Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

BCN Referral and Authorization Requirements

Plan notification, authorization and referral requirements

For members with BCN HMO℠ (commercial), BCN Advantage℠ HMO-POS and BCN Advantage℠ HMO products

For more complete information about plan notification, authorization and referral requirements, refer to the *BCN Provider Manual*.

BCN's Utilization Management department hours:
Monday through Thursday 8:30 a.m. to 12 noon and 1 p.m. to 5 p.m.
Friday 9:30 a.m. to 12 noon and 1 p.m. to 5 p.m.
Telephone: 1-800-392-2512

BCN's Behavioral Health department hours:
Monday through Friday 8 a.m. to 5 p.m.
Telephone – BCN HMO: 1-800-482-5982
Telephone – BCN Advantage: 1-800-431-1059

OUT-OF-STATE SERVICES: Authorization and referral requirements for out-of-state services may vary from those outlined in this document. For information on requirements for out-of-state services, contact BCN's Utilization Management department at 1-800-392-2512.

For all services, noncontracted providers and providers who are not part of the designated network associated with the member's plan must obtain authorization from the BCN's Utilization Management department.

>> FOR MEDICATIONS COVERED UNDER THE MEDICAL BENEFIT, SEE THE MEDICAL BENEFIT DRUGS – PHARMACY PAGE <<

Section 1: Plan notification and authorization requirements

Plan notification alerts BCN to a scheduled service and is used for claims processing purposes. BCN does not perform clinical review on services that require plan notification only. Plan notification must be submitted prior to services being rendered. **Authorization** determinations are conducted for benefit determination or the application of medical necessity criteria or both. Authorization requests must be submitted at least 14 business days prior to services being rendered. **Note:** This list is not all-inclusive. See also the notes at the end of Section 1. **In addition,** authorization of a service by BCN's Utilization Management department based on the clinical information provided does not guarantee payment. When the claim for the service is submitted, it may be subject to edits including, but not limited to, diagnosis, frequency and dose. The outcome of those edits may override the initial authorization.

Note: As a rule, physicians must follow the authorization requirements that apply to the region in which the headquarters for their medical care group is located.

Service	Requirements
Abdominoplasty	Authorization is required for all members. Must complete the **abdominoplasty questionnaire**.
Ambulance, air	- For BCN HMO (commercial) members: For non-emergency flights only, authorization is required from Alacura Medical Transport Management for dates of service on or after April 2, 2018. Fax the **Air ambulance flight information (non-emergency) form** to Alacura at 1-844-608-3572. Then call Alacura at 1-844-608-3676 to get the authorization number. Review the form for additional information, including the definition of a non-emergency flight. Emergency flights do not require authorization. - For BCN Advantage members: Authorization is not required, for either emergency or non-emergency flights.
Arthroscopy, knee	Authorization is required for all members. Must complete the appropriate **knee arthroscopy questionnaire**.
Autism treatment: applied behavior analysis	Contact BCN's Behavioral Health department for authorization. Evaluation at an autism evaluation center approved by Blue Cross / BCN is required, with BCN notified prior to the evaluation. Does not apply to members with BCN Advantage products.
Autism treatment: PT-OT-ST services	See entry for physical / occupational / speech therapy in this section.
Bariatric surgery	Authorization is required for all members.
Biofeedback for urinary incontinence and chronic constipation	Authorization is required for all members. Attach all pertinent clinical information to the request in the e-referral system. Note: BCN's Utilization Management staff, not the Behavioral Health staff, make the determination on the request. Biofeedback is not covered for behavioral health diagnoses.
Blepharoplasty and repair of brow ptosis	Authorization is required for all members. Must complete the **questionnaire for blepharoplasty and repair of brow ptosis**.
Bone anchored hearing aid	Authorization is required for all members.
Breast biopsy, excisional	Authorization is required for all members. Must complete the **breast biopsy (excisional) questionnaire**.
Cardiac rehabilitation	Authorization is required for all members.
Cardiology procedures See also: Coronary computed tomography-angiography (CCTA)	Select cardiology procedures require authorization by AIM Specialty Health® for members of all ages when performed in freestanding diagnostic facilities, outpatient hospital settings, ambulatory surgery centers and physician offices.This applies to BCN HMO (commercial) and BCN Advantage members for dates of service on or after Oct. 1, 2018. Refer to the **list of procedure codes that require authorization by AIM.** Note: eviCore healthcare processes these requests for dates of service prior to Oct. 1, 2018, including postservice requests.
Cervical spine surgery	Authorization is required for all members effective Oct. 3, 2016. Must complete the appropriate **cervical spine surgery questionnaire**.

BCN Referral and Authorization Requirements

For all services, noncontracted providers and providers who are not part of the designated network associated with the member's plan must obtain authorization from the BCN Utilization Management department.

Section 1: Plan notification and authorization requirements

Plan notification alerts BCN to a scheduled service and is used for claims processing purposes. BCN does not perform clinical review on services that require plan notification only. Plan notification must be submitted prior to services being rendered. **Authorization** determinations are conducted for benefit determination or the application of medical necessity criteria or both. Authorization requests must be submitted at least 14 business days prior to services being rendered. **Note:** This list is not all-inclusive. See also the notes at the end of Section 1. **In addition,** authorization of a service by BCN's Utilization Management department based on the clinical information provided does not guarantee payment. When the claim for the service is submitted, it may be subject to edits including, but not limited to, diagnosis, frequency and dose. The outcome of those edits may override the initial authorization.

