Section 11

Medical Policies and Prior Authorization

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Medical Policies – Overview

For most commercial plans, Blue Cross® Blue Shield® of Arizona (BCBSAZ) uses many nationally recognized medical policy guidelines. This includes best-in-class, evidence-based criteria developed by eviCore, Change Healthcare InterQual®, American Specialty Health (ASH), and the National Comprehensive Cancer Network® (NCCN®). We also use policies developed by the BCBS Association and develop our own proprietary evidence-based criteria, based on emerging science and technology, medical literature, and credible clinical data. Please note:

- Self-funded employer groups with plans administered by a TPA, BCBSAZ-contracted administrators of our Medicare Advantage (MA) plans (P3 Healthcare and Arizona Priority Care), and other BCBS Plans may use their own medical and administrative criteria, which might differ from ours, including determination of what services are considered experimental and investigational.
- BCBSAZ-contracted vendor(s) may establish evidence-based criteria for services they provide or administer on our behalf.
- Federal Employee Program® (FEP®) plans and BCBSAZ-administered Medicare Advantage plans use other medical policies. See below for information.

FEP medical policies

Clinical criteria applicable to FEP members is based on the medical policies and utilization management guidelines listed on the FEP website. InterQual is used for inpatient admissions.

Medicare Advantage: Criteria used for BCBSAZ-administered plans

The criteria for outpatient procedures are based primarily on the CMS National Coverage Determinations (NCD) and Local Coverage Determinations (LCD). If there are no applicable NCD or LCD criteria and the service is included in our eviCore program for MA (high-tech radiology, oncology, radiation therapy, lab management, spine/joint surgery, and interventional pain management), eviCore will apply other nationally recognized guidelines or its own guidelines as appropriate. If addressed by NCD, LCD, or eviCore, we may use MCG® care guidelines or our own clinical judgment to determine medical necessity. We use ASH guidelines for musculoskeletal services.

For inpatient review (acute and post-acute settings), we use MCG® care guidelines or our own clinical judgment to determine medical necessity.

We follow the same hierarchy of sources for Part B drug guidelines. When there is no applicable guideline from those sources, we reference Micromedex® to see if the drug is FDA-approved for the patient's indication. For Part D drugs, we use the MedImpact® guidelines.

BCBSAZ review of clinical criteria

We review most clinical criteria applicable to BCBSAZ-administered plans at least annually, and more often as new material data becomes available. Medical and scientific resources for these criteria include, but are not limited to:

- High-grade, published, peer-reviewed, medical, and scientific literature
- Expert specialty reviews
- Professional medical organizations' position statements to support determinations concerning such matters as medical necessity, procedural coverage, and benefit determination and development

Medical Policies – Overview

Credible criteria must meet the following requirements:

- The technology must have final approval from the appropriate governmental regulatory bodies.
- The scientific evidence must permit conclusions concerning the technology's effect on health outcomes.
- The technology must improve the patient's net health outcome.
- The technology must be as beneficial as any established alternative.
- The improvement must be attainable outside of the investigational setting.

Healthcare evidence reviews: Evidence Street®
Evidence Street is a proprietary, subscription-based web platform of the Blue Cross Blue Shield Association, dedicated to transparent, efficient healthcare evidence reviews. During certain review periods, healthcare product and pharmaceutical manufacturers may submit their peer-reviewed evidence for consideration.

Impact of changes in medical technology on claim coding and processing
Rapid changes in the practice of medicine and use of associated supporting technologies can sometimes impact claim adjudication. A procedure or diagnostic test may be considered eligible for coverage when applied in one way or to a particular diagnosis, and not considered eligible for coverage when applied in a new way or for a different diagnosis because recognition of its efficacy in these new circumstances is still developing.

An existing CPT or HCPCS code may not accurately describe the combination of a procedure or diagnostic test and the corresponding utilization. Consequently, BCBSAZ may inadvertently pay a claim that properly should have been denied as non-covered or excluded, and vice versa.

When BCBSAZ receives information about a technology that is being considered for use in a new way, we assess that application for medical safety and efficacy. This assessment may result in a clarification to our clinical criteria. If so, that can result in denials of new claims for procedures that were previously paid or payment of new claims for procedures that were previously denied.

Blue Cross, Blue Shield, the Cross and Shield Symbols, BlueCard, Federal Employee Program, FEP, and Evidence Street are registered service marks of the Blue Cross Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

eviCore is a separate, independent company, contracted with BCBSAZ to provide prior authorization services to BCBSAZ providers and members. eviCore healthcare is a registered service mark of CareCore National, LLC.

InterQual® is a registered trademark of Change Healthcare LLC and/or one of its subsidiaries.

ASH is a separate, independent company, contracted with BCBSAZ to provide the chiropractic network, covered chiropractic services, and related claim processing and appeal/grievance resolution.

NCCN Guidelines are the proprietary and copyright-protected information of National Comprehensive Cancer Network Inc.

MCG care guidelines are the proprietary and copyright-protected information of MCG Health, LLC, part of the Hearst Health network.

Micromedex is a registered trademark of Micromedex, Inc.

