Today’s team

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Agenda

• Introductions
• Project background
• High level process
• Requirements of facilities
• Requirements of BCBSM
• e-referral downtime
• Peer to peer process
• Provider appeal process
• Urgent & after hours
• Questions
• e-referral updates
• Contact us
Project background – the issue

As part of our ongoing efforts to focus on quality care, we’re also constantly looking for ways to manage the spiraling cost of care.

The purpose of this program is the implementation of new criteria around inpatient stays to ensure proper care is delivered in the appropriate setting based on the treatment a member receives for their condition(s) and/or diagnoses.

What we’ve found is that some of those stays are billed incorrectly according to our clinical criteria/guidelines (InterQual).

Member stays are being billed at the more expensive inpatient level for stays that should be treated in a lower level of care such as observations/home.

Inpatient services are also being requested in instances when they should not be.
Project background – What are we doing about it?

We want to expand our inpatient review for our Blue Cross PPO (commercial) product

- This focused review will help to avoid excess costs, reduce recoveries and continue to ensure that the care billed reflects the care delivered.
- Project initially concentrated on select facilities because the data we reviewed identified them as outliers.
- Started with Medicare Advantage PPO members in all Michigan facilities July 31, 2017.
- Wave 1 began July 9, 2018, required prior authorization of PPO commercial, in-state medical acute admissions for 19 select facilities.
- Wave 2 began January 6, 2020 with 18 more select facilities.
- Wave 3 will begin October 5, 2020 and will expand to all Michigan inpatient facilities.
High level process

Inpatient Prior Authorization Process

Automation based on diagnosis

Pended cases requiring review based on InterQual

Requests submitted through e-referral

Physician review for cases not meeting criteria

Two-level provider appeal process

Option for peer to peer to discuss denial
Facilities will be required to:

Starting October 5, 2020, submit inpatient admission requests through e-referral as you do today, however some of these cases may be subject to clinical review.

• If the case pends for review, the documentation submitted needs to include pertinent clinical information that supports the reason for the members inpatient admission which you will attach in the Case Communication.

• If the case approves after submission, no clinical information needs to be attached.

If you determine that the case may be a possible long length of stay (LOS), the facility can refer the member to Blue Cross’ care management by calling 1-800-845-5982.
Facilities will be required to submit requests with clinical information if additional days are needed beyond the initial authorization by completing an extension on the original case.

**Extending an Inpatient Authorization**

To extend service on an existing Inpatient Authorization, begin by locating your authorization. Click the Edit button on the right side of the details page. Scroll down to the Confinement Extension(s) section, click the Create New button and enter your new dates and amount of days. Click Submit.

If all days have been approved, you do not need to add the discharge date to an e-referral communications.
Blue Cross will be required to:

If the case pends for review a Blue Cross RN will review the clinical documentation to determine if it meets InterQual criteria

- If the documentation submitted meets InterQual they will approve the admission.
- If the documentation does not meet InterQual criteria, they will pend the case to a Blue Cross Medical Director (physician) to make the decision. We will send a notification that the case has been pended in the Case Communication section.

If additional information is needed to support the inpatient admission, Blue Cross will send a message in the Care Advance case communication or try to call the facility.

- If the case is on the e-referral users My List, you will note a Blue Dot on the envelope of the case indicating there is an incoming message from Blue Cross with what is needed to complete the review.

If the no clinical information is received or the additional information is not received within 24 hours, the case will be pended to the Blue Cross Medical Consultant for review with the information available.
Case determinations

Case decisions are expected to be turned around within 24-72 hours. Blue Cross will provide a copy of the determination letter in the Case Communication section and will call to notify the facility for all denials.

Note: Timeframes may be longer if the member has already been discharged as we prioritize cases when members remain in your facility.

If a case has been closed (either denied or voided), don’t submit additional clinical documentation or send Blue Cross messages within the case as we don’t receive notification of those messages or any changes to that authorization.

• Instead, please fax, email or call us with your question or request so we can assist you in a timely manner.
  - Fax: 1-800-482-1713
  - Email: ereferralinquiries@bcbsm.com
  - Phone: 1-877-399-1673
If e-referral is unavailable

If issues with e-referral occur, Blue Cross will accept faxed requests with clinical information and will process the case manually. The request for inpatient admission should be submitted with all applicable information including clinical to substantiate the need for the inpatient stay so that a timely review can take place.

If a member is not showing up in the e-referral system (FEP member, NICU admission where baby is not on the contract), you can also fax Blue Cross and we will add the member temporarily until the member is added to the contract.

Fax: 1-800-482-1713
Peer-to-peer process

A peer to peer is a conversation between a Blue Cross physician and treating physician/physician advisor about the members' case/care and determines whether the denial will be maintained or overturned. This process is the same for expedited appeal requests.

Here’s how to request a peer-to-peer review:

1. Complete the [Physician Peer-to-Peer Request Form (for non-behavioral health cases)](found on [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com) under Blue Cross, then Authorization Requirements & Criteria, then Forms – Blue Cross PPO (commercial))
2. Fax it to 1-866-373-9468 during normal business hours of 8 a.m. to 5 p.m. (except for weekends and holidays) or email it to peertopeer@bcbsm.com.

The peer-to-peer review will be scheduled on business days, Monday through Friday between 9 a.m. and 4 p.m. (except for holidays). (All times are Eastern.)

Peer-to-peer requests must be made within 7 days of the initial non-approval decision and prior to the submission of an appeal. If an appeal is received it will take precedence over the peer to peer.

Peer-to-peer decisions will be updated in the e-referral system and a new letter will be sent only if the decision has been overturned.