Note: As a rule, physicians must follow the authorization requirements that apply to the region in which the headquarters for their medical care group is located.

Service	Requirements
Chiropractic services (spinal manipulations)	- For BCN HMO (commercial) members with a primary care physician in the East or Southeast region, the primary care physician must submit a global referral. No global referral is required outside of those regions. The chiropractor must submit a plan notification, which is required even for members whose coverage allows self-referrals. - For BCN Advantage members, no global referral is required in any region but the primary care physician must submit a plan notification.
Cholecystectomy, laparoscopic	Authorization is required for all members effective Dec. 5, 2016. Providers must complete the **laparoscopic cholecystectomy questionnaire**.
Cognitive therapy	Authorization is required for all members.
Colonoscopy – virtual	Authorization is required for all members.
Coronary computed tomography-angiography (CCTA)	This cardiology procedure requires authorization by AIM Specialty Health® for members of all ages when performed in freestanding diagnostic facilities, outpatient hospital settings, ambulatory surgery centers and physician offices.This applies to BCN HMO (commercial) and BCN Advantage members for dates of service on or after Oct. 1, 2018. Refer to the **list of procedure codes that require authorization by AIM.** Note: eviCore healthcare processes these requests for dates of service prior to Oct. 1, 2018, including postservice requests.
Cosmetic surgery See also: Abdominoplasty; blepharoplasty and repair of brow ptosis; otoplasty; and rhinoplasty	Authorization is required for all members.
Cranial neurostimulator pulse generator (deep brain stimulation), insertion or replacement	Authorization is required for all members for dates of service on or after Jan. 1, 2018. Must complete the **deep brain stimulation questionnaire**.
Dental services	Authorization is required for all members.
Developmental delay treatment	Authorization is required for all members.
Diabetic supplies	Authorization is required for all members. Must contact J & B Medical Supply to review all requests for diabetic and insulin pump supplies (1-888-896-6233). Exception: Diabetic shoes and inserts are handled by Northwood for dates of service on or after June 1, 2018. See "DME and P&O."
Diagnostic and therapeutic tests	A global referral is required for BCN HMO members in the East and Southeast regions; for all other members, including BCN HMO members in the Mid, West and Upper Peninsula regions, no plan notification or authorization is required. No plan notification or authorization is required for members with BCN Advantage HMO-POS. Note: For University of Michigan Premier Care, Premier Care 65 and GradCare members, and for members with MSU products and Blue Cross® Metro Detroit HMO, BCN Local Network℠ Southeast, BCN Local Network℠ West, BCN Advantage℠ HMO ConnectedCare, BCN Advantage℠ HMO MyChoice Wellness, BCN Advantage℠ HMO HealthySaver and BCN Advantage℠ HMO HealthyValue coverage, see exceptions to the general rule in Section 2: Referral requirements.
DME and P&O	Authorization is required for all members. Call Northwood at 1-800-393-6432 to identify a contracted supplier. The supplier submits the request to Northwood for review. Note: As a general rule, outpatient diabetic supplies are not provided through the Northwood network. Exception: Northwood provides diabetic shoes and inserts for dates of service on or after June 1, 2018.
Elective termination of pregnancy	Authorization is required for all members.
Electroconvulsive therapy	Authorization is required for all members.
Endometrial ablation (in office only)	Authorization is required for all members. Must complete the **endometrial ablation questionnaire**.

BCN Referral and Authorization Requirements

For all services, noncontracted providers and providers who are not part of the designated network associated with the member's plan must obtain authorization from the BCN Utilization Management department.

Section 1: Plan notification and authorization requirements

Plan notification alerts BCN to a scheduled service and is used for claims processing purposes. BCN does not perform clinical review on services that require plan notification only. Plan notification must be submitted prior to services being rendered. **Authorization** determinations are conducted for benefit determination or the application of medical necessity criteria or both. Authorization requests must be submitted at least 14 business days prior to services being rendered. **Note:** This list is not all-inclusive. See also the notes at the end of Section 1. **In addition,** authorization of a service by BCN's Utilization Management department based on the clinical information provided does not guarantee payment. When the claim for the service is submitted, it may be subject to edits including, but not limited to, diagnosis, frequency and dose. The outcome of those edits may override the initial authorization.

Note: As a rule, physicians must follow the authorization requirements that apply to the region in which the headquarters for their medical care group is located.

