------------|---------------------------------|
| ▶ Claims Status | ▶ Patient Directory |
| ▶ Dental Claim Entry | ▶ Superbill Maintenance |
| ▶ Eligibility and Benefits | ▶ Pre-Treatment Estimate Entry |
| ▶ Other Dental Insurance | ▶ Pre-Treatment Estimate Status |

HOW TO GET AN AUTHORIZATION (CONTINUED)

- 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***.

The screenshot displays the BCBS South Carolina authorization management interface. At the top, the BCBS South Carolina logo is visible, along with the text "powered by Cohere Health". Navigation links for "Support" and "My account" are in the top right corner. A search bar labeled "Search (Patient name, Member ID, Auth ID)" is located at the top center, with a "Start auth request" button to its right. On the left side, there are two filter sections: "Health plan" with radio buttons for "All", "BCBS South Carolina" (selected), and "Humana"; and "Status" with radio buttons for "All (316)" (selected), "Upcoming (116)", "Pending review (2)", "Approved (22)", "Denied (7)", "Draft (2)", "Withdrawn (95)", and "Completed (200)". Below the filters, a "Sort by: Most recent" dropdown is present. The main content area lists three authorization entries for "Doe, John" (DOB: 01/26/1965, Member ID: 10119152022, Health plan: BCBS South Carolina). Each entry shows a table of services, procedure codes, submission dates, and dates of service. The first two entries are marked as "Approved" with a green checkmark and include a "Start continuation" link. The third entry is marked as "Draft" with a red pin icon and includes "Delete" and "Continue" links. The bottom of the screen shows the start of a fourth entry for "Doe, Jane".

HOW TO GET AN AUTHORIZATION (CONTINUED)

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

The screenshot shows a web interface for requesting an authorization. At the top, the user is identified as 'Doe, John' with a dropdown arrow and 'DOB: 09/16/1986'. The header includes the 'South Carolina' logo, 'powered by Cohere Health', and links for 'Support' and 'My account'. The main heading is 'Tell us about your request'. The form is divided into three sections: 'Request details' with radio buttons for 'Outpatient' (selected) and 'Inpatient', and a 'Start date' field set to '06/01/2024'; 'Diagnosis codes' with a 'Primary diagnosis code' field containing 'M48.06' and a search icon, and a 'Search for secondary diagnosis codes (optional)' field with a search icon; and 'Procedure codes' with a 'CPT/HCPCS codes' field containing '63047' and a search icon. At the bottom, there are three buttons: 'Save and exit', 'Cancel', and 'Continue'.

Doe, John
DOB: 09/16/1986

South Carolina | powered by Cohere Health | Support | My account

Tell us about your request

Request details

☒ Outpatient ☐ Inpatient

Start date
06/01/2024

Diagnosis codes

Primary diagnosis code
M48.06

Search for secondary diagnosis codes (optional)

Procedure codes

CPT/HCPCS codes
63047

Save and exit Cancel 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.

HOW TO GET AN AUTHORIZATION (CONTINUED)

- 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***.

The screenshot displays a web form titled "Providers" for selecting healthcare providers and facilities. It includes sections for "Care setting", "Ordering provider", "Performing or attending provider", and "Performing facility or agency", each with search fields and TIN/Address lookup buttons. Suggested results for each search are shown below the input fields.

Providers

Care setting

☒ Outpatient ☐ Inpatient

Place of service ▼

Ordering provider

Search for an ordering provider by NPI, TIN, or name 🔍

TIN 🔍 Address

+ Bailey, Christopher Eric MD

Performing or attending provider

☐ Performing is the same as the ordering

Search for a performing or attending provider by NPI, TIN, or name 🔍

TIN 🔍 Address

+ Bailey, Christopher Eric MD

Performing facility or agency

Search for a performing facility or agency by NPI, TIN, or name 🔍

TIN 🔍 Address

+ 1ST START HEALTHCARE SERVICES

[Save and exit](#)

HOW TO GET AN AUTHORIZATION (CONTINUED)

- 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***.

✓ Requires authorization

Start date: 04/30/2024 - End date: mm/dd/yyyy

Physical Therapy (PT)

Number of visits: 1

97110 Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

+ Add a procedure code

Total Knee Arthroplasty (TKA)

