



Referral and Prior Authorization Tool Guide

Medicare Advantage landing page

premera.com/wa/provider/medicare-advantage/



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Providers

For Providers

Medicare Advantage

Medical

Dental

Tools

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Information for Premera Medicare Advantage Medical Providers

Premera Blue Cross Medicare Advantage plans offer your patients Medicare benefits -plus extra benefits for prescriptions and fitness programs - all in one easy-to-use plan. Medicare open enrollment occurs annually, October 15 through December 7.

Check out our provider training guides to learn more about our Medicare Advantage plans:

- [Quick reference guide \(.pdf\)](#)
- [About our plans \(.pdf\)](#)
- [How to access online tools \(.pdf\)](#)
- [Referrals, prior auth, medical management, and appeals \(.pdf\)](#)
- [Referral and prior auth tool guide \(.pdf\)](#)
- [Pharmacy - Part D \(.pdf\)](#)
- [Annual wellness visits \(.pdf\)](#)

Secure medical tools and resources for providers

Verify eligibility and benefits, check claim status and manage your patient's care.

[Log in to tools and resources](#)

Provider directory

Search for doctors, hospitals, and other specialists within the Premera Blue Cross Medicare Advantage Provider Network.

Forms

Find all the Medicare Advantage medical forms you need, including:

- Appeal and reconsideration forms
- Care Management forms
- Referral forms

Contact us

Find the right contact for Medicare Advantage questions, including:

- General information
- Member benefits and eligibility
- Technical issues
- And more

Policies

[View medical and pharmacy policies.](#)

Sign up for email news

Get the latest Premera Medicare Advantage provider news and policy updates.

[Sign up today!](#)

Resources

Check out the latest CMS updates and provider news

To learn more about participating with Premera while caring for your Medicare Advantage patients, view our [Provider Reference Manual \(.pdf\)](#)

View sample ID cards, learn about plans, new networks, and copays with our [ID Card Guide \(.pdf\)](#)

Referral & prior authorization: Code check

[Home](#) [Eligibility & Benefits](#) [Claims & Payment](#) [Referral & Prior Authorization](#) [Resources](#)

We have one prior authorization list for all medical and pharmacy Part B codes that require a review, but there are a few instances where we have different requirements for some of our plans. We recommend you review the list before you submit your requests.

View the [prior authorization code list](#) to see which code requires review or use the prior authorization tool.

Referral and Prior Authorization Tool

Use the referral and prior authorization tool to:

- Submit a referral
- Submit a new review
- Check the status of an existing review

Access the referral and prior authorization tool

You can also fill out and fax a [prior authorization request form](#) (PDF) or [referral form](#) (PDF)

AIM Specialty Health

AIM Specialty Health is a specialty benefits management company that manages imaging, radiation oncology, and pain management services for Premera. Prior authorization is based on member benefits at the time of service. You can review the [prior authorization code list](#) above to see which codes require a review by AIM.

[Sign in to AIM to submit your review](#)

AIM Resources for Providers

Welcome to AIM

[About AIM reviews for Radiation Oncology](#)

[About AIM reviews for Interventional Pain Management](#)

[How to register with AIM](#)

Behavioral Health Authorization

Optum is a specialty benefits management company that manages behavioral health services for Premera. Prior authorization is based on member benefits at the time of service.

You can review the [prior authorization code list](#) above to see which codes require a review by Optum.

Tool User Guides

Check out these how to videos and guides for tips on using our online tools

- [Prior authorization and case management overview](#)
- [Outpatient authorization and specialty](#)
 - [Outpatient authorization quick reference guide](#)
- [Inpatient authorization](#)
 - [Inpatient authorization quick reference guide](#)
- [Case management request](#)
 - [Case management quick reference guide](#)

Please check the prior authorization code list prior to submission to ensure your service requires prior authorization.

