The Pre-authorization Process, Referrals and Precertification Guidelines

Health Maintenance Organizations, commonly referred to as HMOs, operate under the concept of managed care. The fundamental premise of most managed care plans is that each member selects a primary care physician (PCP), who in turn coordinates the necessary care for the member. To varying degrees, managed care plans also require prior approval by the health plan before certain services can be considered for payment. The Finger Lakes Health Plan is not an HMO; it is a Preferred Provider Organization (PPO) and does not require the member select a PCP.

The terms precertification, referral, pre-authorization/prior authorization and prior justification all refer to scenarios in which a provider or member is responsible for seeking approval from the health-care plan before services can be considered. A provider who is participating with a particular health plan is contractually obligated to meet these responsibilities.

As demonstrated in the graph located later in this section, the requirements vary by health plan with respect to services that require up-front approval.

For the purposes of this manual, the prior approval term definitions are listed below:

- Precertification means that the provider must contact the health plan prior to admitting a patient into the hospital.
- Referral means that the provider must contact the health plan before sending a patient for treatment by a specialist or outpatient treatment facility.
- Prior authorization means that the provider must contact the health plan before prescribing certain medications.
- Prior justification means that the provider must contact the health plan prior to performing specific procedures.

Notification of Prior Approval Decisions

We will review the medical necessity and appropriateness of the requested service and approve or deny the request within one to two business days. Whenever we make a utilization review determination about the medical necessity of a service for which you have requested pre-authorization, we will notify you by telephone of our determination and remind you to inform your patient of the decision. Upon your receipt of this notice from us, you must notify your patient by telephone of our determination. Your call to the patient will be part of your professional relationship with your patient, but will also constitute notice by you as an agent for us for this limited purpose only. **You must provide this notice to the patient within 24 hours of your receipt of notice of our determination, regardless of whether pre-authorization for the service has been approved or denied.** We will follow up with a written notice to both you and the enrollee within two business days.

In any situation where we have a third party utilization review (UR) agent providing pre-authorization services, the UR agent will be notifying you by telephone of their determination. You remain responsible to notify your patient within 24 hours in this case as well.

We assign an authorization number to each request at the time of the notification. This number is for you to use as a reference for all communications regarding this case. The authorization number confirms notification and certifies the medical necessity of the procedure/treatment, but does not guarantee payment. **Prior approval does not guarantee payment. Payment is**
determined when the claim is processed according to the member's eligibility and covered benefits.

Adverse Determinations

Adverse determinations are denials or reductions in payment for reasons such as lack of medical necessity, experimental/investigational procedures, etc. A notice of any adverse determination includes the reasons, including clinical rationale, for the determination. The notice also advises the patient of the right to a review of the adverse determination and includes instructions for initiating an appeal, as well as what additional information or documentation we would need to make an internal appeal determination. It also specifies how to obtain a copy of the clinical review criteria used to make the adverse determination.

If, prior to making an adverse determination, no attempt was made to consult with the provider who requested the authorization, the provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. The reconsideration will take place within one business day of the request for reconsideration, in consultation with the requesting provider. If the adverse determination is upheld, notice is given to the provider, by telephone and in writing, within two business days from the date of reconsideration.

More information about the health plan's obligations with respect to adverse determination notices is included in the Patient Advocacy section of this manual.

Responsibilities of the PCP for HMO Members

Each HMO member is required to select a PCP to provide or otherwise coordinate their care. Women may also choose an obstetrician or gynecologist as an alternate PCP. If a member fails to choose a PCP, coverage will apply for emergency services only.

PCPs perform a key role in the management of their patient’s care by:

- Assuming the primary responsibility for coordinating the overall health care of their patients, including generating and updating specialist referrals and hospital admissions; and
- Promptly notifying BCBSRA of any referrals or hospital admissions made on behalf of their patients.
- Obtain all consult reports, lab tests, test results, note the results in the medical record and document the treatment plan accordingly.

Physicians covering for the PCP in his or her absence must participate with the patient’s plan and are responsible for generating referral or hospital admission requests.

NOTE: Since FLHP members are not required to select a PCP, any participating FLHP provider can notify BCBSRA of any service or admission requiring notification.

