Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

# Provider Preauthorization and Precertification Requirements

**For Blue Cross PPO (commercial) and Medicare Plus Blue℠ PPO members**

Revised Nov. 29, 2021

**SPECIAL NOTE: Clinical review requirements temporarily suspended for admissions to skilled nursing facilities from hospitals in certain states.** See *Section 4: Inpatient Admissions* for more information.

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## 1. Blue Cross Blue Shield of Michigan Definitions

- **Prior Authorization**
  A process that allows physicians and other professional providers to determine, before treating a patient, if Blue Cross Blue Shield of Michigan will cover the cost of a proposed service. BCBSM requires prior authorization for services or procedures that may be experimental, not always medically necessary, or over utilized. Providers must submit clinical documentation in writing explaining why the proposed procedure or service is medically necessary.
- **Precertification**
  A review of a patient's symptoms and proposed treatment to determine, in advance, whether he or she meets Blue Cross Blue Shield of Michigan criteria for treatment in the inpatient setting. Authorizations are for the appropriateness of the inpatient setting only and additional prior authorization requirements may be needed depending on the services requested.
- **E-referral**
  Electronic system for Michigan providers to submit requests for inpatient admission.
- **Electronic Provider Access (EPA)**
  Electronic platform for out-of-state providers to submit requests through their local Blue's plan portal for Blue Cross Blue Shield of Michigan members.

## 2. Behavioral Health

**Blue Cross Blue Shield of Michigan Commercial Products (Non-Medicare)**

Precertification **is** required for:

- Psychiatric inpatient admissions
- Psychiatric residential admissions
- Psychiatric partial hospital admissions
- Substance Use Disorder admissions

Precertification is **not** required for:

- Outpatient services
- Medicare primary contracts
- Coordination of benefits contracts

All inpatient partial and residential mental health and substance abuse facilities are required to notify New Directions for all admissions and discharges; most admissions will require a clinical review. You may access the New Directions Services authorization system at webpass.ndbh.com.

Preauthorization is required for outpatient repetitive transcranial magnetic stimulation (rTMS). It may be a benefit for patients with major depressive disorder that meet strict selection criteria. Criteria are available on the Medical policy, precertification and preauthorization router. Coverage is limited to select groups. Please verify member eligibility prior to seeking preauthorization. Claims will not be paid unless authorization is obtained.

### Autism Spectrum Disorder

There are different types of services to treat autism, such as applied behavior analysis, that require an authorization before treatment for select groups. Speech therapy, physical therapy and occupational therapy do not require authorization. For services requiring preauthorization, an accurate diagnosis is necessary.

For members residing outside of Michigan, the autism diagnosis must meet the criteria specified in the multidisciplinary autism evaluation checklist. The evaluation must confirm the autism spectrum disorder diagnosis and provide a treatment plan containing a comprehensive set of treatment recommendations for the member, including a recommendation for applied behavior analysis. To obtain an accurate diagnosis, please review the *Multidisciplinary Autism Evaluation Checklist.*

If the evaluation results in a diagnosis of autism spectrum disorder and the recommended treatment is applied behavior analysis, the evaluation documentation must be taken to a licensed behavior analyst who participates with the Blue Cross plan in the state where the services would be provided. The behavior analyst is responsible for obtaining preauthorization before providing services for applied behavior analysis.

Behavioral health precertification and prior authorization (including autism) is conducted by New Directions Behavioral Health on behalf of Blue Cross Blue Shield of Michigan. Groups with other service providers can be reviewed on the BCBSM Mental Health Carve-Out List.

Call New Directions at 800-762-2382 to obtain precertification and preauthorization information. If medical records are requested for review, send the records to:

New Directions Behavioral Health
PO Box 6729
Leawood, KS 66206-0729

### Medicare Plus Blue℠ PPO

All behavioral health and substance use disorder inpatient, partial hospital and intensive outpatient treatment admissions or extensions require preauthorization and concurrent review.

