BlueCross BlueShield of Illinois

Blue Cross and Blue Shield of Illinois
Provider Manual

# Health Care Medical Management



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

The intent of the Blue Cross and Blue Shield of Illinois (BCBSIL) Medical Management Department is to help ensure our members have access to affordable, quality health care. Our programs are designed to promote the optimal use of health care resources to improve health care outcomes. We believe the efficient and effective use of health care service results in quality health care outcomes. We use various resources, including MCG™ care guidelines, which are evidence and consensus-based guidelines to support effective care and efficient resource utilization. BCBSIL meets the Blue Cross Association Consortium, National Committee for Quality Assurance (NCQA). As of April 6, 2022, the organization withdrew from the URAC HUM program.

### Medical Management Accessibility

You may contact Medical Management at 800-572-3089 from 8 a.m. to 5 p.m. (CT), Monday through Friday. The hours for prior authorization requests are 7 a.m. to 7:30 p.m. (CT), Monday through Friday; and 7am-4:30 p.m. (CT) on weekends and holidays.

- Outside of regular business hours, calls are received through a contracted answering service.
- BCBSIL provides Telecommunication Device for Deaf (TDD)/Text Telephone (TTY) services and language assistance for incoming callers.
- Toll-free and collect calls are accepted throughout Illinois and all states within the Continental U.S., as well as Alaska and Hawaii.
- An Automated Call Directing (ACD) system allows callers using touch-tone phones to self-direct to the appropriate area. Medical Management personnel will refer the caller or transfer the call to other appropriate departments as needed.
- Outbound calls to members and/or their authorized representatives, providers and vendors will be made during normal business hours.
- Service calls and messages are often responded to immediately during working hours, but no later than within one business day after receipt of a message.

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| Medical Management does not make determinations about whether services are medically appropriate. Medical Management reviews whether benefits are available. The final determination about what treatment or services should be received is between the patient and their health care provider. |

## Utilization Management (UM)

Based in part on industry and national standard of care guidelines, the UM program helps identified members receive benefits for the appropriate level of care in the most cost-effective setting, through short-term discharge planning, facilitating transitions between levels of care or pre-admission and post-discharge calls. For additional information, you may refer to the Health Care Delivery Utilization Management and Reference policies and procedures located in the BCBSIL Provider Manual section on our Provider website.

### UM Clinical Review Criteria

Utilization management reviews use evidence-based clinical standards of care to help determine whether a benefit may be covered under the member's health plan. To view UM clinical review criteria that may apply, refer to the Prior Authorization Support Materials (Commercial) page in the Utilization Management section of our Provider website.

### UM Affirmation Statement

BCBSIL distributes an affirmation statement to all staff and practitioners involved in UM decision-making, affirming that:

- UM decisions are based on medical necessity, as defined in the member's benefit plan, which takes into consideration appropriateness of care and services, and the existence of available benefits.
- The organization does not reward health plan staff, providers or other individuals for issuing adverse determinations of coverage, care or service.
- Incentive programs are not utilized to encourage decisions that result in underutilization.

## Types of UM Review

Types of utilization management review that may be conducted before services are rendered include **prior authorization**, and **pre-notification**. Utilization management also may include **post-service review**. Recommended Clinical Review (predetermination) may be managed within UM dept personnel scope but is functionally separate from Utilization Management Review. These reviews use evidence-based clinical standards of care to help determine whether a benefit may be covered under the member's health plan.

An overview of prior authorization recommended clinical review (predetermination) and pre-notification guidelines and related information is included below as a reminder of definitions and important details. Special processes for out-of-area Blue Plan, Federal Employee Program® (FEP®) and government programs [Blue Cross Medicare Advantage PPO℠ (MA PPO), Blue Cross Medicare Advantage HMO℠ (MA HMO), Blue Cross Community Health Plans℠ (BCCHP℠) and Blue Cross Community MMAI (Medicare-Medicaid Plan)℠] members are referenced later in this section. For more information, refer to the Utilization Management section of our website at bcbsil.com/provider. Also watch our *Blue Review* and News and Updates for important announcements.

