



IMPORTANT! Click on a topic below to go to that page in the chapter.

Contents

Hyperlinks to important information	1
Overview of BCN Utilization Management	2
Managing BCN members' care	5
The referral process for BCN HMO members	8
BCN authorization requirements	19
Requests requiring clinical information	27
Referrals and authorizations summary	30
Procedures reviewed by eviCore for BCN	33
Blue Elect Plus Self-Referral Option	36
BCN's Medicare products	37
BCN HMO products with provider networks	40
BCN 65 and secondary coverage	42
Woman's Choice	43
Guidelines for observations and inpatient hospital admissions	44
Guidelines for transitional care	54
Emergency room and urgent care services	59
Air ambulance services	61
BCN case management activities	64

Contents (continued)

- Coordination of care**70
- Continuity of care**71
- BCN — a resource for physicians**.....73
- Utilization management decisions**.....76
- Appealing utilization management decisions**.....80
- Administrative denials**82
- Medical supplies, durable medical equipment, prosthetics and orthotics**83
- Outpatient laboratory services**.....86
- Managing PT, OT and ST / Managing physical medicine services by chiropractors**88

Blue Care Network has produced this document in accordance with guidelines, policies and procedures current with the date noted on this page. Blue Care Network reserves the right to update, modify, change or replace any portion of this document to reflect later guidelines, policies or procedures. The manual is an extension of the provider contracts. Nothing in it is intended or should be understood to modify the requirements, limitations and/or exclusions in the provider contracts.

This manual is the property of Blue Care Network and is for use solely in your capacity as a participating provider. Duplication is limited to your office staff only. Disclosure to unauthorized persons or use for any other purpose is strictly prohibited. Any violation of the above will be dealt with to the full extent of applicable laws. Federal law provides severe civil and criminal penalties for the unauthorized reproduction and distribution of copyrighted materials.

Blue Cross, BCN and Blue Cross Complete maintain bcbsm.com, MiBlueCrossComplete.com and theunadvertisedbrand.com. Blue Cross, BCN and Blue Cross Complete do not control any other websites referenced in this publication or endorse their general content.

©2020 Blue Care Network. All rights reserved.

Blue Care Network® is a registered trademark of Blue Cross Blue Shield of Michigan.

NCQA is a private, nonprofit organization dedicated to improving health care quality.

HEDIS® is a registered trademark of the National Committee for Quality Assurance.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

CPT is copyright 2019 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

Hyperlinks to important information



The chapter is renamed Utilization Management. The name of the chapter was formerly Care Management.

Links used in this chapter

The following links to important utilization management information are provided within this chapter:

- ereferrals.bcbsm.com website (BCN section)
- [Training Tools](#) page at ereferrals.bcbsm.com
- [Authorization Requirements & Criteria](#) page at ereferrals.bcbsm.com
- [eviCore-Managed Procedures](#) page at ereferrals.bcbsm.com
- [BCN Referral and Authorization Requirements](#)
- Article titled “[How to attach clinical information to your authorization request in the e-referral system](#),” in the November-December 2016 *BCN Provider News* (page 44)
- [Medical Necessity Criteria / Benefit Review Requirements for Services Not Involving Drugs / Biologicals Covered under Medical Benefit](#)
- [Provider Inquiry Contact Information](#)
- [Woman’s Choice Referral and Authorization Guidelines](#)
- [Woman’s Choice specialty and procedure/diagnosis code requirements](#)

Note: Blue Cross Complete information is available at MiBlueCrossComplete.com/providers.



How to find billing / claim information

Referral and authorization requirements affect claim payments.

Providers can find information about billing and claims at the following locations:

- Claims chapter of this manual
- Billing instructions, clinical editing information and other documents

Providers can access billing and claims information on BCN’s Billing / Claims page. Visit bcbsm.com/providers, log in to Provider Secured Services, click *BCN Provider Publications and Resources* and, finally, click *Billing / Claims*.

In addition, claims mailing addresses can be found at ereferrals.bcbsm.com > Quick Guides > [BCN Provider Resource Guide](#). Click to open the Claims page.



Overview of BCN Utilization Management

Scope of chapter This chapter applies to BCN HMOSM (commercial) products, BCN AdvantageSM HMO-POS products (group products and Basic, Classic, Elements and Prestige individual products) and BCN AdvantageSM HMO products (BCN AdvantageSM HMO ConnectedCare, BCN AdvantageSM HMO MyChoice Wellness, BCN AdvantageSM HMO HealthySaver and BCN AdvantageSM HMO HealthyValue), unless otherwise indicated.

Note: In this chapter, “BCN Advantage” refers to both BCN Advantage HMO-POS and BCN Advantage HMO products unless otherwise noted.



This chapter does not apply to Blue Cross Complete. Utilization management information for Blue Cross Complete is found in the *Blue Cross Complete Provider Manual*, available at [MiBlueCrossComplete.com/providers](https://www.mibluccrosscomplete.com/providers).

This chapter also does not apply to MyBlue MedigapSM, which is a BCN product unique in that there are no utilization management requirements. Specifically, no referrals or authorizations are required in order for MyBlue Medigap members to access health care services covered under their plan from any provider who accepts Medicare.

Program goal Blue Care Network’s utilization management program promotes the provision of cost-effective, medically appropriate services. This comprehensive approach employs key interactive medical management activities so that BCN can achieve its goals for BCN members.

Overview of BCN Utilization Management

Utilization Management department services

BCN Utilization Management department provides the following services:

- Inpatient admission, concurrent review and discharge planning
- Utilization management activities
- Development and maintenance of medical review criteria
- Coordination of health care services with chronic condition management programs
- Continuity of care services
- Coordination of care among medical care providers and between medical and behavioral health care providers
- Member health care education
- Clinical review of select services
- Review and determination of requests for out-of-network services
- Joint medical policy development by BCN and Blue Cross
- Processing and management of referrals
- Benefit administration and interpretation, including new technology assessment and determinations regarding experimental procedures
- Processing appeals for physicians and other health care providers
- Postservice review determinations
- Quality improvement initiatives
- Assuring compliance with accrediting and regulatory governing bodies
- Oversight of delegated utilization activities

Contacting BCN Utilization Management

Providers can contact BCN's Utilization Management department at the toll-free numbers below, unless directed to use another number in this chapter.

- Normal business hours: 1-800-392-2512
- After hours: 1-800-851-3904

Staff members in BCN's Utilization Management department are available to answer provider inquiries eight hours a day during normal business hours. Normal business hours are 8:30 a.m. to noon and 1 p.m. to 5 p.m. Monday through Thursday and 9:30 a.m. to noon and 1 p.m. to 5 p.m. on Friday.

When initiating or returning calls related to utilization management, staff members identify themselves by name, title and organization.

Additional information regarding after hours is in the "Emergency room and urgent care services" section later in this chapter.

Overview of BCN Utilization Management

Monitoring utilization

BCN uses various mechanisms to monitor and identify potential underutilization and overutilization of services. This helps ensure that BCN members receive the medical services required for health promotion, as well as acute and chronic illness management. Examples of these mechanisms include:

- Review of Healthcare Effectiveness Data and Information Set data
- Results of member satisfaction surveys
- Rate of select procedures
- Rate of inpatient admissions
- Rate of emergency services
- Rate of primary care physician encounters
- Primary care physician and specialty utilization patterns
- Review of alternative levels of care such as observation

Affirmation statement

BCN bases its utilization decisions about care and service solely on their appropriateness in relation to each member's specific medical condition. BCN's review staff has no compensatory arrangements that encourage denial of coverage or service. Clinicians employed by BCN do not receive bonuses or incentives based on their review decisions. BCN bases all authorization decisions on medical necessity by applying approved clinical criteria and ensures that the care provided is within the limits of the member's plan coverage.

Managing BCN members' care

Focus on primary care	The primary care physician plays a key role in patient care by providing and coordinating medical care for BCN members.
Specialist's role	The specialist provides care within the scope of the primary care physician's referral. The specialist's timely communication with the referring physician is essential to effective management of the member's care.
BCN support	BCN provides the structure to facilitate care to all members, regardless of the treatment setting.
Referral to BCN-contracted specialists - BCN HMO	<p>BCN offers a statewide network of specialty care providers.</p> <p>When BCN HMO members who live in the East or Southeast region need specialty care, their primary care physicians refer them to participating providers within their product's network.</p> <p>Names of BCN-participating providers can be accessed via the online provider search at bcbsm.com/find-a-doctor > Search without logging in. Enter the search criteria and click the search icon.</p> <p>Providers can also contact their medical care group administrator or provider consultant for more information about the BCN contracted provider network.</p> <p>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. For BCN Advantage HMO-POS, BCN Advantage HMO ConnectedCare, BCN Advantage HMO MyChoice Wellness, BCN Advantage HMO HealthySaver and BCN Advantage HMO HealthyValue members, services by providers outside of the network designated for each of those products require authorization.</p>
Access to women's health services through Woman's Choice	<p>Female BCN members may access services from participating BCN women's health specialists without a referral from their primary care physician.</p> <p>Additional information on the Woman's Choice program is available in the "Woman's Choice" section later in this chapter.</p>



Managing BCN members' care

Regional referral differences - BCN HMO

The referral requirements for BCN HMO members vary based on the region assigned to the medical care group with which the member's primary care physician is associated. All care must be coordinated by the member's primary care physician.

For BCN HMO members, the various regional requirements are reflected on the *BCN Referral and Authorization Requirements* document. Look in Section 2: Referral requirements. This document can be accessed by clicking on the following link:

BCN Referral and Authorization Requirements

This document can be accessed by visiting:

- **ereferrals.bcbsm.com** > BCN > Authorization Requirements & Criteria
- **bcbsm.com/providers**, logging in to Provider Secured Services and clicking BCN Provider Publications and Resources > Authorizations / Referrals



Providers who do not know which regional requirements to refer to should contact their Blue Cross/BCN provider consultant. To access provider consultant contact information, providers should visit **bcbsm.com/providers** > Help > **Contact Us**. Click *Blue Care Network provider contacts* (under either the "Hospitals and facilities" or the "Physicians and professionals" heading). Click *Provider consultants*, then, finally, click on the appropriate region.

East and Southeast service areas - BCN HMO

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.

Managing BCN members' care

**Mid, West and
Upper Peninsula
service areas -
BCN HMO**

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.

The referral process for BCN HMO members

Global referrals allow a specialist to provide care Global referrals allow a contracted specialist to perform services necessary to diagnose and treat a BCN HMO member in the office setting, as long as those services do not require plan notification or authorization.

The specialist may also order diagnostic tests and schedule elective surgeries at a facility as long as those services fall within the date range of the global referral; plan notification and authorization requirements apply.

Separate requests must be submitted by the specialist, primary care physician or facility for services requiring plan notification or authorization. Without plan notification or authorization, when required, claims for services will not pay against a global referral.

Submitting a global referral for a BCN HMO member

Global referrals are typically submitted by the BCN HMO member's primary care physician. However, obstetric-gynecologic practitioners may submit a global referral when referring BCN HMO members to contracted specialists for obstetric-gynecologic-related services. All referrals to contracted specialists are considered to be global.

When a primary care physician (or OB-GYN, for obstetric-gynecologic-related services) determines there is a need for a specialist's care and wants to submit a global referral, the following steps must be completed:

1. The primary care physician (or OB-GYN, for obstetric-gynecologic-related services) submits the global referral request to BCN for a minimum of 90 days.
2. BCN reviews all referrals to check the member's eligibility, primary care physician assignment and primary care physician approval, when applicable.
3. BCN determines whether the global referral is approved.

Note: If the member is not eligible or other problems are identified, the referral is pended until the issues can be worked out. If the referral is ultimately denied, all parties are notified. If the referral is approved, a letter is sent to the member; the specialist and primary care physician can check the status of the request on the e-referral system.

4. After the global referral is approved, the specialist performs the services necessary to diagnose and treat the BCN HMO member in the office setting, within the limits specified by the global referral.

Specialists cannot require that the BCN HMO member present a written copy of the referral and cannot expect that the primary care physician or BCN's Utilization Management department fax the referral. Referrals should be confirmed by viewing them in the e-referral system or by calling PARS / Provider Inquiry.

The referral process for BCN HMO members

Specialist responsible for obtaining additional approvals

If the specialist determines services are needed outside those specified by the global referral, including further diagnosis or treatment in an alternate treatment setting (either outpatient or inpatient), the specialist is responsible for making additional referrals for BCN HMO members and for submitting all required plan notifications and authorization requests to BCN.

Additional information about global referrals

Providers should be aware of the following additional information related to global referrals for BCN HMO members:

- Global referrals should be written for a minimum of 90 days.
- For BCN HMO members with chronic conditions, BCN recommends authorizing global referrals for a 365-day period to enhance member satisfaction.

Note: For BCN HMO members with chronic conditions involving oncology, rheumatology and renal management, referrals should be issued for no less than one year.
- Global referrals that are not written for the 90- or 365-day requirements are automatically corrected within the e-referral system. Providers who try to enter a referral for less than the minimum requirement receive a warning message. The system then enters the correct minimum.
- Referrals should be submitted to BCN within one business day via e-referral (or by phone, if e-referral is not available).
- If a BCN HMO member seeks services or a specialist provides services without prior approval from the primary care physician (or OB-GYN, for obstetric-gynecologic-related services) in the form of a global referral, the primary care physician (or OB-GYN, for obstetric-gynecologic-related services) is not obligated to issue a referral after services have been provided.

Providers should refer to the *BCN Referral and Authorization Requirements* document for additional guidelines related to referrals. Look in Section 2: Referral requirements.

The referral process for BCN HMO members

Global referral limitations

A global referral is not a direct path from the BCN HMO member to the specialist. The following limitations apply:

- Members may not refer themselves to a specialist.
Exception: BCN Blue Elect PlusSM SRO members may refer themselves to a specialist.
- Global referrals may be generated only by the BCN HMO member's primary care physician (or OB-GYN, for obstetric-gynecologic-related services).
- Global referrals may be issued for no less than a 90-day period and for no more than 365 days. After 365 days, a new referral must be submitted for ongoing care.
- Specialists may not refer a BCN HMO member to other specialists, with the exception of referrals for occupational, physical and speech therapy when the therapy provider is in network.
- Select services are subject to benefit review and authorization — for example: chiropractic manipulations, chiropractic physical medicine services, physical/occupational/speech therapy and any services from a noncontracted provider.

Refer to other sections in this chapter for additional information:

- See the section titled “BCN HMO products with provider networks” for the regional differences in referral requirements.
- See the section titled “Requests requiring clinical information” for the requirements related to services from noncontracted providers.
- See the sections titled “BCN's Medicare products” and “Other BCN products with provider networks” for the requirements related to providers who are outside the provider network associated with the member's plan.
- See the section titled “Managing PT, OT and ST / Managing physical medicine services by chiropractors” section for the requirements related to physical/occupational/speech therapy and physical medicine services delivered by chiropractors

Referral not required



Some services for BCN HMO members do not require a referral as long as the service is performed by a contracted practitioner or provider.

For more information about referral requirements, providers should refer to Section 2: Referral requirements in the *BCN Referral and Authorization Requirements* document, which is found by visiting:

- ereferrals.bcbsm.com > BCN > Authorization Requirements & Criteria > **BCN Referral and Authorization Requirements**
- bcbsm.com/providers, logging in to Provider Secured Services and clicking BCN Provider Publications and Resources > Authorizations / Referrals

The referral process for BCN HMO members

Plan notification required

Routine plan notifications alert BCN to a scheduled service and are used for claims processing purposes. BCN does not perform clinical review on these services. Primary care physicians and specialists with global referrals must submit plan notifications to BCN prior to the member obtaining the service, to allow for timely claim payment.



Services for which plan notification is required are noted on the *BCN Referral and Authorization Requirements* document, which can be accessed at ereferrals.bcbsm.com > BCN > Authorization Requirements & Criteria > **BCN Referral and Authorization Requirements**. The document can also be accessed via BCN's Authorizations / Referrals page within Provider Secured Services.

Authorization required

Select services require review for the application of medical necessity criteria or benefit determination or both prior to the delivery of the service.

For additional information, refer to the section titled "BCN authorization requirements."

Referral processing

All service requests are reviewed to verify the BCN HMO member's eligibility, primary care physician assignment or the presence of an active global referral to the submitting provider. The member is notified in writing of the status of the service request.

Electronically submitted global referrals and plan notifications are automatically checked for eligibility and the appropriate submitting provider. Approval is given upon submission if the member is eligible and the submitting provider is the member's primary care physician or a specialist with a global referral. Approval notification is then sent to the member.

How to submit referrals



There are two methods for submitting a referral:

- **Electronic** —
 - Service requests should be submitted via e-referral, BCN's customized web-based referral entry system.
 - Referrals can also be submitted by medical care groups via Electronic Data Interchange, using the HIPAA 278 electronic standard transaction. For information on the 278 transaction, providers should email EDICustMgmt@bcbsm.com.
- **Phone** — Phone submissions may be necessary if e-referral is not available. Also, to ensure the timely identification and processing of urgent requests, BCN encourages providers to submit all urgent requests by phone, by calling BCN's Utilization Management department at 1-800-392-2512.

To avoid delays in payment or denial of claims, providers should submit all referrals to BCN within one business day of ordering or authorizing the service.

The referral process for BCN HMO members

e-referral

BCN's web-based referral submission tool, e-referral, enables providers to submit and update all requests — including global referrals, routine plan notifications, routine obstetric admissions and services requiring authorization — over the Internet. Referrals appear online as soon as they are entered and are visible to the contracted provider receiving the referral. The use of e-referral allows specialists and facilities to view any global referral or authorization written to them. Specialists and facilities also receive electronic notification of new referrals made to them. Primary care physicians receive electronic notification of referrals made for their members.

Services that do not require authorization by BCN are automatically approved online at the time of submission. Other services that may require benefit eligibility determination, member eligibility determination or clinical review are reviewed by BCN's Utilization Management staff. Providers can look up the status of a request via e-referral. Written notification is sent to the member.

Sign up for e-referral



Providers who are not already e-referral users can sign up to experience the benefits of fast, easy, paperless referral processing. There is no cost for e-referral. Internet access with 128-bit encryption is needed.

Detailed instructions for signing up for e-referral are found at ereferrals.bcbsm.com > [Sign Up or Change a User](#).



Instructions for using the e-referral system



For complete e-referral system instructions, providers can access training resources at the following locations:

- *User Guide* at ereferrals.bcbsm.com > Training Tools > [e-referral User Guide](#)
- *Authorizations Quick Reference Guide* at ereferrals.bcbsm.com > BCN > eviCore-Managed Procedures > [Authorizations Quick Reference Guide](#)
- General information on web-based training at ereferrals.bcbsm.com > Training Tools > [Online self-paced learning modules](#)

For additional information on e-referral, providers should contact their Blue Cross/BCN provider consultant. They can refer to the BCN System of Managed Care chapter of this manual for contact information.