Acute care hospitals and behavioral health facilities that need to arrange for an inpatient admission, partial hospital admission, intensive outpatient admission or concurrent review for psychiatric or chemical dependency treatment must obtain prior authorization by calling BCBSM Medicare Plus Blue PPO Behavioral Health Department at 888-803-4960 or by faxing 866-315-0442.

BCBSM Medicare Plus Blue PPO Behavioral Health Department case managers are available 24 hours per day, seven days a week for inpatient admissions and member emergencies.

**Note:** If you fail to submit your authorization request, submit an untimely request or your request is denied and you still execute the service, the member must be held harmless.

## 3. Human Organ Transplants

### Blue Cross Blue Shield of Michigan Commercial Products (Non-Medicare)

Providers must contact Blue Cross' Human Organ Transplant Department for preauthorization for the following transplants and combination transplants:

- Bone marrow
- Heart
- Heart-Lung
- Kidney-Liver
- Liver
- Lobar Lung
- Lung
- Multivisceral
- Pancreas
- Pancreas-Kidney
- Partial Liver
- Small Bowel

Preauthorization is not required for:

- Kidney only, cornea or skin transplants
- Pre-transplant evaluations
- Donor benefits
- If BCBSM is the second payer

Blue Cross' Human Organ Transplant Department is available from 8 a.m. to 5 p.m. EST, Monday through Friday. Please call 800-242-3504 to obtain a preauthorization.

### Medicare Plus Blue℠ PPO

All Blue Cross Medicare Plus Blue PPO members have coverage for all transplant procedures that are covered by traditional Medicare. Inquiries about coverage for transplantation should be directed to Provider Inquiry at 866-309-1719.

Although preauthorization of transplants for Medicare Plus Blue PPO members is not required, a request for an organizational determination can be sent to Blue Cross. Please fax your request with substantiating clinical information to 1-877-348-2251.

## 4. Inpatient Admissions

**Blue Cross Blue Shield of Michigan Commercial Products (Non-Medicare)**

Precertification **is** required for:

- Acute care inpatient hospital medical and surgical admissions including but not limited to:
  - Admission for transplants (kidney, cornea, skin, bone marrow and solid organ)
  - Sick newborn admissions (NICU/PICU)
- Admission to a skilled nursing facility
- Admission to an acute inpatient rehabilitation facility
- Admission to a long-term acute care

facility Precertification **is not** required for:

- Outpatient services
  **Note:** Prior authorization may be required for certain services.
- Maternity admissions, including C-section
  **Note:** Complicated admissions related to maternity care may require an additional authorization.
- Observation or short stay admissions
- If Blue Cross is secondary payer

**Acute Care Facilities - Michigan**

The Blue Cross Blue Shield of Michigan e-referral system is available 24 hours, 7 days a week to receive requests for inpatient hospital admissions. Requests must be submitted within 24-72 hours of the admission with complete clinical documentation to support the necessity of inpatient stay. Incomplete requests may delay the processing of the authorization, however Blue Cross will attempt to reach out to obtain the additional information if a clinical review cannot be completed.

If the additional information is not received in a timely manner, Blue Cross will process the request with the information available in accordance with our accreditation time frames. e-referral system information, FAQs and training materials can be found at http://ereferrals.bcbsm.com/.

**Acute Care Facilities - Out-of-State**

Requests for inpatient authorization for Blue Cross Blue Shield of Michigan members can be submitted directly through your local Blue plan's electronic portal via the Electronic Provider Access (EPA) system. Blue Cross encourages the use of the EPA system to effectively and efficiently respond to your request.

Requests must be submitted with complete clinical documentation to support the necessity of inpatient admissions.

Incomplete requests may delay the processing of the authorization, however Blue Cross may attempt to reach out to obtain the additional information if a clinical review cannot be completed. If the additional information is not received in a timely manner, Blue Cross will process the request with the information available in accordance with our accreditation time frames.