MedImpact is a registered trademark of MedImpact Healthcare Systems, Inc.

Arizona Priority Care (AZPC) is a separate, independent company contracted with BCBSAZ to provide healthcare services to BCBSAZ providers and members. Arizona Priority Care is a service mark of Arizona Health Advantage, Inc.

P3 Health Partners is a separate, independent company that provides services to BCBSAZ providers and members.

Medical Policies – Access

How to access medical policies

TYPE OF PLAN	HOW TO ACCESS MEDICAL POLICIES
BCBSAZ Commercial Plans	Access the following resources in the azblue.com secure provider portal at "Practice Management > Medical Policies" • eviCore guidelines • InterQual criteria • BCBSAZ proprietary policies • Site-of-Service Requirements (for certain medications) • ASH chiropractic guidelines • Pharmacy coverage guidelines If you can't find policies by accessing the above resources, call 602-864-4614
Corporate Health Services (CHS) Plans (administered by TPAs)	Check the back of the member ID card for utilization management information
BCBSAZ-TPA Co-Administered Plans	• Group # 039176 (Amkor Technology, Inc. uses AmeriBen 1-800-388-3193 • Group # 037461 (NAEBT) uses American Health Group 1-800-847-7605
BlueCard® (Out-of-Area) Plans	Access the BlueCard medical policy router tool in the azblue.com secure provider portal at "Practice Management > Medical Policies"
FEP Plans	fepblue.org/legal/policies-guidelines
Medicare Advantage (MA) Plans administered by BCBSAZ	• CMS National Coverage Determinations (NCD) • Local Coverage Determinations (LCD) • eviCore guidelines • BCBSAZ proprietary policies • MCG Care Guidelines – Call BCBSAZ at 1-800-446-8331
MA Plans administered by AZPC	Call 480-499-8720
MA Plans administered by P3	Call 520-274-4421

Prior Authorization – Overview

Prior authorization is not a guarantee of payment
Prior authorization is the process BCBSAZ uses to determine a member's eligibility for a requested procedure or service before the service is rendered. Authorization decisions are based on the member's eligibility, condition, specific benefit plan, and any related evidence-based clinical criteria and pharmacy coverage guidelines.

Regardless of prior authorization decisions, patient care decisions are made between the provider and patient. The fact that a provider has prescribed, ordered, recommended, or approved a service or supply does not make it medically necessary or make the service eligible for benefits, even though it is not expressly excluded in the member's benefit book.

Prior authorization requirements
Prior authorization is required for all scheduled inpatient admissions and certain outpatient procedures, services, items, and medications. Our standard prior authorization requirements apply to most BCBSAZ commercial benefit plans. Some plans use other requirements, including:

- Certain large, self-funded groups have customized prior authorization requirements.
- CHS group plans are administered by a third-party administrator (TPA) and have their own utilization management arrangements (see page 11-9).
- BlueCard (out-of-area) plans are governed by the member's BCBS Plan (see page 11-8).
- FEP plans are governed by the Office of Personnel Management (see page 11-11).
- BCBSAZ Medicare Advantage (MA) plans have different prior authorization requirements (see page 11-13).

For provider reference, we post prior authorization requirements online:

- For code lists and comprehensive prior authorization requirements resources, access the azblue.com secure provider portal at "Practice Management > Prior Authorization."
- For most BCBSAZ employer group members, you can also use the Prior Authorization Lookup tool.
- For Medicare Advantage, visit "azbluemedicare.com/login > Prior Authorizations."

Prior authorization process
Prior authorization must be requested *before* the service is rendered. See page 11-19 for information about how to request prior authorization. The review typically considers:

- Member eligibility and benefit coverage, including contract limitations, exclusions, waiting periods, waivers, or benefit maximums that apply to the requested service or procedure
- Provider network status and any site-of-service requirements
- Medical necessity of procedures or treatments based on applicable clinical standards and criteria (see page 11-1)
- The use of procedures or items that might be considered experimental or investigational

Note: Even if a service has been authorized and rendered, all benefit plan provisions (e.g., eligibility, waiting periods, limitations, exclusions, waivers, and benefit maximums) still apply, even if they weren't readily determinable at the time prior authorization is given.

Prior Authorization – Overview

eviCore program

For the services and plans listed below, eviCore handles prior authorization on our behalf.

EVICORE SOLUTION	APPLICABLE BCBSAZ PLANS
Lab Management – Genetic testing	Most commercial group plans, and all PCP Coordinated Care HMO (PCP-HMO), individual/family PPO, and *BCBSAZ-administered* Medicare Advantage (MA) plans
Medical Oncology – Infused drugs (may include site-of-service requirements); supportive agents; companion diagnostics	
Radiation Oncology – Radiation treatment (clinical and non-clinical modalities)	
Radiology – High-tech imaging	
Specialty Drug Management – Drugs that must be administered by a healthcare professional and are covered only under medical benefits	Only for commercial group, PCP-HMO, and individual/family PPO plans (not for MA plans)
Musculoskeletal – Spine and joint surgery and interventional pain management services	*BCBSAZ-administered* MA plans only

eviCore prior authorization does **not** apply to FEP or CHS group members, or BlueCard (out-of-area) members from other BCBS Plans. Also, certain large self-funded BCBSAZ-administered groups may opt out of the eviCore utilization management program.

