BlueCross BlueShield of Texas

CHIP | TEXAS STAR Your Health Plan ★ Your Choice | TEXAS STAR Kids Your Health Plan ★ Your Choice | TEXAS Health and Human Services

Utilization Management Provider Training STAR, STAR Kids, and CHIP.

DECEMBER, 2020

Agenda

- Customer Service
- Intake Department
- Prior Authorization
- Reviews
- Case Management
- Medicaid Provider Website
- Questions

Customer Service

Customer Service

Assists members and providers with benefits, eligibility, primary care physician assignments, or claim information

STAR and CHIP	STAR Kids
Member: 1-888-657-6061	Member: 1-877-688-1811
Provider: 1-877-560-8055	Provider: 1-877-784-6802

TTY:711

Available Monday thru Friday from 8 a.m. to 8 p.m. CT

Intake Department

Intake Department

Intake Department assist with the following:

Assist providers in determining if an authorization is required

Create Cases

Forwards cases to nurses for review as needed

Utilization requests are initiated by the providers by either phone or fax to the Intake Department

STAR and CHIP

Intake Phone Number 1-877-560-8055

Intake Fax Number: 1-855-653-8129

STAR Kids

Intake Phone Number 1-877-784-6802

Intake Fax Number: 1-866-644-5456

Intake Department Continued

Prior authorization and/or continued stay review phone calls and fax requests from provider

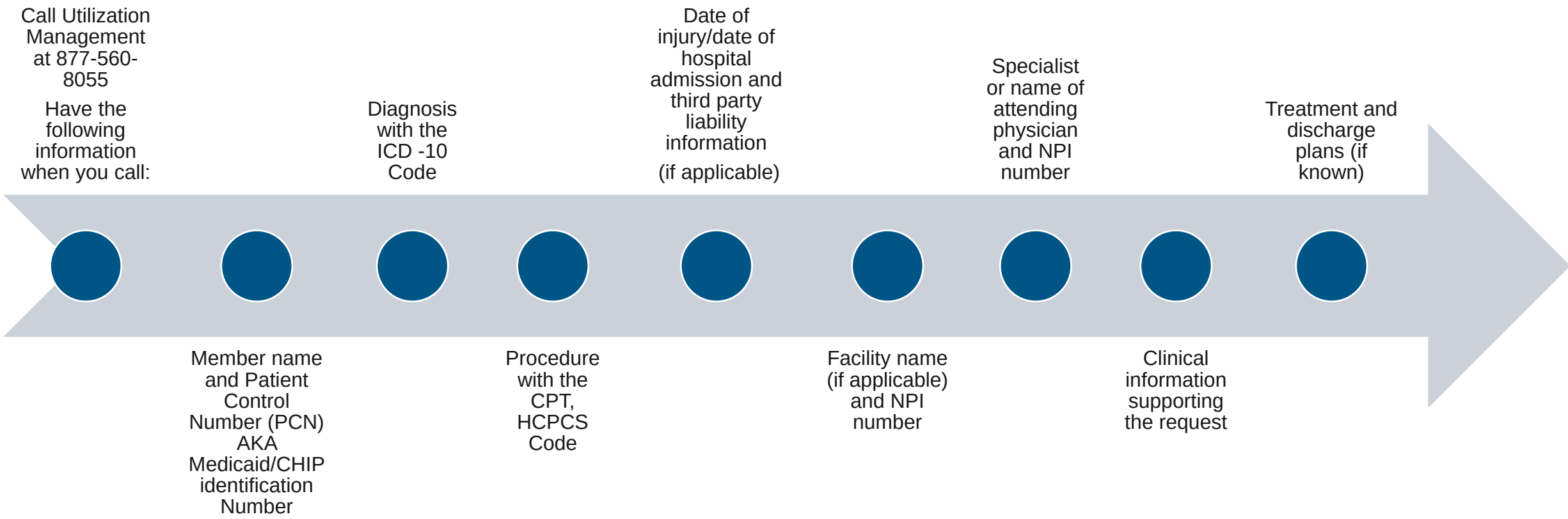
Phone calls regarding overall questions and/or case status inquiries