Note: Please utilize the appeals process for members who have already been discharged to ensure timely peer-to-peer scheduling for those who remain in your facility.
Facility first-level appeals

If you disagree with the non-approval decision, you may request an internal appeal within 45 days of the decision. To do that, follow these steps:

Write or type a letter specifying your request for an internal facility appeal. Include the pertinent information from the medical record for the case in question and any additional information you believe would be helpful and fax the request to 1-877-261-4555.

If you are unable to fax the appeal request, you may mail your appeal to:

Medical Record and Appeals - Mail Code 510C
Blue Cross Blue Shield of Michigan
P.O. Box 321095
Detroit, MI 48232-1095

Internal appeals are processed within 30 days of the request and determinations will be faxed and called to the recipient who sent the appeal request (i.e. internal or third party).
Facility second-level appeals

If you disagree with our decision based on your internal appeal, you may request a review by an external peer review organization within 20 days of the internal appeal decision. To do that, follow these steps:

Write a letter, specifying your request for an external appeal and fax the request to 1-877-261-4555.

If you are unable to fax the second level appeal request, you may mail your second level appeal to:

Medical Record and Appeals - Mail Code 510C
Blue Cross Blue Shield of Michigan
P.O. Box 321095
Detroit, MI 48232-1095

External appeals are processed within 30 days of receipt of the request and the decision is final.
MESSA appeals

Blue Cross Utilization Management handles facility level appeals for all MESSA members.

- If you are requesting a facility level appeal (first or second), please send your appeal request to Blue Cross’ appeals department for processing.

Write a letter, specifying your request for an external appeal and fax the request to 1-877-261-4555.

- If you are unable to fax the appeal request, you may mail your appeal to:

  Medical Record and Appeals - Mail Code 510C
  Blue Cross Blue Shield of Michigan
  P.O. Box 321095
  Detroit, MI 48232-1095
Urgent and after hours

All communication regarding need for information and case decisions will occur directly through the Case Communication within e-referral. However, Blue Cross has created a dedicated phone line *during business hours* for inpatient facilities should you require *urgent escalation* of a case or if you have not heard back on a pending case.

Blue Cross PPO (commercial): 1-877-399-1673
Medicare Plus Blue PPO: 1-866-807-4811

For *after hours* assistance for urgent cases requiring immediate escalation, contact our after-hours phone line. Any requests that are not urgent, Blue Cross asks that you please wait and contact our other dedicated phone lines during business hours.

Blue Cross PPO (commercial)/BCN HMO℠/Medicare Plus Blue PPO/BCN Advantage℠: 1-800-851-3904
New questionnaires for PPO

Beginning January 2021, you may start to see questionnaires like you do today for BCN that require completion when entering an e-referral authorization for Blue Cross PPO and Medicare Plus Blue PPO members.

These questionnaires are focused on surgical admissions when a medical inpatient code (i.e. ‘99222’) is not used.

When a specific procedure code is entered, the questionnaire will require the facility to attest that they have verified the members benefit and eligibility for the procedure code being entered.

This questionnaire will also indicate to the facility that the approval authorization is for the inpatient setting only.
e-referral new features

Create "My List"

You can now flag Referrals and/or Authorizations that you determine need follow up or "watching" for any reason. Each Detail page now includes a My List checkbox:

Selecting the box adds it to My List and displays a flag next to the record in Search results and on the Home page; deselecting removes it:
e-referral new features

The new My List page is the new landing page. When you log in, this will be the first page you will see.

As shown below, it lists only the referrals and authorizations you flagged as items that you want to follow up on or “watch.” The information listed is the same as the Home page, but there is no provider in focus.
e-referral new features

- A new feature in the My List page and the Case Communications panel shows if you have read a specific incoming communication.
- Communications not read by the logged-in user have a new icon:
- Once user reads the communication, the icon will change to:
- If a different user logs in and accesses that case from their My List page, the new icon appears until that user reads the communication.
- Additionally, the logged-in user may choose to change it back to the unread icon by clicking on the read icon:

![Case Communication](image)
<table>
<thead>
<tr>
<th>Authorization requirements</th>
<th>Blue Cross’ PPO &amp; BCN HMO DRG facilities</th>
<th>Blue Cross’ PPO &amp; BCN HMO Non-DRG facilities</th>
<th>Medicare Plus BlueSM PPO</th>
<th>BCN AdvantageSM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial authorization request</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Initial authorization request number of days</td>
<td>7 days</td>
<td>3-5 days</td>
<td>7 days</td>
<td>7 days</td>
</tr>
<tr>
<td>Attach clinical documentation for <em>initial</em> authorization if <em>fully approved</em></td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Attach clinical documentation for <em>initial</em> authorization if <em>pended</em></td>
<td>Yes</td>
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<td>Yes</td>
<td>Yes</td>
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<td>Add extension to original authorization if additional days are needed</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Attach clinical documentation with extension request if additional days are needed</td>
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<td>Yes*</td>
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</tr>
<tr>
<td>Add discharge dates in e-referral</td>
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<tr>
<td>Add discharge summary in e-referral if available</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Required for all UAW Retiree Medical Benefit Trust members in both DRG and Non-DRG facilities
Contact us

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Medicare Plus Blue PPO and BCN Advantage
Jacqueline Redding, director:  JRedding@bcbsm.com
Michelle May, manager:  Mmay2@bcbsm.com
Stacey Brown, manager (Peer to Peer & Appeals):  Sbrown1@bcbsm.com

For issues regarding admission date changes, NPI corrections, or e-referral case corrections, email  e-referralinquiries@bcbsm.com
Additional job aids

- Authorization Requirements & Criteria page on ereferrals.bcbsm.com
- Inpatient authorization requests: Tips*

*This document states peer-to-peer requests can only be accepted by fax. Requests can be accepted by fax or email. This document is currently being updated.
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