To check if a commercial group member is delegated for eviCore, check eligibility and benefits using service type 30: Health Benefit Plan Coverage. Under "Network Unknown," click on "Additional Information" and then click the "Show" links. The message looks like this:

EVICORE DELEGATED MEMBER FOR HIGH TECH IMAGING, GENETIC TESTS, ONCOLOGY, RADIATION THERAPY, SPECIALTY MEDS

To request prior authorization from eviCore, please use their online request tool. *Note: Although this tool is different from the Arizona standardized request forms,* ***BCBSAZ will accept prior authorization requests submitted through eviCore's online tool as valid.***

For program information, code lists, and clinical guidelines, visit our eviCore provider resource page.

Inpatient care requires notification and/or prior authorization

All of our benefit plans require notification and/or prior authorization for all scheduled and unscheduled inpatient admissions and continued stays. For plan-specific information and time frames, check eligibility and benefits, and refer to the prior authorization requirements resources:

- For requirements for most plans: azblue.com secure portal at "Practice Management > Prior Authorization"
- For Medicare Advantage plans: azbluemedicare.com/login at "Prior Authorization."

For information about how to notify us or request authorization, see page 11-19.

Transfers to different levels of care require prior authorization

If a member is moved or transferred between different levels of inpatient care, even within the same facility, the member's cost-share obligation may change to match that level of care. Since prior authorization is required for all non-emergency inpatient care, a new authorization must be obtained before the member begins receiving a different level of inpatient care.

Prior Authorization – Overview

Notifications and prior authorization requests

Any provider may request prior authorization for services requiring prior authorization. Most notifications and requests can be made online – see specific information on page 11-19.

We require the following information to process a notification or prior authorization request:

- Member/subscriber name, date of birth, and ID number
- Provider name(s), NPI, specialty, and contact information
- Date, type, and place of service
- Applicable procedure(s) and procedure code(s)
- Applicable diagnoses and diagnosis code(s)
- Other relevant information specific to the request

Penalties

For most BCBSAZ and BlueCard (out-of-area) commercial benefit plans, BCBSAZ will assess a $500.00 penalty to the servicing network provider for failure to obtain prior authorization for services requiring prior authorization as per the member's benefit plan. For facility-related prior authorization requirements (such as inpatient admissions, SNF, EAR, and LTAC), the penalty applies to the facility and not the professional provider. Providers considered in-network for the member's benefit plan may not bill the member for this penalty amount.

Exception: For members with commercial PPO plans, a penalty may be applied to the member when the rendering provider is out-of-network and a required prior authorization was not obtained.

To avoid unnecessary penalties, ensure all required prior authorization is obtained *before* servicing the member. If you have received prior authorization, include the identifier on your claim submission.

Out-of-network referrals require prior authorization

BCBSAZ network providers must refer members only to contracted providers considered in-network for the member's benefit plan. When non-emergency covered services are not reasonably available within the member's specific network, prior authorization is required for use of an out-of-network provider. The referring provider must also advise the member of non-network status (except in emergency situations).

If BCBSAZ authorizes an exception:

- **Members with HMO plans** are covered for the authorized out-of-network service and held harmless against any balance billing.
- **Members with PPO plans** have an out-of-network benefit with higher out-of-pocket costs. The approved prior authorization will give the member the in-network coinsurance and deductible. The member is still responsible for any balance bill, unless within scope for the balance billing protections in the No Surprises Act (NSA).
- **Members with FEP plans** have plan provisions for situations in which the member has little, or no, choice in selecting a provider. Benefits cover certain types of services at preferred (in-network) levels when provided by non-participating professionals. Examples include non-participating providers, such as hospital-based providers, when the care is provided at a preferred facility other than the emergency room. FEP members are also covered under the NSA balance billing protections.

Prior Authorization – Overview

Prior authorization requirements for medications

For medications covered under the **retail/mail-order pharmacy benefit:**

- For commercial plans, you can access detailed information at azblue.com/Pharmacy.
- Some self-funded employer groups with customized benefit plans may use other (non-BCBSAZ) pharmacy benefit administrators or carriers for pharmacy benefits. Be sure to check eligibility and benefits for each member.
- For FEP plans, see the online list of medications requiring prior approval and other information on the pharmacy FAQs page.
- For MA plans, access the MA Part D drug formulary at azblue.com/medicare > Resources > Plan Documents." Select the plan year and service area to see the formulary resources. The downloadable formulary list includes a "PA" indicator for drugs that require prior authorization, step therapy, or have quantity limits.

For medications covered under **medical benefits**:

- For commercial plans, prior authorization requirements are included in the BCBSAZ prior authorization code lists, available in the azblue.com secure provider portal at "Practice Management > Prior Authorization."
- For FEP plans, see the online list of medications requiring prior approval and get more information at fepblue.org/prior-approval.
- For MA plans, Part B drugs that require prior authorization are included in the BCBSAZ MA prior authorization code list at "azbluemedicare.com/login > Prior Authorization."