Referral & prior authorization tool

[Home](#) [Eligibility & Benefits](#) [Claims & Payment](#) [Referral & Prior Authorization](#) [Resources](#)

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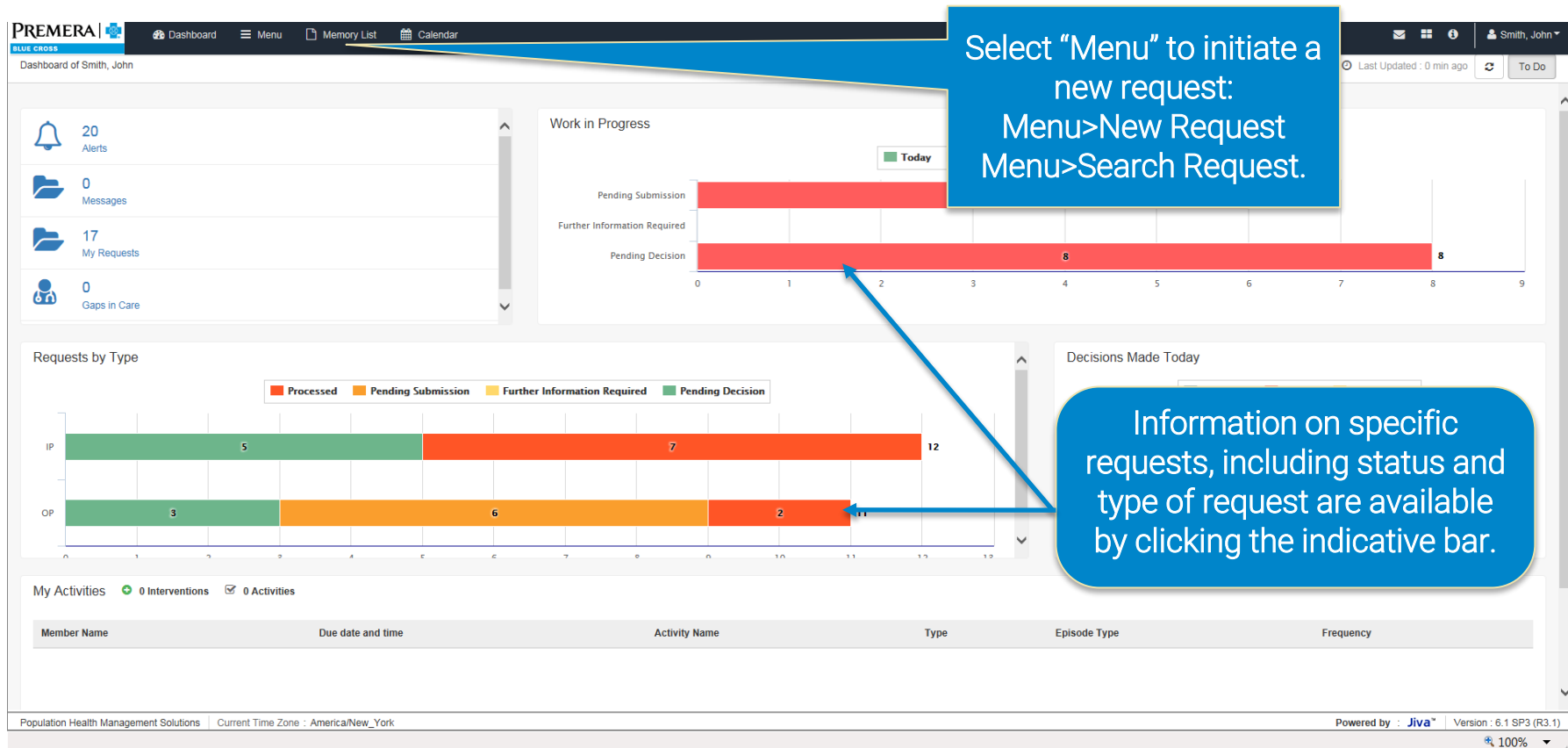
- [Prior authorization and case management overview](#)
- [Prior authorization quick reference guide](#)
- [Outpatient authorization and specialty provider referral](#)
- [Outpatient authorization quick reference guide](#)
- [Inpatient authorization](#)
- [Inpatient authorization quick reference guide](#)
- [Case management quick reference guide](#)

Access the Referral and Prior authorization tool: Jiva.