> **Note:** Should your local plan not have electronic access you can continue to complete the appropriate assessment form and submit the request via fax. Submission of requests must be on the *Acute Inpatient Fax Assessment Form* and should be legible and completed entirety to reduce delays in processing.

## Post Acute Care Facilities: Michigan and Out-of-State

(Acute Inpatient Rehab, Skilled Nursing, Long Term Acute Care Hospitals)

Blue Cross Blue Shield of Michigan precertification services are available 24 hours, 7 days a week to receive faxed requests. Requests will be processed during regular business hours between 8 a.m. to 6 p.m. EST, Monday through Friday and during select holidays. Any requests received after 6 p.m. or on a weekend or holiday will be processed the following business day according to the time it was received.

> **Note:** For Federal Employee Program (FEP) member requests to skilled nursing facilities, additional requirements may be needed prior to requesting a precertification. Please contact FEP benefits at 800-482-3600.

Requests for enhancements for skilled nursing facilities, long term acute care hospitals and fifth-level hospice for commercial contracts are processed within Blue Cross Precertification Services.

Submission of requests must be on Blue Cross Skilled Nursing Inpatient fax assessment forms and should be legible and completed entirety to reduce delays in processing.

- *Skilled Nursing Facility, Acute Inpatient Rehabilitation Facility Fax Assessment Form*
- *Commercial PPO LTAC/SNF Enhancement Form*

Providers can call 1-800-249-5103 to obtain a status on Precertification requests by following the steps below and the prompts as indicated.

When you call:

1. Say “Precertification.”
2. Enter the following information:
   - Your Blue Cross facility code or 10-digit NPI (national provider identifier)
   - Your specialty
   - The member’s contract number, date of birth, the spelling of their first name and their ZIP code
3. Listen to the member’s eligibility information.
4. The following info will be given:
   - Precertification is for the determination of appropriateness of admissions to acute inpatient, skilled nursing, long term acute care and rehab settings only.
   - Assessment forms can be found at bcbsm.com/provider/quick-links.html.
   - Do you still need precertification assistance? **Please say yes or no.**

   If your provider specialty is hospital inpatient or skilled nursing and you answered “yes,” you will be connected with a precertification representative. If you answered “no,” you will be transferred to the benefits path within the Provider IVR.

Incomplete requests may delay the processing of the authorization; however, Blue Cross may attempt to reach out to obtain the additional information if a clinical review cannot be completed.

If the additional information is not received in a timely manner, Blue Cross will process the request with the information available in accordance with our accreditation time frames

Please allow 24-72 hours for the processing of all precertification requests.

> **Note:** InterQual criteria are utilized to complete acute hospital, skilled nursing, inpatient rehabilitation and long–term acute care precertification and recertification requests.

**SPECIAL NOTE: Clinical review requirements temporarily suspended for admissions to skilled nursing facilities from hospitals in certain states**

Blue Cross Blue Shield of Michigan and Blue Care Network are temporarily suspending clinical review requirements for the first three days of admission to skilled nursing facilities from hospitals in certain states. This temporary change is due to the COVID-19 pandemic and applies to all lines of business, including Blue Cross Blue Shield of Michigan commercial, Blue Care Network commercial, Medicare Plus Blue℠ and BCN Advantage℠. The change is in effect until further notice.

For an up-to-date list of states and effective dates, refer to the provider alert: Update: Clinical review requirements temporarily suspended for admissions to skilled nursing facilities from hospitals in certain states (PDF).

**Note:** This temporary change does not apply to Blue Cross commercial (non-Medicare) FlexLink® groups for which a third-party administrator makes authorization determinations. Facilities should check the back of the member's ID card to determine whether a third-party administrator needs to be contacted prior to an admission.

## Commercial PPO Retrospective Reviews (Post-Service)

Commercial PPO will accept requests for retrospective reviews for acute care and post-acute care up to 1 year after the date of service.