27447 Units: 1 Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty) Remove

+ Add a procedure code

☐ Expedite

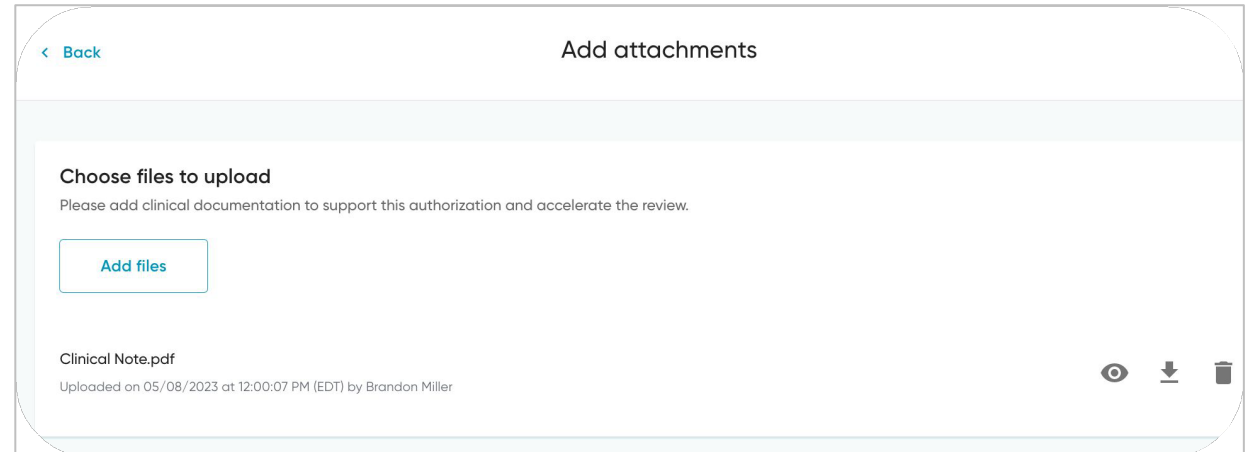
! Doesn't require authorization in most cases 93798 Download PDF

Save and exit Continue with 2 codes

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

HOW TO GET AN AUTHORIZATION (CONTINUED)

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




HOW TO GET AN AUTHORIZATION (CONTINUED)

- Review all the relevant information.
- Select ***Submit services***.

[Back](#)


Review services before submitting

 Physical Therapy (PT), Total Knee Arthroplasty (TKA)


This request duplicates an existing one

Duplicate submissions may be voided. The care setting (outpatient or inpatient), performing provider (if applicable), and facility match an existing request, including overlap in procedure codes and service dates.

You can choose to withdraw the existing request, change details to avoid duplication, or call Cohere for assistance at (833) 283-0033.

 Draft

Tracking #WKGB4665

 Delete

Details

Primary diagnosis

M25.561 - Pain in right knee

Secondary diagnosis

--

Care setting


Outpatient

Place of service

Ambulatory Surgical Center

[Save and exit](#)

[Submit services](#)



1 evidence-based suggestion to improve your request:

Expedited → Not expedited

The coverage and/or services on this request do not meet the requirements for an expedited request.

[Accept](#)

HOW TO GET AN AUTHORIZATION (CONTINUED)

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



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 CohereNext® 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>

HOW TO GET AN AUTHORIZATION (CONTINUED)

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

 South Carolina

powered by  Cohere Health

Your request has been approved

Tracking #: **NPOA6057**
Dates of service: **06/01/2024 – 09/30/2024**

Hello <user's name>,

Thank you for submitting a service request with which we have reviewed your request and it has been approved. We have made a decision (including the authorization number) in favor of your request.

View service summary

 South Carolina

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

powered by Cohere Health

We have finished processing your service request Response

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 CohereNext:® 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.

Final Determination: **Approved** Auth #: **NPOA6057** 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://cohrehealth.zendesk.com> or <https://cohrehealth.com/resources>

Note: You will also receive a notice if the request is denied.

HOW TO GET AN AUTHORIZATION (CONTINUED)

- 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.

 South Carolina

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Questions about this service?
Contact BCBS South Carolina
(800) 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

HOW TO GET AN AUTHORIZATION (CONTINUED)

- 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.

South Carolina

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Support My account

[< Back](#)

Patient summary

Start auth request

Doe, John

Member ID 10119152022

Sex

Male

DOB

01/26/1965

Age

59

Address

420 Harvard St. #301 Brookline, MA

Phone

(617) 283-4909

Preferred written language

English

PCP grouper ID

918401720

Plan

BCBS South Carolina

Membership type

Commercial

Plan type

HMO

Plan year

04/24/2024 - 04/24/2025

Spinal Fusion and Decompression

Approved

Authorization #NPOA6057 • Tracking #NPOA6057

Details

Edit

Primary diagnosis	M48.06 - Spinal stenosis, lumbar region without neurogenic claudication
Secondary diagnosis	--
Care setting	Outpatient
Place of service	Ambulatory Surgical Center
Ordering provider	Bailey, Christopher Eric MD / NPI - 1861781510 View info
Performing or attending provider	Bailey, Christopher Eric MD / NPI - 1861781510 View info
Performing facility or agency	Peachtree Orthopaedic Surgery Center / NPI - 1902861941 View info
Dates of service	06/01/2024 - 09/30/2024
Expedited	No

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

Attachments (1)

Edit

DoeJohn_ClinicalNote.pdf

Uploaded on 05/01/2024 02:39:51 PM (EST) by Connor Feick

Show clinical assessment

Requested by Connor Feick - Portal [View info](#)