Referral & prior authorization tool: Jiva

- Jiva website is accessed via single sign on (SSO) from the provider website.
- Jiva is the comprehensive care management tool used by providers and health management staff.
- Use Jiva for:
 - Entering referrals for specialists
 - Inpatient (IP) and outpatient (OP) prior authorization requests
 - Checking the status of requests

Referral & prior authorization tool: Jiva - Dashboard



Jiva: Dashboard functions

- Once a request has been created in Jiva, it's defined as an episode.
- Widgets are actionable boxes that help providers access alerts and requests.
- From the dashboard, a provider views status of the episodes, including:
 - Approval
 - Denial
 - Needs more information status
 - Documented member contact
- Episodes are viewed by type, including:
 - Inpatient
 - Outpatient (OP)
- Use the indicative bars on the dashboard for complete request or status details.

Jiva: How to search for a member

New Request

| | | | | |
|-------------------|-------------------------------------|---|--|----------------------------------|
| Member Last Name | <input type="text" value="Member"/> | Client | <input type="text"/> | <input type="button" value="Q"/> |
| Member First Name | <input type="text"/> | Member ID * | <input type="text" value="11291904300"/> | |
| Member DOB | <input type="text"/> | <input type="button" value="Calendar"/> | | |

Navigate to “Menu” and “New Request”
Under new request, Member ID is a mandatory field.
Please note: ALPHA pre-fix should be removed from Member ID and two trailing 00's added to end to retrieve member information.

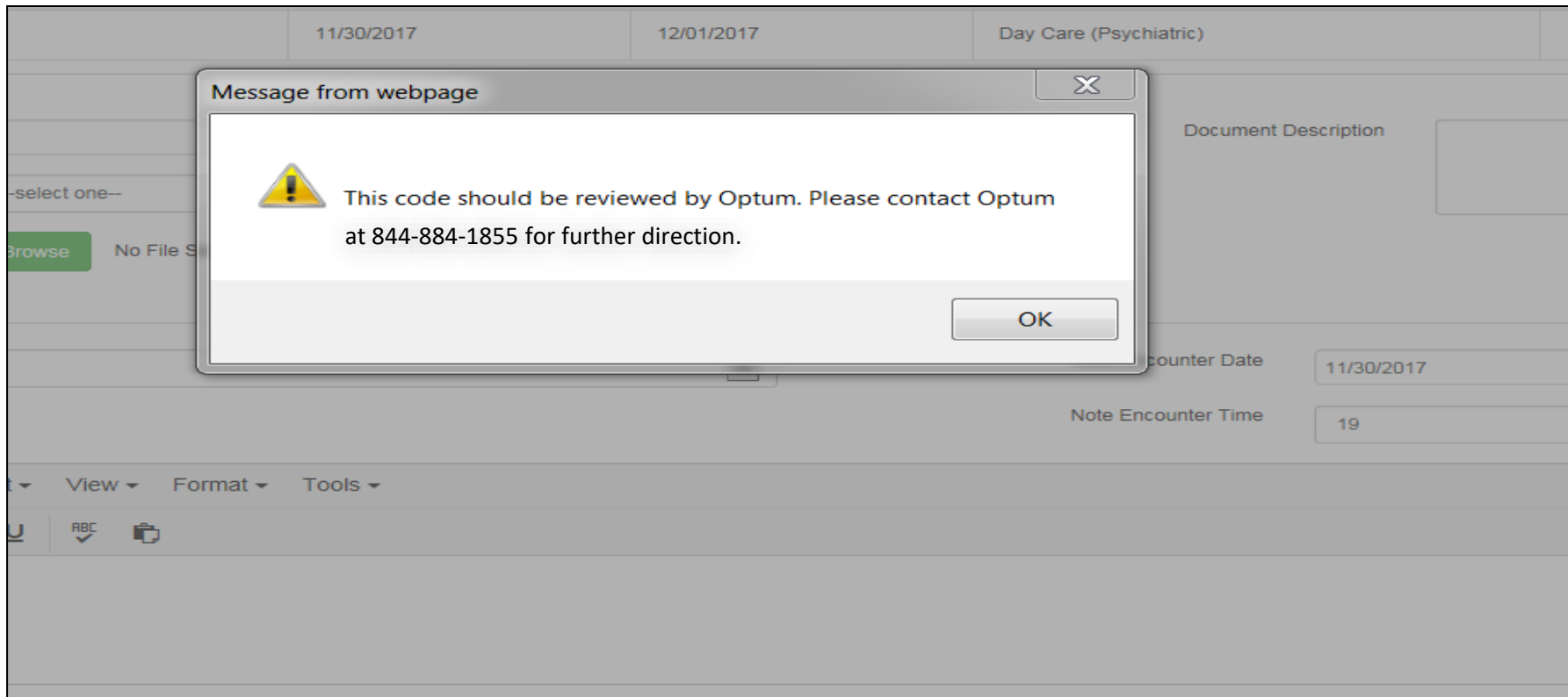
Adding new requests

New requests are made by navigating to:

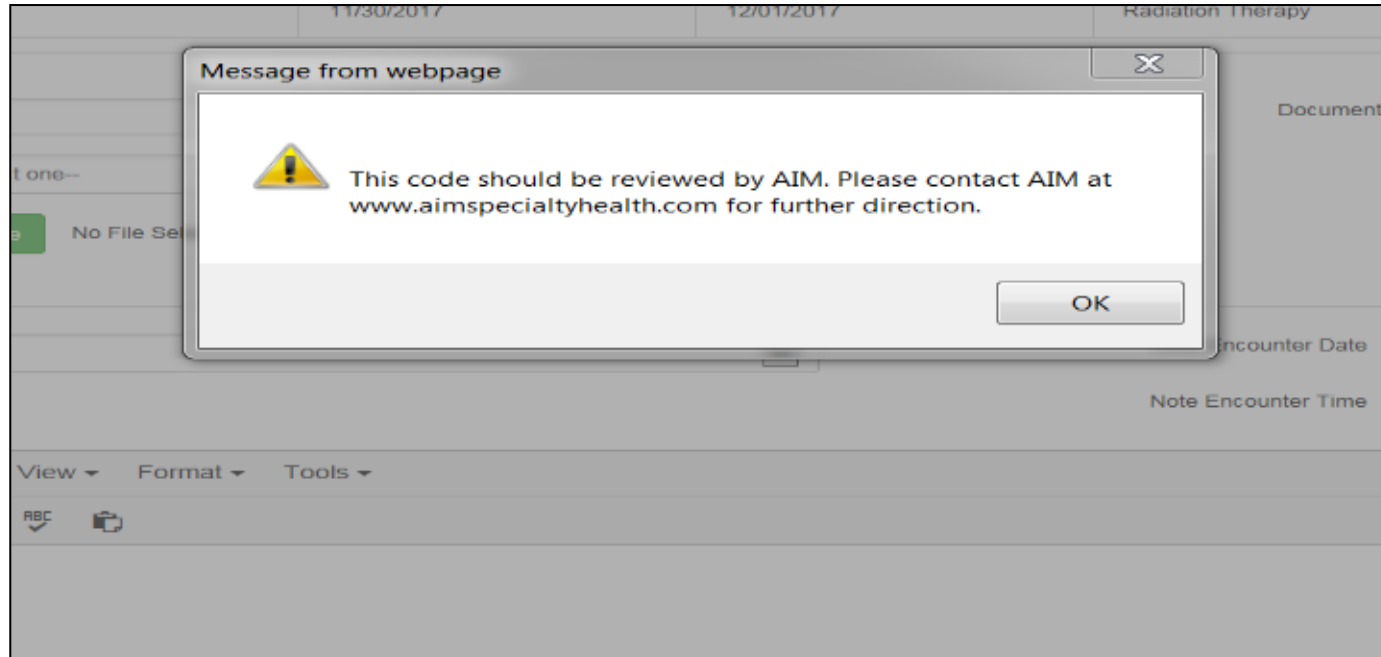
- Menu> Provider> New Request
- Menu> My Members> click on member's name to enter desired member's chart
> + Add Request
- Menu> Search Request> Add New Request

Please Note: For requests processed by delegated entities or a vendor, providers will receive a hard-stop alert and be instructed to contact delegated entity or the vendor with any further questions.