## Commercial PPO Peer-to-Peer Reviews (Medical Necessity Denials)

For Providers who would like to request a peer-to-peer review for a Commercial PPO member due to a medical necessity denial, the request must be submitted within 7 days of the initial denial decision.

If an authorization was denied for administrative reasons (i.e. member ineligibility at time of request or the service was not a covered benefit), a peer-to-peer review cannot be conducted as the denial was not based on medical necessity. These types of administrative denials must be appealed.

Peer-to-peer requests must be submitted prior to submission of a provider appeal and member appeals and grievances are not eligible for peer-to-peer review.

> **Note:** A peer-to-peer request *is not* required prior to submitting an appeal

To submit a peer-to-peer request, complete the *Physician peer-to-peer request form* (for non-behavioral health cases) and fax it to 1-866-373-9468 during normal business hours of 8 a.m. to 5 p.m. Eastern time (except weekends and holidays).

> **Note:** BCBSM will outreach the next business day and the peer-to-peer review will be scheduled on business days, Monday through Friday between 9 a.m. and 4 p.m. Eastern time (except holidays).

## Commercial Appeals for Medical Necessity Denials

For precertification medical necessity denials, Blue Cross Blue Shield of Michigan appeal requests will be accepted up to 45 days after the initial denial decision was issued. Submission of the appeal request must be in writing, complete with any additional information to substantiate the need for the inpatient stay and faxed to 877-261-4555.

## Medicare Plus Blue℠ PPO

### Michigan Acute Care Facilities

The Blue Cross Blue Shield of Michigan e-referral system is available 24 hours, 7 days a week to receive requests for inpatient hospital admissions. Requests must be submitted with complete clinical documentation to support the necessity of inpatient admissions. Incomplete requests will not be processed until all information is received or are at risk for a denial for lack of information. Additional e-referral system information, FAQs and training materials can be found at http://ereferrals.bcbsm.com/

### Out-of-State Acute Care Facilities

Requests for authorization for BCBS Michigan members can be submitted directly through your local Blue plans electronic portal via the Electronic Provider Access system (EPA). BCBSM encourages the use of the Electronic Provider Access system (EPA) to effectively and efficiently respond to your request. Requests must be submitted with complete clinical documentation to support the necessity of inpatient admissions. Incomplete requests will not be processed until all information is received or are at risk for a denial for lack of information.

> **Note:** Should your local plan not have electronic access you can continue to complete the *Medicare Plus Blue PPO Acute Fax Assessment Form* and submit the request via fax. Submission of requests must be legible and completed in its entirety or it could delay processing of the authorization request.

- *Medicare Plus Blue℠ PPO Acute Inpatient Fax Assessment Form*

### Post-Acute Care Facilities: Michigan and Out-of-State

(Acute Inpatient Rehab, Skilled Nursing, Long-Term Acute Care Hospitals)

Effective June 1, 2019, precertification and recertification requests for post-acute care facilities (skilled nursing, long-term acute care and inpatient rehab) for Medicare Plus Blue PPO and BCNA Advantage members should contact naviHealth.

Hours of operation are Monday through Friday 8:00 a.m. to 10:00 p.m. in requesters time zone. Weekends and Holidays 10:00 a.m. to 4:00 p.m. On call Care Coordinator can be reached at 1-855-851-0843

- **How to submit to naviHealth**
  - naviHealth provider portal (nH Access™) reached from the Provider Secured Services home page. Visit bcbsm.com/providers and log in to Provider Secured Services. Click the Medicare Advantage Post-Acute Care Authorization link. Enter your NPI. (If you're having trouble accessing the naviHealth portal using this process, contact the Blue Cross Web Support Help Desk at 1-877-258-3932.)

