Total Healthcare Management, Utilization Management and Transition of Care
Commercial
Authorization Submission Options and Requirements

Options:

• **Online**
  -- Register via BlueAccess℠ at bcbst.com/provider
  -- 24/7 access
  -- Automated approvals when guidelines met

• **Phone**
  • 1-800-924-7141
  • (423) 535-5717, option 2

• **Fax** – See Transition of Care contact list

• **Commercial Requirements**
<table>
<thead>
<tr>
<th>Commercial</th>
<th>BlueCare</th>
<th>MedAdvantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Evidence of Coverage (EOC) / Benefit Plan</td>
<td>1. TennCare SM Contractor Risk Agreement / TennCare Rules</td>
<td>1. The law (Title 18 of the Social Security Act)</td>
</tr>
<tr>
<td>3. MCG Guidelines (Not used for pharmaceutical/specialty medication agents)</td>
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<td>3. National Coverage Determinations (Pub 100-03 of the Internet Only Manual)</td>
</tr>
<tr>
<td>4. If applicable, a Vendor Program Policy (e.g., MedSolutions) is used by the vendor in the absence of a BlueCross or MCG document addressing a given topic.</td>
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<td>4. MA Benefit Policy Manual (Pub 100-02 of the Internet Only Manual)</td>
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<td><strong>Durable Medical Equipment:</strong></td>
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**Durable Medical Equipment Medicare Administrative Contractor (DMEMAC) associated Program Safeguard Contractor (PSC) local coverage determinations (LCD)**
Reconsideration (when services are still active)
- Provide additional information via web/phone/fax.

Peer-to-Peer (two dates and times required)
- 1-800-924-7141
  - Anytime during the hospital stay.
  - Within 24 hours of notification of decision if already discharged.
  - For elective procedures, prior to services being rendered or filing an appeal.
• Commercial:

• Medicare Advantage:
Timeliness Guidelines

- Elective (planned) admissions must be authorized at least 24 hours before admission.
- Notification must occur within 24 hours or next business day of an emergent admission.
  - When a request for an authorization of a procedure, admission/service or a concurrent review of the days is denied, the penalty for not meeting authorization guidelines applies to both the facility and practitioner rendering care for the day(s) or service(s) that were denied.
- Failure to comply within specified authorization timeframes will result in a denial or reduction of benefits due to noncompliance.
- BlueCross participating providers will not be allowed to bill members for covered services rendered except for applicable copayment/deductible and coinsurance amounts.
• A voicemail box is available after business hours and on weekends/holidays so you can call us.

• Contact the normal authorization line at 1-800-924-7141 and listen to prompts for voicemail boxes:
  – Routine authorization notifications/clinical: Calls will be returned the next business day.
  – Urgent situations that cannot wait until the next business day will be returned by the manager on call.
• Related to an authorization?
  – Fax: (423) 591-9451
    BlueCross BlueShield of Tennessee
    1 Cameron Hill Circle, Suite 0017
    Chattanooga, TN 37402-0017

*Must be accompanied by a copy of the denial letter or the appeal form located on bcbst.com: http://www.bcbst.com/providers/forms/Utilization-Management-Appeal-Form.pdf

• Related to a claim?
  BlueCross BlueShield of Tennessee
  1 Cameron Hill Circle, Suite 0039
  Chattanooga, TN 37402-0039

*More detailed training coming soon
• Partnerships developed with multi-disciplinary members of the facility health care team, the payer care manager and the member.

• Prevention of delays in service

• Decreased risk of readmissions

• Increased member education opportunities

• Increased engagement rates with members

• Increased coordination of referrals to post discharge programs for ongoing health care needs.
Transitioning Care Process

- Collaborate with case management department regarding discharge needs.
- Review post acute care requests (SNF/REHAB/LTAC/HH)
- Call member during acute care setting.
- Follow up with member post discharge within 24 to 48 hours.
- Confirm follow-up appointments, help make appointments.
- Review home safety and ensure support is available.
- Ongoing follow up for 30 days post discharge.
- If ongoing needs are identified, member is referred to the appropriate population health program.
Request Transition Assistance

- Phone: 1-800-515-2121 ext. 6900
- Fax: 1-866-230-3424
Our Goals

• Assure the provisions of medically necessary and appropriate health care to all BlueCare℠ and TennCareSelect members in the most cost-effective manner.