Hard-stop alert: Behavioral health



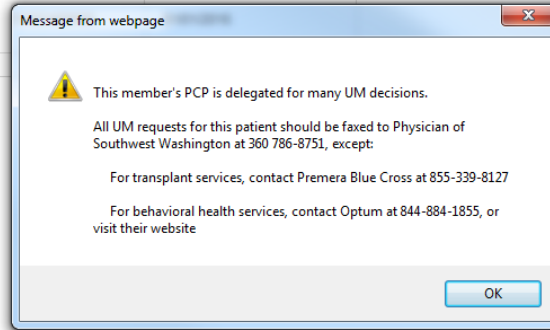
Hard-stop alert: High-tech radiology, interventional pain management, radiation therapy and cardiac imaging authorizations



Hard-stop alert: Delegated Providers

Search Reset

| Jiva Member ID | Member Name | Member Date of Birth | Gender | Coverage ID | Coverage Start Date | Coverage End Date | Group Name |
|----------------|-------------|----------------------|--------|-------------|---------------------|-------------------|---|
| 189551 | | | F | | | | Premiera Blue Cross Medicare Advantage Sound + Rx (HMO) |



Referrals for specialty care

Select Place of Service
='Referral for Office Visit'.

Enter the requested # of visits,
start date and end date.

Service Type *

Place of Service *

Code Type *

Service Code *

[Advanced Search](#)

[Optional Fields](#)

Modifier

Start Date *

End Date *

Requested #

You don't need to include a CPT code. The CPT code auto-fills with code 99242 (office consultation, new established patient 30-minutes). This code is for internal processes only; it doesn't need to match the CPT code on the specialist's claim.

Submitting an outpatient (OP) request & referral

Request Type *

Request Priority *

Optional Fields

Code Type *

Diagnosis Code Type *

Provider Details [Attach Providers](#)

Service/Specialty Drug Request Service Type *

Place of Service *

- OP episodes need to have both a **requesting provider** and **treating provider** attached.
- If an OP request contains CPT codes or HCPCS codes that are not on the prior authorization list, you do not need to submit a request unless you are requesting an organization determination.
- Request will auto-approve if the group has seamless access and refers within their partner system.
- All providers can submit these requests.

Prior authorizations

- An authorization pends for “Clinical Review Required” if the stay or service codes exist on the Premiera prior auth list.
- The request is received by the utilization management team and is reviewed using CMS criteria, medical policy, or InterQual™ Clinical Criteria.
- Providers see a decision based on the designated turnaround time for expedited (up to 72 hours), standard (up to 14 days), or retrospective requests (14 days).
*Generally; although some exceptions may exist.
- For all types of requests, medical records can be attached.
- Necessary fields are indicated with an asterisk.*