    **Note:** Out-of-state providers can access this link by logging into their home plan's website and selecting an ID card prefix from Michigan, which will take the provider to the Blue Cross Blue Shield of Michigan website.
  - nH Access™ at access.navihealth.com. You must first register with naviHealth for access to their portal. Visit naviHealth Partner Resources to register. Download the *New User Account Form* and follow the instructions within the *Account Creation Guide*.
  - Phone: 1-855-851-0843
  - Fax for new authorization requests: 1-844-899-3730

- Fax for discharges: 1-844-729-2951
- Fax for continued stay requests: 1-844-736-2980
- Email for discharges: mid-west_discharge_info@navihealth.com
- Submit through Allscripts. Follow your current process.

- **What documentation should I submit with the authorization request?**

  naviHealth requires the following documentation:

  - At admission
    - Hospital face sheet, including name of ordering physician
    - History and physical
    - Current physician notes and nurses' notes
    - Physician orders sheet with medication list
    - Physical therapy, occupational therapy and speech therapy evaluations
    - Nursing admission assessment
    - Prior living situation

      **Note:** This information is required for members admitted on or after June 1, 2019. It is typically found in the physical therapy assessment or the nursing admission notes.
    - Current cognitive status
    - Prior level of function
  - For continued stays
    - Face sheet from skilled nursing facility, inpatient rehabilitation facility or long-term acute care hospital, including name of attending physician
    - Hospital discharge summary
    - Nursing admission assessment
    - Physician order sheet with medication list
    - PT, OT and ST evaluations
    - Nursing notes
    - Therapy notes
    - Physician order changes
  - At discharge
    - Patient's discharge instructions
    - Therapy discharge summaries
    - Therapy billing logs

- **naviHealth uses the following criteria**
  - CMS National Coverage Determinations and Local Coverage Determinations, within the appropriate jurisdictions
  - InterQual® criteria

    **Note:** naviHealth will apply these criteria in the order in which they are listed.

**SPECIAL NOTE: Clinical review requirements temporarily suspended for admissions to skilled nursing facilities from hospitals in certain states**

Blue Cross Blue Shield of Michigan and Blue Care Network are temporarily suspending clinical review requirements for the first three days of admission to skilled nursing facilities from hospitals in certain states. This temporary change is due to the COVID-19 pandemic and applies to all lines of business, including Blue Cross Blue Shield of Michigan commercial, Blue Care Network commercial, Medicare Plus Blue℠ and BCN Advantage℠. The change is in effect until further notice.

For an up-to-date list of states and effective dates, refer to the provider alert: Update: Clinical review requirements temporarily suspended for admissions to skilled nursing facilities from hospitals in certain states (PDF).

**Note:** This temporary change does not apply to Blue Cross commercial (non-Medicare) FlexLink® groups for which a third-party administrator makes authorization determinations. Facilities should check the back of the member's ID card to determine whether a third-party administrator needs to be contacted prior to an admission.

## Retrospective Reviews

Medicare Plus Blue PPO will process retrospective authorization requests for acute inpatient hospitalization up to 1 year after the admission date.

## Medicare Plus Blue Peer-to-Peer Reviews (Medical Necessity Denials)

**Effective Jan. 4, 2021:** Blue Cross Blue Shield of Michigan will no longer accept peer-to-peer requests for Medicare Plus Blue℠ members regarding inpatient medical hospital admission denials.

Facilities are encouraged to follow the two-level provider appeal process for Medicare Plus Blue to reevaluate the denial decision on an inpatient admission request. See the "Contracted MI Provider Acute Inpatient Admission Appeals" section in the *Medicare Plus Blue℠ PPO Manual*.

**Prior to Jan. 4, 2021:** To request a peer-to-peer review for a Medicare Plus Blue member due to a medical necessity denial, providers must submit the request:

- Within 14 days of the initial denial decision.
- Before submitting a provider appeal.

**Note:** Providers can submit appeals without requesting peer-to-peer reviews.

If an authorization was denied for administrative reasons (i.e. member ineligibility at time of request or the service was not a covered benefit), a peer-to-peer review cannot be conducted as the denial was not based on medical necessity. These types of administrative denials must be appealed.