Service	Requirements
Endoscopy, upper gastrointestinal, for gastroesophageal reflux disease	Authorization is required for all members for dates of service on or after Jan. 1, 2018. Must complete the **endoscopy for GERD questionnaire**. For the pertinent diagnosis codes, see the footnote attached to the list of procedure codes in Section 3 of this document.
Endovascular intervention, peripheral artery	Authorization is required for all members for dates of service on or after Jan. 1, 2018. Must complete the **endovascular intervention questionnaire**.
Experimental and investigational	Authorization is required for all members.
Gastric stimulation	Authorization is required for both BCN HMO (commercial) and BCN Advantage members. Must complete the **gastric pacing / stimulation questionnaire** for BCN Advantage members only, for dates of service on or after Jan. 1, 2018.
Hammertoe surgery	Authorization is required for all members for dates of service on or after Jan. 1, 2018, for certain diagnosis codes. Must complete the **hammertoe surgery questionnaire**. For the pertinent diagnosis codes, see the footnote attached to the list of procedure codes in Section 3 of this document.
Home health care	Authorization is required for UAW Retiree Medical Benefits Trust members. For all other members, no plan notification or authorization is required.
Home TPN and enteral feedings	Authorization is required for all members.
Hyperbaric oxygen therapy	Authorization is required for all members.
Infertility procedures	Authorization is required for all members.
Inpatient admissions	Authorization is required for all members. This includes for long-term acute care, inpatient rehabilitation and skilled nursing care. Providers should notify BCN of all emergency admissions within 1 business day.
Intensive outpatient therapy (mental health / substance use disorders)	Authorization is required for all members.
Joint replacement (initial or revision), total – hip or knee	Authorization is required for all members, for both an initial replacement (effective Oct. 3, 2016) and a revision (effective Jan. 1, 2018). Must complete the **appropriate questionnaire**.
Joint replacement (initial), total – shoulder	Authorization is required for all members (effective Oct. 3, 2016). Must complete the **shoulder replacement surgery questionnaire**.
Laboratory services, genetic tests	Authorization is required for all members. Must send requests to JVHL at 1-800-445-4979. Exception: No authorization is required for the Cologuard® colorectal cancer screening test. This applies to all members for dates of service on or after March 1, 2017. Medical necessity criteria must still be met for the test to be eligible for reimbursement. Refer to the **medical policy** for information on medical necessity criteria. Also, JVHL does not coordinate this testing and providers do not need to contact JVHL about this test. Instead, the ordering physician should request a test kit from Exact Sciences Corporation, using the **order form** on the Cologuard website.
Lumbar spine surgery	Authorization is required for all members. Must complete the appropriate **lumbar spine surgery questionnaire**.
Maternity: up to 48 hours following routine delivery / 96 hours following C-section	Plan notification is required for all members, including those whose coverage allows self-referrals.
Medications covered under the medical benefit	For requirements related to drugs covered under the medical benefit, refer to the **Medical Benefit Drugs – Pharmacy** page, in the BCN section at **ereferrals.bcbsm.com**.
MRI of breast	This radiology procedure requires authorization by AIM Specialty Health for members of all ages when performed in freestanding diagnostic facilities, outpatient hospital settings, ambulatory surgery centers and physician offices.This applies to BCN HMO (commercial) and BCN Advantage members for dates of service on or after Oct. 1, 2018. Refer to the **list of procedure codes that require authorization by AIM.** Note: eviCore healthcare processes these requests for dates of service prior to Oct. 1, 2018, including postservice requests.

BCN Referral and Authorization Requirements

For all services, noncontracted providers and providers who are not part of the designated network associated with the member's plan must obtain authorization from the BCN's Utilization Management department.

Section 1: Plan notification and authorization requirements

Plan notification alerts BCN to a scheduled service and is used for claims processing purposes. BCN does not perform clinical review on services that require plan notification only. Plan notification must be submitted prior to services being rendered. **Authorization** determinations are conducted for benefit determination or the application of medical necessity criteria or both. Authorization requests must be submitted at least 14 business days prior to services being rendered. **Note:** This list is not all-inclusive. See also the notes at the end of Section 1. **In addition,** authorization of a service by BCN's Utilization Management department based on the clinical information provided does not guarantee payment. When the claim for the service is submitted, it may be subject to edits including, but not limited to, diagnosis, frequency and dose. The outcome of those edits may override the initial authorization.

Note: As a rule, physicians must follow the authorization requirements that apply to the region in which the headquarters for their medical care group is located.

Service	Requirements
Nasal sinus endoscopy (sinusotomy or ethmoidectomy)	Authorization is required for all members for dates of service on or after Jan. 1, 2018. Must complete the **sinusotomy questionnaire** or the **ethmoidectomy questionnaire**, as appropriate.
Neurofeedback (outpatient)	Authorization is required for all members. A report from an independent evaluation confirming the diagnosis of ADHD/ADD must be submittted with the initial authorization request. This could be the Conners, the NICHQ Vanderbilt Assessment Scales, the Test of Variables of Attention (T.O.V.A.®) or another psychological or neuropsychological test. In the e-referral system, must complete the questionnaire for requests involving additional visits. If no questionnaire displays, attach the required clinical documentation to the case in the e-referral system Note: BCN's Behavioral Health staff, not the Utilization Management staff, make the determination on the request. When authorized, the service is covered only for specific behavioral health diagnoses, not for medical diagnoses.
Neuropsychological / psychological testing for bariatric surgery	Plan notification is required for all members. No global referral is required for any member in any region.
Noncoronary vascular stents	Authorization is required for all members for dates of service on or after Jan. 1, 2018. Must complete the **noncoronary vascular stents questionnaire**.
Orthognathic surgery	Authorization is required for all members.
Otoplasty	Authorization is required for all members. Must complete the **otoplasty questionnaire**.
Pain management (interventional) with epidural or facet joint injections (adult and pediatric)	**Effective with dates of service on or after Sept. 1, 2016,** interventional pain management procedures involving epidural or facet joint injections require authorization by eviCore healthcare when performed in freestanding diagnostic facilities, outpatient hospital settings, ambulatory surgery centers and physician offices. This applies to BCN HMO (commercial) and BCN Advantage members. Refer to the **list of procedure codes that require authorization by eviCore** and to the **Procedures Managed by eviCore for BCN** page.
Pain management (interventional) involving epidural adhesiolysis, radiofrequency ablation, regional sympathetic blocks and sacroiliac joint injections (adult and pediatric)	**Effective with dates of service on or after Dec. 1, 2016,** interventional pain management procedures involving epidural adhesiolysis, radiofrequency ablation, regional sympathetic blocks and sacroiliac joint injections require authorization by eviCore healthcare when performed in freestanding diagnostic facilities, outpatient hospital settings, ambulatory surgery centers and physician offices. This applies to BCN HMO (commercial) and BCN Advantage members. Refer to the **list of procedure codes that require authorization by eviCore** and to the **Procedures Managed by eviCore for BCN** page.
Partial hospitalization (mental health / substance use disorders)	Authorization is required for all members.
Physical / occupational / speech therapy - autism treatment	The provider is responsible for verifying whether each member has autism benefits and, if so, how they are managed and what the authorization requirements are. In general, authorization is not required for members whose autism benefits are managed separate from their medical benefits. It may be required for members whose autism benefits are managed as part of their medical benefits. When authorization is required, those requests are handled by BCN's Utilization Management department. Refer to the **Autism** page in the BCN section at **ereferrals.bcbsm.com** for additional information.
Physical / occupational / speech therapy (including physical medicine services by chiropractors) - unrelated to autism treatment	Authorization is required for all members. Contact **eviCore healthcare** and see additional information on **Outpatient PT-OT-ST Management Program**.
Prostatic urethral lift procedures	Authorization is required for all members.
Proton beam therapy	This radiation therapy procedure requires authorization by eviCore healthcare for adult members only (18 and older) when performed in freestanding diagnostic facilities, outpatient hospital settings, ambulatory surgery centers and physician offices. This applies to BCN HMO (commercial) and BCN Advantage members for dates of service on or after Oct. 1, 2015. Refer to the **list of procedure codes that require authorization by eviCore** and to the **Procedures Managed by eviCore for BCN** page.
Pulmonary rehabilitation	Authorization is required for all members.