## Prior Authorization

**Prior authorization (also called benefit pre-certification or preauthorization)** is the process of determining whether the proposed treatment or service meets the definition of "medically necessary" as set forth in the member's benefit plan, by contacting BCBSIL or the appropriate benefit prior authorization vendor for prior approval of services.

Remember, member benefits and review requirements will vary based on service/drug being rendered and individual/group policy elections. **Always check eligibility and benefits first,** via Availity® Essentials or your preferred web vendor, prior to rendering care and services. In addition to verifying membership/coverage status and other important details, **this step returns information on prior authorization requirements and utilization management vendors, if applicable.**

**Verification of benefits and/or approval of services after prior authorization are 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 as well as any pre-existing conditions waiting period, if any, at the time services are rendered.**

### Prior Authorization for Inpatient and Ancillary Medical Services

Most of our PPO member contracts require that prior authorization is requested from BCBSIL or the prior authorization vendor, if applicable, for the following services:

- Inpatient hospital admission and rehabilitation
- Inpatient Skilled Nursing Facility admission
- Long-term acute care
- Coordinated home health care.
- Inpatient hospice (some employer groups)
- Residential Treatment Center (RTC) admission
- Partial Hospitalization Program (PHP) admission

Many employer groups also require prior authorization for Private Duty Nursing, certain intravenous (IV) medication and certain outpatient services. When eligibility and benefits are verified, providers will be able to determine if a group requires prior authorization for outpatient services.

### Prior Authorization for Outpatient Medical/Surgical Services

There may be general categories of covered services that require prior authorization.

To determine whether a specific service may require prior authorization, always check eligibility and benefits first via Availity or your preferred web vendor. This step returns important information, including prior authorization requirements and utilization management vendors, if applicable.

Refer to our Prior Authorization Support Materials (Commercial) page for more information, such as prior authorization code lists and links to our digital lookup tool, which allows you to conduct a search by service, code or category. These resources are updated when services are added, replaced or removed.

If you have questions, call the Customer Service number on the member's BCBSIL ID card. You can use our automated phone system to check eligibility and benefits, determine if prior authorization is required, and initiate the prior authorization process, if applicable.

## Time Frames

Prior authorization for elective or non-emergency admissions/selected outpatient services is required prior to admission or the treatment start date. Specific time frames for prior authorization may vary according to the member's benefit plan. To help ensure clinical review and determination in time for the member's elective or non-emergency service, requesting prior authorization is recommended at least two weeks prior to the scheduled service or as early as possible.

For an emergency admission, notification should take place as soon as possible.

## Responsibility for Prior Authorization

Unless the member's plan states otherwise, the provider is responsible for obtaining prior authorization for inpatient and outpatient, facility and professional services, in those circumstances where authorization may be required. If prior authorization is not obtained and the services are denied as not medically necessary, the service or drug may not be covered consistent with the member's benefits and/or the ordering or servicing in-network provider may be held responsible for any associated charges and may not balance bill the member.

Most out-of-network services require utilization management review. Except for emergency services, if a provider or member does not obtain prior authorization for services from out-of-network providers and out-of-state Blue Cross and Blue Shield (BCBS) participating providers, the claim may be denied or may be subject to post-service medical necessity review.

Note: The Host BCBS Plan's participating provider is required to obtain prior authorization for inpatient facility services for BlueCard® out-of-area members. For more information, refer to the Utilization Review section of the BlueCard Program Provider Manual, located in the Standards and Requirements section of our website.

## How to Obtain Prior Authorization

Some requests are handled by BCBSIL; others are handled by utilization management vendors. As noted above, when you check eligibility and benefits, in addition to confirming if prior authorization is required, you'll also be directed to the appropriate vendor, if applicable. ***Note:*** *This information does not apply to services for our HMO members where prior authorization (for medical necessity under the applicable benefit plan) is performed by the member's medical group.*

BCBSIL has contracted with Carelon formerly known as AIM Specialty Health® (AIM) to provide certain utilization management services for select outpatient molecular and genomic testing, outpatient radiation therapy, advanced imaging, musculoskeletal and cardiology procedures for some BCBSIL members with the commercial PPO products/networks listed below:

- PPO (PPO)
- Blue Choice Preferred PPO℠ (BCE)
- Blue Choice PPO℠ (BCS)
- Blue Options℠/BlueChoice Options℠ (BCO)
- High Performance Network (HPN)

**Always check eligibility and benefits first,** via Availity or your preferred web vendor, prior to rendering care and services. In addition to verifying membership/coverage status and other important details, this step returns information on prior authorization requirements and utilization management vendors, if applicable.

