BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Gold Card Prior Authorization Program

AZ Blue Policy and Procedure

I. Purpose

To facilitate access to care and further the program goals listed in this policy by enabling qualifying network providers to use a streamlined process for Blue Cross® Blue Shield® of Arizona (AZ Blue) prior authorization requests.

II. Scope

The AZ Blue Gold Card Prior Authorization Program (Program) applies to individual professional providers we have identified as meeting the provider selection criteria included in this policy. The Program does not apply to facilities or to group provider practices.

The Program only applies to prior authorization requests for services and procedures that require prior authorization under the commercial group and individual benefit plans as described in section V(4) below (does not include all lines of business, all services, or referral approvals for PCP-HMO plans).

III. Program Goals

The Program is designed to:

- Strengthen clinical partnerships between network providers and the AZ Blue Clinical Excellence team
- Make patient care more user-friendly for providers
- Streamline the prior authorization request process
- Reduce administrative time spent on the prior authorization process
- Facilitate quicker access to care for AZ Blue members

IV. Definitions

(1) **Medical Policies:** Evidence-based clinical criteria and coverage policy guidelines developed from reviews of published, peer-reviewed medical, behavioral health, and pharmaceutical literature and other relevant information, and used to help AZ Blue, or the applicable benefit administrator or plan, determine whether a service, procedure, item, medical device, or drug is eligible for benefits under a member's benefit plan.

(2) **Prior Authorization Decision:** A written decision explaining whether a request for prior authorization is approved or denied, the scope of the approval, and the rationale for the decision. Authorization decisions are based on the member's eligibility, condition, specific benefit plan requirements, and any related medical and pharmacy coverage guidelines.

(3) **Prior Authorization Process:** The process AZ Blue uses to determine a member's eligibility for certain procedures or services before they are ordered or rendered.

(4) **Program:** Refers to the AZ Blue Gold Card Prior Authorization Program and related processes and procedures described in this policy.

(5) **Qualifying Network Provider ("Program provider"):** An individual professional provider who meets the criteria in section V(1) of this policy and who continues to maintain compliance with those criteria.

V. Procedures

(1) Selection Criteria and Process

The AZ Blue Clinical Excellence team analyzes a provider's prior authorization history over a one-year period to assess the provider's eligibility for the Program and has sole discretion to determine who qualifies for participation based on the criteria listed here. To be a qualifying network provider, the provider must meet the following requirements:

- Provider has been a participating provider in the AZ Blue statewide PPO and HMO networks for at least two years preceding the date of the invitation to participate in the Program.
- During the 24 months preceding the invitation to participate in the program, the provider has not been on focused provider review or the subject of a fraud, waste, and abuse investigation or a substantiated quality complaint.
- Provider has received a written invitation to participate in the Program.
- Provider has requested prior authorization at least 10 times (for services and procedures) within the one-year lookback period.
- Provider has an initial (not retrospective) prior authorization approval rate of at least 90%.
- Provider consistently obtains required prior authorization before rendering services.

(2) Provider Participation

Program participation is specific to qualified providers who have been invited to participate. It is not transferrable to any other provider, including other professional providers working in the same provider group practice. Providers affiliated with multiple organizations are eligible to use the Gold Card prior authorization privilege with any of their tax IDs.

(3) Applicable Services

The Program applies to services covered under medical benefits that require prior authorization except for all medications and excluded codes that are indicated on the prior authorization code list. It does not apply to referrals. The Gold Card privilege applies when the service is rendered by a Program provider. It also applies to services that are ordered by a Program provider (such as high-tech imaging) when the Program provider requests/obtains the prior authorization.

Exceptions

The following services are ***not*** included in the Program:

- Excluded codes on the prior authorization requirements lists (these are clearly indicated)
- Medications (covered under both medical and pharmacy benefits)
- Medical devices
- DME
- Lab management (for genetic testing)
- Clinical trials
- Transplant services
- Services excluded from coverage in the member's health plan (e.g., benefit exclusions and services considered by AZ Blue to be experimental/investigational)
- Out-of-network professional or facility services

(4) Member Eligibility and Benefits

The Program provider takes responsibility for validating member eligibility and checking benefits to ensure coverage and medical necessity. Treatment must be consistent with applicable medical policies.

Applicable Plans: Included and Excluded Plans

Included – The Program applies to AZ Blue members with individual and group medical benefit plans.

Excluded – The Program ***does not*** apply to the following types of benefit plans:

- Federal Employee Program® (FEP®) plans
- BlueCard® out-of-area plans (from other Blue Plans)
- Medicare Advantage, Medicare Supplement, Medicare PDP, and Medicaid plans
- Corporate Health Services (CHS) group plans administered by a third-party administrator (TPA)
- Group plans with TPA-administered utilization management programs (prefixes K8Y, K8Z, NBT)
- Stand-alone dental and vision plans

(5) Place of Service Must Be In-Network

The Program applies only to prior authorization requests for services or procedures performed at a facility or office that is in-network for the member's specific benefit plan.

(6) How to Use the Gold Card Privilege to Receive an Authorization Number

For AZ Blue-managed authorizations: Call the Gold Card hotline at **602-864-4811** (M – F, 8 a.m. – 4:30 p.m. MST). No clinical review is required. Simply share the rendering provider, member, and service information and receive the authorization number to include on your claim.

For eviCore-managed authorizations: Use the normal online request process (available 24/7) via the eviCore provider portal. After you identify the rendering provider, member, and services, eviCore will build your case, bypassing the clinical pathway questions, and issue a case (authorization) number immediately on the portal (and via fax within 24 hours).

(7) Claim Reviews and Payments

Claims associated with a Gold Card prior authorization will generally be processed without clinical review, unless the claim indicates that the service rendered does not match what is on the authorization. We will review claims to ensure that all required authorizations are obtained.

(8) Program Audits

AZ Blue will review Program data on a monthly basis for anomalies. We will also perform randomized audits across all participants on a regular basis. These audits will verify that the requests would have been approved under our routine prior authorization process. Program providers must respond promptly to Program records requests.

(9) Continued Participation in the Program

To remain eligible for participation in the Program, providers must: (i) respond promptly to records requests for Program audits/reviews; (ii) pass Program audits, claim reviews, and prior authorization volume reviews, (iii) have no substantiated quality-of-care complaints, and (iv) be in good standing in the AZ Blue network for credentialing requirements and avoidance of fraud, waste, and abuse.

(10) Termination from the Program

AZ Blue may immediately revoke a provider's qualifying status, on written notice to the provider, for any one or a combination of the following events:

- The provider is no longer contracted with AZ Blue.
- The provider allows a non-qualified provider to use his/her Gold Card privileges.
- The provider fails to timely send requested records for Program audits/reviews.
- The provider fails an audit, claim review, or prior authorization volume review.
- The provider fails to adhere to applicable medical policies.
- The provider uses the Gold Card prior authorization privilege for excluded services.
- The provider comes under professional board or other disciplinary review.

(11) Revocation and Future Eligibility

AZ Blue's revocation decision is not appealable or grievable. A provider whose status has been revoked must send AZ Blue a written request for reinstatement. The provider may not request reinstatement until 12 months after the date of revocation.

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