Blue Cross Blue Shield Blue Care Network of Michigan

Medicare Advantage PPO
Prior Authorization of Specialty Medications (Part B)

Frequently Asked Questions

Which members will Pharmacy Services Medicare manage for the prior authorization program?
Effective July 5, 2017, BCBSM will manage Medicare Advantage members receiving select Medicare Part B medications administered in the physician office by Michigan participating providers.

- Out of Scope sites of service are: Out of state or out of network offices, Infusion centers, and home infusion

Which specialty medications will be subject to prior authorization?
Log into to the Provider Secured Services homepage and a drug list will be provided under the link "Medicare Advantage PPO Medical Benefit – Medication Prior Authorization."

How do I gain access to the web tool to initiate a prior authorization request?

- If you already use Provider Secured Services:
  - Complete the form *Addendum P*.
  - Fax the form to us at 1-800-495-0812.
- If your office has never used Provider Secured Services:
  - Sign up using the instructions and forms on **bcbsm.com** under "How do I get access to Provider Secured Services?" Be sure to check Medical Drug PA in Section 6 when completing the application.
  - Call 1-877-258-3932 Monday through Friday from 8 a.m. to 8 p.m. Eastern time

How do I initiate a prior authorization request?

1. You can access the NovoLogix® online tool through Provider Secured Services.
   - Access the Provider Secured Services homepage at https://provider.bcbsm.com/ or log in at BCBSM.com/providers (LOGIN located at upper right corner of page)
   - Click on the link "Medicare Advantage PPO Medical Benefit – Medication Prior Authorization" and follow login instructions
   - If you can't access Provider Secured Services, call 1-877-258-3932 Monday through Friday from 8 a.m. to 8 p.m. Eastern time, to get access to Provider Secured Services and the NovoLogix® tool.
2. You may call the Pharmacy Help Desk at 1-800-437-3803 Monday through Friday from 8 a.m. to 4:30 p.m. Eastern time.

How long does it take to obtain a decision on a prior authorization request?

- Decisions will be made as expeditiously as the member's health condition requires.
- Standard requests for prior authorization will be completed within 14 days after the date Blue Cross receives the request. Standard appeals will be completed within 30 days.
- Expedited requests will be completed within 72 hours from when the request is received by Blue Cross.

What will happen if the specialty medication is administered without previously obtaining a prior authorization?
Your claim will not be paid without a pre-service authorization from Blue Cross.

> **Note:** Original Medicare benefit coverage rules and benefit exclusions/limitations on the member's plan will apply. Providers must obtain prior authorization approval and also verify the member's benefits to be eligible for claim payment on the date of service. Providers may be held financially liable if services are rendered without a prior authorization approval. Providers may not bill members for services that required, but did not receive pre approval

What is the messaging on the provider's voucher if a claim for a specialty medication isn't matched to a prior authorization?
The message on the provider voucher will state "Denied - No Authorization."

What information is needed to request approval for drugs subject to prior authorization?

- Member name, date of birth and Blue Cross member ID number
- Ordering doctor's name, national provider identifier and fax number
- Drug being requested (J Code/HCPCS code)
- All relevant clinical notes, imaging and X-ray reports, patient history and physical findings

Will I have a reference number when a prior authorization request is made?
Yes, the reference number will be a five-digit number called an Authorization # generated by the NovoLogix® online tool.

How do I check for the authorization status ?
Providers can check the authorization status by accessing the NovoLogix® online tool from the Provider Secured Services home page or calling the Pharmacy Help Desk at 1-800-437-3803.

How will members be notified of approvals and denials of an organization determination?
Written notices will be sent to the member as well as the requesting provider. Oral notification may also be given if on expedited cases. If a service is denied, an appeal must be filed to have the request reviewed again.

How will I be notified of approvals and denials of an organization determination?
The provider will receive written fax notification of the decision.

How long is an authorization valid?
Authorizations will vary with each specific medication request. Most authorizations will be 12 months.

Can claims be submitted for payment as soon as an authorization approval is received?
No. Providers should wait at least seven (7) business days receipt of the fax authorization approval letter. This will allow time for the authorization to be loaded to the system and the claim to process appropriately.

How do I check benefits and eligibility of a member?
Member eligibility can be viewed in web-DENIS. Access web-DENIS by logging into Provider Secured Services then click on the web-DENIS link.

How do I appeal a medical necessity determination?
Please refer to the denial notice letter you received via fax. The denial notice will provide instructions of how to appeal a decision. Appeal requests must be received within 60 calendar days from the date of the denial notice.