**For prior authorization requests handled by BCBSIL:**
There are three ways to initiate your request.

- **Online (Availity Authorizations Tool) –** Registered Availity users may use the Availity's Authorizations tool (HIPAA-standard 278 transaction). For instructions, refer to the Availity Authorizations User Guide.
- **Online (BlueApprovR℠) –** Registered Availity users may access BlueApprovR via a single-sign-on process on the Availity portal. This user-friendly tool helps expedite the process. It also allows you to attach medical records, check approval status and view history of your request. For more information, including a user guide, refer to our BlueApprovR page.
- **By phone –** Call the prior authorization number on the member's ID card.

If the member's ID card is not available, providers may call the Customer Care Call Center (CCCC) at 800-572-3089 or the BCBSIL Provider Telecommunications Center (PTC) at 800-972-8088; upon verification of eligibility and benefits, you will be advised on how to proceed.

**For prior authorization requests handled by Carelon formerly known as AIM:**
There are two ways to submit your request to Carelon formerly known as AIM.

- **Online** – The Carelon (AIM) ProviderPortal is available 24x7.
- **Phone** – Call the Carelon (AIM) Contact Center at 866-455-8415, Monday through Friday, 6 a.m. to 6 p.m., CT; and 9 a.m. to noon, CT on weekends and holidays.

## Prior Authorization Exceptions

### HMO Members

BCBSIL has delegated medical management and prior authorization for the HMO products (HMO Illinois®, Blue Advantage HMO℠, Blue Precision HMO℠, BlueCare Direct HMO℠ and Blue Focus Care HMO℠) to the medical groups (MGs) and Independent Practice Associations (IPAs). Services provided to HMO members must have prior MG/IPA approval to be eligible for benefits.

### Behavioral Health (Mental Health and Substance Abuse)

BCBSIL manages benefits for behavioral health care services for most PPO and Blue Choice PPO members; however, some employer groups are managed by other behavioral health vendors. For details, including prior authorization guidelines, refer to the Behavioral Health Program section of our website.

#### Government Programs

For information on prior authorization requirements for non-emergency services provided to Government Programs members (MA PPO, MA HMO, BCCHP and MMAI), refer to the corresponding Provider Manual. You may also call the appropriate number on the member's BCBSIL ID card.

Medical necessity, as defined in the Member Handbook, must be determined before a prior authorization number will be issued. Claims received that do not have a prior authorization number may be denied. Independently contracted providers may not seek payment from the MA PPO, MA HMO, BCCHP and MMAI member when services are deemed not to meet the medical necessity definition in the Member Handbook and the claim is denied.

#### BlueCard Out-of-area Members

An online "router" tool is available to help you locate Plan-specific prior authorization/pre-certification and medical policy information for out-of-area Blue Plan members. Look for the Pre-cert Router (out-of-area) link under the Claims and Eligibility tab on our website at bcbsil.com/provider. When you enter the three-character prefix from the member's ID card, you will be redirected to the appropriate Blue Plan's website for more information. Predetermination of benefits requests for members with Blue Plan benefits in another state should be sent to the Plan indicated on the member's ID card. For additional information, refer to the BlueCard Program Provider Manual.

#### Federal Employee Program (FEP) Members

For FEP members, you must contact the local Blue Plan where services are being rendered for prior authorization, regardless of the state in which the member is insured. A predetermination of benefits review is required for the following services: outpatient/inpatient surgery for morbid obesity; outpatient/inpatient surgical correction of congenital anomalies; and outpatient/inpatient oral/maxillofacial surgical procedures needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth.

## Recommended Clinical Review (Predetermination)

**For commercial non-HMO members,** providers have the option of submitting a **r**ecommended clinical review (predetermination) request, which is a pre-service review of medical necessity for services that are not listed on prior authorization lists. Recommended Clinical Review can help identify services that may not be medically necessary and help reduce unnecessary denials based upon post-service medical necessity reviews.