Notification of delivery processing and tracking via phone calls and fax

Assembly and indexing of incoming faxes

Out-of-network claims processing

Required information for Intake Department



Time Frames

Turn Around Times:

24 Hours
Concurrent Stay requests (when a member is currently in a hospital bed)

3 Business Days
Prior authorization routine requests (before outpatient service has been provided)

72 hours
Urgent prior authorization requests are initiated before outpatient services have been provided and are reviewed within this time frame. ***

***URGENT Prior Authorization is defined as a condition that a delay in service could result in harm to a member.**

Note: BCBSTX Prior Authorization form or the Standard Authorization form must be included with submission.

Prior Authorization

Prior Authorization vs. Concurrent Review

Prior Authorization

- Review Outpatient request
- Examples: Home Care, DME, CT/MRI, etc.

Concurrent Review

- Review inpatient request
- Examples: Acute Hospital, Skilled Nursing Facility, NICU, Rehabilitation, etc.

Prior Authorization

- Department of Insurance (TDI) Standard Prior Authorization Request Form for Health Care Services
- Request for Prior Authorization Form:
  - STAR and CHIP Fax: 1-855-653-8129
  - STAR Kids Fax: 1-866-644-5456
- Submittal of Medical Records not accepted in place of Prior Authorization
- Include Prior Authorization Number on claim for faster processing

Neonatal ICU

NICU Members

- BCBSTX utilizes MCG to determine appropriate level of care (LOC)
- NICU admissions are unique in that the member may stay for an extended period
- Levels of care can vary throughout the stay
- Progression can go from higher to lower level and then back to higher level, depending on acuity
- Clear and detailed documentation of baby's current clinical status helps ensure appropriate LOC determination
- NICU authorization should be requested as soon as baby admits to NICU
- Always reference authorization number in all communication about baby including claims submissions

Prior Authorizations

What Services Don't Require a Prior Authorization?

- Diagnosis and treatment of sexually transmitted diseases (out of network –OK)
- Testing for the Human Immunodeficiency Virus (HIV) (out of network – OK)
- Family Planning services to prevent or delay pregnancy (out of network – OK)
- Behavioral Health Services (in network only – Magellan Network)
- Annual Well Women exam (in-network Only)
- Prenatal services (in-network Only- Obstetric care
- Texas Health Steps (out of network- OK)
- **(*) Additional Services may apply**

STAR Kids Referral and Authorizations

Continuity of Care

Allow for the lesser of the authorization period:

- 180 days with no prior authorization required for existing delivery of service
- End of pre-existing authorization period.