The referral process for BCN HMO members

Avoid HIPAA violations:
Use caution when selecting members in the e-referral system

When using the e-referral system, providers should avoid violations of the Health Insurance Portability and Accountability Act of 1996 by **making sure they have selected the right member under the correct contract before submitting their request**. Providers should avoid errors that involve selecting the correct member under the wrong contract number or selecting the wrong member under the correct contract.

Incorrect submissions could result in violations of the federal Health Insurance Portability and Accountability Act of 1996 and BCN may be required to treat them as reportable disclosures of protected health information.

Errors in selection also slow BCN's referral process and lead to increased member dissatisfaction and improper claim denials.

Specialty group NPIs



Referrals are usually issued to individual practitioners except in the case of Michigan Medicine (formerly called the University of Michigan Health System) and the Henry Ford Health System. When issuing referrals to Michigan Medicine or Henry Ford Health System specialty providers, referring providers should use the specialty group National Provider Identifier. No referrals or authorizations should be issued to individual providers in those groups.

Providers may obtain more specific information at ereferrals.bcbsm.com > Provider Search > [Specialty Group NPIs \(for referrals\)](#).

The referral process for BCN HMO members

BCN Referral Notification Form



BCN provides written notification of all approved services to its members, including changes to the date of service and/or extensions of services via the *Referral Notification Form*. The *Referral Notification Form* is mailed within one business day of the decision. Providers can obtain the status of approved services via e-referral. See “Sign up for e-referral” earlier in this chapter.

Approved elective services have a specific date range on the notification form indicating the effective period:

- Approvals for elective services are based on clinical criteria and are valid for six months from the date of the service request. Examples are bariatric surgery and breast reduction.
- Approvals for transplants and orthognathic services are valid for one year from the date of the service request.

Elective services must be reauthorized after the approved time period has passed.

BCN assumes no responsibility for the following:

- Services provided to a person who is not an eligible BCN member on the date services are performed
- Services not covered under the member’s BCN contract
- Services provided to a person who has used all available benefits as defined by their BCN contract

The *Referral Notification Form* is not a guarantee of payment or an assurance of benefits.

Extending a referral

There are times when it is necessary for the BCN HMO member’s primary care physician to extend an existing referral. The primary care physician may extend an existing referral to cover the member’s specialty care for up to one year. Situations requiring a referral extension can include allergy injections, or nephrology, rheumatology, oncology or other conditions that require ongoing long-term care with a specialist. Unless otherwise specified, referrals for extended care are authorized for one year.

Referrals can be easily extended by primary care physicians via e-referral. Primary care physicians should find the referral using the treatment search feature, select the Extend button and make the necessary changes. The Extend button will be available for only 90 days after the original referral end date has passed.

In the case of extended care, the specialist should confirm the member’s continued eligibility and coverage each month.

The referral process for BCN HMO members

Updating a referral

There are also times when it is necessary for the BCN HMO member's primary care physician or specialist to update an existing referral. Situations requiring a referral update can include a change in facility, a change in treatment setting (for example, outpatient rather than inpatient) or a change in date of service.

These changes cannot be done via e-referral. Providers should contact BCN's Utilization Management department at 1-800-392-2512 to make these types of updates to referrals or authorizations.

Effect of change of primary care physician or end of eligibility

If the BCN HMO member is no longer eligible for BCN coverage, the referral is no longer valid. If the member has changed primary care physicians, the member needs to get a new referral from his or her new primary care physician.

The referral process for BCN HMO members

Tips for making the process run smoothly

Providers should follow these tips to make the referral process run smoothly for BCN HMO members:

- Managing member expectations is critical to the member's satisfaction with specialist referrals and referral processing regardless of whether the referral needs to be sent to BCN.
 - Providers who don't think a referral to a specialist is necessary should take the time to explain the reason to the member. Practitioners with high member satisfaction consistently explain the entire treatment plan, including when it is appropriate to refer to a specialist.
 - If a BCN HMO member requests a referral to a specialist or another provider other than the primary care physician's specialist of choice, providers should explain the rationale for the clinically based decision to the member.
- Communication should occur between the specialist and referring practitioner. BCN HMO members should not serve as a go-between.
 - Instructions issued to the specialist regarding care or the course of treatment should be communicated directly by the primary care physician or office staff to the specialist. Similarly, if the specialist has any special requests or questions, communication should be between the specialist and primary care physician.
 - Specialists are expected to communicate their findings and treatment plan to the primary care physician as soon as possible but not later than 30 days after the visit.
- Referral start and end dates should accommodate the type of services being requested. Start and end dates are strongly recommended, even for referrals that do not need to be sent to BCN. For example:
 - If a BCN HMO member is being referred for treatment of a chronic condition, referrals should be written for up to 12 months of care.
 - If the referral is for a specialty for which an appointment might not be readily available (for example, neurology or oncology), the provider should leave the referral open long enough to accommodate the future appointment. The provider can also schedule the appointment for the member and build the referral around the appointment date.
- Referrals should be processed promptly.
 - One of the attributes most often mentioned by practitioners who have very high member satisfaction is the speed with which referrals are processed.
 - If referrals are necessary, they should be submitted daily to BCN or to the medical care group for timely processing.
 - Referrals should be done as far in advance of the specialist appointment as possible so that any questions or problems can be resolved prior to the appointment.

The referral process for BCN HMO members

Postservice referrals

The primary care physician is not obligated to issue a referral after services have been provided if the BCN HMO member did not request a referral prior to the date of service. BCN accepts postservice referrals that are received within one year of the date of service.

Ensuring prompt payment



If referral submission to BCN is required for the region in which the primary care physician is located, claims submitted must correspond to an approved referral to facilitate payment. If a referral was not submitted in a timely manner, the claim may be denied for payment.

Providers should not perform services requiring BCN approval until that approval has been obtained. Providers should verify approval on e-referral or contact the primary care physician or attending physician for an authorization number prior to performing services that require BCN approval.

Role of the primary care physician

BCN members rely on their primary care physician to do the following:

- Manage their overall health care
- Explain their treatment plan
- Communicate with them in easy-to-understand language
- Select a specialist, explain the rationale for selecting that specialist and do the following:
 - Create and submit referrals promptly in the e-referral system (for BCN HMO members only), including determining the date span of referrals
 - Define the conditions for which the member is being referred
 - Provide specific instructions to the specialist
 - Instruct specialists regarding facility and urgent care usage
 - Provide expectations regarding written reports by the specialist to the primary care physician (if the referral is for an extended period)
- Direct care to specific facilities as necessary

The referral process for BCN HMO members

Role of the specialist provider

BCN members rely on their specialist to:

- Follow all instructions provided by the primary care physician or contact the primary care physician to discuss suggested changes to instructions
- Notify the primary care physician of all services performed and the results of services or tests
- Refer the member back to the primary care physician if the services of another specialist are required
- Verify member eligibility
- Contact the primary care physician for a referral extension (for BCN HMO members only)

If a specialist plans to perform any service requiring plan notification or authorization in an inpatient or outpatient facility setting, the specialist must:

- Submit the required clinical information at the same time as the referral if the service requires authorization
- Refer members to contracted facilities designated by the primary care physician

Specialists must follow these guidelines:

- For office services for BCN HMO members, always abide by the start and end dates of the global referral. Do not order or provide a service after the end date of the global referral, as the claim may not be paid.
- When required, submit a plan notification or authorization request to BCN's Utilization Management department via e-referral prior to the date of service for services that are outside of the scope of the global referral, including those ordered or performed in an outpatient or inpatient facility setting. Providers must submit the required clinical information along with the request. For all urgent requests, call BCN's Utilization Management department at 1-800-392-2512.
- Call within the time frame of the global referral (for BCN HMO members only) for a service that will be performed within 30 days of the end date of the referral (inpatient or outpatient in a facility).
- Honor the request from the primary care physician to perform services at the facility that the primary care physician specifies.
- Provide a consultation report to the primary care physician within 30 days of treating the member.

BCN authorization requirements

Overview of authorization

BCN's authorization process is established to do the following:

- Ensure uniformity in the provision of medical and behavioral health care
- Ensure the medical appropriateness and cost effectiveness of certain services
- Improve the overall quality of care BCN members receive
- Lower the cost of coverage for BCN members

BCN determines which services are subject to authorization by analyzing the plan's utilization data and comparing it with the following:

- Internal goals
- External benchmarks, such as HEDIS®
- Medical policies

Other factors are also taken into consideration, such as:

- Procedures high in cost or volume
- Trends toward increasing use of a procedure or service
- Evidence of or reason to suspect actual or potential misuse
- Variations in practice patterns
- Services provided without direct physician oversight
- Services provided without any method of cost or quality control — for example, services not subject to capitation or physician referral processes

In deciding which services require authorization, BCN also looks carefully at:

- The negative impact the proposed review program might have on providers
- The acceptability of any existing criteria, such as InterQual® criteria, Medicare guidelines or information from the medical literature
- Administrative impacts to the health plan and providers
- Market analysis or benchmarking, to determine whether the procedure is within the range of reasonable or accepted practice
- Net cost savings, considering any possible administrative cost offset

Prior to implementation, proposed authorization requirements are vetted internally and also externally, with actively practicing BCN-contracted providers.

BCN authorization requirements

Authorization required

BCN must review and approve select services before they are provided. The primary reason for authorization is to determine whether the service is medically necessary, whether it is performed in the appropriate setting and whether it is a benefit. Clinical information is necessary for all services that require authorization, to determine medical necessity.

All pertinent clinical information must be submitted with the authorization request. For requests submitted through the e-referral system, the clinical information can be attached to the case. For instructions on how to attach the clinical information, refer to the subsection titled “Submit the required clinical information with the initial authorization request” found elsewhere in this section.

A complete list of the clinical criteria and required information that apply to each requested service can be accessed at ereferrals.bcbsm.com > BCN > Authorization Requirements & Criteria > [Medical Necessity Criteria / Benefit Review Requirements for Services Not Involving Drugs / Biologicals Covered under Medical Benefit](#).

This list is also available on BCN’s Authorizations / Referrals page within Provider Secured Services.

Note: This list shows the clinical information required for services that do not involve drugs or biologicals covered under the medical benefit. For the clinical information required for drugs covered under the medical benefit, providers should refer to “Medications covered under the medical benefit” later in this section.

Services for which authorization is required are noted on the *BCN Referral and Authorization Requirements* document, which can be accessed at ereferrals.bcbsm.com > BCN > Authorization Requirements & Criteria > [BCN Referral and Authorization Requirements](#). The document can also be accessed via BCN’s Authorizations / Referrals page within Provider Secured Services.



BCN authorization requirements

Submit authorization requests using the e-referral system

Using the e-referral system is the most efficient way to submit an authorization request to BCN Utilization Management and check the status of the request.

Submitting the request

Here are some advantages to using the e-referral system to submit authorization requests to BCN Utilization Management:

- Authorization requests that involve a questionnaire and that meet criteria can be automatically approved through e-referral, with no waiting.
- BCN Utilization Management phones are busy and using e-referral is the best way to submit an authorization request quickly. No waiting on hold.
- The e-referral system is available anytime, day or night. While, it's best to submit authorization requests before the service is performed, the request can be submitted anytime using e-referral.
- Required clinical documentation can be attached to authorization requests in e-referral. No need to fax it.
- Using e-referral instead of faxing speeds up these tasks:
 - Requesting extensions of approved authorization requests
 - Requesting continued stays
 - Submitting discharge dates

Checking the status of a request

Providers can also check the status of their requests using the e-referral system.

The status of the request will be one of these:

- Pending decision
- Fully approved
- Partially approved
- Denied
- Voided

Providers can see the case status in the dashboard, in the Status column. The case status is also visible when the case is opened, at the upper left of the screen. For additional information, refer to the [e-referral User Guide](#).



Information is added showing why it is best to submit authorization requests to BCN Utilization Management using the e-referral system.. Providers can also check the status of their requests through the e-referral system.

BCN authorization requirements

Submit the required clinical information with the initial authorization request



Providers are encouraged to submit the required clinical information with the initial request for authorization sent via e-referral. The clinical information can be submitted in one of the following ways:

- By entering it directly into the Case Communication section in the e-referral system

Note: Clinical information can also be attached to the case. Instructions for attaching a document from the member's medical record are outlined in the article "[How to attach clinical information to your authorization request in the e-referral system](#)," in the November-December 2016 *BCN Provider News*, page 44. These instructions are also in the [e-referral User Guide](#), in the subsection titled "Create New (communication)."

- By faxing it to BCN's Utilization Management department at 1-800-675-7278

Note: If the information is being faxed, providers should indicate that in the e-referral Case Communication section.

For clinically urgent procedures, providers can call BCN's Utilization Management department at 1-800-392-2512.

It is important to submit all pertinent supporting documentation with the authorization request so BCN can make a decision as quickly as possible. If BCN hasn't received all the required clinical information, the review cannot be completed. Submitting all the required clinical information up front prevents the delays that occur when the case pends for review.

BCN is required by regulatory agencies and by Medicare to notify members as to what clinical information is needed to process a request for authorization. When providers submit the clinical information with the initial request, it decreases the number of letters that BCN is required to send to members.



Information is added showing why it is best to submit all required clinical information up front, when the authorization request is first submitted.

BCN authorization requirements

Providers must complete a questionnaire in e-referral for some procedures

For some procedures, providers must complete a questionnaire regarding the need for the procedure when submitting the request through e-referral.

If the provider's responses indicate that the procedure meets criteria, the procedure will automatically be approved. If the criteria are not met, the request will be pended for clinical review by BCN's Utilization Management staff.

For cases that are not automatically approved via e-referral after a questionnaire is completed, providers must include additional clinical information in e-referral using the Case Communication section, to help facilitate a determination by BCN's Utilization Management department.

For instructions on how to attach the clinical information, refer to the subsection titled "Submit the required clinical information with the initial authorization request" found elsewhere in this section.

Preview questionnaires for several procedures are available at ereferrals.bcbsm.com > BCN > [Authorization Requirements & Criteria](#). Providers can use these preview questionnaires to prepare their responses, to save time when submitting their request.

Procedures reviewed by eviCore healthcare for BCN

For information about the procedures reviewed by eviCore healthcare for BCN, providers should do the following:

- For information on the select interventional pain management and radiation therapy procedures that eviCore reviews for BCN, refer to the section titled "Procedures reviewed by eviCore for BCN," later in this chapter.
 - For information on physical, occupational and speech therapy by therapists and physical medicine procedures by chiropractors, which are reviewed by eviCore for BCN, refer to the section titled "Managing PT, OT and ST / Managing physical medicine services by chiropractors," later in this chapter.
-

Procedures reviewed by AIM Specialty Health® for BCN



AIM Specialty Health processes requests to review select outpatient cardiology and radiology procedures for members of all ages, for dates of service on or after Oct. 1, 2018.

For information about the procedures reviewed by AIM Specialty Health for BCN, providers should refer to the [AIM-Managed Procedures page](#) in the BCN section of the ereferrals.bcbsm.com website.

Note: For dates of service prior to Oct. 1, 2018, submit authorization requests to BCN Utilization Management using the e-referral system.

A statement is added that for dates of service prior to Oct. 1, 2018, authorization requests for select outpatient cardiology and radiology services should be submitted to BCN Utilization Management.

BCN authorization requirements

Procedures reviewed by TurningPoint Healthcare Solutions, LLC, for BCN



TurningPoint Healthcare Solutions manages authorizations for certain musculoskeletal surgical and other related procedures for both BCN HMO and BCN Advantage members, for dates of service on or after ~~July~~ **June 1, 2020**.

For information on how to submit authorization requests to TurningPoint, refer to the document [Musculoskeletal procedure authorizations: Frequently asked questions for providers](#).

For additional information, providers should refer to the [Musculoskeletal Services page](#) in the BCN section of the ereferrals.bcbsm.com website.

Note: For dates of service before July 1, 2020, some of these services require authorization by BCN Utilization Management through the e-referral system; other services do not require authorization at all.

Information is added showing that TurningPoint Healthcare Solutions manages authorizations for certain musculoskeletal surgical and other related procedures for both BCN HMO and BCN Advantage members, for dates of service on or after July 1, 2020. Providers can submit authorization requests to TurningPoint as early as June 1, 2020.

Sleep Management Program



Detailed information about BCN's Sleep Management Program is available at ereferrals.bcbsm.com > BCN > [Sleep Management Program](#).

Providers may also access the medical necessity criteria for sleep studies at:

- [Medical Necessity Criteria / Benefit Review Requirements for Services Not Involving Drugs / Biologicals Covered under Medical Benefit](#)
- Medical policy on sleep studies, accessed by logging in to Provider Secured Services and clicking BCN Provider Publications and Resources > Medical Policy Manual > Policies by Name > S > Sleep Disorders, Diagnosis and Medical Management

Bariatric surgery



For information on bariatric surgery requirements, refer to:

- The Evaluating the Quality of Care chapter of this manual. Look in the section titled "Blue Distinction Specialty Care."
- The [Bariatric Surgery webpage](#) in the BCN section of the ereferrals.bcbsm.com website

Medications covered under the medical benefit

Medications that are not self-administered are generally covered under the medical benefit rather than the pharmacy benefit. These are medications that are typically administered in a specialty clinic or practitioner office.

For additional information on these drugs, refer to the Pharmacy chapter of this manual. Look in the section titled "Drugs covered under the medical benefit."

BCN authorization requirements

NOC codes require clinical information

Services with “not otherwise classified” codes* require authorization, including the clinical information, prior to the service being performed.

Note: NOC codes are also referred to as “unclassified codes,” “unlisted codes” and “unspecified codes.”

If it is determined that an NOC code is the most appropriate code only after the service has already been provided, the provider must call BCN's Utilization Management department at 1-800-392-2512. This applies even if BCN had previously approved the service with a non-NOC code.

If the request involving an NOC code is submitted to a vendor (for example, J&B Medical Supplies, Northwood or JVHL) and the vendor cannot approve it, the request is forwarded to BCN Utilization Management for review.

Providers should have the following information available when calling BCN Utilization Management for a review by telephone related to an NOC code:

- The member's information, including name and member number
- The member's diagnosis
- The NOC code to be submitted and the name of the service
- The clinical information relevant to the service being reviewed (for example, the operative report or the office medical record notes), including information that specifically describes the procedure being reported with the NOC code and the reason the NOC code is being used

If the necessary clinical information is readily available, the case is entered or updated with the NOC code and the call is transferred directly to a BCN Utilization Management nurse.

