Referrals, Prior Authorizations, and Care Management

044506 (12-29-2023)

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Contents

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Referrals

Medicare Advantage referrals

- Primary care providers (PCP) are responsible for communicating and arranging care with a specialist.
- Referrals to in-network Premera Medicare Advantage providers don't need to be submitted to Premera.
- Referrals to out-of-network specialists will require submission to Premera for review and approval.
- Premera HMO plans require members to see in-network providers unless it's emergency care. To see who is in network go here.

Medicare Advantage out-of-network referrals

- Referrals to out-of-network providers can be submitted online by clicking on the “Sign in to tools and resources” link on this page.
- Referrals can also be submitted by fax.
  - Completed referral forms can be faxed to 866-809-1370.
  - Referral submission forms are available online on our Medicare Advantage website under forms: premera.com/wa/provider/medicare-advantage.

Prior Authorizations

Services that require prior authorization

Acute

CPT code 99222 will automatically be added to your authorization request.

- Acute hospital admissions
- Elective inpatient surgeries

Post Acute

For initial authorization and ongoing continued stay reviews, updated clinical information will need to be submitted in a timely manner.

- Skilled nursing facility admissions
- Long-term acute care hospital admissions
- Inpatient rehabilitation

Outpatient

- Select Part B drugs
- Select outpatient surgeries/procedures and DME

Click here to find the correct PA form for your request

Prior authorization reviews for MA

- Prior authorization is required for all inpatient admissions, elective inpatient surgeries, skilled nursing facility admissions, inpatient rehabilitation, long-term acute care hospital admissions.
- For outpatient and part B drug prior authorizations, our Medicare Advantage plans have a separate prior authorization list.
  - Use our online tool, Symphony to enter your requests. Symphony will check your procedure codes and tell you if a prior authorization is required. Or
  - Check the Medicare Advantage policy web page for the most current list for both medical and part B drugs.
- Please refer to the Evidence of Coverage for additional prior authorization requirements.
- For pharmacy part D information, please visit this site and click on the prescriptions tab.

Submitting prior authorization requests

- You can submit your request online by signing in to tools and resources, from the MA landing page or through OneHealthPort to access the referral and prior authorization tool.
- You can also fill out and fax a prior authorization form located on the provider MA website in the forms section. Please be sure to use the correct form and include pertinent medical records.

Health Management
Prior authorizations
Fax : 866-809-1370
Phone: 855-339-8127

Pharmacy Part B
Prior authorizations
Fax: 866-544-3078
Phone: 844-339-8127

CVS Caremark for Pharmacy Part D
Prior authorizations
Fax: 855-633-7673
Phone: 844-499-4723

CVS Caremark is an independent company providing select services to Premera Medicare Advantage providers.

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About Medicare Advantage forms

If you're not submitting requests online, make sure you're filling out the correct form. Whether submitting your request online or using a form, all requests must be submitted with clinical information that justifies the need for the service. There are different prior authorization and request forms:

- Prior authorization form – General prior authorization request for services
- Part B drug request form – Prior authorization request for Part B medications
- Request for Medicare prescription drug coverage determination – Requesting appeal of Premera denial of coverage for a prescription drug
- Long-term acute care hospital care management form – Prior approval for long-term acute care
- Skilled nursing facility (SNF) and inpatient rehabilitation (IPR) form – Prior authorization for SNF or IPR

Carelon Medical Benefits and Optum

We've delegated reviews for select services to our partners Carelon Medical Benefits and Optum.

- Carelon Medical Benefits (formerly AIM) is for high-tech radiology, interventional pain management, radiation therapy, and cardiac imaging authorizations.
- Optum is for behavioral health authorizations.
- To save time, check the MA prior authorization list located on our policy page before you submit your review. The list will tell you if a service requires a review and where to submit your request.
- You can also use our online tool Symphony to check procedure codes. Symphony will tell you if a prior authorization is required and alert you if your request should be submitted to Carelon or Optum.