BCN Referral and Authorization Requirements

For all services, noncontracted providers and providers who are not part of the designated network associated with the member's plan must obtain authorization from BCN Utilization Management.

Section 1: Plan notification and authorization requirements

Plan notification alerts BCN to a scheduled service and is used for claims processing purposes. BCN does not perform clinical review on services that require plan notification only. Plan notification must be submitted prior to services being rendered. **Authorization** determinations are conducted for benefit determination or the application of medical necessity criteria or both. Authorization requests must be submitted at least 14 business days prior to services being rendered. **Note:** This list is not all-inclusive. See also the notes at the end of Section 1. **In addition,** authorization of a service by BCN's Utilization Management department based on the clinical information provided does not guarantee payment. When the claim for the service is submitted, it may be subject to edits including, but not limited to, diagnosis, frequency and dose. The outcome of those edits may override the initial authorization.

Note: As a rule, physicians must follow the authorization requirements that apply to the region in which the headquarters for their medical care group is located.

Service	Requirements
Radiation therapy procedures See also: Proton beam therapy	Select radiation therapy procedures require authorization by eviCore healthcare for adult members only (18 and older) when performed in freestanding diagnostic facilities, outpatient hospital settings, ambulatory surgery centers and physician offices. This applies to BCN HMO (commercial) and BCN Advantage members for dates of service on or after Oct. 1, 2015. Refer to the **list of procedure codes that require authorization by eviCore** and to the **Procedures Managed by eviCore for BCN** page.
Radiology procedures See also: MRI of breast	Select radiology procedures require authorization by AIM Specialty Health for members of all ages when performed in freestanding diagnostic facilities, outpatient hospital settings, ambulatory surgery centers and physician offices.This applies to BCN HMO (commercial) and BCN Advantage members for dates of service on or after Oct. 1, 2018. Refer to the **list of procedure codes that require authorization by AIM.** Note: eviCore healthcare processes these requests for dates of service prior to Oct. 1, 2018, including postservice requests.
Rhinoplasty	Authorization is required for all members. Must complete the **rhinoplasty questionnaire**.
Sacral nerve stimulation	Authorization is required for all members for dates of service on or after Jan. 1, 2018. Must complete the **sacral nerve stimulation questionnaire**.
Sleep studies - home	Authorization is not required for any member. Exception: Services associated with procedure code G0400 require authorization for all members, as they are considered experimental and investigational.
Sleep studies - outpatient facility or clinic	Authorization is required for all members. Must complete a questionnaire in the e-referral system. In addition - - A nondiagnostic home sleep test is required for adult members with symptoms of obstructive sleep apnea without certain other comorbid conditions prior to consideration for coverage of a sleep study in the outpatient facility or clinic. - Outpatient facility and clinic-based sleep management studies for adult members 18 years of age and older require the submission of evidence from the member's medical record. This evidence must both confirm the signs and symptoms of obstructive sleep apnea (effective with requests submitted on or after July 17, 2017) and indicate the specific condition the member has that would exclude or contraindicate a home sleep study (effective with requests submitted on or after Oct. 3, 2016).
Specialist office visits and treatment	A global referral is required for HMO members in the East and Southeast regions; for all other members, including HMO members in the Mid, West and Upper Peninsula regions, no plan notification or authorization is required. No plan notification or authorization is required for members with BCN Advantage HMO-POS. Note: For University of Michigan Premier Care, Premier Care 65 and GradCare members, and for members with MSU products and Blue Cross Metro Detroit HMO, BCN Local Network Southeast, BCN Local Network West, BCN Advantage HMO ConnectedCare, BCN Advantage HMO MyChoice Wellness, BCN Advantage HMO HealthySaver and BCN Advantage HMO HealthyValue coverage, see exceptions to the general rule in Section 2: Referral requirements.
Spinal cord stimulator or intrathecal or epidural catheter (trial or permanent placement)	Authorization is required for all members for dates of service on or after Jan. 1, 2018. Must complete the **neurostimulator implantation questionnaire**.
Spine care for low back pain	See "specialist office visits and treatment."