If the necessary clinical information is not readily available, the case is entered or updated with the NOC code and is pended until the clinical information is available. If the clinical information is not received within the required time frame, the request is denied for lack of clinical information.

Note: Information on the time frames within which decisions are made can be found in the “Utilization management decisions” section of this chapter.

To avoid claim payment delays or denials, providers should contact BCN Utilization Management for authorization of services with NOC codes.

When a claim is submitted with an NOC code, the following occurs:

- If the case has been pended and a claim is submitted before the clinical information is received, the claim may be denied for lack of authorization.

Note: If BCN does not receive the clinical information within 45 days of the request, the request will be denied for lack of clinical information.

- If the service was performed and the claim was denied because BCN's Utilization Management department was not contacted at all, the provider may contact BCN Utilization Management. The claim may be resubmitted if the service is authorized.

BCN authorization requirements

Criteria and guidelines for decisions

The criteria adopted by the plan are updated annually and include CMS Medicare Guidelines and also the following:

Criteria	Application
InterQual Acute – Adult and Pediatrics	<ul style="list-style-type: none"> Inpatient admissions Continued stay and discharge readiness
InterQual Level of Care – Subacute and Skilled Nursing Facility	<ul style="list-style-type: none"> Subacute and skilled nursing facility admissions
InterQual Rehabilitation – Adult and Pediatrics	<ul style="list-style-type: none"> Inpatient admissions Continued stay and discharge readiness
InterQual Level of Care – Long Term Acute Care	<ul style="list-style-type: none"> Long-term acute care facility admissions
InterQual Level of Care – Home Care	<ul style="list-style-type: none"> Home care requests
InterQual Imaging	<ul style="list-style-type: none"> Imaging studies and X-rays
InterQual Procedures – Adult and Pediatrics	<ul style="list-style-type: none"> Surgery and invasive procedures
Blue Cross/BCN medical policies (jointly developed)	<ul style="list-style-type: none"> Services that require clinical review for medical necessity
BCN-developed imaging criteria	<ul style="list-style-type: none"> Imaging studies and X-rays
BCN-developed Local Rules	<ul style="list-style-type: none"> Exceptions to the application of InterQual criteria that reflect BCN’s accepted practice standards

Obtaining criteria



The review criteria used to make a determination on a specific authorization request are available to practitioners upon request.

To request the criteria, complete the [BCN Criteria Request Form](#) and fax it to 1-866-373-9468.

The *BCN Criteria Request Form* is available at ereferrals.bcbsm.com > BCN > Authorization Requirements & Criteria. Look under the “Referral and authorization information” heading.

Note: This applies to non-behavioral health authorization requests only.

Requests requiring clinical information

How to submit clinical information



Clinical information is required for all authorization requests to ensure timely decisions by BCN. The preferred method of submitting clinical information is through e-referral. (There is more information about the e-referral system earlier in this chapter.)

Supporting clinical information must be included in the Case Communication section in the e-referral system. Clinical information can be attached to the case. Instructions for attaching a document from the member's medical record are outlined in the article **"How to attach clinical information to your authorization request in the e-referral system,"** in the November-December 2016 *BCN Provider News*, page 44. These instructions are also in the **e-referral User Guide**, in the subsection titled "Create New (communication)."

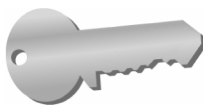
Clinical information may also be sent to BCN's Utilization Management department as follows:

- By phoning it in to 1-800-392-2512
- By faxing it to 1-800-675-7278

The caller and the nurse review the clinical information, using established criteria, and the member's benefits. Whenever possible, the provider receives a determination during the discussion. Clinical information includes relevant information regarding the member's:

- Health history
- Physical assessment
- Test results
- Consultations
- Previous treatment

Clinical information should be provided prior to the service. The facility is responsible for ensuring authorization. BCN provides a reference number on all authorizations.



If clinical information is not received with the request, BCN's Utilization Management department contacts the practitioner verbally to request the necessary documentation. In addition, follow-up letters are sent to the member and the provider requesting the required information. If documentation is not submitted within the designated time frame, the request is denied.

The most efficient way to submit clinical information is through the e-referral system. Providers should use the Case Communication section to document how the clinical criteria are met.



We've removed references to providers submitting authorization requests or providing clinical information related to those requests at least 14 business days prior to the service. Providers should submit authorization requests and clinical information prior to the service being provided but can submit through the e-referral system anytime.

Requests requiring clinical information

How a determination is made

In addition to reviewing clinical information, BCN evaluates the following:

- The member's eligibility and coverage
- The medical need for the service
- The appropriateness of the service and setting

If additional clinical information is required to approve the service, a BCN Utilization Management representative telephones the specialist's or primary care physician's office. To ensure that all needed information is received in a timely manner, a written request may also be sent to the member, the primary care physician and the specialist or to another provider to whom the member may have been referred.

Notification of determination

When the determination is made, notification is sent as follows:

- If the request is approved, BCN sends written notification to the member. Providers can look up the status of the request via e-referral.
 - If the request is denied, BCN sends a letter to the member and the primary care physician and to other providers and practitioners, as appropriate, explaining the reason(s) for the denial along with instructions for filing an appeal and information on how to reach the BCN plan medical director who made the decision. Providers who have access to e-referral may also view the determination online as soon as one is made.
-

Referrals to noncontracted providers

Noncontracted providers are those who do not have an affiliation agreement with BCN. For members whose coverage requires use of a designated provider network, the primary care physician must coordinate care with specialists and hospitals within that network.

BCN must review and approve all requests to noncontracted providers before services are provided, to determine medical necessity and the availability of contracted providers or practitioners. This is true whether the provider is in state or out of state. Redirection to a contracted provider is attempted, to promote the use of network resources.

Referrals to noncontracted providers may be approved when medically necessary in emergency situations or when an in-network provider cannot provide the necessary service.

A plan medical director reviews all requests to noncontracted providers. A plan medical director also reviews instances in which the primary care physician declines redirection to a contracted practitioner or provider.

Requests requiring clinical information

Steps to take before providing services that are not or may not be covered

It is recognized that the member may consent to receive services that are not or may not be covered by BCN and that therefore may be payable by the member.

Providers should refer to the BCN Advantage chapter of this manual for the steps they should take before providing a service that is not or may not be covered. The information is in the “Exclusions and limitations” section.

Providers should follow the same steps for BCN HMO (commercial) members as for BCN Advantage members.

Referrals and authorizations summary

What providers need to know



When providing services to BCN members, providers should make sure they are aware of these referral and authorization highlights:

- BCN's referral program guidelines for BCN HMO members differ by region. Providers should remember to access the regional program grid applicable to the region in which they are located. Providers should refer to the referral and authorization requirements for each region at ereferrals.bcbsm.com > BCN > Authorization Requirements & Criteria > **BCN Referral and Authorization Requirements**.
- The facility is responsible for verifying the authorization prior to providing a service. Up-to-date referral information is available on e-referral.

Global referrals (for BCN HMO members only)

Only the member's primary care physician can issue a global referral.

- If a global referral is available, the specialist can request authorization from BCN, according to the referral and authorization requirements applicable to the region in which he or she is located.
- Global referrals may be issued for no less than a 90-day period and no more than 365 days.
- Global referrals may not be submitted to any noncontracted provider or to any facility.

Referral not required

- Select services do not require a referral or authorization submission to BCN as long as the service is performed by a contracted practitioner or provider and both the primary care physician and the provider who received the referral can document that a referral was made.
- No referrals are required for BCN Advantage members.

Note: When a provider submits a referral for a BCN Advantage member through the e-referral system, the following message will be displayed:

"Referrals are not accepted or needed for BCN Advantage members seeing providers in their health plan's network, but authorizations and plan notifications are still required for certain services. For more information, go to ereferrals.bcbsm.com."

When a provider submits a referral request for a BCN Advantage member through a 278 electronic standard transaction, the referral response will state "NA," which means that no action is needed.

Referral submission to BCN not required

- Select services do not require a referral or authorization as long as the member is referred for the service by the primary care physician.

Referrals and authorizations summary

What providers need to know (continued)

Plan notification

- BCN must be notified of the service in order for a facility or professional provider to be paid.

Hospitals should contact the primary care physician prior to urgent or emergency admissions and notify BCN within one business day with the member's demographic and clinical information.

Authorization

- Notify BCN before elective services start.
- All out-of-network services require authorization prior to the service being provided.
- All services with unclassified medical codes (CPT and HCPCS codes) require authorization.
- The most efficient way to submit an authorization request is through e-referral, documenting how the clinical criteria are met in the Case Communication section.
- Photographs and/or written documentation may be required for review of selected services.
- Authorization must be obtained prior to the service being provided.

Approved elective services date range

- Bariatric surgery and breast reduction services are valid for six months from the date of the service request.
- Transplants and orthognathic services are valid for one year from the date of the service request.
- All other elective services must be reauthorized after the approved time period has passed.

Air ambulance transports, for BCN HMO (commercial) members only

Submit authorization requests for non-emergency air ambulance transports to Alacura Medical Transport Management. by faxing a completed [Air ambulance flight information \(non-emergency\) form](#), along with clinical documentation in support of the request, to Alacura at 1-844-608-3572. Then call Alacura at 1-844-608-3676 to obtain the authorization number.

Emergency air ambulance transports do not require authorization. Additional information is available in the section titled "Air ambulance services."

Behavioral health services

Contact BCN's Behavioral Health department as follows:

- For BCN HMO (commercial) members, call 1-800-482-5982.
- For BCN Advantage members, call 1-800-431-1059.

Outpatient diabetic supplies

Contact J&B Medical Supply at 1-888-896-6233. Exception: Diabetic shoes and inserts are handled through Northwood, Inc.

Referrals and authorizations summary

What providers need to know (continued)

Outpatient durable medical equipment and P&O

Contact Northwood's customer service department at 1-800-393-6432 to identify a contracted supplier. The supplier submits the request to Northwood for review.

Note: As a rule, Northwood provides nondiabetic outpatient medical items. Exception: Northwood provides diabetic shoes and inserts.

Pharmacy inquiries

For pharmacy inquiries about eligibility and benefits, providers should call PARS / Provider Inquiry using the appropriate number as indicated on the [Provider Inquiry Contact Information](#) list.

Physical, occupational and speech therapy services by therapists in office and outpatient settings, including outpatient hospital settings, and physical medicine services by chiropractors

For information on referral and authorization requirements, including eviCore healthcare contact information, providers should refer to the "Managing PT, OT and ST / Managing physical medicine services by chiropractors" section.

For claims questions, providers should call PARS / Provider Inquiry using the appropriate number as indicated on the [Provider Inquiry Contact Information](#) list.

Select outpatient interventional pain management and radiation therapy procedures

Submit requests for authorization to eviCore healthcare online at www.evicore.com* or by telephone at 1-855-774-1317. Refer to the "Procedures reviewed by eviCore for BCN" section of this chapter.

*Clicking this link means that you're leaving the Blue Cross Blue Shield of Michigan and Blue Care Network website. While we recommend this site, we're required to let you know we're not responsible for its content.

Select outpatient cardiology and radiology procedures

For dates of service on or after Oct. 1, 2018, submit requests for authorization to AIM Specialty Health online at providerportal.com or by telephone at 1-844-377-1278. Refer to the [AIM-Managed Procedures page](#) in the BCN section of the ereferrals.bcbsm.com website.

Member responsibilities

Members should be aware of their benefits and are advised to direct questions to Customer Service at the number on the back of their BCN ID cards. They are also responsible for coordinating out-of-state care with BlueCard for urgent or emergency and follow-up care at 1-800-810-BLUE (2583).



Procedures reviewed by eviCore for BCN

Overview of eviCore-managed procedures

The information in this section does not apply to physical, occupational and speech therapy by therapists and physical medicine services by chiropractors, which are managed by eviCore for BCN. For information on those services, refer to the section titled “Managing PT, OT and ST / Managing physical medicine services by chiropractors,” later in this chapter.

The information in this section does apply to select non-emergency outpatient interventional pain management and radiation therapy procedures that require authorization when performed in freestanding diagnostic facilities, outpatient hospital settings, ambulatory surgery centers and physician offices for BCN HMO (commercial) and BCN Advantage members.

All BCN-participating freestanding diagnostic facilities, outpatient hospital settings, ambulatory surgery centers and practitioner offices that provide these services must submit authorization requests by visiting www.evicore.com or by calling 1-855-774-1317, preferably prior to providing services.

Information about the eviCore review process is available on BCN’s [eviCore-Managed Procedures](#) page at ereferrals.bcbsm.com. Specifically:

- The document [Frequently asked questions about requesting authorization from eviCore healthcare](#) offers an overview of the eviCore authorization requirements.
- Refer to the [list of procedure codes that require authorization by eviCore healthcare](#).
- The [Authorizations Quick Reference Guide](#) tells how to submit authorization requests through the www.evicore.com* website.
- The document [Guidelines for services reviewed by eviCore healthcare for Blue Cross Blue Shield of Michigan and Blue Care Network](#) offers contact numbers and other information.



Services performed in conjunction with an inpatient or observation stay or during an emergency visit do not require authorization.

Urgent requests — in which the member’s medical condition is jeopardizing his or her life or health and is deemed life-threatening — should be called in to eviCore at 1-855-774-1317. Providers should ask the eviCore representative to expedite the request because the member needs medically urgent care. Refer to the [Guidelines](#) document for more details about the correct number to call for each type of service.

*Clicking this link means that you’re leaving the Blue Cross Blue Shield of Michigan and Blue Care Network website. While we recommend this site, we’re required to let you know we’re not responsible for its content.

Procedures reviewed by eviCore for BCN

What providers should be aware of

With regard to the outpatient interventional pain management and radiation therapy procedures managed by eviCore for BCN, providers should be aware of the following:

- Except for interventional pain management services, “add-on” codes do not require authorization. Authorization is required only for the primary code. A separate authorization is not needed to bill Blue Care Network for add-on codes if there is a valid authorization on file for the primary code. Claims submitted to BCN for add-on codes without authorization for the associated primary code will not be reimbursed.
- eviCore makes radiation therapy worksheets available on its website. Providers must complete a worksheet with pertinent clinical information and attach it to the case in eviCore’s online system when submitting authorization requests for radiation therapy procedures. eviCore updates its radiation therapy worksheets from time to time. To access the most current worksheets:
 1. Visit www.evicore.com.*
 2. Click *Providers* at the upper right.
 3. Click *Clinical Worksheets*.
 4. Type “Blue Care Network” into the search field and click the search icon.
 5. Click *Radiation Oncology*.
 6. Click to open the desired worksheet.
- For procedures other than radiation therapy, worksheets are available but providers are not required to submit them to eviCore with the case.

Note: For physical, occupational and speech therapy and for physical medicine procedures by chiropractors, see the section titled “Managing PT, OT and ST / Managing physical medicine services by chiropractors” later in this chapter.

(continued on next page)

*Clicking this link means that you’re leaving the Blue Cross Blue Shield of Michigan and Blue Care Network website. While we recommend this site, we’re required to let you know we’re not responsible for its content.



Procedures reviewed by eviCore for BCN

What providers should be aware of (continued)

- For interventional pain management services, authorization is required for all diagnoses, for adult and pediatric members. These services include epidural and facet joint injections, sacroiliac joint injections, epidural adhesiolysis, radiofrequency ablation and regional sympathetic blocks.
For multiple pain management injections:
 - eviCore will authorize only a single injection per date of service. The single injection could be the same injection at various levels.
 - An additional authorization is needed for each subsequent injection. This is because eviCore does not authorize “a series of injections.” Instead, eviCore will evaluate the medical necessity of each subsequent injection after considering the member’s response to the previous injection.
- All requests should be submitted to eviCore first. If the eviCore system responds that a particular request should be reviewed by BCN’s Utilization Management department instead, the request should be submitted through the e-referral system. (This occurs when the code submitted to eviCore is not included on the list of codes eviCore reviews.)
- For all procedures, the provider office submitting the e-referral request and the hospital performing the procedure should make sure the codes submitted and the procedures to be performed match those requested by the ordering practitioner and are authorized by eviCore. If there is a discrepancy, the hospital should contact the ordering provider and ask him or her to submit the request for the appropriate procedure. This should occur prior to the service being provided, if possible. Errors related to procedure codes can result in delays in processing the request and in billing problems.



Providers with additional questions can also refer to the [eviCore training material](#).

Scheduling phone appointments for eviCore clinical consultations about reviews



Providers can go online to schedule phone appointments for a clinical consultation with an eviCore healthcare clinical representative and not have to wait on hold. This applies to any authorization request reviewed by eviCore for BCN HMO (commercial) and BCN Advantage members.

For instructions on how to schedule an appointment for a phone consultation, refer to the article “[Providers can schedule a phone appointment for eviCore clinical consultations on BCN radiology reviews](#),” in the July-August 2017 issue of *BCN Provider News* (page 39).

Note: Since that article was published, the option for scheduling phone appointments online has been extended to apply to any service eviCore manages for BCN. This includes the select cardiology and radiology services that eviCore is managing for dates of service prior to Oct. 1, 2018, including postservice requests.

Before this scheduling option was made available, providers had to call eviCore and wait on hold until an eviCore physician became available.

Blue Elect Plus Self-Referral Option

Blue Elect Plus Self-Referral Option overview

Blue Elect Plus Self-Referral Option is a self-referral option product. Members covered by this product must select a primary care physician from BCN's provider network. Members may choose to self-refer to any in-network or out-of-network provider, but are always encouraged to partner with their primary care physician for their health care.

Members pay the lowest costs when their care is provided by their primary care physician or by another provider in the BCN network. Certain services are covered only when provided by a BCN provider.

Requirements for plan notification and authorization apply whether services are performed by BCN or non-BCN providers.

No referrals needed

Providers do not need to give referrals to Blue Elect Plus Self-Referral Option members.

General utilization management requirements



For detailed guidelines on plan notification and authorizations for Blue Elect Plus Self-Referral Option members, providers should refer to the *Blue Care Network Referral and Authorization Requirements* document, which can be accessed at ereferrals.bcbsm.com > BCN > Authorization Requirements & Criteria > [BCN Referral and Authorization Requirements](#).

When authorization is required, it needs to be completed in advance regardless of network affiliation. The requirements for plan notification and authorization apply whether services are performed by in-network or out-of-network providers.