Responsibilities of the Specialist for HMO Members

Specialists are responsible for making sure necessary referrals are in place for covered services, and for providing care to referred patients to the extent of treatment authorized by the PCP (except in emergency situations where prior approval cannot be sought). Specialists must submit a written report to the patient’s PCP within five (5) business days after rendering services to the patient. If an initial report is provided orally, a written report may be submitted within 10
calendar days after treatment. Specialists must request approval from the referring physician to continue treatment beyond the care authorized on the referral. A provider who is participating with a particular health plan is contractually obligated to meet these responsibilities. The patient cannot be billed for coverable services which have been denied unless the patient self-referred.

**Responsibilities of BCBSRA**

Whenever we make a decision concerning the status of any medical necessity or experimental/investigational determination, we will notify the requesting physician by phone that the service is either approved or denied. In addition, we will follow-up with a written notice to both the physician and the member within 3 business days (prospective) or one business day (concurrent) of the decision.

HMOs must provide education to the community on issues concerning advance directives. At the time of enrollment into our HMOs, we will provide copies of informational materials for members, including:

- “Planning in Advance for Your Medical Treatment”
- “Do Not Resuscitate Order - A Guide for Patients and Families”
- “Appointing Your Health-Care Agent - New York State’s Proxy Law”

If you have any questions regarding Advance Directives, contact a Managed Care Provider Representative at (585) 454-4951 or (800) 462-0116.

HMOs must routinely review the medical records of their members to ensure compliance. See Member Rights and Responsibilities at the end of this section for additional details.

**Continuity of Care: When a Provider Leaves the Network**

If a member’s health-care provider leaves the health plan network of providers for reasons other than imminent harm to patient care, a determination of fraud, or a final disciplinary action by the state licensing board that impairs the health professionals ability to practice, coverage shall be permitted in order to continue an ongoing course of treatment with the member’s current health care provider during the transitional period.

The transitional period shall continue up to 90 days from the date of the provider’s disenrollment from the network; or up through postpartum care resulting from delivery, if the member has entered the second trimester of pregnancy. The care shall be authorized for the transitional period only if the provider agrees to accept reimbursement as payment in full; adhere to quality assurance requirements and to provide medical information related to such care; and adhere to the policies and procedures as outlined by BCBSRA.

**Continuity of Care: New Member**

New members shall be permitted to continue an ongoing course of treatment with the member’s current health-care provider if the member has a life-threatening or a degenerative and disabling disease or condition for a transitional period of up to 60 days. If the member has entered the second trimester of pregnancy at the effective date of enrollment, the transitional period shall include the provision of postpartum care related to the delivery.

The care shall be authorized only if the provider agrees to accept reimbursement as payment in full, adhere to the quality assurance requirements and provide medical information related to such care; and adhere to the policies and procedures as outlined by the health plan.
Direct Access

As of January 1, 1999, Blue Choice Plus eliminated referrals to participating specialists and consulting health-care professionals. (See the referral chart for plan limitations.) Participating specialists and the HMO have a responsibility to notify PCPs when their patients have utilized specialist care within a direct access managed care HMO plan.

Responsibility of the Participating Specialist
The specialist shall submit to the member’s PCP, within three business days after the visit, a report of the examination or treatment provided. However, the report may be given verbally provided that a written report is submitted within 10 business days following the member’s visit.

Responsibility of the HMO
The HMO will issue an automatically generated computer listing of all Direct Access specialty services within 14 business days of their receipt of a claim from a specialist. The HMO will send the list to the member’s PCP indicating the member’s name, date of service, name of specialist and diagnosis. The HMO will instruct the PCP to review and retain this information in the member’s medical record maintained in the PCP’s office.

Administrative Simplification for Referrals
Referrals generated on or after January 1, 2003 can be approved for continuous, open-ended treatment at the discretion of the PCP or referring physician. When unlimited visits are approved for a referral, your patients will receive a notification that reflects the number of visits approved as, "according to treating physician's discretion." This will allow you to discontinue or limit a referral if you make the decision to do so.

Please note that these referral changes will not apply for the following:
- the specialties of dermatology, plastic surgery, behavioral health, podiatry, physical therapy, occupational therapy and speech therapy
- out-of-area referrals or referrals to providers who do not participate in the patient's health plan network
- durable medical equipment and supplies
- services that require prior justification

Authorization requirements for inpatient admissions will remain unchanged.