BCN Referral and Authorization Requirements

For all services, noncontracted providers and providers who are not part of the designated network associated with the member's plan must obtain authorization from BCN Utilization Management.

Section 1: Plan notification and authorization requirements

Plan notification alerts BCN to a scheduled service and is used for claims processing purposes. BCN does not perform clinical review on services that require plan notification only. Plan notification must be submitted prior to services being rendered. **Authorization** determinations are conducted for benefit determination or the application of medical necessity criteria or both. Authorization requests must be submitted at least 14 business days prior to services being rendered. **Note:** This list is not all-inclusive. See also the notes at the end of Section 1. **In addition,** authorization of a service by BCN's Utilization Management department based on the clinical information provided does not guarantee payment. When the claim for the service is submitted, it may be subject to edits including, but not limited to, diagnosis, frequency and dose. The outcome of those edits may override the initial authorization.

Note: As a rule, physicians must follow the authorization requirements that apply to the region in which the headquarters for their medical care group is located.

Service	Requirements
Surgical procedures, routine	A global referral is required for HMO members in the East and Southeast regions; for all other members, including HMO members in the Mid, West and Upper Peninsula regions, no plan notification or authorization is required. No plan notification or authorization is required for members with BCN Advantage HMO-POS. Note: For University of Michigan Premier Care, Premier Care 65 and GradCare members, and for members with MSU products and Blue Cross Metro Detroit HMO, BCN Local Network Southeast, BCN Local Network West, BCN Advantage HMO ConnectedCare, BCN Advantage HMO MyChoice Wellness, BCN Advantage HMO HealthySaver and BCN Advantage HMO HealthyValue coverage, see exceptions to the general rule in Section 2: Referral requirements.
TMJ treatment	Authorization is required for all members.
Transcatheter aortic valve implantation (TAVI) and replacement (TAVR)	Authorization is required for all members.
Transcranial magnetic stimulation for psychiatric or neurological disorders	Authorization is required for all members.
Transgender surgery and related services	Authorization is required for all members.
Transplants	Authorization is required for all members, for solid organ and bone marrow evaluations and harvesting (except kidney / skin / cornea): • **HMO members** should be directed to a Blue Distinction® Center+ for Transplants if one is available for the type of transplant the member needs. If one is not available, a Blue Distinction® Center for Transplants facility may be used. This is effective May 1, 2015. • **BCN Advantage members** must have their transplants performed in a CMS-approved facility that is contracted with BCN. When a Blue Distinction Center for Transplants is available, BCN Advantage members should be referred there.
Unclassified procedures	Authorization is required for all members. (Also called "not otherwise classified (NOC)," "unlisted" and "unspecified.")
Varicose veins, treatment	Authorization is required for all members. Must complete the **varicose vein treatment questionnaire**.
Vascular embolization or occlusion (TACE, RFA or UAE)	Authorization is required for all members for dates of service on or after Jan. 1, 2018. Must complete the **TACE / RFA / UAE questionnaire**.
Ventricular assistive devices, percutaneous	Authorization is required for all members.
Woman's Choice services	See **Woman's Choice Referral and Authorization Guidelines**.

Note: BCN 65 members: BCN's Utilization Management department must be notified before a member's Medicare days are exhausted. Infusion is not routinely covered by Medicare. All care should be coordinated by the primary care physician.

Note: BCN as secondary carrier: BCN does not require authorization when it is the secondary payer. However, the claim will be denied when the service is not a BCN covered benefit and the member has not followed the requirements of the primary carrier.

BCN Referral and Authorization Requirements

Section 2: Referral requirements

GENERAL RULE. BCN's referral requirements vary based on the region assigned to the medical care group for the member's primary care physician. (See the Blue Care Network Provider Consultant Regions map at the end of this document.) As a rule, physicians must follow the referral requirements that apply to the region in which the headquarters for their medical care group is located.

- For **BCN HMO** members who have a primary care physician that is part of a medical care group based in the **Mid, West or Upper Peninsula region,** no global referral or individual referral is required for claims processing as long as the specialist or provider is in the provider network associated with the member's health plan. The primary care physician must still manage the member's care and communication between physicians is still recommended. The primary care physician can communicate with the specialist by phone or fax or through instructions on a prescription. Both the primary care physician and the specialist should include written documentation about the communication in the member's medical record. Note: For members identified as males, a global referral from the primary care physician is required for gynecologic services. This applies regardless of the region.
- For **BCN HMO** members who have a primary care physician that is part of a medical care group based in the **East or Southeast region,** their primary care physician (or OB-GYN, for obstetric-gynecologic services) must submit a global referral to BCN for the member to see a contracted provider to get specialty care. A global referral allows the specialist to perform necessary services to diagnose and treat a member in the office, with the exception of services that require authorization. It also allows for the processing of claims. Specialists may not refer patients to other specialists, except for OB-GYNs, who may submit a global referral to BCN for contracted specialists for obstetric-gynecologic services. If the specialist determines that services are needed outside of those specified by a global referral, including further diagnosis or treatment in an alternate treatment setting (either outpatient or inpatient), the specialist is responsible for submitting all required plan notifications or authorization requests to BCN.

BCN's referral requirements also vary based on the product the member has:

- For **BCN Advantage** members in any region, no global referral or individual referral is required as long as the specialist or provider is part of the provider network for the member's health plan.