Other utilization management requirements

The following utilization management requirements also apply:

- If a specific service is not available from an in-network provider and the member wishes to see an out-of-network provider, the provider must request and receive authorization from BCN's Utilization Management department for the member to receive the in-network benefit.
 - If a member wishes to see an out-of-network provider for a service that normally requires an authorization, the out-of-network provider in coordination with the member must contact BCN's Utilization Management department in advance to obtain authorization.
-

Provider Information Card



Blue Elect Plus Self-Referral Option members receive a **Provider Information Card** along with their new ID card. The Provider Information Card provides a brief overview of Blue Elect Plus Self-Referral Option billing and utilization management requirements for participating and nonparticipating providers.

BCN instructs members to carry both cards and present them together when visiting their provider. Providers should place a copy of both cards in the member's file.

BCN's Medicare products

Medicare products offered by BCN	<p>BCN offers three products for Medicare-eligible members that are subject to utilization management: BCN Advantage HMO-POS products (group products and Basic, Classic, Elements and Prestige individual products), BCN Advantage HMO products (BCN Advantage HMO ConnectedCare, BCN Advantage HMO MyChoice Wellness, BCN Advantage HMO HealthySaver and BCN Advantage HMO HealthyValue) and BCN 65.</p> <p>The BCN Advantage products provide comprehensive HMO benefits, and all benefits are provided by and managed by BCN.</p> <p>BCN 65 coordinates with Medicare coverage. It covers the deductibles and copayments for all services that Medicare covers and also offers additional benefits. Additional information on BCN 65 is available in the “BCN 65 and secondary coverage” section of this chapter.</p>
BCN Advantage products	<p>BCN Advantage HMO-POS and BCN Advantage HMO products function as Medicare replacement products rather than as supplemental products. Members use their BCN Advantage HMO-POS or BCN Advantage HMO membership card instead of the government-issued red, white and blue Medicare card to get covered services.</p>
BCN Advantage HMO-POS provider network	<p>The BCN Advantage HMO-POS network is separate from the BCN network but includes primary care physicians, specialists, hospitals and other providers who are licensed and certified by Medicare and by the state to provide health care services. Not all BCN providers are included in the BCN Advantage HMO-POS network.</p> <p>Primary care physicians must send BCN Advantage HMO-POS members to providers in the BCN Advantage HMO-POS network.</p>
Services outside the provider network	<p>Other BCN Advantage products have a designated provider network associated with each product. The general rule is that if a member goes to a provider who is not included in the network for that member's product, authorization from BCN's Utilization Management department is required in order for that out-of-network provider to provide services to the member.</p> <p>The member's primary care physician must request authorization through BCN's Utilization Management department and may be asked to supply supporting clinical information as to why the member needs to be referred to an out-of-network provider.</p> <p>If the services are available through an in-network provider, the primary care physician is asked to redirect the member to an in-network provider.</p> <p>Additional information on products with designated provider networks is provided in the “Other BCN products with networks” section, which appears later in this chapter.</p>

BCN's Medicare products

BCN Advantage HMO MyChoice Wellness provider network The BCN Advantage HMO MyChoice Wellness product has a designated provider network that consists primarily of providers and hospitals affiliated with Mercy Health. Not all BCN Advantage HMO-POS providers are part of the MyChoice Wellness network.

Primary care physicians (or OB-GYN, for obstetric-gynecologic-related services) must send MyChoice Wellness members to providers in the MyChoice Wellness network. If a service needed by a member is not available within the BCN Advantage HMO MyChoice Wellness network, the primary care physician must submit a request for authorization to BCN to send the member to a provider in the wider BCN Advantage network. This request should be submitted on the e-referral system as an outpatient or inpatient authorization request.

BCN Advantage HMO ConnectedCare provider network The BCN Advantage HMO ConnectedCare product has a designated provider network that includes providers and hospitals that serve members who live in Arenac, Genessee, Iosco, Kalamazoo, Livingston, Macomb, Oakland, Saginaw, St. Clair, Washtenaw or Wayne County. Not all BCN Advantage HMO-POS providers are part of the BCN Advantage HMO ConnectedCare network.

Members with this product must select a BCN Advantage HMO ConnectedCare primary care physician. The primary care physician coordinates care and sends the member to providers who are within the BCN Advantage HMO ConnectedCare network when specialty or hospital care is needed. If a service needed by a member is not available within the BCN Advantage HMO ConnectedCare network, the primary care physician must submit a request for authorization to BCN to send the member to a provider in the wider BCN Advantage network. This request should be submitted on the e-referral system as an outpatient or inpatient authorization request.

Obstetric-gynecologic care must be provided within the BCN Advantage HMO ConnectedCare network. If a member wishes to visit an OB-GYN outside of the BCN Advantage HMO ConnectedCare local network, the primary care physician (or OB-GYN, for obstetric-gynecologic-related services) must submit a request for authorization to BCN.

For additional information about BCN Advantage HMO Connected Care, see the BCN Advantage chapter of this manual.

BCN's Medicare products

Provider network for BCN Advantage HMO HealthySaver and BCN Advantage HMO HealthyValue

The BCN Advantage HMO HealthySaver and BCN Advantage HMO HealthyValue products are available to individuals who reside in Arenac, Genesee, Iosco, Kalamazoo, Kent, Livingston, Macomb, Muskegon, Oakland, Oceana, Ottawa, Saginaw, St. Clair, Washtenaw or Wayne county.

In the West region of Michigan, HealthySaver and HealthyValue members are served by the doctors and hospitals of Mercy Health. In Southeast Michigan, the Bay area and Kalamazoo, HealthySaver and HealthyValue members are served by the doctors and hospitals affiliated with Trinity Health and Ascension.

Care provided outside the HealthySaver / HealthyValue provider network requires authorization from BCN.

BCN Advantage authorization requirements



For details related to BCN Advantage authorization requirements, providers should consult the relevant information on the following link:

[BCN Referral and Authorization Requirements](#)

This information is also available by visiting:

- ereferrals.bcbsm.com > BCN > [Authorization Requirements & Criteria](#)
- bcbsm.com/providers, logging in to Provider Secured Services and clicking BCN Provider Publications and Resources > Authorizations / Referrals

Note: For BCN Advantage members, no referrals are required.

Accessing more information on BCN's Medicare products

Physicians and other providers who have questions regarding participation with BCN Advantage HMO-POS or BCN Advantage HMO products should refer to the BCN Advantage chapter of this manual or contact their Blue Cross/BCN provider consultant.

BCN HMO products with provider networks

Provider networks connected with BCN HMO products

Providers need to be aware of provider network considerations when referring BCN HMO members or when accepting members who are referred.

Network considerations that need to be taken into account include:

- For members with coverage through the Blue Cross® Select product, services provided by providers outside of the network designated for that product require a referral from the primary care physician (or OB-GYN, for obstetric-gynecologic-related services) and submission of a request for authorization.
- Members with coverage through Blue Cross® Metro Detroit HMO select their primary care physician from provider network associated with that product. The primary care physician coordinates care with local network specialists and hospitals. The primary care physician's medical care group can provide guidance on which specialists and hospitals should be used for Metro Detroit HMO members. The following guidelines also apply:

- If the primary care physician refers a member for services within the Metro Detroit HMO local network or within the larger BCN network, standard BCN referral and authorization requirements will apply. If the primary care physician refers a member for services outside of the BCN network, out-of-network rules apply. (A request for authorization must be submitted to BCN.)

Note: When selecting a servicing provider during the submission of a request in the e-referral system, the system will indicate "In" or "Out" in the Network column. In this case, "In" means the provider is in the large BCN network. The e-referral system does not yet identify providers by the local Metro Detroit HMO network.

- BCN's Woman's Choice program allows members to seek care with a BCN network OB-GYN without a referral. Members are instructed to remain within the Metro Detroit HMO network.
- For members with coverage through Trinity Health and Metro Health products, services provided by providers outside of the network designated for each product may require BCN approval and typically result in higher out-of-pocket costs.
- For University of Michigan Premier Care, Premier Care 65 and GradCare members, when a member assigned to a non-UM primary care physician is referred to any specialist (U-M or non-UM), a referral is required. This guideline applies regardless of where the member lives or where the practitioners are located.
- For members with coverage through an MSU plan, refer to the [MSU Health Plans page](#) in the BCN section at ereferrals.bcbsm.com for information on referral requirements.

BCN HMO products with provider networks

Referral and authorization requirements for BCN HMO members



For details about referral and authorization requirements for BCN HMO members, providers should consult the relevant information at the following link:

[BCN Referral and Authorization Requirements](#)

This information is also available by visiting:

- ereferrals.bcbsm.com > BCN > [Authorization Requirements & Criteria](#)
- bcbsm.com/providers, logging in to Provider Secured Services and clicking BCN Provider Publications and Resources > Authorizations / Referrals

BCN 65 and secondary coverage

BCN 65 BCN 65 is an HMO product that is secondary to Medicare. It covers Medicare copayments and deductibles and provides some additional benefits such as preventive care.

BCN 65 referrals Members with the BCN 65 certificate are required to have all nonemergency care coordinated by their primary care physician. BCN 65 members are expected to seek care from providers contracted with both BCN and Medicare. Referrals are not required for claims processing.

BCN's Utilization Management department must be notified in the following circumstances:

- Before a member's Medicare days are exhausted, for inpatient and skilled nursing facility services
- For infusion services not routinely covered by Medicare

When BCN is secondary to another insurance When BCN is the secondary health plan, no referral or authorization will be required as long as the member is eligible for BCN coverage, the service is a covered benefit, information about the primary plan's payment is provided and the member has followed the rules of the primary carrier.

If the primary plan denied the claim because its rules were not followed, one of the following applies:

- If BCN requires a referral or authorization for the service and it was not obtained, BCN will deny the claim.
- If BCN does not require a referral or authorization, BCN will pay the claim, but only after validating that all other BCN requirements were met.

Woman's Choice

What is Woman's Choice? Woman's Choice is a program that allows female BCN members to do the following:

- Directly access affiliated practitioners who perform women's health services without a referral from their primary care physician
- Obtain certain professional services from primary care-related specialists without either a referral or a specific diagnosis code
- Obtain other professional services from primary care-related specialists without a referral but with a specific diagnosis code

All female BCN members are eligible to participate in the Woman's Choice program.

Woman's Choice documents Providers can access the following detailed information about Woman's Choice at ereferrals.bcbsm.com > BCN > [Authorization Requirements & Criteria](#). This information is also accessed by visiting bcbsm.com/providers, logging in to Provider Secured Services and clicking BCN Provider Publications and Resources > Authorizations / Referrals, or by clicking on the links provided here:



- **Woman's Choice Referral and Authorization Guidelines:** This document describes which Woman's Choice services require referral, plan notification or authorization and which are direct-access services (not requiring referral, plan notification or authorization).
 - **Woman's Choice specialty and procedure/diagnosis code requirements:** This document outlines the women's health specialists who can provide services without a referral and the procedure/diagnosis code requirements that apply to the Woman's Choice program.
-

For more information



BCN-affiliated practitioners should direct any questions about Woman's Choice to their Blue Cross/BCN provider consultant or to PARS / Provider Inquiry using the appropriate number on the [Provider Inquiry Contact Information](#) list.

Guidelines for observations and inpatient hospital admissions

Admission review

Contracted facilities must notify BCN of all admissions and provide clinical information within one business day of the admission. Timely notification helps ensure that BCN members receive care in the most appropriate setting, that BCN is involved in the evaluation and coordination of discharge planning and that there are appropriate referrals to case management for members who need those services, including those managing active disease processes, those demonstrating high use of health resources or those who are at high risk for health complications.

Refer to the document [Submitting acute inpatient admission requests to BCN](#) for the details about which requests must be submitted through the e-referral system and which must be faxed.

Clinical information must be submitted with the request. Providers may submit the required clinical information by completing the *Request for Review of Initial Inpatient Admission* form and attaching it to the case in the e-referral system. Providers who choose not to submit the form should use it as a guide in determining which parts of the medical record to submit. Providers should not submit the entire medical record; they should submit only the parts that are outlined on the form.

Providers can access the form at ereferrals.bcbsm.com > BCN > Authorization Requirements & Criteria > [Request for Review of Initial Inpatient Admission](#) form.

Note: Instructions for attaching a document to the request in e-referral are outlined in the article [“How to attach clinical information to your authorization request in the e-referral system,”](#) in the November-December 2016 *BCN Provider News*. These instructions are also in the [e-referral User Guide](#), in the subsection titled “Create New (communication).”

For information on how to submit authorization requests for inpatient admissions on holidays, when the Blue Cross and BCN corporate offices are closed, refer to the document [Holiday closures: How to submit authorization requests for inpatient admissions](#).



In this section, a link is added to the document [Holiday closures: How to submit authorization requests for inpatient admissions](#).

Guidelines for observations and inpatient hospital admissions

Admission review decision time frames

The following table outlines the times within which BCN's Utilization Management department makes decisions on admission reviews.

If...	Then...
The information provided meets BCN's criteria without requiring additional information	The case is approved within one calendar day of receipt of the request if the member has not been discharged.
The admission or continued stay cannot be approved with the information provided	<p>If the member has not been discharged at the time BCN is notified of the admission, the BCN nurse may ask the facility and/or attending physician for more information within 24 hours of receipt of request and makes a determination within 72 hours of receipt of request.</p> <p>Note: BCN may request that clinical documentation be submitted on weekends or holidays so that the 72-hour time frame for determinations can be met.</p> <p>Refer to the BCN Advantage chapter of this manual for additional information on reviews of those admissions. Look in the section titled "BCN Advantage Utilization Management Program."</p>
After obtaining all available information, the case still cannot be approved	The BCN nurse discusses the information with BCN's plan medical director.
The plan medical director cannot approve the case based on the information available	The plan medical director may contact the attending physician for additional information related to any review, as deemed necessary. The BCN nurse notifies the practitioner, primary care physician, member and facility of the determination within 72 hours of receipt of the request.
Notification of the admission is received after the member is discharged	BCN has up to 30 days after receipt of the request to make a determination.

Guidelines for observations and inpatient hospital admissions

Decision criteria and guidelines

BCN criteria for certifying services are based on input from appropriate providers, nationally recognized criteria adopted by the plan or a combination of both. Individual circumstances of a member are taken into consideration when applying the criteria, as are characteristics of the local delivery system such as:

- Availability of skilled nursing facilities, subacute care facilities or home care in the network to support the member after discharge
- Member's coverage of benefits for skilled nursing facilities, subacute care facilities or home care, where needed
- Ability of network hospital(s) to provide all recommended services within the established length of stay

The criteria adopted by the plan are updated annually and include:

- InterQual Acute

Note: In reviewing acute inpatient medical admissions, BCN uses the InterQual criteria as a guideline. BCN's medical directors make the final determination about the most appropriate level of care based on their medical judgment. Determinations on authorization requests for BCN HMO and BCN Advantage members are made based on InterQual criteria and any associated BCN Local Rules. Determinations are not made based on the two-midnight rule.

- InterQual Level of Care, Subacute and Skilled Nursing Facility
- InterQual Rehabilitation
- InterQual Level of Care — Long Term Acute Care
- InterQual Level of Care — Home Care
- InterQual Imaging
- InterQual Procedures
- Jointly developed BCN and Blue Cross medical policies
- BCN-developed medical policies
- BCN-developed Local Rules
- CMS Medicare Guidelines

The review criteria are available to practitioners upon request by calling BCN's Utilization Management department at 248-799-6312.



A statement is added clarifying that determinations made on authorization requests for inpatient acute care admissions are not made based on the two-midnight rule. They are made based on the pertinent InterQual criteria and any associated BCN Local Rules.

Guidelines for observations and inpatient hospital admissions

Discussing a denial with a BCN medical director

BCN allows onsite physician advisors at contracted facilities to discuss a preservice or postservice denial of a non-behavioral health inpatient admission with a BCN medical director. In accordance with Blue Cross and Blue Care Network policy, facilities should initiate these peer-to-peer conversations only through their employed physician advisors and not through third-party advisors or organizations.

The purpose of the peer-to-peer discussion is to exchange information about the clinical nuances of the member's medical condition and the medical necessity of the inpatient admission, not to talk about the InterQual criteria or BCN's local rules.

There are additional guidelines that apply to peer-to-peer requests as well.

Providers should refer to Section 1 of the document [How to request a peer-to-peer review with a Blue Cross or BCN medical director](#) to learn about:

- The guidelines that apply to requesting a peer-to-peer review of a determination made on an inpatient or outpatient medical service
- The process for submitting the request, which includes completing the [Physician Peer-to-Peer Request Form \(for non-behavioral health cases\)](#) and following the instructions for sending it to the appropriate location

Note: These guidelines and the process for requesting a peer-to-peer review apply to both inpatient and outpatient medical services.

Emergency admissions

When an admission occurs through the emergency room, BCN asks that the facility contact the primary care physician prior to admission to discuss the member's medical condition and to coordinate care prior to admitting. A member's primary care physician assignment is available via PARS (Provider Automated Response System), formerly known as CAREN. (Providers should refer to "Emergency room and urgent care services" later in this chapter.)

Guidelines for observations and inpatient hospital admissions

Elective admissions

Primary care physicians and specialists are required to notify BCN before arranging elective inpatient and certain outpatient facility services, whenever possible. When a specialist has received a referral from the primary care physician, the specialist is responsible for contacting BCN for selected services that are ordered or performed in a facility setting and for all services requiring authorization. (Providers should see the referral and authorization requirements at ereferrals.bcbsm.com > BCN > [Authorization Requirements & Criteria](#) and by visiting bcbsm.com/providers, logging in to Provider Secured Services and clicking BCN Provider Publications and Resources > Authorizations / Referrals.) The specialist should call within the time frame of the referral for a service that will be performed in the inpatient or outpatient facility within 30 days of the end date of the referral.

BCN reviews the request to determine whether the setting is appropriate and, if required, meets criteria. BCN notifies the member, primary care physician, attending physician and facility of the determination.

Facilities must provide clinical information to BCN's Utilization Management department within one business day of the elective admission.

Obstetrical admissions

BCN requires that facilities provide both admission and discharge information on normal deliveries at the time of discharge via e-referral. For all deliveries, the facility should notify BCN one day after discharge. The following information must be provided:

- Admission date, delivery date and discharge date
- Type of delivery
- Whether the baby was born alive
- Whether both mother and baby were discharged alive

Guidelines for observations and inpatient hospital admissions

Sick newborn baby admissions Newborn babies who are discharged home with their mothers from the newborn nursery do not require a separate authorization from their mother's. However, a separate authorization is required when the newborn requires services of greater intensity. Examples include when a newborn:

- Is transferred to a neonatal intensive care unit or special care nursery from the newborn nursery (The admit date is the date the transfer occurred.)
- Is admitted directly into the neonatal intensive care unit or special care nursery from the delivery room (The admit date is the date of birth.)
- Remains in the nursery after the mother is discharged (The admit date is the mother's discharge date.)