Prior Authorization Non-Emergency

- BCBSTX will work with Providers to obtain the prior authorization

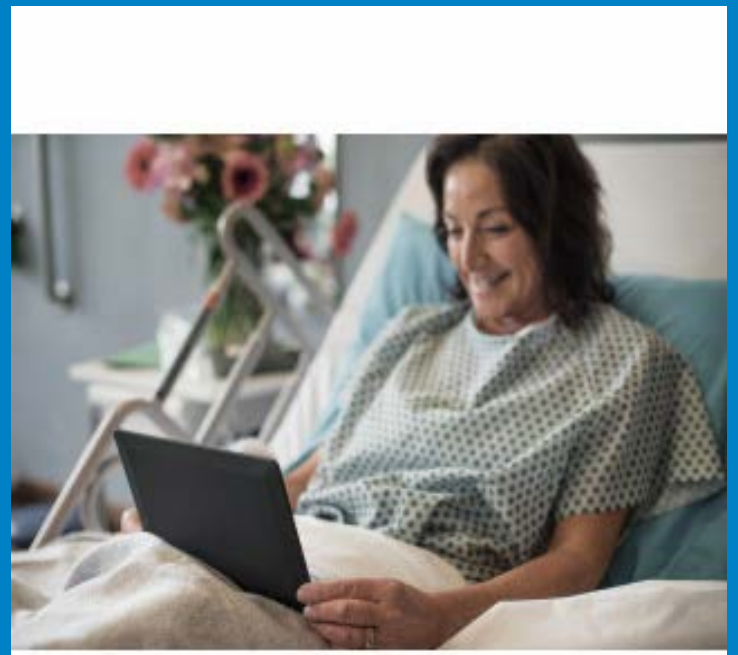
eviCore Prior Authorizations

Using eviCore

24/7 Availability to submit prior authorizations request and check status via online	eviCore is a partner of BCBSTX, allowing provider to initiate a case for prior authorizations.	To register and receive training using eviCore, please contact your BCBSTX Provider Representative.	Prior Authorization Call Center: 7:00am- 7:00pm M-F, 1-855-252-1117 Website: www.evicore.com Web Based Services: portal.support@evicore.com 800-646-0418 Option 2 Client Providers Operations: clientservices@evicore.com	Providers seeking Prior Authorizations for the following type of services will be required to use eviCore: 1. Radiology 2. Medical Oncology 3. Molecular Genetics 4. Musculoskeletal (OT,PT,ST,Chiro,Joint, and Pain) 5. Radiation Therapy 6. Sleep 7. Specialty Drug

Note: eviCore does not process claims.

Post Stabilization Care



Stabilized Members

- Require notification of admission for post stabilization care
- Within 1 business day following treatment of an emergency condition
- Failure to timely notify and obtain pre-approval may result in denial of claim

Questions

Important Utilization Management Questions

Three most important questions for Utilization Management (UM) request are:

- What service is being requested?
- When is the service scheduled?
- What is the clinical justification?

Reviews

Nurse Review

Nurses utilize the following to determine whether or not coverage of a request can be approved:

- If the request meets criteria, then the nurse will authorize the request
- Nurses review for medical necessity only, and never initiate denial
- If the request does not appear to meet criteria the nurse refers the request to a Peer Clinical Reviewer (PCR) – a.k.a. Physician Reviewer

Clinical Guidelines

Medical Policies

Milliman Guidelines

Plan Benefits

Physician Review

- The Peer Clinical Review (PCR) reviews the cases that are not able to be approved by the nurse
- Only a physician can deny service for lack of medical necessity
- If denied by the PCR, the UM staff will notify the provider's office of the denial. Providers have the right to:

Request a peer-to-peer discussion with the reviewing physician

Appeal UM adverse determinations:

- Submit no later than 60 calendar days from the date of the letter that explains the reason for your denial of coverage for a medical service.
- Providers can file an appeal, or expedited appeal by:

Phone:
BCBSTX Customer Service
1-877-688-1811
Or
Fax 1-855-235-1055

Mail:
Blue Cross and Blue Shield of Texas
C/O Complaints and Appeals Department
P.O. Box 660717
Dallas, TX 75266

Case Management

Case Management

The mission of Case Management (CM) is to empower members to take control of their health care needs by coordinating quality health care and the optimization of benefits

The CM team includes credentialed, experienced registered nurses many of whom are Certified Case Managers (CCMs) as well as social workers

Social Workers add valuable skills that allow us to address not only the member's medical needs, but also any psychological, social and financial issues

Providers, nurses, social workers and members, or their representative, may refer members to Case Management