  Note: For **BCN Advantage HMO-POS, BCN Local Network Southeast, BCN Local Network West, BCN Advantage HMO ConnectedCare, BCN Advantage HMO MyChoice Wellness, BCN Advantage HMO HealthySaver and BCN Advantage HMO HealthyValue** members, services rendered by providers outside of the network designated for each of those products require authorization. See also the **MSU Health Plans** page at **ereferrals.bcbsm.com**, for information on the referral requirements for those plans.
- For **University of Michigan Premier Care, Premier Care 65 and GradCare** members assigned to a non-U-M primary care physician and referred to any specialist (U-M or non-U-M), a referral is required. This guideline applies regardless of where the member lives or where the practitioners are located.
- **Blue Cross Metro Detroit HMO** members must choose their primary care physician from within the Blue Cross Metro Detroit HMO provider network. That physician coordinates services within the Blue Cross Metro Detroit HMO provider network. Standard referral and authorization requirements apply.
- Members who have coverage through **Blue Elect Plus Self-Referral Option**[SM] may choose to self-refer to any provider within or outside of the statewide BCN HMO provider network without need for a referral, but authorization requirements do apply for certain services and some services are covered only if rendered by an in-network provider. Providers should go to web-DENIS to get full information on the requirements for each service.
- For members who have coverage through **self-funded or other products** that allow members to refer themselves directly to a specialist within a designated provider network, no referral is required from the primary care physician in order to access specialist services within that network. However, authorization requirements apply. Providers should always check Section 1 of this document for authorization requirements.

Some services do not require a referral as long as the service is performed by a contracted provider. In these instances, or whenever a referral does not need to be submitted to BCN, the primary care physician (or OB-GYN, for obstetric-gynecologic services) can recommend the member seek care with the specialist or provider using any method. However, the primary care physician and the specialist or other provider are encouraged to communicate with each other and document the recommendation and care in the member's health record. Also note:

- For chiropractic spinal manipulations, for neuropsychological / psychological testing for bariatric surgery, for physical medicine services provided by chiropractors and for physical, occupational or speech therapy, see Section 1 for the specific requirements for those services.
- The table below provides a list of services that do not require a referral for ANY member. Note: This list is not all-inclusive.

Office / outpatient / ancillary services

Ambulance - emergent	Referral is not required for any member.
Anesthesia	Referral is not required for any member.
Bone density studies	Referral is not required for any member.
Cardiac stress tests	See Section 1 - Cardiology procedures.
Chemotherapy	Neither referral nor authorization is required for any member unless the chemotherapeutic agent used is shown elsewhere as requiring authorization. Refer to the information on the **Medical Benefit Drugs – Pharmacy** page in the BCN section at **ereferrals.bcbsm.com**.
Diagnostic and therapeutic tests	See Section 1.
Echocardiograms	See Section 1 - Cardiology procedures.
EKGs	Referral is not required for any member.

This list is continued on the next page.

BCN Referral and Authorization Requirements

Section 2: Referral requirements

This list is continued from the previous page.

Office / outpatient / ancillary services	
Emergency room services	Referral is not required for any member.
Fetal non-stress tests	Referral is not required for any member.
Hearing aid services (with hearing aid rider)	Referral is not required for any member.
Holter monitor	Referral is not required for any member.
Home health care	See Section 1.
Home infusion	Referral is not required for any member.
Immunizations	Referral is not required for any member.
Laboratory services, general	Referral is not required for any member.
Neuropsychological / psychological testing for other than bariatric surgery	Referral is not required for any member.
Observation stays	Referral is not required for any member. Note: Surgical procedures rendered during an observation stay require a separate outpatient referral, plan notification or authorization. For the authorization requirements pertaining to other procedures rendered during observation, see Section 1.
Pacemaker adjustments	Referral is not required for any member.
Pediatric Choice services	See **BCN Requirements for Pediatric Choice Program**.
Radiation therapy	See Section 1 - Radiation therapy procedures. For radiation therapy procedures other than those identified in Section 1, referral is not required for any member.
Radiology - routine	See Section 1 - Radiology procedures. For radiology procedures other than those identified in Section 1, referral is not required for any member.
Specialist office visits and treatment	See Section 1.
Sterilization procedures (with appropriate benefit)	Referral is not required for any member.
Surgical procedures, routine	See Section 1.
Urgent care	Referral is not required for any member.
Woman's Choice services	See **Woman's Choice Referral and Authorization Guidelines**.

VENDOR CONTACT INFORMATION

Vendor	Services	Contact information
AIM Specialty Health	Reviews authorization requests for select cardiology and radiology procedures, for dates of service on or after Oct. 1, 2018	**providerportal.com** 1-844-377-1278
eviCore healthcare	Reviews authorization requests for select interventional pain management and radiation therapy procedures Note: eviCore reviews authorization requests for select cardiology and radiology procedures for dates of service prior to Oct. 1, 2018, including postservice requests.	**www.evicore.com** 1-855-774-1317
	Provides utilization management for members receiving PT/OT/ST (by therapists) and physical medicine services (by chriopractors) in office and outpatient settings, including hospital outpatient settings	**www.LMhealthcare.com**
J&B Medical Supply	Reviews all requests for outpatient diabetic and insulin pump supplies (not including diabetic shoes and inserts)	1-888-896-6233
JVHL	Provides statewide network and third-party administration for outpatient laboratory services	1-800-445-4979
Northwood, Inc.	Reviews all requests for outpatient DME and P&O (including diabetic shoes and inserts)	Call Northwood's customer service department at 1-800-393-6432 to identify a contracted supplier. The supplier submits the request to Northwood for review.