- There is no reimbursement penalty if a provider does not elect to request recommended clinical review, unless the services are subsequently determined not to be medically necessary.

- BCBSIL will review the request to determine if it meets required BCBSIL Medical Policy, American Society of Addiction Medicine (ASAM), or MCG™ Care Guidelines criteria before services are provided.
- Once a Recommended Clinical Review has been completed, the same services will not be reviewed for medical necessity again on a retrospective basis absent extenuating or special circumstances, and consistent with the member's benefit plan.
- Providers will be notified of the results of the Recommended Clinical Review and may have the opportunity to appeal on behalf of the member if the recommended clinical review determination indicates that the proposed service does not meet medical necessity criteria.
- Submitted claims for services not included as part of a request for recommended clinical review, may be reviewed retrospectively for medical necessity.

BCBSIL's Medical Policies are accessible online in the Standards and Requirements section of our Provider website.

To determine if a recommended clinical review (predetermination) is available for a specific service, refer to our Medical Policy Reference List. This list is located on our Recommended Clinical Review (Predetermination) page, under the Related Resources. The list is updated when new services are added or when services are removed.

**Note: A recommended clinical review (predetermination) approval does not guarantee payment for services. Providers should also verify eligibility and benefits since benefits are also subject to eligibility and coverage limitations at the time services are rendered.**

**How to Submit a Recommended Clinical Review (Predetermination) Request**
If you've decided you'd like to obtain a recommended clinical review (predetermination), there are two ways to submit your request:

- **Online** – Use the Availity Attachments tool to quickly submit recommended clinical review (predetermination) requests to BCBSIL via the Availity Portal. For navigation tips, see our Electronic Recommended Clinical Review (Predetermination) User Guide. ***Electronic options are preferred to help expedite your request.***
- **By Fax** – If you don't have online access, you may download, complete and fax the Recommended Clinical Review Request (Predetermination) Form to BCBSIL, along with necessary supporting documentation. ***Please note that faxed documents do not enter our system immediately.***

**Note:** The recommended clinical review (predetermination) process is not available for government programs (MA PPO, MA HMO, BCCHP, MMAI) members or any of our commercial HMO members (HMO Illinois, Blue Advantage HMO, Blue Precision HMO, BlueCare Direct HMO, Blue Focus Care HMO),

## Pre-notification

Generally, pre-notification is the process by which BCBSIL is typically alerted before a member undergoes a course of care such as a hospital admission or a complex diagnostic test.

**Pre-notification may be required for some members/services, as specified by the member's benefit plan.**
For example:

- Pre-notification **through BCBSIL** may be required for **maternal delivery** and some **dialysis** services.
- Pre-notification through **a vendor** may be required for **advanced imaging**, as outlined below.

**Always check eligibility and benefits first,** via Availity or your preferred web vendor, prior to rendering care and services. In addition to verifying membership/coverage status and other important details, this step returns information on prior authorization or pre-notification requirements and utilization management vendors, if applicable.

**Radiology Quality Initiative (RQI) Pre-notification Program**
**Carelon formerly known as AIM Specialty Health (AIM)** administers the RQI Program for BCBSIL. Obtaining an RQI number through Carelon is required, prior to ordering non-emergent advanced imaging services (CT/CTA scans, MRI/MRA scans, Nuclear Cardiology studies, PET scans) for **some** BCBSIL members.

**Exceptions:**

- Obtaining RQI numbers for Blue Choice Options℠ and Blue Choice Select PPO℠ members is *not* required.

- Obtaining an RQI number for HMO and government programs members is *not* required.
- **Certain employer groups may require prior authorization or pre-notification through other vendors for advanced imaging services.** Always check eligibility and benefits first, as noted above. If you have any questions, call the number on the member's BCBSIL ID card.