Member appeals and grievances are not eligible for peer-to-peer review.

To submit a peer-to-peer request, complete the *Physician peer-to-peer request form* (for non-behavioral health cases) **Error! Hyperlink reference not valid.**and fax it to 1-866-373-9468 during normal business hours of 8 a.m. to 5 p.m. Eastern time (except weekends and holidays).

**Note:** BCBSM will outreach the next business day and the peer-to-peer review will be scheduled on business days, Monday through Friday between 9 a.m. and 4 p.m. Eastern time (except holidays).

**Medicare Plus Blue Appeals for Provider Precertification Medical Necessity Denials**

For Precertification medical necessity denials, Medicare Plus Blue PPO appeal requests will be accepted up to 45 days of the date of the denial decision on the denial notification. Requests must include additional clarifying clinical information to support the request.

Requests can be submitted via:

- Fax: 1-877-495-3755
- Email: MedicarePlusBlueInpatientAppeals@bcbsm.com
- Mail:

Medicare Plus Blue Inpatient Provider Appeal
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd. MC 1516
Detroit, MI 48231-26271

## 5. Medical Benefit Drugs

**Blue Cross Blue Shield of Michigan PPO (commercial) and Medicare Plus Blue℠ PPO Products**

Some medications administered by healthcare professionals require prior authorization, and certain clinical criteria must be met before they can be administered.

- Click on this link for the medical policy, criteria and request form: Medical Policies.
- Refer to the Blue Cross Medical Benefit Drugs page on the ereferrals.bcbcm.com website:
    - For information on Blue Cross' PPO requirements, look in the "Blue Cross' PPO (commercial)" column.
    - For information on Medicare Plus Blue requirements, look in the "Medicare Plus Blue" column.

## 6. Other Medical/Surgical Procedures

### Blue Cross Blue Shield of Michigan Commercial Products (Non-Medicare)

Any service that does not meet our clinical criteria guidelines may require prior authorization; for example:

- Gender reassignment
- Genetic testing
  - When seeking approval for a commercially available genetic test panel, provide the name of the panel.
  - When there is a specific CPT or HCPCS code representing the panel, submit the specific code.
- Investigational procedures
- NOC codes
- Off label drugs
- Optune Device
- Potentially cosmetic procedures

Blue Cross Blue Shield of Michigan clinical criteria can be viewed at Medical Policies.

Services that meet clinical criteria guidelines do not require prior authorization. If you have a question about whether a service requires prior authorization, call 1-800-344-8525 (out-of-state providers
1-800-676-2583). Select Eligibility and Benefits and answer the appropriate questions about the service you are requesting. If your question is not answered via automated response, you will be given the opportunity to be transferred to a live representative.

You can request a prior authorization in writing by submitting the request and supportive documentation to the following address or fax to: 1-866-311-9603, Monday through Friday 8:30 a.m. to 4:30 p.m.:

Blue Cross Blue Shield of Michigan
P.O. Box 2227 Detroit, MI 48231-2227
Attention: Prior authorization, Provider Inquiry Service Mail Code 0450

**Routine prior authorizations are responded to within 15 calendar days.**

**Urgent prior authorizations are responded to within 3 calendar days.***

***** Limit the use of Urgent, STAT or ASAP on a prior authorization request to when medical care or services where application of the time frame for making routine or non-life threatening care determinations:

- Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

### Medicare Plus Blue℠ PPO

To see a list of elective (non-emergency) procedures or services that require prior authorization, see the Blue Cross Authorization Requirements & Criteria page on our ereferrals.bcbsm.com website. Scroll to the "For Medicare Plus Blue members" section and see the subsection titled "Authorization criteria and preview questionnaires – Medicare Plus Blue."