BCN Referral and Authorization Requirements

Section 3: Procedures That Require Authorization

For services not involving medications covered under the medical benefit and not involving review by eviCore healthcare or AIM Specialty Health

Procedure codes (Note: This list is not all inclusive.)

Note: ALL procedures with "not otherwise classified (NOC)," "unclassified," "unlisted" or "unspecified" codes require authorization.

*0159T	*19316	*21154-*21155	*22586	*29800	*33990-*33993	*41872	*52441-*52442	*62281-*62282	*63685	*92521-*92524	*97532-*97533	S9472-S9473
*00170	*19318	*21159-*21160	*22590	*29804	*36468-*36471	*41874	*55970	*62287	*64479-*64480	*93797-*93798	*97535	S9485
*0190T	*19324-*19325	*21188	*22595	*29870	*36475-*36476	*42120	*55980	*62310-*62311	*64483-*64484	*95782-*95783	*97537	T1023
*0219T	*19328	*21193-*21199	*22600	*29873-*29877	*36478-*36479	*43180 [b]	*56805	*62318-*62319	*64490-*64495	*95805	*97542	
*0238T	*19330	*21206	*22612	*29879-*29883	*37220-*37221	*43191 [b]	*57335	*62350	*64561	*95807-*95811	*97545-*97546	
*0318T	*19340	*21208-*21210	*22630	*29885-*29887	*37224-*37231	*43193 [b]	*58150	*62360-*62362	*64581	*97001-*97004	*97750	
*0331T-*0332T	*19342	*21215	*22633	*30400	*37236	*43197-*43198 [b]	*58152	*63001	*64590	*97010	*97755	
*11920-*11922	*19350	*21230	*22856	*30410	*37238	*43200 [b]	*58180	*63005	*64595	*97012	*99183	
*15780-*15783	*19355	*21235	*22858	*30420	*37242-*37243	*43202 [b]	*58275	*63012	*67900-*67909	*97014	G0277	
*15786-*15789	*19357	*21240	*22861	*30430	*37718	*43206 [b]	*58291	*63015	*69300	*97016	G0289	
*15792-*15793	*19361	*21242-*21249	*23470	*30435	*37722	*43235 [b]	*58353	*63017	*69710-*69718	*97018	H0031-H0032	
*15819-*15830	*19364	*21255	*23472	*30450	*37765-*37766	*43239 [b]	*58356	*63020	*70328	*97022	H2014	
*15832-*15839	*19366-*19371	*21270	*27090-*27091	*30460	*37780	*43252 [b]	*58563	*63030	*70336	*97024	H2019	
*15847	*19380	*21280	*27130	*30462	*37785	*43254 [b]	*59840-*59841	*63040	*74263	*97026	L8039	
*15876-*15879	*19396	*21282	*27132	*30620	*40840	*43257 [b]	*59850-*59852	*63042	*75571	*97028	L8600	
*17340	*21010	*21295-*21296	*27134	*31253	*40842-*40845	*43644-*43645	*59855-*59857	*63045	*77003	*97032-*97036	L8692	
*17360	*21050	*21480	*27137-*27138	*31257	*41800	*43647-*43648	*61580-*61581	*63047	*77058-*77059	*97110	Q4100	
*17362	*21060	*21485	*27332-*27333	*31660-*31661	*41805-*41806	*43770-*43775	*61850	*63050-*63051	*77520	*97112-*97113	S0190-S0191	
*17380	*21070	*21490	*27425	*31254-*31255	*41820-*41823	*43842-*43848	*61863-*61864	*63056	*90867-*90870	*97116	S0199	
*19101	*21116	*22533	*27446 *27447	*31259	*41825-*41828	*43881-*43882	*61867-*61868	*63075	*90875-*90876	*97124	S2083	
*19120	21120-*21127	*22551	*27486-*27488	*31276	*41830	*43886-*43888	*61880	*63650	*90901	*97140	S2202	
*19125-*19126	*21141-*21147	*22554	*28160 [a]	*31295-*31298	*41850	*44130	*61885-*61886	*63655	*90911	*97150	S5108	
*19300	*21150-*21151	*22558	*28285-*28286 [a]	*33361-*33369	*41870	*47562-*47564	*61888	*63663	*92507-*92508	*97530	S5111	

[a] These services require authorization only for the following diagnosis codes: M12.271-M12.279, M20.40-M20.42, M20.5x1-M20.62, M24.571-M24.576, M24.671, M24.676, M65.871-M65.879, M67.00-M67.02, M77.50-M77.52, M77.9, Q66.7, Q74.2, S92.521x-S92.529x and S93.121x-S93.129x.

[b] These services require authorization only for the following diagnosis codes: K21.0 and K21.9.

Note: Additional details are provided about the services represented by these codes in the tables found earlier in this document.