BlueCard (Out-of-Area) Plans

Preservice review for BlueCard (out-of-area) members

Preservice review includes notification, precertification, prior authorization, and prior approval. The online tool for out-of-area member pre-service review allows providers to access other BCBS Plans' websites and use available online resources. It uses a secure routing mechanism initiated by entering the member ID prefix. Using the tool is simple:

1. Log in to the secure provider portal at azblue.com/providers and go to "Practice Management > Prior Authorization > BlueCard (Out-of-Area) Members."
2. Enter the member ID prefix (first three characters) from the member's ID card.

BlueCross BlueShield Arizona

Search provider portal

Practice Management Provider Resources Education & Training Population Health

Home > Out-of-area Member Precertification

Out-of-area Member Precertification

Pre-service review includes notification, precertification, pre-authorization and prior approval

Use this form to obtain precertification information for an out-of-area BlueCard® member. Enter the first three characters of the member ID and submit.

Member ID Prefix* YDJ Submit

3. On the next screen, click on the "Provider Lookup" link to validate your provider NPI. After validation, the tool will securely route you to the member's BCBS Plan's landing page.

Home > Out-of-area Member Precertification

Pre-service Review for Out-of-Area Members

Pre-service reviews include notification, pre-certification, pre-authorization and prior approval

To conduct a pre-service review of an out-of-Arizona Blue Cross Blue Shield member, please select Provider Lookup.

Pre-service reviews for Arizona BCBS members may be conducted by calling (602) 864-4320 or (800) 232-2345, ext. 4320.

4. Sample of a pre-service review landing page.

BlueCross BlueShield of Montana

Pre-Service Review for Out-of-Area Members

Blue Cross and Blue Shield of Montana (BCBSMT)
Welcomes

You have been routed from Blue Cross Blue Shield AZ to BCBSMT to conduct pre-service review for a BCBSMT member.

Please choose from the following options:

Medical Policy
Inpatient Authorizations
Outpatient Authorizations
Referrals

Please note that the pre-service review is not a substitute for checking eligibility and/or benefits and is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered.

Because processes for pre-service reviews vary from one BCBS Plan to another, landing pages may include information about online pre-service reviews, a phone number, or other instructions.

Corporate Health Services (CHS) Group Plans

Prior authorization requirements for a Corporate Health Services (CHS) group member can be accessed by contacting the group's prior authorization administrator. The contact information is included in the CHS/TPA information list and search tool results, available in the secure provider portal at azblue.com/providers. Go to "Practice Management > Eligibility and Benefits > CHS Group Information."

Most CHS group member ID cards also display a prior authorization contact number on the back. If you have questions, contact the group's TPA.

Reminder: **Prior authorization is not a guarantee of payment.** Prior authorization is the process used to determine a member's eligibility for a requested procedure or service before the service is rendered. Authorization decisions are based on the member's eligibility, condition, specific benefit plan, and any related evidence-based clinical criteria and pharmacy coverage guidelines.

PCP Coordinated Care HMO (PCP-HMO) Plans

Effective January 1, 2023, PCP Coordinated Care HMO (PCP-HMO) plans will use the BCBSAZ standard list of prior authorization requirements. You can find this code list in the secure provider portal at “Provider Management > Prior Authorization > BCBSAZ Members-Prior Authorization Code Lists.

Also effective January 1, 2023, PCP-HMO plans will be included in our eviCore program.

Prior authorization requests/status

BCBSAZ

For the quickest results, you may request prior authorizations 24/7 using the online tool at “Practice Management > PCP Coordinated Care HMO Plans > Prior Auth Requests (Non-Standard Online Option).” The tool confirms and displays the status of your requests.

Note: Although this tool is different from the Arizona standardized request forms, ***BCBSAZ will accept PCP-HMO requests made through this tool as valid.***

We also offer a fax form option for PCP-HMO plans. For phone requests, including urgent requests after normal business hours, call 1-844-807-5106.

eviCore

To request prior authorization from eviCore, you may use their online request tool directly or from the link on the BCBSAZ secure provider portal at “Practice Management > Prior Authorization > BCBSAZ Plans-Request Online: eviCore.”

Note: Although this tool is different from the Arizona standardized request forms, ***BCBSAZ will accept prior auth requests submitted through eviCore’s online tool as valid.***

For eviCore program information, code lists, and clinical guidelines, visit our eviCore provider resource page.

Pharmacy

For pharmacy prior authorization requests or status, you may use Cover My Meds® and Surescripts® for electronic prior authorization (ePA) or call 1-866-325-1794.

Cover My Meds is a separate, independent company contracted with BCBSAZ to provide pharmacy benefit management services.
Surescripts is a separate, independent company contracted with BCBSAZ to provide pharmacy benefit management services.