## 7. Prescription Drugs

### Blue Cross Blue Shield of Michigan Commercial Products (Non-Medicare)

Some drugs require prior authorization (PA), and certain clinical criteria must be met before they can be dispensed. Other drugs are part of our step therapy (ST) program, which means the patient must have been treated with one or more formulary agents before these drugs are covered. Drugs that require PA or ST differ based on the formulary the member's plan uses.

- BCBSM Clinical Drug List (Formulary)

BCBSM Pharmacy Services is available 24/7.

Web Login to Provider Secured Services at: http://www.bcbsm.com/providers.html

Select Medication Prior Authorization or call 800-437-3803 to obtain criteria and forms.

### Medicare Plus Blue℠ PPO and Prescription Blue℠ PDP

BCBSM Medicare Plus Blue PPO and Prescription Blue PDP plans include prescription drug coverage. These plans will generally cover drugs listed in our formulary as long as:

- The drug is medically necessary
- The prescription is filled at network retail or mail-order pharmacies
- All other plan rules are followed, such as prior authorization, step therapy and quantity limits

The formulary document provides a brief description of the plans' benefits, including any deductibles. It is updated regularly. Refer to Medicare Plus Blue PPO and Prescription Blue PDP Formularies on bcbsm.com for details.

Providers can request a coverage determination (prior authorization, step therapy, formulary exception or quantity limit exception) by phone at 1-800-437-3803, or referencing the information on the Medicare Plus Blue℠ PPO and Prescription Blue℠ PDP Formularies page on bcbsm.com.

## 8. Advanced Imaging, Cardiology and In-Lab Sleep Study Services

### Blue Cross Blue Shield of Michigan Commercial Products (Non-Medicare)

Prior authorization is required for non-Michigan providers for select groups.

For dates of services on or after Jan. 1, 2021, this service will require prior authorization from AIM Specialty Health:

- Cat Scan, or CT Scan, of the thorax to screen for lung cancer

### Medicare Plus Blue℠ PPO

Prior authorization is required from AIM Specialty Health before ordering select advanced imaging, cardiology and in-lab sleep study services to be performed in office, outpatient hospital or freestanding centers. This includes out-of-state UAW Retiree Medical Benefits Trust members with Medicare Plus Blue coverage.

For dates of services on or after Jan. 1, 2021, these services will also require prior authorization from AIM:

- Cardiac resynchronization therapy
- Implantable cardioverter defibrillator
- Arterial ultrasound services
- CT scan of the thorax to screen for lung cancer

Refer to the document **Procedures that require authorization by Aim Specialty Health** to see which outpatient advanced imaging, cardiology and in-lab sleep study services require prior authorization. For additional information, refer to the Blue Cross **AIM-Managed Procedures webpage**.

Out-of-state providers: Prior authorization is not required for non-Michigan providers except for UAW retiree medical benefit trust members residing in Alabama, Florida, Indiana, Missouri and Tennessee. Refer to the **Non-Michigan Provider Radiology Precertification, Preauthorization Requirements** document for more information.

## 9. Air Ambulance

### Blue Cross Blue Shield of Michigan and Blue Care Network HMO Commercial Products (Non-Medicare)

Only non-emergency flights require authorization. Effective April 2, 2018, non-emergency flights must be authorized by Alacura Medical Transport Management. To request authorization, fax the *Air Ambulance flight information (non-emergency) form* to 1-844-608-3572, then call Alacura at 1-844-425-2287 to obtain the authorization number. Review the form for additional information, including the definition of a non-emergency flight.

### Medicare Plus Blue℠ PPO and Blue Care Network Advantage Products

Please call Provider Inquiry at 866-309-1719.

## 10. Other Services

### AIM Specialty Health: Blue Cross Blue Shield of Michigan PPO (commercial) and Medicare Plus Blue℠ PPO

See Advanced Imaging, Cardiology and In-Lab Sleep Study Services.