Carelon Medical Benefits Management and Optum are independent companies providing select services to Premera Blue Cross Medicare Advantage providers.

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Utilization management decision timelines

Type of Request	Decision	Initial Notification	Written Notification
*Expedited Pre-service	Within 72 hours from receipt of request	Within 72 hours from receipt of request	Within 3 days of verbal notification
Standard Pre-service	Within 14 days of receipt of request	Within 14 days of receipt of request	Within 14 days of receipt of request
Retrospective review	Within 14 days of receipt of request	N/A	Within 14 days of receipt of request

** Expedited pre-service should ONLY be requested 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.*

Utilization management decision timelines: Part B Drugs

Type of Request	Decision	Initial Notification	Written Notification
*Expedited Pre-service	Within 24 hours from receipt of request	Within 24 hours from receipt of request	Within 3 days of verbal notification
Standard Pre-service	Within 72 hours from receipt of request	Within 72 hours from receipt of request	Within 3 days of verbal notification

** Expedited pre-service should ONLY be requested 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 is in serious jeopardy.*

Appeals and Reconsiderations

Appeals and reconsiderations

We have a provider appeal form available to help you with submitting appeals. The form includes instructions to help you submit your appeal. You can find the provider appeal form in the forms section of our Medicare Advantage provider website.

Care Management

Care management overview

- The care management team consists of registered nurses and support staff who work with members to help them take an active role in managing their chronic or complex health conditions.
- We provide several case management programs dedicated to improving the health and quality of life for our members.
- All Medicare Advantage members have access to these programs.
- Members identified as eligible are automatically enrolled. Member may decline participation in the program at any time.
  - To refer a member, contact our Care Management department

Phone: 855-339-8125 Fax: 800-431-3981
Email: MABXCMPremera@bcbsm.com

Case management programs

Complex Case Management: This overarching program uses a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates members' health status.

- The case manager works with the member, their family, 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.
- Members receive condition-specific information, education, and support.
- Conditions managed include:
  - Complex conditions such as Parkinson, ALS, advanced liver disease, cancer
  - Chronic conditions such as diabetes, congestive heart failure, kidney disease including end stage renal disease, ischemic heart disease
  - Catastrophic conditions such as motor vehicle accident, loss of limb, multiple burns
  - Transplants

Case management programs

Chronic Condition Management: In this program, the focus is on condition-specific education and management.

- Registered nurses help members learn how to manage their conditions through education and by encouraging proper use of medications and regular provider follow-ups.
- Case managers also assist with coordination of the patient's care to help improve communication with their providers.
- Conditions managed are:
  - Chronic obstructive pulmonary disease (COPD)
  - Coronary artery disease (CAD)
  - Diabetes
  - Chronic kidney disease (CKD)
  - Congestive heart failure (CHF)

Case management programs

Care Transitions to Home:
This is an enhanced acute care discharge program that incorporates care coordination principles to include a primary care follow-up schedule, community resources, medication review, and other best practices to reduce the risk of readmission and to improve overall quality of care.

Emergency Department Utilization Follow-up:
A follow up call by a member of the case management team after a patient's emergency room visit. The focus is on reducing avoidable utilization of the ED department and connecting members with care providers and needed resources.

Additional CM program information

- **Nurse Advice Line:** Available 24 hours a day, 7 days per week to provide recommendations to members over the phone for appropriate level of care. Also provides member education for specific conditions. Phone number: 855-339-8123.
- **Health Risk Assessment:** Questionnaire used to evaluate the member's health risks and quality of life. If appropriate, members are referred to a case management program based on their medical history and personal health habits.
- **Coordination with Optum:** To ensure members' medical and behavioral health needs are well managed, referrals are made to Optum as appropriate for behavioral health needs. Optum Customer Service: 844-884-1855.

Optum is an independent company providing select services to Premera Blue Cross Medicare Advantage providers.