Federal Employee Program (FEP) Plans

Federal Employee Program (FEP) precertification and prior approval

FEP uses two processes for pre-service reviews:

- **Precertification** is the process by which, prior to an inpatient admission, BCBSAZ evaluates the medical necessity of the proposed stay, the procedure or service to be performed, the number of days required to treat the member's condition, and any applicable benefit criteria.
- **Prior approval** is written assurance that benefits will be provided by the BCBS Plan where the services will be performed, or by the retail pharmacy program, the mail service prescription drug program, or the specialty drug pharmacy program. Prior approval is required for certain services.

Some services require both precertification and prior approval.

Precertification and prior approval requirements

You can find FEP precertification and prior approval requirements in our compiled code lists Excel file. You'll find it in the secure provider portal at azblue.com/providers. Go to "Practice Management > Prior Authorization > BCBSAZ Members-Prior Auth Code Lists."

All requirements are explained in more detail in the FEP health plan brochures at fepblue.org/plan-brochures. You can also visit the FEP medical policy page for information about clinical criteria.

Requesting FEP precertification and prior approval

The attending physician, provider, or facility must request precertification or prior approval before all inpatient admissions or the rendering of other services requiring precertification or prior approval. To request, call the BCBSAZ FEP team at 602-864-4102 or 1-800-345-7562.

- If the member has an **emergency admission**, you must notify us and obtain authorization for a continued stay within two business days following the day of the emergency admission. If the member has been discharged from the hospital, you must still notify us.
- FEP requires the following information for inpatient admission precertification:
  - Enrollee's name and plan ID number
  - Patient's name, birth date, and phone number
  - Reason for inpatient admission, proposed treatment, or surgery
  - Name and phone number of admitting physician
  - Name of hospital or facility
  - Number of days requested for inpatient stay
  - If the admission is to a residential treatment center (RTC), include a preliminary treatment and discharge plan that has been agreed on by the member, admitting provider, BCBSAZ case manager, and the RTC
  - Other information as requested

We will inform the provider of the number of approved inpatient days and send written confirmation of the decision to the member, physician, and hospital.

Predetermination requests

FEP issues predeterminations (also known as advance benefit determinations) for services that are likely to cost more than $7,000.00. This preview offers providers a preliminary review of the medical necessity determination for the service. It is *not* a prior authorization. To request a predetermination, call the BCBSAZ FEP team at 602-864-4102 or 1-800-345-7562.

Federal Employee Program (FEP) Plans

Penalties for failure to obtain required precertification and prior approval
Current precertification and prior approval requirements for FEP members are available in the secure provider portal at "azblue.com/providers > Practice Management > Prior Authorization > BCBSAZ Members-Prior Auth Code Lists.".

1. Penalties (for all FEP benefit plans)
   BCBSAZ will assess a $500.00 penalty to the servicing network provider for failure to obtain precertification for all services requiring precertification for FEP members. For facility-related precertification requirements (such as inpatient admissions, SNF, EAR, LTAC, and RTC), the penalty applies to the facility and not the professional provider. This penalty may not be billed to the member.
2. Prior approval penalties (only for FEP Blue Focus benefit plans)
   BCBSAZ will assess a $100.00 penalty to the servicing provider *and* the facility for failure to obtain prior approval for all services requiring prior approval for FEP Blue Focus members.

Medicare Advantage (MA) Plans

BCBSAZ MA plan administrators

BCBAZ administers prior authorization for the Blue Medicare Advantage HMO plans offered in Maricopa and Pinal counties. We also administer prior authorization for all of the BlueJourney PPO plans in Maricopa and Pima counties. We partner with eviCore for utilization management of certain services for these plans. Arizona Priority Care (AZPC) and P3 Health Partners administer prior authorization for the following plans:

- **AZPC:** BluePathway Plan 1 (HMO) in Maricopa County.
- **P3:** All of the MA HMO plans offered in Pima and Santa Cruz counties.

How to request prior authorization

Be sure to check the member ID card to see if the MA plan is administered by BCBSAZ, AZPC, or P3 Health Partners. Submit requests directly to the plan administrator.

Note: BCBSAZ-administered plans include an eviCore utilization management program for medical oncology, radiation therapy, high-tech radiology, genetic testing, spine/joint surgeries, and interventional pain management services. Request prior authorization directly from eviCore for these services. For all other services, request prior authorization from BCBSAZ as indicated in the table below. The BCBSAZ fax form is available at azbluemedicare.com/login > Prior Authorization.