### CareCentrix®: Medicare Plus Blue℠ PPO

Home health care requires prior authorization through CareCentrix, for episodes of care that start on or after June 1, 2021. This applies to home health agencies both inside and outside of Michigan. Refer to the **Home health care: Quick reference guide** for information on how to submit prior authorization requests. For additional information, refer to the Blue Cross **Home Health Care webpage** at ereferrals.bcbsm.com. Scroll to the Medicare Plus Blue section.

### eviCore healthcare: Blue Cross Blue Shield of Michigan PPO (commercial) and Medicare Plus Blue℠ PPO

Please call BCBSM at 1-800-676-2583 or log in to Provider Secured Services at http://www.bcbsm.com/providers.html to determine if the member requires a prior authorization by eviCore healthcare for the following services:

- Inpatient and outpatient lumbar spinal fusion surgery — for dates of service prior to Jan. 1, 2021
- Outpatient interventional pain management — for dates of service prior to Jan. 1, 2021
- Outpatient radiation therapy (oncology)

- Physical therapy and occupational therapy — Medicare Plus Blue℠ PPO only

You can also call eviCore at 1-877-917-2583 or go to **Error! Hyperlink reference not valid.**to initiate an authorization.

For more information about procedures managed by eviCore for BCBSM go to:
http://ereferrals.bcbsm.com/bcbsm/bcbsm-managed-procedures.shtml or
https://www.evicore.com/implementation/healthplan/blue-cross-blue-shield/michigan

**TurningPoint: Blue Cross Blue Shield of Michigan PPO (commercial) and Medicare Plus Blue℠ PPO**

TurningPoint Healthcare Solutions LLC manages inpatient and outpatient authorizations for musculoskeletal procedures as follows:

- Orthopedic surgical procedures, including joint replacement surgeries and other related procedures:
  - For Blue Cross commercial members
    - All fully insured groups, for dates of service on or after Jan. 1, 2021
    - Select self-funded groups — Groups were eligible to join this program for dates of service on or after Jan. 1, 2021.

      **Note:** This includes UAW Retiree Medical Benefits Trust non-Medicare members, for dates of service on or after May 31, 2021; providers can submit authorization requests to TurningPoint for URMBT members starting on May 3, 2021.
    - All members with individual coverage for dates of service on or after Jan. 1, 2021
  - For Medicare Plus Blue℠ PPO members for dates of service on or after July 1, 2020
- Pain management and spinal surgical procedures:
  - For Blue Cross commercial members
    - All fully insured groups, for dates of service on or after Jan. 1, 2021
    - Select self-funded groups – Groups were eligible to join this program for dates of service on or after Jan. 1, 2021.

      **Note:** This includes UAW Retiree Medical Benefits Trust non-Medicare members, for dates of service on or after May 31, 2021; providers can submit authorization requests to TurningPoint for URMBT members starting on May 3, 2021.
    - All members with individual coverage for dates of service on or after Jan. 1, 2021
  - For Medicare Plus Blue℠ PPO members for dates of service on or after Jan. 1, 2021

See the Blue Cross Musculoskeletal services page for a list of the codes that require authorization from TurningPoint.

**Retroactive Requests:** Providers can submit retroactive requests to TurningPoint for up to 90 days after the procedure is performed.

Providers can request an authorization through the TurningPoint provider portal, accessed by logging in to Provider Secured Services at bcbsm.com/providers. When authorization is received, provide the appropriate facility with the authorization number.

**Out-of-state providers:** Register with TurningPoint by visiting myturningpoint-healthcare.com and selecting *Register for Access.* You'll fill out a validation form and submit it to TurningPoint. Once TurningPoint sets up your account, you can access the TurningPoint Provider Portal through

myturningpoint- healthcare.com. You can also access it through your local plan's website by selecting an ID card prefix from Michigan. This will take you to the Blue Cross Blue Shield of Michigan website where you can select the *Musculoskeletal service authorization through TurningPoint* link and enter your NPI.