When a sick newborn requires a separate authorization, the authorization request must be submitted by fax, since the newborn is not yet a member covered by BCN. Submit these requests to fax number 1-866-313-8433.



Information is added about where to fax authorization requests for sick newborns.

BCN 65 admissions

For BCN 65 admissions, providers should contact BCN's Utilization Management department before the member's Medicare days are exhausted.

Guidelines for observations and inpatient hospital admissions

- Observation care** Observation care is a well-defined set of specific, clinically appropriate services that are described as follows:
- The services include ongoing short-term treatment, assessment and reassessment.
 - The services are provided while a decision is being made regarding whether a member requires further treatment as a hospital inpatient or is able to be discharged from the observation bed.

Observation stays of up to 48 hours for BCN commercial and BCN Advantage members may be eligible for reimbursement when providers need more time to evaluate and assess a member’s needs in order to determine the appropriate level of care. Examples (not all-inclusive) of diagnoses that may be treated in an observation setting include:

- Chest pain
- Syncope
- Cellulitis
- Asthma
- Pneumonia
- Bronchitis
- Abdominal pain or back pain
- Pyelonephritis
- Dehydration (gastroenteritis)
- Overdose or alcohol intoxication
- Closed head injury without loss of consciousness

Note: Providers should refer to the “Billing guidelines for observation stays” section in the Claims chapter of this manual for information on billing observation stays.

Requirements for observation For BCN commercial and BCN Advantage members, observation stays do not require referral, plan notification or authorization.

Requirements for services provided during observation stays For the most current information on requirements for services provided during an observation stay, the provider should refer to the referral and authorization requirements at ereferrals.bcbsm.com > BCN > [Authorization Requirements & Criteria](#).



Note: When the radiation therapy and interventional pain management procedures reviewed by eviCore healthcare and the cardiology and radiology procedures reviewed by AIM are performed in an observation, emergency or inpatient care setting, they do not require authorization. When they are performed in freestanding diagnostic facilities, outpatient hospital settings, ambulatory surgery centers and physician offices, they do require authorization. See the document [Procedures that require authorization by eviCore healthcare](#) for the procedures reviewed by eviCore. See the document [Procedures that require authorization by AIM Specialty Health](#) to identify the procedures reviewed by AIM.

Guidelines for observations and inpatient hospital admissions

Options available beyond the observation period

For members who require care beyond the observation period, the following options are available:

- Contact BCN's Utilization Management clinical staff to discuss alternate treatment options such as home care or home infusion therapy.
- Request an inpatient admission.

Note: If the member is not discharged within the 48-hour observation stay limit covered by the plan, the provider should re-evaluate the member's need for an inpatient admission. Approval of an inpatient admission is dependent upon criteria review and plan determination. Additional information about medical necessity considerations as applied to questions of inpatient vs. observation stays for BCN Advantage members is available in the BCN Advantage chapter of this manual.

For members who are ready for discharge, providers may call BCN's Utilization Management department 1-855-724-4285 for assistance with discharge planning.

Review of readmissions that occur within 14 days of discharge

BCN reviews inpatient readmissions that occur within 14 days of discharge from a facility reimbursed by diagnosis-related groups (DRGs) when the member has the same or a similar diagnosis. BCN reviews each readmission to determine whether it resulted from one or more of the following:

- A premature discharge or a continuity of care issue
- A lack of, or inadequate, discharge planning
- A planned readmission
- Surgical complications

In some instances, BCN combines the two admissions into one for purposes of the DRG reimbursement. BCN's guidelines for bundling a readmission with the initial admission are available by visiting bcbsm.com/providers, logging in to Provider Secured Services and clicking BCN Provider Publications and Resources > Billing / Claims > Guidelines for Bundling Admissions.

BCN requests that inpatient facilities complete the *14-Day Readmission Checklist* when a member is readmitted within 14 days of discharge from the initial admission with the same or a similar diagnosis. This checklist helps ensure that all the necessary information is available when a decision must be made as to whether to bundle the two admissions together or approve the second admission separately. The checklist is one of the utilization management forms that can be accessed by visiting bcbsm.com/providers, logging in to Provider Secured Services and clicking BCN Provider Publications and Resources > Forms.



Guidelines for observations and inpatient hospital admissions

Facility transfers Requests for transfers of patients from one acute care facility to another are permissible for medical necessity reasons (when required services or procedures are not available or cannot be provided safely at the referring facility) only when the attending physician determines that the member is stable or a medical emergency exists. Primary care physicians may request that their patients be directly admitted from an ER to another acute care facility when the attending physician determines the member's medical condition is stable. Facilities must obtain authorization from BCN prior to any nonurgent transfer.

Members requiring urgent transfers due to medical necessity should be transferred as soon as the attending physician deems the member medically stable. BCN must be notified of the transfer within one business day of the occurrence.

Note: BCN Advantage members may request a non-emergency transfer to a facility of their choice at any time.

During normal business hours, the facility should contact the BCN nurse reviewer or call 1-800-392-2512. After normal business hours and on weekends and holidays, the facility should call the after-hours utilization management number at 1-800-851-3904.



The phone number for business hours is corrected to 1-800-392-2512.

Discharge planning

Discharge planning begins at the time of admission and is a collaborative effort involving:

- Member and his or her family members
- Primary care physician and specialist
- Hospital discharge planning staff
- Ancillary providers, as necessary

BCN monitors all hospitalized members to assess their readiness for discharge and assist with posthospital arrangements to continue their care. The goal is to begin discharge planning before or at the beginning of the hospital stay. BCN nurses work in conjunction with members' primary care physicians to authorize and coordinate posthospital needs, such as home health care, durable medical equipment and skilled nursing placement. For these members, providers should follow the processes described in the "Guidelines for transitional care" section of this chapter.

Note: For BCN-contracted providers, home health care services do not require authorization except in the case of BCN members who are covered through the UAW Retiree Medical Benefits Trust. For BCN members with coverage through the URMBS, home health care services require authorization.

Guidelines for observations and inpatient hospital admissions

Postdischarge follow-up care program

All members who are discharged home from an inpatient admission are contacted by BCN nurses either by letter or by phone. The purpose of this program is to support the discharge plan prescribed by the member's practitioner by assessing the member's knowledge level, evaluating the effectiveness of the discharge instructions and offering additional information and/or services to the member when indicated. During the postdischarge phone call to the member, the nurse:

- Assesses comprehension of the discharge instructions received in the hospital
- Recommends scheduling a follow-up visit with his or her practitioner
- Provides instructions about medications
- Assists in arranging prescribed services after discharge
- Determines whether additional services may be indicated
- Provides information on community resources as needed
- Offers information about BCN's applicable utilization management programs

Guidelines for transitional care

Transitional care services are coordinated by BCN Transitional care services assist members in meeting their health care needs following discharge from an inpatient care setting when placement in a transitional setting is necessary or to prevent inpatient hospitalization through the provision of skilled care in the home. The transitional services listed in the following table are coordinated by BCN's Utilization Management nurses unless otherwise noted:



In this chapter, the information about home health, TPN and IDPN services is updated to show the changes in the authorization requirements for these services.

Service type	Services / settings	Additional information
Home health care (by home health care facilities only)	<p>This includes services such as nursing visits and physical, occupational and speech therapy that are provided in a member's home.</p> <p>Note: Members do not need to be homebound to qualify for traditional home health care services.</p>	<ul style="list-style-type: none"> • For BCN HMO and BCN Advantage members with coverage through the UAW Retiree Medical Benefits Trust (group number 00278806), traditional home health care services do not require a referral or an authorization. This applies to both contracted and noncontracted providers. • For BCN HMO and BCN Advantage members not covered through the UAW Retiree Medical Benefits Trust, home health requires authorization for these providers only: <ul style="list-style-type: none"> - Noncontracted providers. Call these requests in to BCN Utilization Management at 1-800-392-2512. - Providers who are contracted with BCN but who do not belong to the provider network associated with the member's plan. Submit these authorization requests through the e-referral system. - Other contracted providers. No referral or authorization is required.
Home enteral feedings (by home infusion therapy providers only)	<p>This includes enteral feeding services that are provided in a member's home.</p> <p>Note: Members do not need to be homebound to qualify for enteral feedings in the home.</p>	<ul style="list-style-type: none"> • Home enteral feedings may be provided only by agencies contracted with BCN to provide those services. • For all members, authorization is required for enteral feeding services. Submit the authorization request through the e-referral system and complete the questionnaire that opens. <p>Note: Authorization is not required for either total parenteral nutrition or intradialytic parenteral nutrition services. This applies to both contracted and noncontracted providers and to all BCN HMO and BCN Advantage members.</p>

(continued on next page)

Guidelines for transitional care

Transitional care services are coordinated by BCN (continued)

Service type	Services / settings	Additional information
Rehabilitation care	Typically provided in an inpatient rehabilitation facility or a rehabilitation unit in an inpatient hospital	<ul style="list-style-type: none"> For BCN HMO members, BCN's Utilization Management nurses manage the authorizations. For BCN Advantage members admitted on or after June 1, 2019, naviHealth manages the authorizations. Providers should follow the process described in "Expediting admissions for rehabilitation or skilled nursing care" later in this section.
Skilled nursing care	Typically provided in a skilled nursing facility	
Long-term acute care	Typically provided in a long-term acute care hospital	<ul style="list-style-type: none"> For BCN HMO members, BCN's Utilization Management nurses manage the authorizations. For BCN Advantage members admitted on or after June 1, 2019, naviHealth manages the authorizations. Providers should follow the process described in "Expediting admissions for long-term acute care" later in this section.
Hospice care	Can be provided in one of the following settings: <ul style="list-style-type: none"> Member's home Nursing facility (custodial care) Palliative care unit of an inpatient hospital 	<ul style="list-style-type: none"> For BCN HMO members, hospice care is eligible for reimbursement by BCN only when provided in one of the settings listed here. Hospice care may be provided only by agencies contracted with BCN to provide those services. For BCN Advantage members, hospice care is covered through traditional Medicare.



A statement is added to show that hospice care may be provided only by agencies contracted with BCN to provide those services.

Guidelines for transitional care

Contacting BCN's Utilization Management department



Providers can contact BCN's Utilization Management department for any transitional care services using the following phone numbers:

- When the member is transitioning to home care, call 1-855-724-4285.
- When a member is transitioning to a skilled nursing or rehabilitation facility or to a long-term acute care hospital, do the following:
 - **For BCN Advantage members** admitted to post-acute care on or after June 1, 2019, naviHealth manages the authorization. Refer to [Post-acute care services: Frequently asked questions for providers](#).
 - **For BCN HMO members**, BCN's transitional care services unit manages the authorization. Call 1-855-724-4286.

The hours of operation for BCN's transitional care services unit are 8 a.m. to 5 p.m. Monday through Friday. BCN requires that requests for transitional or discharge planning services for BCN HMO members be handled during these business hours.

When an emergency need arises for these services for BCN HMO members outside of business hours or on holidays, providers can call 1-800-851-3904 to reach an after-hours utilization management staff member. Additional information about after-hours utilization management assistance is found later in this chapter.

Expediting the transition to home care



To expedite the transition to home care for BCN members with coverage through the URBMT, providers should call BCN's Utilization Management department at 1-800-392-2512 to submit the initial review.

For visits requested beyond the initial review, providers should fax the following documents to 1-866-578-5482:

- Form 485 for initial request
- One evaluation or synopsis from each discipline for each month of additional services being requested

Guidelines for transitional care

Expediting admissions for rehabilitation or skilled nursing care



To expedite a same-day-as-discharge request for transitional care placement of a BCN HMO member in a rehabilitation or skilled nursing setting, providers should fax the following documents to 1-866-534-9994:

- A completed *Rehabilitation Assessment Form*

Note: The *Rehabilitation Assessment Form* can be accessed at ereferrals.bcbsm.com > BCN > **Forms**. It can also be found on BCN's Forms page within Provider Secured Services.

- History and physical from the hospital admission
- Physical medicine and rehabilitation consultation notes, as appropriate

Note: For BCN Advantage members admitted to post-acute care on or after June 1, 2019, naviHealth manages the authorization. Refer to **Post-acute care services: Frequently asked questions for providers**.

Expediting admissions for long-term acute care



To expedite a request for transitional care placement of a BCN HMO member in a long-term acute care setting, providers should fax the following documents to 1-866-534-9994:

- A completed *LTACH Assessment Form*

Note: The *LTACH Assessment Form* can be accessed at ereferrals.bcbsm.com > BCN > **Forms**. It can also be found on BCN's Forms page within Provider Secured Services.

- History and physical from the hospital admission
- Physical medicine and rehabilitation consultation notes, as appropriate
- Last two days of practitioner progress notes (admission and concurrent)
- Current intravenous and subcutaneous medication lists

Note: For BCN Advantage members admitted to post-acute care on or after June 1, 2019, naviHealth manages the authorization. Refer to **Post-acute care services: Frequently asked questions for providers**.

(continued on the next page)

Guidelines for transitional care

Expediting admissions for long-term acute care (continued)

(continued from the previous page)

Before placement of a BCN HMO member in a long-term acute care setting can be considered, BCN also requires that the member be assessed by three skilled nursing facilities affiliated with BCN, two of which must be facilities identified by BCN as accepting members who require higher levels of care such as ventilators. A determination must be made by these three facilities that they cannot provide the level of care the member needs. For information on higher-acuity skilled nursing facilities capable of doing these assessments, providers should call BCN at 1-855-724-4286, ext.122584.

Note: If the member was placed on a ventilator during an inpatient admission and failed to wean during the inpatient stay, the member can be assessed for appropriateness for the long-term acute level of care by applying the criteria for long-term acute care rather than the criteria for skilled nursing care.

Process for approval and review by plan medical director

When a request is submitted to BCN, if all or part of the clinical information is provided within the required time frame, the following occurs:

- If the member meets the appropriate criteria, the provider receives an approval.
- If the member does not meet the criteria, the case is forwarded to a plan medical director for review. The BCN case manager notifies the provider that the case is pending review by a plan medical director and indicates the date by which a determination can be expected.

Emergency room and urgent care services

Emergency care defined	<p>BCN provides eligible members with coverage for emergency and urgent care services necessary to screen and stabilize their condition without precertification or primary care physician referral.</p> <p>Emergency care definitions:</p> <ul style="list-style-type: none">• Medical emergency: The sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to a member's health or pregnancy (in the case of a pregnant woman), serious impairment to bodily functions or serious dysfunction of any bodily organ or part• Accidental injury: A traumatic injury that, if not immediately diagnosed and treated, could be expected to result in permanent damage to the member's health <p>BCN members should not be referred to emergency rooms or urgent care centers for services that can be performed in the primary care physician's office during regular business hours or that do not meet emergency or urgent care definitions.</p>
Access to emergency and urgent care	<hr/> <p>Primary care physicians are responsible for providing on-call telephone service 24 hours a day, seven days a week for BCN members. With the exception of severe injuries and life-threatening medical emergencies, members should always contact their primary care physician for assistance before seeking medical treatment elsewhere. It is not necessary to submit a referral to BCN for urgent or emergency services.</p> <p>For information about members who require care while traveling outside BCN's service area, providers should refer to the Member Benefits chapter in this manual.</p>
Coordination of emergency and urgent care services	<hr/> <p>Members are encouraged to contact their primary care physician to assist in arranging urgent care services required after hours. It is not necessary to submit a referral to BCN for urgent or emergency services. Emergency and urgent care providers should send a written summary of the services provided and the treatment plan to the primary care physician within 30 days of the date of service.</p>
Emergency care requiring outpatient surgery	<hr/> <p>Facilities do not need to submit a referral request when the member is transferred directly to surgery or observation from the emergency room.</p> <p>Note: The ER service (revenue code 450) must be billed on the same claim as the surgical service (for example, revenue codes 360 and 361) in order for the surgery to be paid without an authorization from BCN.</p>

Emergency room and urgent care services

Excessive use of emergency services

All BCN members receive information on the appropriate use of emergency room services, as well as guidelines to follow when a situation does not require emergency care.

Case managers address the unique needs of the high-volume ER user. The member is assessed and interventions are employed including interaction with the BCN Pharmacy Services department as well as the member and primary care physician. Members are educated regarding appropriate ER usage and follow up with the primary care physician is arranged as appropriate. In addition, members identified for case management services are sent a document with tips for appropriate ER usage.

The case manager provides written communication to the practitioner regarding opportunities to assist the member and coordinate an appropriate plan of care.

After-hours utilization management assistance

BCN utilization management staff are available after normal business hours Monday through Friday from 5 p.m. to 7 a.m. and on weekends and holidays, with 24-hour service to assist physicians and other providers.

Providers should call 1-800-851-3904 and follow the prompts to reach a BCN utilization management staff member for any of the following needs:

- Determining alternatives to inpatient admissions and triaging members to alternate care settings
- Expedited appeals of utilization management decisions

Note: The dates on which BCN is closed for holidays are published in the *BCN Provider News*.

The after-hours utilization management phone number can also be used after normal business hours to discuss any urgent or emergency determinations with a plan medical director.

This number should **not** be used to notify BCN of an admission for commercial or BCN Advantage members. Admission notification for these members should be done through the e-referral system.



The information about the BCN after-hours utilization management phone number is updated to clarify the types of assistance that can be requested by calling that number.

Air ambulance services

Applicability of requirements

The requirements described in this section apply as follows:

- They apply only to BCN HMO (commercial) and Blue Cross PPO (commercial) members.
 - They do not apply to BCN Advantage or to Blue Cross Medicare Plus BlueSM PPO members.
 - They apply to both in-state and out-of-state providers.
 - They apply seven days a week, 24 hours a day.
-

Emergency air ambulance transports do not require authorization

Emergency air ambulance transports do not require authorization.

Emergency transports are those that meet the following criteria:

- The flight is medically necessary.
- The patient cannot safely wait six hours to take off.

Note: Delays due to weather or stabilizing the patient are not counted as part of the six hours.

- The flight will take the patient to the nearest acute care facility capable of providing the care necessary or to a capable facility within a 25-mile radius of the nearest facility.

Providers transporting a member on an air ambulance flight that meets these emergency criteria should go ahead and fly the member and bill Blue Cross or BCN. The provider must keep the pertinent documentation on hand and must make it available in the event of an audit.

Non-emergency air ambulance transports require authorization

Non-emergency air ambulance transports require authorization from Alacura Medical Transport Management.

Facilities and other providers should submit authorization requests by taking the following steps:

1. Faxing a completed **Air ambulance flight information (non-emergency) form**, along with clinical documentation in support of the request, to Alacura at 1-844-608-3572
2. Calling Alacura at 1-844-608-3676 to obtain the authorization number

Authorization requests should be submitted prior to the service being provided.