STAR and CHIP: 1-877-560-8055

STAR Kids: 1-877-784-6802

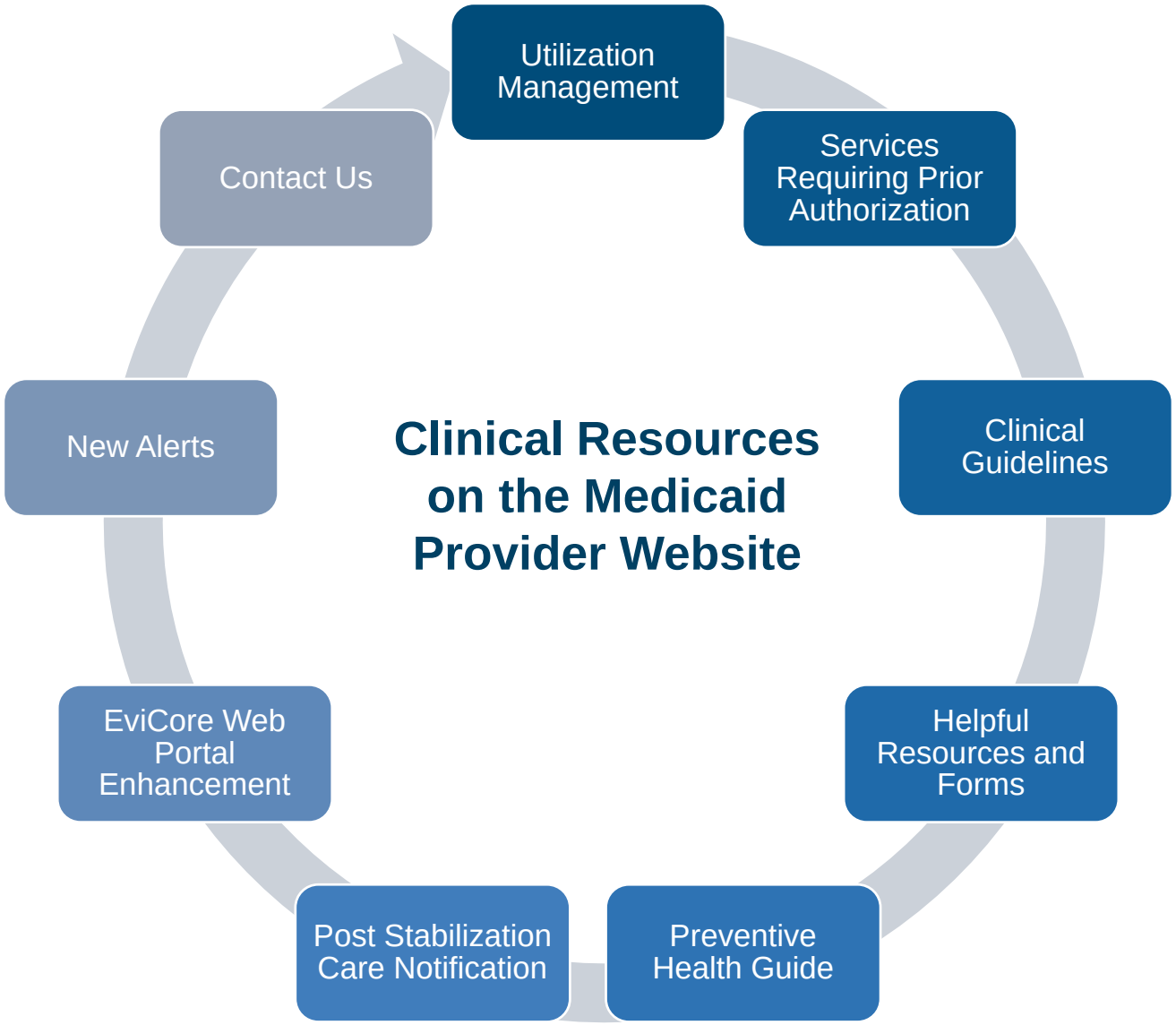
Submitting Appeals and Complaints

Blue Cross and Blue Shield of Texas
Attn: Complaints and Appeal Department
PO Box 660717
Dallas, TX 75266
Fax: 1-855-235-1055

BCBSTX Medicaid Provider Website Clinical Resources

Website link:

https://www.bcbstx.com/provider/ medicaid/index.html



BlueCross BlueShield of Texas

Questions?

Please contact:

BCBSTX Network Representatives

Phone: 1-855-212-1615

TexasMedicaidNetworkDepartment@bcbstx.com

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Thank you for attending our training.