BENEFIT PLAN NAME and PLAN ID#	PREFIX	SERVICE AREA	PRIOR AUTHORIZATION REQUESTS
Blue Medicare Advantage Classic (HMO) H302-006	M2K	Maricopa and Pinal counties	**eviCore / BCBSAZ** **eviCore ONLINE:** Log in to eviCore.com/provider **BCBSAZ FAX FORM** (azbluemedicare.com/login): Standard: 602-544-5652 / Expedited: 602-544-5651 Inpatient Notification: 602-544-5653 Concurrent Review: 602-544-5654 Post-acute Care/Behavioral Health: 602-544-5654 Part B Drugs: 602-544-5622 Part D Drugs: 1-858-790-7100 or request online at https://mp.medimpact.com/partdcoveragedetermination **PHONE** (after hours immediate service): 1-888-905-1172
Blue Medicare Advantage Plus (HMO) H0302-001			
BluePathway Plan 2 (HMO) H6936-003	M2V	Maricopa County	
BlueJourney (PPO) H5140-001, H5140-002	M3P	Maricopa and Pima counties	
BluePathway Plan 1 (HMO) H6936-006	M4K	Maricopa County	**Arizona Priority Care (AZPC)** **ONLINE:** Log in to AZconnect **FAX:** Services/Items/Part B Drugs: 480-499-8798 Inpatient Notification/Concurrent Review: 480-499-8779 Part D Drugs: 1-858-790-7100 **PHONE:** 480-499-8700
Blue Medicare Advantage Classic (HMO) H0302-008	M2K	Pima County	**P3 Health Partners** **ONLINE:** Log in to P3portal.P3hp.org **FAX:** 520-274-4943 Part B and D Drugs: 1-858-790-7100 **PHONE** (after hours immediate service): 520-274-4421
Blue Medicare Advantage Standard (HMO) H0302-009		Santa Cruz County	
BluePathway Plan 2 (HMO) H6936-005	M3V	Pima County	

Medicare Advantage (MA) Plans

Inpatient notification and prior authorization requirements

All of our MA benefit plans require notification and/or prior authorization for inpatient admissions. Notification of unscheduled admissions is required within 24 hours of admission or by the next business day.

NOTIFICATION OF UNSCHEDULED ADMISSIONS		
BCBSAZ	**Arizona Priority Care**	**P3 Health Partners**
Fax: 602-544-5653	Fax: 480-499-8779	Fax: 520-274-4943 / Online: P3portal.P3hp.org
Phone: 1-800-446-8331	Phone: 480-499-8700	Phone: 520-274-4421

Coverage determination criteria for unscheduled admissions follows MCG care guidelines and includes:

- Severity of signs/symptoms
- Medical predictability of an adverse event
- Need for care that can only be delivered safely and effectively in the inpatient setting

Prior authorization requirements for medications

- Part B drugs that require prior authorization or step therapy are included in the BCBSAZ Medicare Advantage prior authorization code list.
- For Part D drugs, you can access the MA drug formulary at azblue.com/medicare > Resources > Plan Documents." Select the plan year and service area to see the formulary resources. The downloadable formulary list includes a "PA" indicator for drugs that require prior authorization, step therapy, or have quantity limits. For more information about pharmacy benefits and the drug formulary, see Section 24.

Initial organization determinations

Organization determinations are decisions made by BCBSAZ about MA benefit coverage for requested services. MA members, their representatives, and providers may request an initial organization determination when considering services that are not typically covered by Medicare or by the member's MA benefit plan. All services must meet medical necessity criteria.

To request an initial organization determination on behalf of a member, download and submit the MA prior authorization request fax form, located in the secure MA provider portal at "azbluemedicare.com/login > Prior Authorizations."

MA prior authorization resources

You can find prior authorization resources in the secure MA provider portal at azbluemedicare.com/login in the "Prior Authorizations" and "Resources" sections. These include a prior authorization status tool, requirements code lists and request links, and clinical criteria.

Here is a screenshot of the "Prior Authorizations" page (status tool and prior auth resources):

Medicare Advantage (MA) Plans

Below is a screenshot of excerpts from the “Resources” page, under “Prior Authorization and Care Management” (for prior authorization requirements) and “Provider Guidelines and Training Materials” (for clinical guidelines):

Prior Authorization and Care Management

Care Management Referral Form

Code List - Prior Auth Required - BCBSAZ

Code List - Prior Auth Required 2021 - P3 Health Partners

Code List - Prior Auth Not Required - AZPC

eviCore Prior Auth Request/Status

eviCore Program Overview

eviCore Program FAQs

Fax Form - Prior Auth Requests

Part D Drug Coverage Determination Form (submit online)

Part D Drug Coverage Determination Form (fax)

Provider Guidelines and Training Materials

2022 BCBSAZ Provider Operating Guide (includes Medicare Advantage)

MA HEDIS and Stars Toolkit for Providers

Medical Policies

- BCBSAZ clinical guidelines
  - eviCore clinical guidelines
  - CMS National Coverage Determinations (NCD)
  - Local Coverage Determinations (LCD)
  - MCG care guidelines (call us at 1-800-446-8331)
- AZPC clinical guidelines: 480-499-8700
- P3 clinical guidelines: 520-274-4421

COB Info Form for Medicare Advantage Members

Medicare Advantage – BCBSAZ E-learning

Quick Reference Guide - AZPC

Quick Reference Guide – P3 Health Partners

HIPAA Transaction Standard – BCBSAZ Companion Guide

Compliance Guidance

You can also visit our eviCore resource page for clinical guidelines and code lists.

Peer-to-Peer Requests – BCBSAZ

BCBSAZ peer-to-peer conversations (for eviCore peer-to-peer consultations, see page 11-18)
A BCBSAZ peer-to-peer conversation is a one-on-one discussion between a BCBSAZ medical director or clinical advisor and a treating physician (e.g., M.D., D.O.), nurse practitioner (N.P.) or physician assistant (P.A.). These phone conversations are intended to help you understand how we determine if medical necessity criteria have been fully met.

