



# Referrals, Prior Authorizations, Medical Management, and Appeals

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# Referrals

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# Medicare Advantage referrals

- The primary care provider (PCP) is responsible for making sure the referral is submitted and approved
- The PCP must fill out and submit the referral request online or by fax for all services performed by a specialist
- Fully complete the form, otherwise, a new referral form will need to be completed and submitted.
- As a courtesy, providers have the ability to submit referrals with a retroactive date, no greater than 60 days after the date of care
- Make sure you're [referring patients to in-network providers](#). Our MA members don't have out-of-network benefits unless it's emergency care.

# Medicare Advantage referrals

If a patient needs to see a provider other than their PCP, a referral from their provider is required.

## Examples of types of services that require referrals

Office visits with a specialty provider

Chiropractic care

Nutritional counseling

# Examples of types of services that don't require referrals

- Physical therapy, occupational therapy, speech therapy– only a written order is needed from the PCP or specialist
- Routine women's healthcare: breast exams, mammograms, pap tests, and pelvic exams provided by an in-network provider
- Flu and pneumonia vaccinations
- Behavioral health services
- Routine vision exams for plans with vision benefits
- Routine hearing exams for plans that include that benefit
- Emergency services

# Medicare Advantage referral submission

- [Referrals can be submitted online](#) through the Medicare Advantage referral and prior authorization website tool
- Alternatively, referrals can be submitted by fax
  - Completed referral forms can be faxed to 866-809-1370
  - [Referral submission forms](#) are available online on our secure and non-secure Medicare Advantage website under forms:  
[premera.com/wa/provider/medicare-advantage](https://premera.com/wa/provider/medicare-advantage)

# Prior Authorizations

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# These types of services require clinical review for prior authorizations

- [Acute hospital admissions](#)
- [Skilled nursing facility admissions](#)
- [Long-term acute care hospital admissions](#)
- [Inpatient rehabilitation](#)
- [Part B medication prior authorization](#)
- [Outpatient prior authorization](#)



# AIM Specialty Health and Optum

We've delegated reviews for select services to our partners AIM Specialty Health and Optum.

- To save time, check the [MA prior authorization](#) list before you submit your review
- The list will tell you if a service requires a review and where to submit your request

# Prior authorization reviews for MA

- Our Medicare Advantage plans have a [separate list of services requiring prior authorization](#). It's not the list we use for our commercial plans  
Check the Medicare Advantage website for the most current list for both medical and pharmacy
- You can submit your request online by [logging in](#) and using the referral and prior authorization tool
- Or fill out and fax the [prior authorization form](#) located on the provider MA website in the [forms section](#). Include pertinent medical records.

## Medical Management

Prior authorizations

Fax : 866-809-1370

Phone: 855-339-8127

## CVS Caremark for Pharmacy Part D

Prior authorizations

Fax: 855-633-7673

Phone: 844-499-4723

# Medical utilization management process for decisions

Care Management conducts timely reviews of all requests for service, according to the type of service requested.

Type of Request	Decision	Initial Notification	Written Notification	Type of Service
*Pre-service urgent/ concurrent	Within 72 hours from receipt of request	Within 72 hours from receipt of request	Within 3 days of initial notification	Acute and Post Acute Admissions
Pre-service non-urgent	Within 14 days of receipt of request	Within 14 days of receipt of request	Within 14 days of receipt of request	Part B Medications and members already admitted
Post-service	Within 30 days of receipt of request	N/A	Within 30 days of receipt of request	Services already provided

\* Pre-service urgent/concurrent means if the provider believes that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

# Case Management

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# About our case management program

We provide a number of case management programs dedicated to improving the health and quality of life for our members.

- Registered nurses work with members to help them take an active role in managing their chronic or complex health conditions
- Members receive condition-specific information, education, and support
- All Medicare Advantage members have access to this program
- Members identified as eligible are automatically enrolled
- Member may decline participation in the program at any time.
- To refer a member, call our Chronic Condition Management/Health Education department **855-339-8125**

# Case management programs overview

**Complex case management:** A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services needed to meet members' health needs and to promote quality and cost-effective interventions and outcomes across the continuum of care.

- An integrated team works with members, their families, their doctors, and other health professionals to facilitate appropriate use of healthcare services, and to help members reach their best level of wellness through education, support, and coordination of care
- Conditions managed include:
  - Complex conditions (e.g. Parkinson, ALS, advanced liver disease)
  - Co-morbid conditions (diabetes, congestive heart failure, kidney disease, ischemic heart disease, etc.)
  - Catastrophic conditions such as MVA, loss of limb, multiple burns
  - Oncology
  - Transplant

# Chronic condition management overview

The chronic condition management program helps members learn how to manage their conditions by encouraging regular provider follow-ups, and proper use of medications. Clinical nursing staff will assist with coordination of the patient's care to help improve communication with their providers.

Some types of diseases that will be managed and/or coordinated by the clinical nursing staff are:

- Chronic obstructive pulmonary disease (COPD)
- Coronary artery disease (CAD)
- Diabetes
- Chronic kidney disease (CKD)
- Congestive heart failure (CHF)

# Case management programs

## Additional program information

- **24/7 nurse advice line** - Provides recommendations over the phone for appropriate level of care. Also provides member education for specific conditions
- **Health risk assessment** – Questionnaire used to provide individuals, providers, and the health plan with an evaluation of their health risks and quality of life. With a simple look at the member’s medical history and personal health habits, we can get the information needed to engage participants in the proper care and treatment of their health
- **Coordination with Optum** to ensure members medical and behavioral health needs are well managed
- **Coordination with Landmark** to prevent duplication of outreach services
- **Care transition to home** - Focuses on the safe and successful transition of members from an acute, inpatient setting to home. Care includes an assessment, develop care plan, schedule follow up visits and coordinating the patient’s care.
- **Emergency room follow up** – A follow up call by a registered nurse after a patient’s emergency room visit to make sure they understands their discharge instructions, and to make sure any follow up visits are scheduled or have occurred



# Appeals and Reconsiderations

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# Appeals and Reconsiderations

We'll send you a letter when a claim for medical services is fully or partially denied for a clinical edit or medical denial. The letter will contain instructions and contact information to submit an appeal.

# Thank You

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