



Referrals, Prior Authorizations, and Care Management

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 services that require referrals

- Office visits with a specialty provider
- Chiropractic care
- Nutritional counseling

Examples of services that don't require referrals

- Emergency services
- Routine women's healthcare: breast exams, mammograms, pap tests, and pelvic exams provided by an in-network provider.
- Flu and pneumonia vaccinations.
- Routine vision exams for plans with vision benefits.
- Routine hearing exams for plans with hearing benefits

Medicare Advantage referral submission

- Referrals can be submitted online by clicking on the “Sign in to tool and resources” link on [this page](#).
- 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.

Prior Authorizations

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Prior authorization reviews for MA

- Prior Authorization is required for all inpatient admissions, 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 list of services. 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 part B drugs.
- Please also refer to the [Evidence of Coverage](#) for additional prior authorization requirements.
- For pharmacy part D information, please visit [this site](#) and click on the Pharmacy tab.

Submitting Prior Authorization Requests

- You can submit your request online by logging in and using 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.

Medical 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

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 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.

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	Members already admitted
Post-service	Within 14 days of receipt of request	N/A	Within 14 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.*

Medical utilization management process for decisions

For Part B medications

Type of Request	Decision	Initial Notification	Written Notification	Type of Service
*Pre-service urgent/ concurrent	Within 24 hours from receipt of request	Within 24 hours from receipt of request	Within 3 days of initial notification	Part B medications
Pre-service non-urgent	Within 72 hours from receipt of request	Within 72 hours from receipt of request	Within 3 days of initial notification	Part B medications

** 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.*

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.

Care Management

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Care Management Overview

- The care management team consists of registered nurses, a social worker, and support staff who work with members to help them take an active role in managing their chronic or complex health conditions.
- We provide a number of 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, call our Care Management department **855-339-8125**.

Case Management Programs

Complex Case Management: This overarching program utilizes 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 (e.g. Parkinson, ALS, advanced liver disease, cancer)
 - Chronic conditions (diabetes, congestive heart failure, kidney disease, ischemic heart disease, etc.)
 - 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.