There are some important differences between BCBSAZ and eviCore peer-to-peer processes and also in how peer-to-peer consultations may be used for Medicare Advantage (MA) plans, in keeping with CMS guidance. Here are the guidelines:

- **For our commercial plans,** a BCBSAZ peer-to-peer conversation is about an adverse medical necessity decision on a prior authorization request that was submitted ***before*** the service was rendered. You must request the peer-to-peer conversation within seven calendar days of the date on the prior authorization denial letter and ***before*** initiating the member appeal process.
- **For our MA plans,** a BCBSAZ peer-to-peer conversation must be requested ***before*** the prior authorization decision has been made and is typically requested when a prior authorization request has been pended for additional information. To challenge an MA authorization denial, you must submit an appeal.
- **An eviCore peer-to-peer conversation** may be requested at any point in the prior authorization and claim processes. However, the information shared in the consultation can't always be used to overturn the authorization or claim denial.
  - For MA plans, an eviCore consultation may *not* be used to overturn an authorization denial, but the information shared in the consultation may be used in submitting an appeal.
  - For all plans, an eviCore consultation may not be used to overturn an authorization denial ***after*** the service has been rendered.
  - For all plans, an eviCore consultation may *not* be used to overturn a *final* authorization denial decision, but the information shared in the consultation may be used in submitting an appeal.

How to prepare for a BCBSAZ peer-to-peer conversation
BCBSAZ peer-to-peer conversations focus on medical necessity. The following steps will help you determine if a peer-to-peer conversation is appropriate and how to prepare:

1. Access the clinical criteria for the service or procedure (see page 11-1).
2. Review the clinical criteria to check for applicable indications for the patient's condition or illness.
3. Check to see if the criteria for the applicable indications have been met or mostly met.
4. Check to see if the submitted medical records document that criteria are met.

Situations that are not eligible for a BCBSAZ peer-to-peer conversation
Below are some common situations and topics that do *not* qualify for a peer-to-peer conversation:

- Benefit plan exclusions and non-covered benefits; examples of this would be dosing outside the FDA-recommended doses, out-of-network services, and services and items considered experimental or investigational
- Retrospective reviews where prior authorization was required but not obtained prior to the services being rendered

Peer-to-Peer Requests – BCBSAZ

- Denied claims—for any reason
- Active, denied, or upheld member appeals—for claims or prior authorization
- Decision about credentialing or waivered conditions
- BCBSAZ clinical criteria
- Requests received after seven calendar days from the prior auth denial letter receipt date

How to request a BCBSAZ peer-to-peer conversation
For BCBSAZ and Federal Employee Program (FEP) members, call and leave a voicemail message on the peer-to-peer phone line at 602-864-4209 or 1-800-232-2345, ext. 4209. We will return your call within one business day.

- For Medicare Advantage members, call the reviewer's phone number (included in the denial letter).
- For BlueCard (out-of-area) members, call the member's BCBS Plan.
- For Corporate Health Services (CHS) group members, call the group's TPA at the number displayed on the member ID card.
- For eviCore peer-to-peer conversations, follow the instructions in the prior authorization denial notice.
- For Pharmacy-related requests, call 602-864-4028.

Member appeals
A member appeal/reconsideration process is available if a prior authorization request for a service or procedure is not approved. Refer to Section 23 for a summary of the member appeal processes, including an expedited appeal process for urgently needed services not yet provided.

Peer-to-Peer Requests – eviCore

You may request an **eviCore** clinical consultation at any time during the prior authorization and claim processes. How the consultation may be used varies depending on if the request is for a Medicare Advantage (MA) member and if a determination (decision) has been made:

- If your MA prior authorization request has been pended for additional clinical information, follow the instruction on the notice from eviCore. If the determination has not yet been made, the consultation could influence the initial decision.
- If an MA prior authorization denial decision has already been made, the information shared in an eviCore consultation may *not* be used to overturn the denial. However, the information may be used in submitting an appeal.

eviCore authorization scenarios and follow-up options

See below for different situations and the options available for commercial and MA plans.