Compliance with the RQI program is required for the outpatient diagnostic non-emergency imaging services listed below when performed in a physician's office, the outpatient department of a hospital or a freestanding imaging center:

- CT scans
- CTA scans
- MRI, MRS, MRA scans
- Nuclear cardiology studies
- PET scans and Breast MRI (must meet medical policy criteria)

The RQI number is not required when the place of service is a hospital (inpatient), emergency room, urgent care, immediate care center or during a 23-hour observation period. The ordering physician must prospectively obtain the RQI number. The performing imaging provider cannot obtain an RQI number but should verify that an RQI number was issued prior to performing the service. Hospitals have access to the Carelon (AIM) website to verify the RQI by entering the member's name and identification number. Facilities may not obtain an RQI on behalf of ordering physicians.

To obtain an RQI number, the physician may access the Carelon (AIM) website at carelon.com or contact the Carelon (AIM) Call Center at 800-455-8415. The RQI is valid for 30 days. There is no grace period if the service is not performed.

In addition to BCBSIL, other BCBS Plans may also have radiology management programs that are tied to member benefits. Therefore, it is important to check benefits for out-of-area BCBS members prior to rendering services. For additional information, refer to the BlueCard Program Provider Manual.

**Please note that the fact that a guideline is available for any given treatment, or that a service has been prior authorized or an RQI number has been issued is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage, including, but not limited to, exclusions and limitations applicable on the date services were rendered.**

## Wellbeing Management Programs

Our Wellbeing Management and other health condition management programs take a more comprehensive approach to improving health outcomes and delivering cost savings through holistic health management, expanded utilization management, and increased digital engagement strategies.

- **Holistic Health Management:** This approach proactively engages the highest-risk, highest-cost members to ensure continuity and consistency of care. This clinical model is designed to address the problems and silos of traditional, episodic care management by offering a more comprehensive approach to preventive care, complex/chronic care management, and life-long wellness.
- **Expanded Utilization Management:** A more rigorous UM approach for inpatient, outpatient, and pharmacy services to align with evolving industry best practices regarding misuse and overuse. This pinpointed approach can help generate hard dollar savings for our clients and members.
- **Increased Digital Engagement Strategies:** Personalized engagement strategies meet members where they are and engage them through a variety of convenient channels, including the ability to engage with a health advisor beyond traditional telephonic channels or access to increased self-management resources and tools.

## Holistic Health Management Program

As part of our Holistic Health Management Program, formerly known as our Case Management (CM) Program, CM services are available for many PPO and Blue Choice PPO members. These services help to facilitate benefits for clinically appropriate care. Case management is a collaborative process that assesses plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual's health needs using communication and available resources to promote quality and a cost-effective outcome.

Holistic Health Management provides education and assistance for members with chronic medical conditions. Assistance may include, but is not limited to, unexpected catastrophic occurrences, psychosocial issues, and proactive management of anticipated medical management situations.

The objectives of the Holistic Health Management Program are designed to provide an individualized approach to managing the member's health care needs. The program is an effort to:

- Coordinate medically necessary health care services in a manner that enhances the member's quality of life.
- Coordinate medically necessary health care services that promote high quality, cost-effective services in a manner that achieves better outcomes.
- Involve the member or an authorized representative and the health care team in the development of a plan of care.
- Provide member and family education regarding the patient's benefits, disease process and choices regarding services including the right to refuse services.
- Offer support services and assist the member with the monitoring of his or her condition in an effort to prevent complications.
- Protect the welfare and safety of members and Case Management Coordinators
- Increase member and provider satisfaction by providing excellent customer service.
- Evaluate results of member and practitioner surveys annually and develop processes to improve as indicated.
- Establish guidelines for reasonable CM caseload and maintain an adequate number of Case Management Coordinators to provide optimum service for the population served.

CM referrals may originate from a member, their family, physician, employer, hospital discharge planner, Integrative Predictive Modeling, Condition Management/Wellness, Utilization Management, an account executive, private duty nurse or other provider of services. All Case Management Coordinators performing Case Management functions are Registered Nurses in the State of Illinois with current unrestricted licensure, with a minimum of three years clinical practice experience and one year minimum of Health Insurance/Managed Care experience *preferred* and practice Case Management within the scope of their licensure (based on the standards of the discipline).

For additional information providers may contact a BCBSIL Case Manager by calling 888-978-9034.

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| The health condition management programs referenced here are not a substitute for the sound medical judgment of a member's doctor. The final decision regarding any treatment or services is between the patient and their health care provider. |