Note: Providers calling PARS about an air ambulance transport will be given the Alacura number to call.



Air ambulance services

How Alacura handles authorization requests



When Alacura receives an authorization request for a non-emergency air ambulance transport, they take the following steps:

- Use web-DENIS to verify the member's eligibility and confirm that the member has coverage for air ambulance services
- Let the provider requesting authorization know what the member's benefits are, including any cost-sharing that applies, so that the member can be informed before the service is provided
- Request that the provider fax a completed **Air ambulance flight information (non-emergency) form** and any pertinent clinical information in support of the request, to them at 1-844-608-3572
- Review the request using the Blue Cross/BCN **Air Ambulance Services medical policy**
- Make a determination as to whether the request meets medical policy guidelines and:
 - Approve any request that clearly meets the guidelines
 - Contact Blue Cross/BCN Utilization Management staff about any request that does not clearly meet the guidelines

Note: For requests referred to them, Blue Cross/BCN Utilization Management staff conduct a standard authorization review using medical policy guidelines, which includes an assessment of medical necessity that may involve a plan medical consultant.

- Document all information and any actions taken and send the information to Blue Cross/BCN Utilization Management staff
-

Notification of decisions on authorization requests

The provider requesting authorization for a non-emergency air ambulance transport is notified of the decision as follows:

- For requests that are approved, either Alacura or Blue Cross/BCN Utilization Management, as appropriate, informs the provider of the approval decision and sends a letter to both the provider and the member indicating the approval and the rationale for the decision.

Note: For requests approved by Blue Cross/BCN Utilization Management, Alacura will be contacted to coordinate the transport.

- For requests that are denied, Blue Cross/BCN Utilization Management sends a letter to both the provider and the member indicating the denial and the rationale for the decision. The letter also describes the process for appealing the decision.
-

Case management referrals

Members covered through the UAW Retiree Medical Benefits Trust who have received an air ambulance transport are referred for case management services, as appropriate, for help in coordinating services to meet complex medical needs.

Air ambulance services

Billing guidelines

Guidelines on billing air ambulance services are found in the Claims chapter of this manual, in the section titled “Other billing and payment guidelines.”

Other information

Providers can find a description of the air ambulance initiative in the document titled [Air ambulance initiative: Description](#).

This document is available at ereferrals.bcbsm.com > BCN > [Authorization Requirements & Criteria](#).



BCN case management activities

BCN's case management program

BCN's case management program helps manage health care resources for members with a variety of health care needs in multiple care settings. The program works with members who have complex or chronic illness and who exhibit high use of services or who are at risk for progression of illness.

The program provides patient-focused, individualized case management for members who meet trigger criteria, including the following:

- Are dealing with an active complex or chronic disease process
- Are at high risk for health complications, such as those that may result from medication compliance issues
- Demonstrate high use of health care resources
- Experience readmissions to an inpatient care setting

Members with complex conditions who need coordination of care may be eligible for the case management services described in this section. Members with chronic conditions who require less coordination of care may be eligible for one of BCN's chronic condition management programs. Information on the chronic condition management programs is found in the Health Education and Chronic Condition Management chapter of this manual.

Case management direct referral sources

Typical case management referral sources include:

- BCN Customer Service
 - BCN chronic condition management programs
 - Completion of health assessments (for BCN Advantage members only)
 - Employer groups
 - Inpatient admissions
 - Discharges from skilled nursing facilities and rehabilitation centers
 - BCN Medication Therapy Management program (for BCN Advantage members only)
 - 24-hour Nurse Advice Line
 - Caregivers and members
 - Practitioners and medical care groups
 - Contracted vendors
-

Predictive modeling indicators

In addition to the typical direct referral sources for case management, BCN uses a predictive modeling approach to prospectively identify members who might benefit from case management. Predictive modeling allows for assessment of the entire BCN population and identification of members who are most apt to experience high health care costs or disease complications in the absence of intervention.

BCN case management activities

Calling for case management services	Providers can contact the BCN's Case Management staff during normal business hours for any case management services at 1-800-775-2583.
Case management team	The case management team is staffed by registered nurse case managers. Case managers receive extensive training in case management and many are certified in case management.
Conditions addressed by case management services	<p>Case management services are available for the following:</p> <ul style="list-style-type: none">• Asthma (for BCN commercial members only)• Catastrophic health event• Chronic obstructive pulmonary disease• Complex conditions• Diabetes• Heart failure• High-risk pregnancy• Ischemic heart disease• Kidney health management• Oncology• Pediatric care, including asthma, diabetes, heart failure and heart disease (for BCN commercial members only)• Transplants, including bone marrow, stem cell and solid organ <p>A licensed medical social worker is also available to provide support to the member and to case managers in addressing the member's psychosocial needs.</p>
Tracking members using case management services	<p>Providers can find information about members enrolled in case management programs via BCN Health e-BlueSM, the web-based clinical support tool that helps providers track the health of BCN members.</p> <p>Case managers may also call a provider about a member's condition, such as when there is a significant change in health status, a compliance issue or any potential urgent or emergency situation that requires immediate attention.</p>

BCN case management activities

The case manager role

Case managers, in collaboration with the member's treating practitioners, provide education and coordination of services in an effort to help the member achieve optimal health outcomes and prevent disease complications. The case manager contacts members by phone to perform an assessment of the member's health care status. Goals are identified and interventions are implemented to support the practitioner's treatment plan. The case manager provides personalized support and education on disease, nutrition, medication and managed care processes and also identifies and facilitates access to benefits and resources available to prevent complications and progression of disease.

The case manager coordinates care with the treating practitioner and offers suggestions to practitioners for member management. Timely communication with the treating practitioner is essential in the performance of case management activities. Ongoing communication is based on changes in the member's condition or identified needs.

The case manager may contact the treating practitioner, and talk with the plan medical director, as necessary, in the following circumstances:

- When there are significant changes in the member's health status
- When intervention on the part of the treating practitioner is thought to be necessary
- When the member uses emergency room services or is admitted for inpatient care
- To review the member's progress at various intervals in the case management process
- To obtain the health information necessary to ensure the highest quality of care
- To notify the treating practitioner about a member who has not been compliant with the recommended plan of care
- To notify the treating practitioner of a member who was in the complex case management program but who refuses further intervention prior to goals being met

To contact a case manager or to provide comments and feedback regarding case management services, providers should call 1-800-775-2583 during normal business hours.

BCN case management activities

Possible referral for 2nd.MD consultation For complex cases, the case manager, in conjunction with a plan medical director, may refer the member to 2nd.MD for an expert medical consultation. 2nd.MD is a vendor with access to medical experts in various specialties on a nationwide basis. The 2nd.MD consultation helps the plan ensure that the member is receiving the best care possible and that all treatment options are considered.

This service can be requested for BCN HMO (commercial) and BCN Advantage members and for Blue Cross PPO (commercial) and Blue Cross Medicare Plus BlueSM PPO members as well.

Note: 2nd.MD consultations may be requested only for members with fully insured coverage. 2nd.MD consultations are not available for members with coverage through self-insured plans.

When the member is referred, the medical director contacts the member's treating physician to discuss the case and to advise that a referral to 2nd.MD has been made. The case manager sends the provider a *Notice of 2nd.MD consultation request*. The member is notified as well.

2nd.MD contacts all the member's treating physicians to obtain the member's medical records.

Once the 2nd.MD consultation is available, a copy of it is provided to the treating physician and the member. Neither the treating physician nor the member is obligated to follow the recommendations made by 2nd.MD.

BCN's social worker

A licensed medical social worker is available to help practitioners locate community resources for members. For members who have complex family situations, a social worker is available to develop a plan addressing the member's psychosocial needs. For more information, providers should call BCN's Case Management staff at 1-800-775-2583 during normal business hours.

BCN case management activities

What practitioners can expect from case management

Case managers recognize the provider's right to:

- Obtain information about BCN's case management programs and staff, including staff qualifications, with which the provider's members are involved
- Be informed about how BCN coordinates case management activities, interventions and treatment plans
- Be supported by the case manager in making decisions interactively with members regarding member health care needs
- Receive courteous and respectful treatment from the case management staff
- Communicate a complaint to the case manager or to BCN's Case Management staff and receive appropriate follow up on the complaint
- Know how to contact the person responsible for managing and communicating with the provider's patients

Note: Case managers may receive requests for services specifically excluded from the member's benefit package. BCN does not make exceptions to member benefits, which are defined by the limits and exclusions outlined by the individual member's certificate and riders. In these situations, BCN case managers inform the member about alternative resources for continuing care and how to obtain care, as appropriate, when a service is not covered or when coverage ends.

Renal management

A number of BCN-contracted nephrologists participate as renal management practitioners. The renal management practitioner has the responsibility of providing and arranging care for their members, as well as issuing referrals for non-ESRD services as necessary. BCN encourages members with ESRD to select a renal management practitioner to act as their primary care physician. Members who do not choose a renal management practitioner can continue to access their internal medicine physician, pediatrician or family practice physician for services within the scope of the practitioner's practice. Primary care physicians receive fee-for-service for these members, and members in the renal program are not included in the practitioner's eligibility data files. The practitioner no longer receives a capitation reimbursement for these members. In addition, the renal management practitioner and primary care physician may refer members with ESRD to specialists for service without a referral if the services do not require authorization.



Authorization is not required for dialysis services with BCN-contracted providers. Requests for dialysis services provided by noncontracted providers, however, must be submitted to BCN's Utilization Management department prior to the initiation of the services. Providers should consult the online provider search (available at bcbsm.com/find-a-doctor) or contact BCN's Utilization Management department at 1-800-392-2512 to confirm the status of dialysis providers.

BCN case management activities

AMC Health monitors members with CHF and COPD

BCN contracts with AMC Health to manage high-risk BCN commercial and BCN Advantage members with congestive heart failure and BCN Advantage members with chronic obstructive pulmonary disease.

The goals for these high-risk populations are to promote optimal health status and quality of life and reduce the number of avoidable admissions, readmissions and emergency room visits related to their conditions.

The key features of this program include:

- Home biometric monitoring for blood pressure, weight and oxygen saturation using remote monitoring technology
- Nurse review of symptom information 365 days a year and comparison of this information to preset parameters for each member
- Notification to the member's practitioner by fax when the member's symptoms exceed the preset parameters

The member's biometric information is communicated to AMC Health through a remote monitoring device. If AMC Health does not receive any alerts about changes in the member's symptoms, AMC Health simply sets up a regular schedule of educational sessions with the member. When AMC Health receives an alert, AMC Health calls and engages the member in a one-on-one assessment discussion about what's going on. AMC Health lets the member's primary care physician know about any concerning changes in the member's condition that are being transmitted.

AMC Health's biometric monitoring provides the treating practitioner with timely alerts about changes in the member's symptoms while the members are at home. Through its monitoring activities, AMC Health also gathers data from individual members' responses to tailored questions that are based on each member's specific plan of care.

BCN identifies members eligible for in-home biometric monitoring through a predictive model database using claims and demographic data. Once a member is identified, AMC Health contacts the member directly. AMC Health notifies the member's primary care physician when the member agrees to enroll in the program.

Practitioners can refer members for AMC Health monitoring by calling BCN's Utilization Management department at 1-800-392-2512.

Coordination of care

Expectation that information is shared with primary care physician

As part of BCN's continuing commitment to ensure that members receive the highest quality and safest care possible, specialists, including OB/GYNs and behavioral health practitioners, are expected to share members' clinical information with members' primary care physicians.

BCN medical record and National Committee for Quality Assurance standards require evidence of continuity and coordination of care. In addition, provider contracts specify that the specialist's timely communication with the referring practitioner is essential to effectively manage the member's care. This requires providing information to the member's primary care physician about the episodes of care provided in different settings. Documentation should be sent to and received by the primary care physician within 30 days of service.

Note: Behavioral health specialists should refer to the Behavioral Health chapter of this manual for information on the laws governing what information can be shared and what consents are required. Look in the "Coordination of care" section.

Coordination of medical and behavioral health care needs

Members with potential coexisting medical and behavioral health care needs are identified through clinical case management and medical management activities. A process is in place to ensure concise communication among the medical and behavioral health teams and the member's practitioners, to coordinate the member's care.

The practitioner is encouraged to discuss potential concerns with the member (prior to discharge, if inpatient), if indicated, and offer the member the phone number of the BCN Behavioral Health department.

Members can contact the BCN Behavioral Health department at the number listed on their ID card or arrange for behavioral health services or can contact a BCN-affiliated behavioral health provider directly.

Depression screening tools

Depression screening is conducted by BCN nurses periodically during member contacts. For members identified to be at risk for depression, the nurse sends a BCN-approved *Depression Screening* tool from the Center for Epidemiological Studies – Depression to the primary care physician. The form should be placed in the member's medical record for use at the member's next visit.

Depression screening tools can be accessed by visiting **bcbsm.com/providers**, logging in to Provider Secured Services and clicking BCN Provider Publications and Resources > Forms.

Continuity of care

Written notification required within 15 days for continuity of care

Continuity of care services are available for the following members:

- Existing BCN members whose primary care physician, specialist or behavioral health provider voluntarily or involuntarily disaffiliates from BCN
- New BCN members who require an ongoing course of treatment

Members cannot see their current practitioner if that practitioner was terminated from BCN for quality reasons. In this instance, the member must receive treatment from an in-network practitioner.

BCN provides notification to members within 15 days after learning of the effective date of the practitioner's termination.

Appropriate notification permits members to continue treatment, with constraints

BCN permits the member to continue treatment in the situations described in the subsection "Continuity of care available for certain situations," when the disaffiliated practitioner:

- Continues to accept as payment in full reimbursement from BCN at rates applicable prior to the termination
- Adheres to BCN standards for maintaining quality health care and provides the necessary medical information related to the member's care
- Adheres to BCN policies and procedures regarding referral and authorization requirements

Continuity of care

Continuity of care available for certain situations

Primary care physicians may provide continuity of care for a member in the situations described in the table below. Specialists may provide continuity of care for a member receiving an ongoing course of treatment in the situations described in this table.

Note: An ongoing course of treatment is one in which a disruption of the current course of treatment could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes. Some examples of an ongoing course of treatment include:

- Postsurgical care
- An acute episode of a chronic illness
- An acute medical condition
- Behavioral health services for an acute exacerbation of a chronic psychiatric condition

Situation	Length of continuity of care
General care	90 days after the date of the practitioner notification to the member of the practitioner's disaffiliation
Pregnancy	Through postpartum care directly related to the pregnancy, if the member is in the second or third trimester of pregnancy at the time of the practitioner's disaffiliation
Terminal illness	For the remainder of the member's life for treatment directly related to the terminal illness, if the member was being treated for terminal illness prior to the practitioner's disaffiliation

How to notify BCN about continuity of care arrangements

Disaffiliating practitioners must notify both BCN and their BCN members of their intention to disaffiliate.

A disaffiliating practitioner who would like to offer a member continuity of care in accordance with BCN's conditions of payment and BCN policies must notify both BCN and the member.

Practitioners may contact BCN's Utilization Management department at 1-800-392-2512 to arrange for continuity of care services.

Members should contact Customer Service by calling the number on the back of their ID card.

A nurse provides written notification of continuity of care decisions to the member and practitioner.

Newly enrolled members must select a primary care physician before requesting continuity of care services. The request for continuity of care services must be made within the first 90 days of enrollment.

BCN — a resource for physicians

BCN as a resource for physicians: overview

Plan medical directors and other clinical staff work with affiliated practitioners and providers to ensure appropriate care and service for BCN members. Plan medical directors and BCN's Utilization Management staff are available throughout the state.

BCN's medical directors are a resource

Medical directors at the BCN corporate offices in Southfield:

- Provide clinical support for utilization management activities, including investigation and adjudication of individual cases
- Assist in the design, development, implementation and assessment of clinical protocols, practice guidelines and criteria that support the appropriate use of clinical resources
- Adjudicate provider appeals

Medical directors in the local service areas (East, Mid, Southeast, West and Upper Peninsula):

- Work with physicians and other health care providers to improve performance with regard to clinical outcomes, appropriate use of clinical resources, access to services, effectiveness of care and costs
 - Serve as a liaison with the physician community in each of the BCN service areas
 - Adjudicate provider appeals
-

How to contact a medical director



Plan medical directors are available in BCN's local service areas to discuss specific cases involving BCN members, as follows:

- To discuss medical services for a specific BCN HMO (commercial) or BCN Advantage case, providers should follow the instructions that are outlined in the document [How to request a peer-to-peer review with a Blue Cross or BCN medical director](#).

Note: Also refer to the subsection titled "Discussing a decision with a plan medical director in a peer-to-peer review" in the "Utilization management decisions" section of this chapter, for guidelines related to submitting a request for a peer-to-peer review for either an inpatient or an outpatient medical service.

- For decisions on pharmacy services for BCN HMO (commercial) members, refer to the Pharmacy chapter of this manual. Look in the section titled "Appealing pharmacy decisions."
- For decisions on pharmacy services for BCN Advantage members, refer to the BCNA chapter of this manual. Look in the section titled "BCN Advantage member appeals," in the "Who may file a member appeal" subsection.

BCN — a resource for physicians

Role of BCN clinical review coordinators

Clinical review coordinators are nurses who review select elective inpatient, outpatient, out-of-network and ancillary authorization requests in addition to assisting in the coordination of care through the health care continuum. In conjunction with the medical director, the clinical review coordinators utilize jointly developed Blue Cross/BCN medical policy, member benefit certificates, applicable riders, and InterQual criteria when reviewing requests. Clinical review coordinators can be reached at 1-800-392-2512.

24-hour Nurse Advice Line available to members

The Nurse Advice Line is telephone-based, toll-free, confidential service available to members 24 hours a day, seven days a week. The service is available to members who have BCN HMO (commercial), BCN Advantage, BCN 65 and MyBlue Medigap coverage.

Members can call 1-855-624-5214 to get a nurse's help in assessing their symptoms and determining the most appropriate level of care. (TTY users should call 711.)

With the consent of the member, the nurse may communicate the details of a call to the member's practitioner or case manager.

The Nurse Advice Line does not take the place of the member's relationship with his or her practitioner. Instead, the service is intended to complement the relationship by offering an opportunity for members to talk to a health care professional when their practitioner is not readily available or when they have additional questions after a practitioner visit, especially when the questions arise late at night or on weekends. The service is also intended to help members avoid the unnecessary use of emergency services and related cost-sharing responsibilities. In some instances, the nurse places follow-up calls to the member, when self-care was recommended.

After conferring with a Nurse Advice Line nurse, it remains the caller's responsibility to seek medical care. Practitioners continue to be responsible for managing the care of the members who contact their office, clinic or hospital.

