BlueCross BlueShield of Illinois

Blue Cross Community Health Plans[SM]
Utilization Management, Prior Authorization and Clinical Review Tip Sheet

Timeliness

Notification of Admission – Notification to the Plan is needed within **one** business day from admission. Friday notifications can be sent to the Plan on Monday if the facility does not have weekend Utilization Management staff available to respond to questions or requests for clinical documentation.

Turnaround Time for Urgent Cases – 48 hours (two calendar days) Blue Cross and Blue Shield of Illinois has full weekend support, which includes Medical Director support for -peer-to peer-discussions.

- Acute inpatient care is categorized as "urgent."
- Once the Plan receives notification of admission the TAT will start. (Example: Provider calls BCBSIL at 8:15 a.m. on Monday; BCBSIL will render a decision to the member prior to 8:15 a.m. on Wednesday.)
- We recommend submitting clinical documentation at the time of notification.

Turnaround Time for Standard Cases – **Four** calendar days (Example: Scheduled elective procedures.)

Clinical Documentation

Clinical documentation for prior authorization reviews handled by BCBSIL may be submitted in one of two ways:

- **Online** through Availity® Essentials using the Availity Authorizations tool
- **Fax** to BCBSIL at 312-233-4060.

If clinical information is not received timely the prior authorization may be denied for missing clinical information. A peer-to-peer review or further clinical review will not be performed at a later date if initial clinical documentation to support the admission is not received timely.

Clinical Re-review Options

If the decision rendered by the BCBSIL medical director is an adverse determination, providers have an additional **seven calendar days from the date on the notification of the adverse determination (denial letter) to schedule/complete a peer-to-peer discussion and/or to submit an updated clinical packet for review.**

Peer-to-peer discussions are allowed for requests where clinical information was submitted with the original request. If a request was denied for missing clinical information or due to failure to request prior authorization, a peer-to-peer discussion is not permitted.

Scheduling a Peer-to-peer Discussion – Providers will be notified by phone or fax of potential adverse determinations and given the deadline for completing a peer-to-peer. Providers must call 800-981-2795 to schedule a peer-to-peer discussion. Please have at least three date/time options that work for your physician before the peer-to-peer deadline when calling to schedule.

Updated Clinical Packet – If the provider wishes to forego the peer-to-peer discussion and submit an updated clinical packet for review, the BCBSIL Utilization Management team will review one packet of additional supporting documentation after the adverse determination. The clinical packet must be submitted **by fax only within seven days of the adverse determination.** The fax cover sheet must clearly identify that you are seeking a clinical re-review in lieu of a peer-to-peer discussion. Additional clinical information will not be reviewed by the utilization management team if the initial determination was an adverse determination due to failure to submit clinical information with the original request.

To schedule a peer-to-peer discussion, call 800-981-2795.

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To submit an updated clinical packet for adverse determination dispute, fax, your request with a cover sheet listing "Request for Clinical Re-Review" to 312-233-4060

Note: BCBSIL does not offer a post-service review process to review clinical documentation for providers who fail to follow the utilization management process to request a prior authorization or submit clinical information timely. The only re-review processes available are described above under Clinical Re-review Options section above and the Service Authorization Disputes section below. Both re-review processes require prior authorization/pre-notification and submission of clinical documentation.

Service Authorization Disputes

The provider service authorization dispute process occurs independently of the member appeals process. A dispute does not need to be filed prior to an appeal and does not affect any member appeal rights.

Disputes are an official challenge to the claim or prior authorization disposition due to an administrative error and are submitted by a provider when a concern about an administrative process resulted in a denial. These are generally errors on the part of the health plan but may also be due to Medicaid administration errors. Examples include:

- Being informed there is no prior authorization requirement, but then having a claim deny for no prior authorization;
- Member eligibility issues;
- Length of stay or date of service change for an authorized service;
- Evidence of submitted faxes/clinical information that BCBSIL did not receive.

If there is no evidence of a process issue that resulted in the denial, the denial will be upheld and not undergo medical necessity review.

If there was a failure in the administrative process as described above that resulted in a denial, the request will be reviewed for medical necessity.

- If the case is deemed medically necessary, it will be overturned and effectuated.
- If the case is deemed not medically necessary, it will be upheld, and a letter will be sent to the provider.

The Medicaid Service Authorization Dispute Resolution Request Form can be submitted by fax to 312-653-9443.

Checking eligibility and benefits and/or obtaining prior authorization is not a guarantee of payment of benefits. Payment of benefits is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, supporting medical documentation, and other terms, conditions, limitations, and exclusions set forth in the member's policy certificate and/or benefits booklet and or summary plan description. Regardless of any prior authorization or benefit determination, the final decision regarding any treatment or service is between the patient and their health care provider.

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