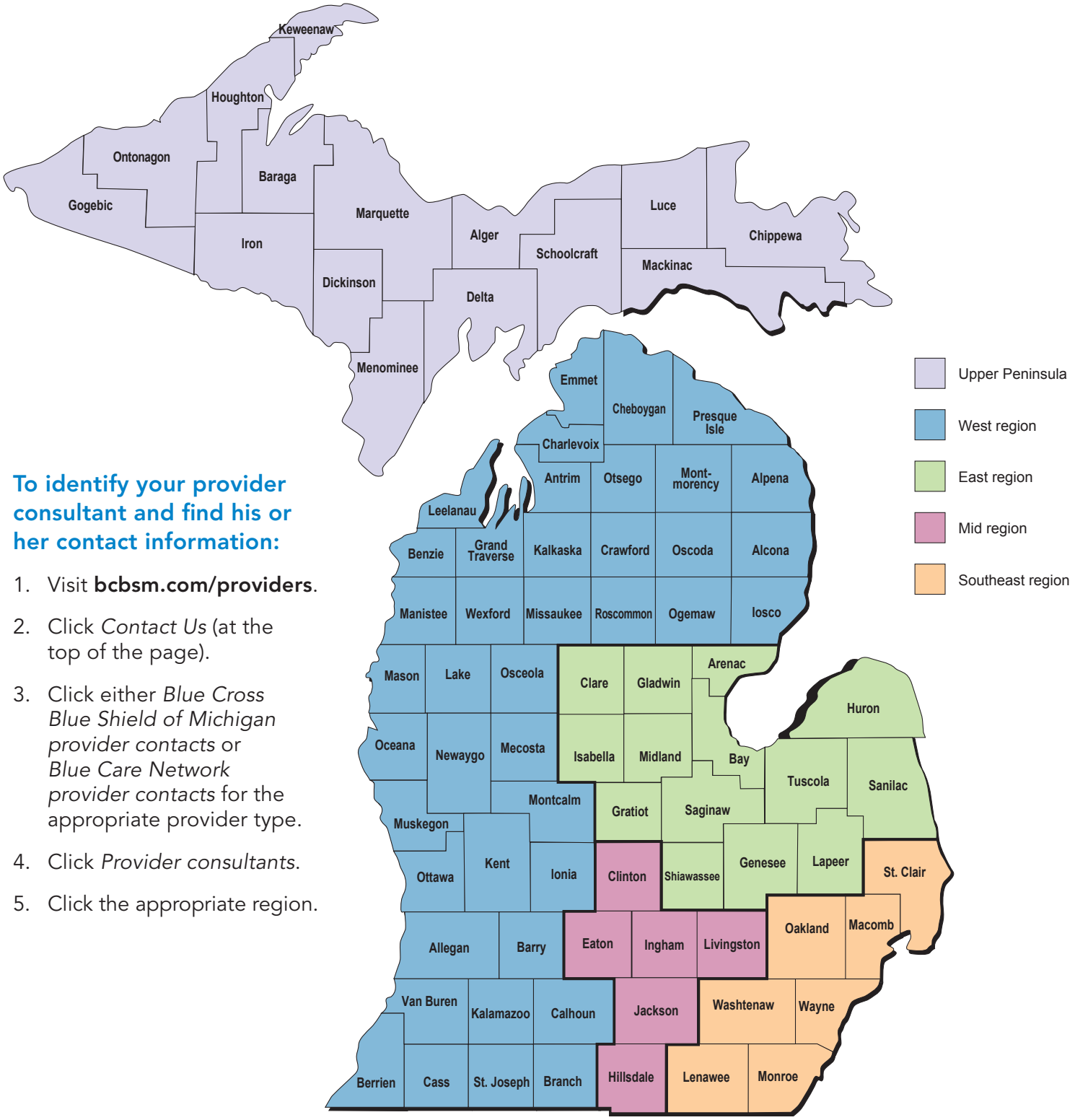
Blue Dot Changes to the BCN Referral and Authorization Requirements

Service / Topic	Change Description
Biofeedback and neurofeedback	In Section 1 of this document, the information about biofeedback and neurofeedback is updated to clarify the following: • Biofeedback is not covered for behavioral health diagnoses. BCN's Utilization Management staff, not the Behavioral Health staff, make the determination on requests to authorize biofeedback. Providers must attach all pertinent clinical information to the request in the e-referral system. • Neurofeedback, when authorized, is covered only for specific behavioral health diagnoses, not for medical diagnoses. BCN's Behavioral Health staff, not the Utilization Management staff, make the determination on authorization requests. In the e-referral system, providers must complete the questionnaire for requests involving additional visits.
Section 1: Plan notification and authorization requirements	In Section 1 of this document, the information is clarified to show that authorization requests must be submitted 14 business days prior to services being provided.
Codes for procedures that require authorization	In Section 3 of this document, the list of codes for procedures that require authorization is updated to include the following codes: • *17362 • *22856 • *31253 • *43206 • *58563 • *22590 • *22861 • *31257 • *43252 • *63040 • *22595 • *30460 • *31259 • *43257 • *63030 • *22633 • *30462 • *31298 • *47562-*47564 • *69300
Abdominoplasty, otoplasty and rhinoplasty	Section 1 of this document is updated to show that for abdominoplasty, otoplasty and rhinoplasty, providers must complete the pertinent questionnaire in the e-referral system.
Blepharoplasty	A hyperlink to the preview questionnaire for blepharoplasty and repair of brow ptosis is added to the entry for that service in Section 1 of this document.
Referral requirements	In Section 2 of this document, the referral requirements are updated to make it clear that referrals are not required for BCN Advantage members. Primary care physicians must still coordinate the care of these members with specialists but do not need to submit a referral to BCN. For members with a specific provider network associated with their plan, services by providers outside of that network require authorization.

Provider Consultant Regions

Blue Cross Blue Shield Blue Care Network of Michigan

Confidence comes with every card.®



To identify your provider consultant and find his or her contact information:

1. Visit **bcbsm.com/providers**.
2. Click *Contact Us* (at the top of the page).
3. Click either *Blue Cross Blue Shield of Michigan provider contacts* or *Blue Care Network provider contacts* for the appropriate provider type.
4. Click *Provider consultants*.
5. Click the appropriate region.