BCN — a resource for physicians

New technology assessment

In order to keep pace with change and to assure that members have access to safe and effective care, BCN has a formal committee process to evaluate and address developments in medical technology. The Joint Uniform Medical Policy Committee evaluates new technologies as well as new uses of existing technologies. The JUMP Committee conducts a comprehensive assessment using the following resources, as indicated:

- Food and Drug Administration status on drugs or devices
- Peer reviews of medical literature
- Published scientific evidence
- Information from the treating physician and the primary care physician
- Status on the procedure with other organizations, including as appropriate, representative Blue Cross and Blue Shield plans
- Blue Cross and Blue Shield Association medical policy
- National Cancer Institute
- National Institutes of Health
- National Medicare coverage decisions
- Medicare intermediaries and carriers
- Federal and state Medicaid coverage decisions
- Specialty consultant panel

A provider may request committee review of a new technology by contacting BCN's Utilization Management medical policy staff at 1-800-392-2512.

Experimental treatment

BCN has a formal process for evaluating medical necessity requests and coverage decisions for experimental treatment, procedures, drugs or devices. BCN's process includes compiling information from various sources. (Providers may refer to the list in the "New technology assessment" subsection earlier in this chapter.) BCN communicates all determinations in writing, with detailed information on members' right to appeal if a requested service is not authorized. Mechanisms are in place to ensure that appropriate professionals participate in the evaluation process.

Appropriate professionals

BCN continues to demonstrate its commitment to a fair and thorough utilization decision process by working collaboratively with its participating physicians.

A plan medical director reviews all medical necessity determinations that cannot be approved through the application of decision criteria by BCN Utilization Management nurses. It may be necessary for the plan medical director to contact physicians for additional information about their patients to assist in making a determination.

A psychiatrist, a doctoral-level clinical psychologist or a certified addiction medicine specialist reviews all denial decisions related to mental health or substance use disorders that are based on medical necessity.

Utilization management decisions

How providers are notified about denials

When a service request is denied for a BCN HMO (commercial) member, written notification is sent to the requesting physician, primary care physician, facility, if applicable, and member. The notification includes the reason(s) the service was denied as well as instructions for contacting a plan medical director to discuss the decision and the process for filing an appeal. When urgent or concurrent services are denied, BCN also provides initial verbal notification to the facility and the primary care and attending physicians within 72 hours of receipt of the request.

Note: For information on the BCN Advantage utilization management process, refer to the BCN Advantage chapter of this manual; look in the section titled “BCN Advantage utilization management program.”

Discussing a decision with a plan medical director in a peer-to-peer review

Providers are encouraged to discuss any preservice or postservice denial decision with a plan medical director in a peer-to-peer conversation.

To request a peer-to-peer review on a non-behavioral health case:

1. Complete the [Physician Peer-to-Peer Request Form \(for non-behavioral health cases\)](#).
2. Follow the instructions for faxing that are outlined in Section 1 of the document [How to request a peer-to-peer review with a Blue Cross or BCN medical director](#).

Note: Section 1 of the document titled *How to request a peer-to-peer review with a BCN medical director* also includes the guidelines related to requesting a peer-to-peer review. The information in Section 1 of this document applies to requests related to both inpatient and outpatient medical determinations.

3. To contact a plan medical director after normal business hours, call 1-800-851-3904. This applies to medical services only (not pharmacy services) for BCN HMO (commercial) members.

To request a peer-to-peer review on a behavioral health case:

To discuss a behavioral health determination for a BCN member, providers should follow the instructions in Section 2 of the document [How to request a peer-to-peer review with a Blue Cross or BCN medical director](#).

For additional information, refer to the Behavioral Health chapter of this manual.



Utilization management decisions

Standard time frames for all requests for service

BCN’s Utilization Management staff conduct timely reviews of all requests for service, by the type of service requested.

The time frames for decisions on BCN Advantage requests are found in the BCN Advantage chapter of this manual. Look in the section titled “BCN Advantage Utilization Management program,” in the subsection titled “Standard time frames for BCN Advantage decisions.”

The time frames for decisions on BCN HMO (commercial) requests are as follows:

Time frames for decisions			
Type of request	Decision	Initial notistatusfication	Written notification
Preservice urgent with information*	Within 24 hours of receipt of request	Within 24 hours of receipt of request	Within 3 days of receipt of request
Preservice urgent without information**	Within 3 days of receipt of request	Within 3 days of receipt of request	Within 3 days of initial notification
Urgent concurrent*	Within 24 hours of receipt of request	Within 24 hours of receipt of request	Within 3 days of receipt of request
Preservice concurrent	Within 3 days of receipt of request	Within 3 days of receipt of request	Within 3 days of initial notification
Preservice nonurgent*	Within 14 days of receipt of request	Within 14 days of receipt of request	Within 14 days of receipt of request
Postservic*	Within 30 days of receipt of request	N/A	Within 30 days of receipt of request

*These time frames apply when all required information is received at the time of the initial request. See the subsection “Request for an extension of the standard time frames” for additional information.

**These time frames apply when all required information is not received at the time of the initial request.

Request for an extension of the standard time frames

For preservice nonurgent and postservice requests, an extension of the standard time frames is allowed if BCN needs more information to make a decision.

For these requests, an extension of up to 14 days is allowed. BCN notifies the provider and the member in writing about the specific information required to make the decision. BCN gives the member or the provider acting on behalf of the member a minimum of 45 days within which to provide the information required.

The extension period after which a decision must be made by BCN begins on either of the following:

- The date on which the complete information is received by BCN
- The end of the 45 days allowed for the information to be provided, if an incomplete response or no response is received

Utilization management decisions

Final decision and written notification on requests for which extensions have been granted

For all requests for which extensions have been granted, depending on the information received, BCN makes a final decision as follows:

- When the requested information is received within the 45-day period allowed, BCN makes a decision and sends written notification within 14 days of receipt of the information.
- If an incomplete response or no response is received, BCN makes a final decision and sends written notification when the 45-day period expires.

Approvals can be viewed by the provider on e-referral.

Members held harmless

In accordance with their affiliation agreement, providers may not seek payment from members for elective services that have not been approved by BCN unless the member is informed in advance regarding his or her payment responsibility. Some of the circumstances in which members are held harmless for denied covered services include:

- Urgent or emergency admission denials
 - Partial denial of a hospital stay
 - Requests for elective services provided by contracted providers that require authorization but were not forwarded to BCN's Utilization Management department prior to the service being provided
 - Denials issued for postservice requests for services provided by contracted providers when the information submitted is not substantiated in the medical record
-

Members at risk

In certain instances, members are held at financial risk for denied services. These instances occur when:

- The member's primary care physician or specialist did not provide a referral.
Note: No referrals are required for BCN Advantage members.
- The member's contract was not in effect on the date of service.
- The member refuses to leave an inpatient setting after the attending physician has discharged the member.
- A denial has been issued for precertified services.
- Services are provided that are not a covered benefit under the member's certificate.
- Services are provided at a noncontracted facility.

Utilization management decisions

Quality initiatives

The BCN's Utilization Management staff undertakes numerous initiatives to facilitate the provision of care to BCN members. One of these initiatives is to identify the number of members who are hospitalized with an acute myocardial infarction and who are prescribed a beta blocker at discharge. Clinical research indicates that appropriate use of beta blocker therapy can reduce mortality in these members and that therapy should be continued for life. Occasionally, BCN's clinical staff may contact the primary care physician or cardiologist to obtain beta blocker information.

BCN members and their providers may also receive informational mailings following discharges from admissions for selected diagnoses or procedures. Examples of these mailings include mailings encouraging members to receive a postpartum checkup at some point from the 21st through the 56th day after delivery.

Medical records requests

Medical records may be requested to make a medical management decision or to investigate potential quality concerns. The member's contract allows BCN to review all medical records. BCN must receive all records within 10 days of the request. Providers cannot charge a copying fee for medical records requested by BCN.

Appealing utilization management decisions

Appealing BCN's decision Denials of care related to medical necessity or medical appropriateness are made by plan medical directors and are based on:

- Review of pertinent medical information
- Consideration of the member's benefit coverage
- Information from the attending physician and primary care physician
- Clinical judgment of the medical director

All providers have the right to appeal an adverse decision made by BCN's Utilization Management staff. The two-step appeal process is designed to be objective, thorough, fair and timely.

At any step in the appeal process, a plan medical director may obtain the opinion of a same-specialty, board-certified physician or an external review board.

When a provider appeal request is received and a member appeal or grievance is in process, the member appeal or grievance takes precedence. When the member process is complete, the decision is considered to be final and the provider appeal request is not processed.

Appealing utilization management decisions

Filing deadlines for provider appeal requests The table that follows outlines the filing deadlines for provider appeal requests.

Filing deadlines for provider appeal requests (medical necessity or medical appropriateness determinations)	
Expedited appeals	<p>May be requested by a practitioner when circumstances require that a decision be made in a short period of time because a delay in making the decision may seriously jeopardize the life or health of the member. Retrospective appeals (when service has already been provided to the member) will not be considered for an expedited appeal. Requests for expedited appeals may be initiated verbally for decisions regarding precertification of urgent care and concurrent cases that result in denial. BCN notifies the provider of the decision within 72 hours of receiving the request. An expedited appeal can be initiated by calling a plan medical director or designee at 248-799-6312. This decision is final and no other appeal option is available to the provider.</p>
Level One appeals	<p>Must be submitted to BCN within 45 calendar days of the date noted on the written denial notification. Requests are to be in writing and must include additional clarifying clinical information to support the request. BCN notifies the provider of the decision within 30 calendar days of receiving all necessary information.</p> <p>Mail appeal requests to:</p> <p>Utilization Management — Provider Appeals, Mail Code C336 Blue Care Network P.O. Box 5043 Southfield, MI 48076-5043</p>
Level Two appeals	<p>Must be submitted to BCN within 21 calendar days of the date noted on the Level One appeal decision notification. Level Two appeal requests must be submitted in writing and must contain at least one of the following:</p> <ul style="list-style-type: none"> • New or clarifying clinical information <p>or</p> <ul style="list-style-type: none"> • A clear statement that the provider is requesting a BCN physician reviewer different from the one who reviewed the Level One appeal <p>If neither the clinical information nor the request for a different physician reviewer is included, BCN is not obligated to review the Level Two appeal request.</p> <p>All Level Two requests should be sent to the same address to which Level One appeal requests are sent.</p> <p>BCN notifies the provider of the decision within 45 calendar days of receiving all the necessary information. This decision is final.</p>

Note: If an appeal request is received by BCN outside the designated time frame, BCN is not obligated to review the case. A letter is sent to the requesting provider either advising that the appeal was not reviewed or notifying the physician of the outcome of the request if the plan has chosen to review the case.

Administrative denials

Administrative denials

Administrative denials are determinations made by BCN in accordance with administrative policies and procedures and/or contract language. These determinations are not based on medical necessity or appropriateness. Administrative denials can be issued by BCN with or without review by a plan medical director. Examples of situations likely to result in administrative denials include but are not limited to:

- The member's contract is not in effect on the requested date of service.
- The request is for a service specifically excluded from the member's benefit package or Certificate of Coverage.
- The service requested by a specialist requires a global referral in the e-referral system but no global referral was submitted.
Note: No referrals are required for BCN Advantage members.
- The service requires authorization but no authorization request was submitted.

The administrative determination appeal process affords providers and practitioners one level of appeal for BCN's Utilization Management department determinations related to administrative denials.



In this section, the examples of situations likely to result in administrative denials are updated for clarity.

Appealing administrative denials

Administrative appeal requests must be submitted to BCN within 45 calendar days of the provider's receipt of the denial decision. Documentation submitted must include a written appeal request along with the rationale and supporting documentation, if applicable, related to the denial and any other information pertinent to the request. BCN notifies the provider of the decision within 30 calendar days of receiving all necessary information.

Providers should mail appeal requests to:

Utilization Management — Provider Appeals, Mail Code C336
Blue Care Network
P.O. Box 5043
Southfield, MI 48076-5043

The decision regarding the administrative determination appeal process is final. If the administrative denial is overturned but a denial determination is subsequently made in accordance with BCN criteria, the provider is eligible to appeal through the clinical determination appeal process described on the previous page.

Medical supplies, durable medical equipment, prosthetics and orthotics

BCN uses J&B Medical Supply for outpatient diabetic supplies

BCN contracts with J&B Medical Supply to provide outpatient diabetic supplies for BCN members statewide.

Exception: Diabetic shoes and inserts are handled through Northwood, Inc. To locate the nearest provider affiliated with J&B Medical Supply, providers should call J&B Medical Supply at 1-888-896-6233.

Representatives are available from 8 a.m. to 5 p.m. weekdays. On-call associates are available after normal business hours at 1-888-896-6233.

BCN uses Northwood, Inc. for outpatient DME and P&O services

BCN contracts with Northwood, Inc. to provide outpatient home durable medical equipment, as well as prosthetic and orthotic appliances for BCN members statewide.

Note: As a rule, Northwood provides nondiabetic outpatient medical items. Exception: Northwood provides diabetic shoes and inserts.

To locate the nearest provider affiliated with Northwood, providers should contact Northwood's customer service department at 1-800-393-6432 to identify a contracted supplier. The supplier submits the request to Northwood for review.

Representatives are available from 8:30 a.m. to 5 p.m. weekdays. On-call associates are available after normal business hours at 1-800-393-6432.

Primary care physician initiates services

The primary care physician is responsible for:

- Determining the member's need for medical supplies or DME and P&O
- Issuing a prescription for the equipment or services and instructing the member to have the prescription filled at a provider affiliated with J&B Medical Supply (for diabetic supplies, not including diabetic shoes and inserts) or Northwood (for outpatient DME and P&O).
- Contacting the vendor and requesting services as follows:
 - For diabetic supplies contact J&B Medical Supply at 1-888-896-6233. Exception: Diabetic shoes and inserts are handled through Northwood.
 - For outpatient DME and P&O, contact Northwood's customer service department at 1-800-393-6432 to identify a contracted supplier. The supplier submits the request to Northwood for review.

Note: As a rule, Northwood provides nondiabetic outpatient medical items. Exception: Northwood provides diabetic shoes and inserts.

The vendor verifies the member's benefits and either refers the member to a network provider in the member's geographic area or otherwise fills the request.

Note: A specialist may also directly contact the vendor when the primary care physician has referred the member to that specialist.

Medical supplies, durable medical equipment, prosthetics and orthotics

Covered supplies and equipment provided

Northwood and J&B Medical Supply follow BCN benefit criteria. BCN's clinical review staff reviews all requests that Northwood or J&B Medical Supply determine do not meet criteria and provides written notification to the provider and member if the service cannot be approved.

Coverage is provided for basic supplies, equipment or appliances and for any medically necessary features prescribed by the primary care physician.

Members who have coverage for basic items only but wish to receive items deemed deluxe may pay the difference between the deluxe item charge and the charges covered under their benefit. For requests that exceed the basic benefit and quantity limitations, the primary care physician may need to document medical necessity. These requests are reviewed individually.

Requesting replacement of an insulin pump

Providers can get approval to replace an insulin pump (represented by code E0784) that is more than four but less than five years old when they document in the member's medical record that the warranty has expired and that the pump is malfunctioning.

Providers must submit these requests to J&B Medical Supply, along with the documentation from the patient's medical record. Email documents to ProviderServices@jandbmedical.com or fax them to 1-800-737-0012. Providers who have questions should contact J&B at 1-888-896-6233.

This process applies to both BCN HMO and BCN Advantage members.



Information is added about the process for requesting that J&B replace an insulin pump. This process went into effect on March 1, 2020.

Wound care

BCN's home care policy covers wound care supplies if ordered by a physician in conjunction with skilled nursing visits in the home. Providers may contact Northwood for the physician-ordered supplies necessary to provide wound care. The member's BCN case manager can answer questions related to wound care supplies.

Medical supplies, durable medical equipment, prosthetics and orthotics

Outpatient and inpatient settings

In general, medical supplies and durable medical equipment are only covered when appropriate for use outside of a hospital, skilled nursing facility or hospice program setting. The following guidelines apply to inpatient settings:

- For members in a hospital, skilled nursing facility or hospice program, neither J&B Medical Supply nor Northwood provides supplies or equipment.
- For members who are receiving custodial or basic care (not skilled care) in an extended care facility, the facility must contact J&B Medical or Northwood to arrange for supplies or equipment.

Note: When calling Northwood, contact their customer service department at 1-800-393-6432 to identify a contracted supplier. The supplier submits the request to Northwood for review.

Providers can contact BCN's Utilization Management department at 1-800-392-2512 and follow the prompts for case management for questions regarding medical supplies or DME and P&O services or to coordinate these services.

Servicing equipment

Northwood and J&B Medical Supply are accountable for servicing equipment to BCN members in their home. This also applies to members receiving custodial or basic care in an extended care facility (not skilled care).

Hospital or ancillary providers must contact Northwood or J&B Medical Supply prior to dispensing supplies and equipment for in-home use. Otherwise, liability for costs may reside with the provider.

Outpatient laboratory services

BCN uses JVHL for outpatient laboratory services

Joint Venture Hospital Laboratories is BCN's contracted provider for outpatient laboratory services. The entire laboratory procedure, from taking the specimen to conducting the test, may be done at a JVHL network laboratory or patient service center. Physicians may also choose to draw blood and send the specimen to a JVHL network laboratory.

Refer to "BCN in-office laboratory billable procedures" in the Claims chapter of this manual for a description of laboratory services that can be performed by BCN providers in their office.

JVHL is also contracted to conduct in-home laboratory services when the member does not have a skilled need. JVHL coordinates home draw services with the appropriate JVHL hospital. Providers should be sure to allow 24 to 48 hours' advanced notice for routine home draws. STAT draws are available when medically necessary.

JVHL network information

Providers should call the JVHL administrative offices at 1-800-445-4979 for assistance with the following:

- Identifying a JVHL network laboratory to service a practice
 - Locating the nearest patient service center
 - Following up if a member receives a bill for laboratory services
 - Arranging for in-home laboratory services for a member who does not have a skilled services need
 - Providing clinical review for genetic testing authorization requests
-

Test results

Routine lab reports:

- JVHL issues test results within 24 hours for most routine testing.
- Test results are distributed via U.S. mail, courier, fax or electronic transmission depending on the provider's specific arrangement.

Critical test results:

The physician is contacted directly by JVHL immediately upon the availability of a critical result.

STAT test results:

The physician's office is contacted directly by JVHL with all STAT results within four hours of initial telephone contact or within three hours of receipt of the specimen by the laboratory.

Confirmation and questions

Any test-related questions or requests for result confirmation should be directed to JVHL.