Withdraw



AUTHORIZATION VENDORS



THIRD-PARTY VENDORS THAT MANAGE SELECT AUTHORIZATIONS

- HealthHelp
- Evolent
- Avalon Healthcare Solutions
- Specialty Pharmacy Manager (MBMNow)
- Companion Benefit Alternatives (CBA)

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

HEALTHHELP

- Manages authorizations for select procedures related to:
 - Musculoskeletal (MSK)
 - Procedures not currently reviewed by Evolent.
 - Cardiology
 - Surgical
 - Sleep studies
- Only applies to our Exchange plans with group numbers starting with 61, 62 and 65
- To request an authorization:
 - Use: My Insurance ManagerSM
 - Call: 833-715-2255
 - Fax: 844-470-2666



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



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





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.**



SERVICES THAT REQUIRE PRIOR AUTHORIZATION STANDARD LIST EFFECTIVE OCTOBER 2024

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 www.SouthCarolinaBlues.com or 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.SouthCarolinaBlues.com www.CompanionBenefitAlternatives.com <https://www.bcbs.com/blue-distinction-center/facility>

- Medical Policies
- Prior Authorization Forms and Information
- Clinical Form Resource Center
- Blue Distinction Center Facility Finder

Prior Authorization List Applies to the Following BlueCross Lines of Business:

- National Alliance
- Major Group Fully Insured and ASO
- Small Group and Individual
- Planned Administrators Inc (PAI)
- State Health Plan

AUTHORIZATION RESOURCES

Benefit Program	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	Avalon PAS (inside My Insurance Manager)	844-227-5769	813-751-3760
CBA	Behavioral/Substance Abuse	www.CompanionBenefitAlternatives.com	800-868-1032	
Evolut	<ul style="list-style-type: none"> • Advanced Radiology • Musculoskeletal Care • Radiation Oncology 	www.RadMD.com	BlueCross: 866-500-7664 BlueChoice: 888-642-9181	888-656-1321
MBMNow	Specialty Medical Drug	My Insurance Manager	877-440-0089	612-367-0742

OUT-OF-STATE MEMBER AUTHORIZATIONS

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

Providers Providers

[Home](#) / [Providers](#) / [Policies and Authorizations](#) / [Prior Authorization](#) / [BlueCard Prior Authorization/Medical Policies](#)

BlueCard Prior Authorization/Medical Policies

Need prior authorization for a patient who is a member of another Blue plan? If prior authorization is required, you can initiate the process through [My Insurance ManagerSM](#). Once you've logged in, go to Patient Care. Then select "Pre-Service Review for Out-of-Area Members" from the menu.

To view an out-of-area Blue Plan's medical policy or general prior authorization information, please select the type of information you need, enter the first three letters of the identification number on the member's Blue Cross and/or Blue Shield card, and click Submit.

Type of Information

Please select only one.

☐ Medical Policy

☐ General Precertification/Preauthorization Information

This field is required.

Alpha Prefix

This field is required.

If you experience difficulties or need additional information, please contact 800-676-BLUE.

Routes you to the member's Home plan.

OUT-OF-STATE MEMBER AUTHORIZATIONS (CONTINUED)

Example

BlueCard Prior Authorization/Medical Policies

Need prior authorization for a patient who is a member of another Blue plan? If prior authorization is required, you can initiate a [ManagerSM](#). Once you've logged in, go to Patient Care. Then select "Pre-Service Review for Out-of-Area Members" from the

To view an out-of-area Blue Plan's medical policy or general prior authorization information, please select the type of information and enter the first four letters of the identification number on the member's Blue Cross and/or Blue Shield card, and click Submit.

Type of Information

Please select only one.


- ☐ Medical Policy
- ☒ General Precertification/Preauthorization Information

Alpha Prefix

YPP 

Submit

If you experience difficulties or need additional information, please contact 800-676-BLUE.

Shop PlansMembersProvidersEmployersAgentsContact Us

Home > Providers > Prior authorization > Prior plan approval

PROVIDERS

Prior plan approval

Prior review (prior plan approval, prior authorization, prospective review or certification) is the process Blue Cross NC uses to review the provision of certain behavioral health, medical services and medications against health care management guidelines prior to the services being provided. Inpatient admissions, services and procedures received on an outpatient basis, such as in a doctor's office, and prescription medications may be subject to prior review.

You can search for [services and durable medical equipment](#), or [medications](#) that require authorization for all places of service, including when performed during any inpatient admission, including both planned inpatient admissions and emergent inpatient admissions.¹

Reviews may confirm:

- Member eligibility
- Benefit coverage
- Compliance with Blue Cross NC corporate and Blue Medicare medical policies regarding medical necessity
- Appropriateness of setting
- Requirements for use of in-network and out-of-network facilities and professionals
- Identification of comorbidities and other problems requiring specific discharge needs

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