Submitting an inpatient (IP) request

Service Type ★ 

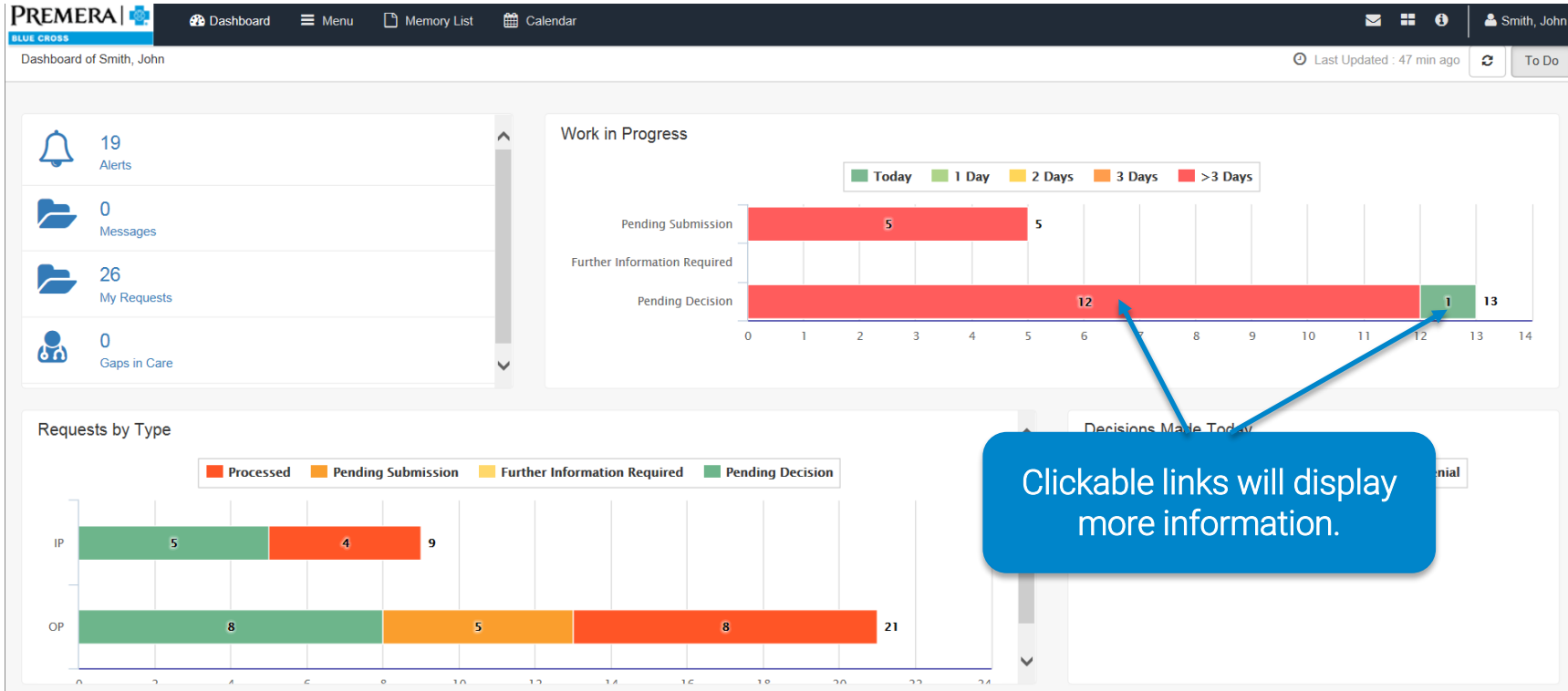
Place of Service 

[Optional Fields](#)

Expected Admit Date 

- An inpatient episode can include many service requests, but only one initial stay request.
- IP episodes need to have an **admitting, requesting, treating provider, and servicing facility attached**.
- For inpatient hospital setting, please be sure to add CPT code 99222 to authorization request.
- If an IP request includes auto-approvable ICD-10 codes and/or CPT codes and includes in-network providers with an appropriate length of service, it may auto-approve.
- Otherwise, the episode pends for clinical review.

Checking status of requests



Checking status of requests: continued

Work in Progress Quick Links ▾

Inpatient ▾

Pending Decision ▾

Today ▾

Filter by Date

01/17/2018

-

01/17/2018

| | Episode Type | Cert Number | Episode ID | Member Name | Admit/Start Date | Diagnosis | Procedure | Provider | Created By |
|---|--------------|-------------|------------|----------------------------------|------------------|-----------|-----------|--|-------------|
| ⚙ | IP | 18100181 | 22151 | TESTMember, Mary | 01/22/2018 | R52 | 27700 | Bruce Sangeorzan, Bruce Sangeorzan, Bruce Sangeorzan | Smith, John |

- Requests made by providers are filtered by type (IP or OP) and status-pending submission, pending decision, further information required, or processed.
- Navigate back to the MCV (member centric view) by clicking on the member's name.

Additional user guides



[Log out](#)

[Home](#)

[Eligibility & Benefits](#)

[Claims & Payment](#)

[Referral & Prior Authorization](#)

[Resources](#)

All Premera Medicare Advantage plans use the same prior authorization list for medical and pharmacy Part B codes. We recommend you review the list before you submit your requests. Have a question? [Contact Us](#).

View the [prior authorization code list](#) to see which code requires review or use the prior authorization tool.

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[Access the referral and prior authorization tool](#)

You can also fill out and fax a [prior authorization form or referral form](#).

Please note: Per CMS, expedited requests should ONLY be requested when the health care provider believes that waiting for a decision under the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function. Please be mindful of this definition when submitting your requests so that we can prioritize and process all requests appropriately.

Tool User Guides

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- [Prior Authorization Quick Reference Guide](#)
- [Outpatient Authorization and Specialty Provider Referrals Quick Reference Guide](#)
- [Inpatient Authorization Quick Reference Guide](#)
- [Case Management Quick Reference Guide](#)