Forms and supplies

JVHL provides all required forms and laboratory supplies.

Outpatient laboratory services

In-office tests Although JVHL is BCN's statewide laboratory vendor, BCN recognizes that physicians should be able to perform specific procedures in their offices to promote the continuity of patient care. See the section titled "BCN in-office laboratory billable procedures" in the Claims chapter of this manual for a list of the lab procedures that physicians are authorized to conduct and bill for in their offices. The list includes lab services that both primary care physicians and specialists can perform in the office, as well as those procedures only specialists are allowed to perform.

Managing PT, OT and ST / Managing physical medicine services by chiropractors

BCN uses eviCore healthcare for management of PT, OT and ST services provided by therapists and physical medicine services provided by chiropractors



BCN is contracted with eviCore healthcare to provide utilization management for members receiving physical, occupational and speech therapy services in office and outpatient settings, including outpatient hospital settings.

eviCore also manages physical medicine services provided by BCN-contracted chiropractors for BCN HMO (commercial) members.

Under their agreement, BCN and eviCore collaborate to establish evidence-based clinical practice standards that help ensure the best possible outcomes for members.

eviCore is responsible for authorizing therapy or physical medicine services and managing the benefit limits for physical, occupational and speech therapy services provided by therapists and physical medicine services provided by chiropractors. This includes authorization requests for both initial and follow-up visits, for contracted and noncontracted providers.

Providers should refer to the [Outpatient rehabilitation services: Frequently asked questions for rehab providers](#) document for more details. This and other documents are available on BCN's [Outpatient PT, OT, ST](#) page on the [ereferrals.bcbsm.com](#) website. Refer also to eviCore's [Web Portal Presentation](#) document.

Therapy or physical medicine services with an autism diagnosis



For BCN HMO members 19 years of age or older with an autism diagnosis, eviCore manages authorization requests for therapies and physical medicine services by chiropractors.

For BCN HMO members under age 19 with an autism diagnosis, no authorization is needed. Claims for members under age 19 pay without a referral or an authorization if billed by a BCN-contracted provider with a childhood autism diagnosis code — specifically, for diagnosis codes F84.0, F84.5, F84.8 and F84.9.

With some exceptions, physical, occupational and speech therapy services used as part of the autism benefit do not count toward the number of medical rehabilitation visits or day limits for these therapies.

The information in this section is corrected to show that eviCore manages authorizations for PT, OT and ST by independent therapists and physical medicine services by chiropractors for BCN members age 19 or older with an autism diagnosis. For BCN members under age 19, no referral or authorization is needed for these services as long as they are provided by a BCN-contracted provider using a childhood autism diagnosis code.

Managing PT, OT and ST / Managing physical medicine services by chiropractors

Monitoring and reporting on utilization

eviCore monitors the compliance of each therapist and chiropractor with evidence-based practice standards and compares this performance to BCN peer performance standards. eviCore uses these data to work with therapists and chiropractors to increase the use of efficient best practice patterns, as appropriate.

Note: eviCore reports utilization data to physical therapists (only) on a regular basis in the form of Provider Performance Summary reports. Physical therapists can also access this information at www.evicore.com at any time through the secure provider portal.

Accessing patient information using eviCore's secure provider portal

A user identification number and password is required to access patient information using eviCore's secure provider portal. Providers can apply for access in one of the following ways:

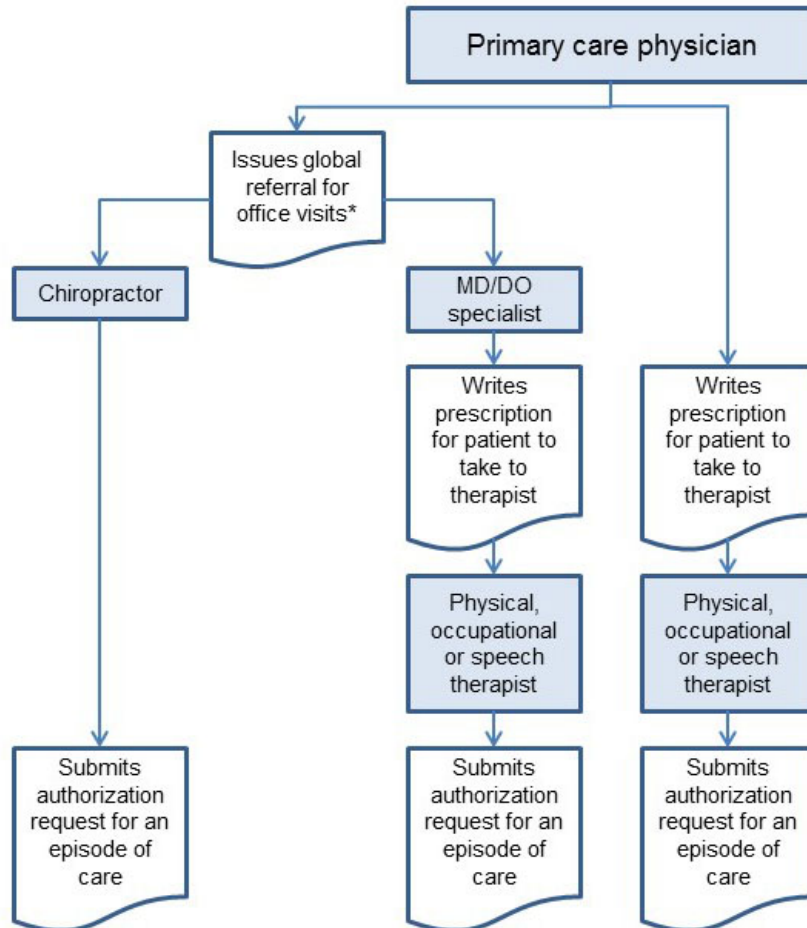
- Online, at www.evicore.com.* Click *Register Now*, in the Provider Portal section.
- By calling eviCore's Client & Provider Services department at 1-855-774-1317



*Clicking this link means that you're leaving the Blue Cross Blue Shield of Michigan and Blue Care Network website. While we recommend this site, we're required to let you know we're not responsible for its content.

Managing PT, OT and ST / Managing physical medicine services by chiropractors

Overview:
How the referral and authorization process works



* Global referral is required only when a BCN HMO member is from the East or Southeast region or has a plan with a designated provider network the chiropractor or specialist does not belong to. Otherwise, the chiropractor or specialist can initiate the authorization request with the primary care physician's approval. No referral is required for BCN Advantage members.

Writing the prescription for a therapist

When referring a member for physical, occupational or speech therapy from a therapist, the referring physician may write the prescription for “evaluate and treat.” Writing the prescription for “evaluate and treat” allows the therapist the latitude needed to plan upcoming visits in line with the progress the member makes.

Writing the prescription in this way allows the treating therapist to work with the member in establishing a treatment plan based on both medical necessity and the member’s anticipated response to treatment over a period of time. The treatment plan should include the proposed frequency and duration necessary to reach the expected outcomes.

Managing PT, OT and ST / Managing physical medicine services by chiropractors

Requests to authorize an episode of care



Providers can submit authorization requests to eviCore electronically or by phone or fax. For information on how to submit authorization requests to eviCore, refer to these resources:

- [Outpatient rehabilitation services: Frequently asked questions for rehab providers](#) document
- eviCore's [Web Portal Presentation](#) document

Note: Additional resources are available on eviCore's [BCN implementation page](#).*

Providers who request authorization for therapy or physical medicine services must follow the process described here.

- The therapist or the chiropractor performing physical medicine services submits an authorization request for an episode of care.
- The request to authorize treatment should be submitted only after the initial evaluation is done so that the clinical information learned during the evaluation can be used to complete the authorization request. This will help expedite the request.

Note: The initial evaluation does not require authorization.

Separate authorization requests must be submitted for each type of treatment the member needs — physical, occupational and speech therapy from a therapist or physical medicine services from a chiropractor — and for each new episode of care.

Note: Authorization requests submitted by chiropractors for physical medicine services must be separate from authorization requests submitted for manipulation services. Authorization requests for physical medicine services must be submitted to eviCore. Authorization requests for manipulation services must be submitted to BCN.

Therapists and chiropractors who practice within a group should use their group's NPI as the servicing site.

The therapist or chiropractor can view the number of visits authorized on eviCore's secure provider portal. The total number of visits may be authorized at one time, or additional visits may be authorized as needed. The referring physician does not need to be involved in this process.

eviCore works with the therapy provider to ensure that the member receives medically necessary treatment.

*Clicking this link means that you're leaving the Blue Cross Blue Shield of Michigan and Blue Care Network website. While we recommend this site, we're required to let you know we're not responsible for its content.

Managing PT, OT and ST / Managing physical medicine services by chiropractors

Post-evaluation treatment visits require authorization For additional services after the evaluation, therapists and chiropractors must obtain treatment plan authorization from eviCore according to the guidelines that apply for the type of service to be provided. The guidelines are outlined in the table below.

eviCore healthcare: Authorization guidelines by therapy type	
Physical therapy services provided by physical therapists	<p>eviCore assigns physical therapists as Category A, B or C providers based on their utilization of therapy. Utilization category assignments are based on the claims data reported for each provider and on an understanding of the best practices in the field. Physical therapists' utilization category assignments are reviewed every six months, based on the most recent paid claims data.</p> <p>Note: Outpatient therapy centers and hospitals must follow the authorization process for their assigned category (A/B/C). Refer to eviCore's Musculoskeletal Specialized Therapy Program* document for more information.</p> <p>A physical therapist who believes that circumstances beyond their control affect their utilization may request reconsideration of their utilization category. To request reconsideration, follow the steps outlined in eviCore's Musculoskeletal Specialized Therapy Program* document. Information about the reconsideration process is also included in the semi-annual categorization letter that is mailed.</p>
Physical medicine services provided by chiropractors	<p>Authorization requests for physical medicine services must be submitted to eviCore. eviCore will make determinations on visits in accordance with the severity and complexity of the member's condition, the member's functional loss and confirmation that care is progressing as planned.</p>
Occupational therapy services	<p>Authorization requests for occupational therapy must be submitted to eviCore. eviCore will make determinations on visits in accordance with the severity and complexity of the member's condition, the member's functional loss and confirmation that care is progressing as planned.</p> <p>Note: Outpatient therapy centers and hospitals must follow the authorization process for their assigned category (A/B/C). Refer to eviCore's Musculoskeletal Specialized Therapy Program* document for more information.</p>
Speech therapy services	<p>All providers must submit a treatment plan authorization request for all therapy visits after the evaluation. The request must include the results of the evaluation and the proposed treatment plan.</p>

*Clicking this link means that you're leaving the Blue Cross Blue Shield of Michigan and Blue Care Network website. While we recommend this site, we're required to let you know we're not responsible for its content.

Managing PT, OT and ST / Managing physical medicine services by chiropractors

Process of requesting authorization



To submit a treatment plan authorization request, therapists and chiropractors must log in to eviCore's secure provider portal at www.evicore.com.*

Note: You can also access the eviCore provider portal through web-DENIS. On the Eligibility / Coverage screen, click the *Authorizations and Referrals* button for that member, in the Prior Authorization column of the table.

Note: Only eviCore treatment plans are accepted. Additional information on eviCore's treatment plan forms and the process of requesting authorization is available at ereferrals.bcbsm.com > BCN > [Outpatient PT, OT, ST](#).

*Clicking this link means that you're leaving the Blue Cross Blue Shield of Michigan and Blue Care Network website. While we recommend this site, we're required to let you know we're not responsible for its content..

Establishing medical necessity

Providers must establish medical necessity for the initiation of treatment by objectively documenting any or all of the following, as applicable, using a validated tool whenever possible and reporting the scores on the eviCore treatment plan form:

- Level of impairment or significant functional limitations
- Deficits in strength or motion
- Pain-limiting function
- Altered neurological signs

For additional information, refer to eviCore's [Web Portal Presentation](#) document.

eviCore reviews treatment plans submitted by providers

Qualified licensed clinical peers at eviCore review all treatment plans submitted by providers.

eviCore uses proprietary practice guidelines

eviCore's proprietary clinical practice guidelines are the basis for the clinical rationale. These guidelines are developed by content experts and practicing clinicians and are reviewed annually.

Managing PT, OT and ST / Managing physical medicine services by chiropractors

Criteria used in making decisions

eviCore's judgments about treatment frequency and duration are based on the following:

- Severity of the clinical findings
- Presence of complicating factors
- Natural history of the condition
- Expectation of functional improvement
- Need for skilled therapy or physical medicine services

Judgments about frequency and duration require continuous assessment and modification based on patient progress and response to treatment.

Discharge from treatment may be considered appropriate when one of the following conditions is present:

- Reasonable functional goals and expected outcomes have been achieved.
- The caregiver and the member can continue management of symptoms with an independent home program.
- The member is unable to progress toward outcomes because of medical complications or psychosocial factors.
- Services become routine and repetitive in nature, indicating they are not of a skilled nature.
- The member is no longer objectively demonstrating benefit from treatment.

Additional information on the efficient use of treatment services is available at ereferrals.bcbsm.com > BCN > Outpatient PT, OT, ST > **Suggestions for the Efficient Utilization of Therapy and Physical Medicine Services.**



Managing PT, OT and ST / Managing physical medicine services by chiropractors

Elements of an eviCore authorization

eviCore sends written notification of authorization to providers by fax. The written notifications are also posted on eviCore's secure provider portal.

Each notification includes two elements:

- The number of visits authorized
- The time period (duration) in which those authorized visits should be used

Providers should note that the benefit duration is the period of time included in the member's contractual benefit; it is **not** the same as the authorized duration.

Examples include:

- 60 calendar days for a benefit that allows unlimited visits over 60 consecutive calendar days
- 120 calendar days for a benefit that allows 60 visits over the benefit year. (Additional days are added if necessary.)

The member's visits must be spread through the authorized duration to avoid a gap in care at the end of the time period (duration). If the member has a setback or complication, additional visits may be requested before the authorized time period is over. An updated treatment plan must be submitted with this request and must include objective clinical findings and a detailed explanation of the reasons for the early request for additional visits. Without this information, the request will be denied.

Note: When eviCore approves an authorization request for therapies, they authorize a certain number of visits for each type of therapy. The physical, occupational and speech therapy visits eviCore approves on the authorization can be provided on the same day or on separate days. Also, eviCore authorizes therapy treatment but does not authorize specific procedure codes. In the eviCore provider portal, providers select the therapy type (MSMOT, MSMPT or MSMST). Providers must submit a separate authorization request for each therapy type and eviCore makes a determination on each authorization request submitted.

IMPORTANT! All therapists and chiropractors are constrained by the limits of the member's benefits, including the number of visits and the duration of treatment. The visits are allocated and coordinated among therapists and chiropractors based on medical necessity so as not to exceed the member's benefit limits.



This section is updated to show that the physical, occupational and speech therapy visits eviCore approves on the authorization can be provided on the same day or on separate days.

Managing PT, OT and ST / Managing physical medicine services by chiropractors

Requesting a copy of the criteria or clinical judgment

Providers may request a copy of the clinical criteria or clinical judgment used in making a determination by sending a request, along with a copy of the determination letter, to the address shown in the denial letter.

Checking the status of the treatment request



Providers may check the status of their treatment plan request in one of the following two ways:

- Check electronically via eviCore's secure provider portal at www.evicore.com.*

Note: If the provider submitted the authorization request after accessing the portal through web-DENIS, the provider can view the status of the request on the portal only when accessing it through web-DENIS.

- Call eviCore's Client & Provider Services department at 1-855-774-1317.

*Clicking this link means that you're leaving the Blue Cross Blue Shield of Michigan and Blue Care Network website. While we recommend this site, we're required to let you know we're not responsible for its content.

Correcting or changing a request

To correct or change an authorization request already submitted, providers should call eviCore at 1-855-774-1317. Providers should not correct or change a request using the eviCore provider portal.

Managing PT, OT and ST / Managing physical medicine services by chiropractors

Provider appeals process for BCN-participating providers

Provider appeals are handled as follows:

- **BCN Advantage appeals.** BCN-participating providers who disagree with a determination related to medical necessity or medical appropriateness made by eviCore for a BCN Advantage member should follow BCN’s process for standard or expedited appeals, which is outlined in the “Appealing Utilization Management decisions” section of this chapter.
- **BCN HMO appeals.** BCN-participating providers who disagree with a determination related to medical necessity or medical appropriateness made by eviCore for a BCN HMO member should follow eviCore’s process for standard or expedited appeals, as described in the table below.

eviCore healthcare: Filing deadlines for provider appeal requests (medical necessity or medical appropriateness determinations)	
Standard appeals – BCN HMO	Must be submitted to eviCore within 45 calendar days of the date noted on the written denial notification. Requests are to be in writing and must include additional clarifying clinical documentation to support the request. eviCore notifies the provider of the decision within 30 calendar days of receiving all necessary information. This decision is final. Providers should follow the instructions in the denial letter when submitting standard appeal requests for BCN HMO members to eviCore.
Expedited appeals– BCN HMO	May be requested by a practitioner when circumstances require that a decision be made in a short period of time because a delay in making the decision may acutely jeopardize the life or health of the member. Retrospective appeals (when service has already been provided to the member) will not be considered for an expedited appeal. Requests for expedited appeals may be initiated verbally for decisions regarding precertification of urgent care and concurrent cases that result in denial. eviCore notifies the provider of the decision within 72 hours of receiving the request. This decision is final. Providers should follow the instructions in the denial letter when submitting expedited appeal requests for BCN HMO members to eviCore.

Provider appeals process for providers not participating with BCN

Providers who disagree with a determination made by eviCore and who do not participate with BCN should follow BCN’s process for standard or expedited appeals. Specific instructions for submitting the appeal are included in the denial letter. Information on BCN’s provider appeals process is found in the “Appealing Utilization Management decisions” section of this chapter.

Managing PT, OT and ST / Managing physical medicine services by chiropractors

Provider appeals decision-making for BCN HMO requests

Appeals related to BCN HMO members that are handled by eviCore are reviewed as follows:

- BCN HMO appeals from therapists related to physical, occupational or speech therapy are reviewed by an eviCore physician.
- BCN HMO appeals from chiropractors related to physical medicine services are reviewed by an eviCore chiropractor.

For all BCN HMO provider appeals, the individual at eviCore who made the original denial determination is not the same individual who makes the appeal decision.

Contact information related to therapy and physical medicine services

The contact information related to physical, occupational and speech therapy or physical medicine services is as follows:

- For authorization or treatment questions, providers should contact eviCore's Client & Provider Services department at 1-855-774-1317.
- For claims issues, providers should call PARS / Provider Inquiry using the appropriate number as indicated on the [Provider Inquiry Contact Information](#) list.