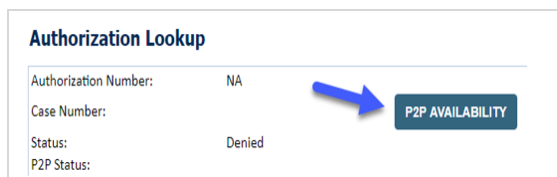
<table>
<tr><th>SCENARIO</th><th>COMMERCIAL PLANS</th><th>MEDICARE ADVANTAGE PLANS</th></tr>
<tr><td>1. My authorization request was pended for additional information.
I haven't rendered the service yet.</td><td colspan="2">Request eviCore peer-to-peer clinical consultation or submit additional clinical information to eviCore.*</td></tr>
<tr><td>2. My authorization request was denied.
I haven't rendered the service yet.</td><td>Request eviCore reconsideration (re-review) within 7 calendar days of the denial for potential overturn of denial.*</td><td>Request eviCore consultation or submit appeal with supporting records to BCBSAZ.*
eviCore consultation can't be used to overturn the denial. You must file an appeal.</td></tr>
<tr><td rowspan="2">3. My authorization request was denied.
I have already rendered the service but haven't submitted a claim yet.</td><td>Submit appeal with supporting records to BCBSAZ.*</td><td>Submit claim with supporting records to BCBSAZ.</td></tr>
<tr><td colspan="2">eviCore consultation can't be used to overturn the denial.</td></tr>
<tr><td>4. Oops! I didn't request authorization before rendering the service.
I haven't submitted a claim yet.</td><td colspan="2">Request post-service retrospective review within 30 days.
The request may be denied and penalties may apply.</td></tr>
<tr><td>5. Oops! I didn't request authorization before rendering the service.
I have already submitted a claim.</td><td colspan="2">Follow instructions on your remit for post-service, post-claim retrospective review.
The request may be denied and penalties may apply.</td></tr>
<tr><td>6. I disagree with the final authorization denial decision.</td><td colspan="2">Submit appeal with supporting records to BCBSAZ.*
eviCore consultation can't be used to overturn the denial.</td></tr>
</table>

** Follow the instructions in your eviCore notice about submitting additional information or requesting clinical consultations.*

How to request an eviCore peer-to-peer consultation

Providers, nurse practitioners, and physician assistants may request a clinical consultation by:

- Visiting the eviCore website at evicore.com/provider/request-a-clinical-consultation.
- Using the self-service "P2P" consultation option in eviCore's online Authorization Lookup tool. This eliminates the need to receive a scheduling callback.



Prior Authorization Requests – Quick Guide

BCBSAZ (use these request options for most plans – see "Exceptions" rows below)	
BCBSAZ prior authorization requests (Unscheduled admissions require notification within 48 hours)	**Online requests/status – Arizona standardized forms** Use the online request tool at "azblue.com/providers > Practice Management > Prior Authorization > BCBSAZ Plans-Request AZ Standard Online." **Phone requests (including after-hours assistance for urgent issues)** Call the numbers listed below. Extended hours include weekday evenings (4:30 – 8 p.m.) and weekends and holidays (8 a.m. – 4:30 p.m.). Follow the prompts to leave a message for the nurse on call to request immediate services or discharge planning. Most BCBSAZ plans: **602-864-4320 or 1-800-232-2345** State of Arizona employer group plans (prefixes SYD and S3Z): **1-866-287-1980** *Note: Some large groups have customized extended hours (check the member ID card for specific prior authorization and contact information)*
eviCore prior authorization requests (most BCBSAZ commercial plans and all BCBSAZ-administered Medicare Advantage plans)	**Online requests/status – eviCore** Access the tool directly at eviCore.com/provider or via the azblue.com secure portal at "Practice Management > Prior Authorization > BCBSAZ Plans-Request eviCore." *Note: Although the eviCore tool is different from the AZ standardized forms,* ***BCBSAZ will accept prior auth requests submitted through eviCore's online tool as valid.*** **Provider resources** Find code lists, clinical guidelines, and more at evicore.com/healthplan/azblue.

Exceptions:
1. **PCP Coordinated Care HMO (PCP-HMO) plans** (prefixes FLH, FQL, NNG, NNJ, PMK, XAH, and XHK) For the quickest turn-around times, use the PCP-HMO online request tool in the azblue.com secure provider portal at "Practice Management > PCP Coordinated Care HMO Plans > Prior Auth Requests (Non-Standard Online Option)." *Note: Although this tool is different from the Arizona standardized request forms,* ***BCBSAZ will accept PCP-HMO requests made through this tool as valid.*** We also offer a fax option. For phone requests, call **1-844-807-5106.**
2. **BlueCard® (out-of-area) plans** (members from other BCBS Plans) Use the online router tool on the azblue.com secure provider portal at "Practice Management > Prior Authorization > BlueCard (Out-of-Area) Members" or call the prior authorization phone number on the back of the member's ID card.
3. **CHS group plans** (large, self-funded employer groups that use a third-party administrator) Access the group's TPA information online via the azblue.com secure provider portal at "Practice Management > Eligibility & Benefits > CHS Group Information" or call the prior authorization phone number on back of the member's ID card.
4. **BCBSAZ-TPA co-administered plans** Use the prior authorization phone number on the back of the member's ID card.
5. **FEP plans** (prefix R) Call **602-864-4102** or **1-800-345-7562** (includes evenings, weekends, and holidays for urgent issues)
6. **Medicare Advantage (MA) plans** (Unscheduled admissions require notification within 24 hours) Please use the BCBSAZ MA prior authorization fax form or the eviCore online request tool, available on the secure MA provider portal at "azbluemedicare.com/login > Prior Authorizations." For urgent issues after hours, call **1-888-905-1172.**

eviCore is a separate, independent company, contracted with BCBSAZ to provide prior authorization services to BCBSAZ providers and members.