• Success is attained through joint decisions between the Primary Care Practitioner (PCP), another provider (if applicable), BlueCare and/or TennCareSelect.
Inpatient Admissions include room and board and may be DRG or Per Diem based on the facility’s contract.

All inpatient admissions require a prior authorization for medical necessity.

**Per Diem Facilities**
- An Inpatient Per Diem Concurrent Review is any extension of services rendered in the Per Diem hospital setting beyond the initial approval timeframe.
- Inpatient extension requests require a medical necessity determination before approval.

**DRG Facilities**
- DRG facilities are requested to send a clinical update if the length of stay exceeds eight days. These are updates only and as such do not require a medical necessity determination to be made.
Compliance

• Observation requests do not require notification/authorization, but if the member converts to inpatient, timely notification is required. This type of request must be received within 24 hours or one working day after conversion to inpatient from observation.

• Emergencies from an inpatient admission require prior authorization within 24 hours or one working day after inpatient admission/conversion from observation.

• Non-urgent services rendered without obtaining notification/prior authorization before services are provided is considered “non-compliant.”

• Re-notification/Re-authorization for ongoing services beyond dates previously approved require re-notification/re-authorization within 24 hours or one working day of the last approved date or update due date.
### Turnaround Times (TAT)

<table>
<thead>
<tr>
<th>Prospective Review must be completed before obtaining services or care.</th>
<th>Non-Urgent requests – decision is made within 14 calendar days of the request.</th>
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<td></td>
<td>Urgent initial requests – decision is made within 72 hours of receiving the request. These timeframes begin with the receipt of the request for a Utilization Management determination.</td>
</tr>
<tr>
<td>Concurrent Review is an extension of a previously approved ongoing course of treatment over a period of time or number of treatments.</td>
<td>Non-Urgent concurrent requests – the decision is completed within 14 calendar days of the request.</td>
</tr>
<tr>
<td></td>
<td>Urgent concurrent review - verbal notification is provided within 24 hours of the request. Written notification will be completed within 72 hours.</td>
</tr>
<tr>
<td>Retrospective (post service) review examines medical appropriateness of medical services on a case-by-case or aggregate basis after services have been provided.</td>
<td>Retrospective Determinations will be completed within 30 calendar days.</td>
</tr>
</tbody>
</table>
Contacts for Submitting Requests

Urgent
• Online: bcbst.com
• Call:
  • BlueCare
    1-888-423-0131
  • TennCareSelect
    1-800-711-4104
  • CHOICES
    1-888-747-8955
  • SelectCommunity
    1-800-292-8196
  • TennCareSelect
    1-888-747-8955

Non-Urgent
• Fax:
  • BlueCare or TennCareSelect
  • West Grand Region 1-800-919-9213
  • East Grand Region 1-800-292-5311
  • SelectCommunity 1-888-255-9175
• Mail:
  BlueCare or TennCareSelect (specify)
  Attn: UM Support CH 4.3
  1 Cameron Hill Circle
  Chattanooga, TN 37402
Submit authorization requests (and register for BlueAccess) 24/7 on bcbst.com.
BlueAccess for Providers

Quick Jump »

e-Health Services  Additional Provider Services  Account Management

e-Health Services (®)

Electronic Claims Filing is the preferred method for claims submission. To sign up or discuss how to submit all claims electronically call (423) 535-5717 (select option 2). You can find additional information regarding enrollment and benefits of electronic claims filing on our website at bcbst.com/providers/ecomm.

Service Center

See coverage, eligibility, claim status, authorization and other insurance information for Commercial, BlueAdvantage, BlueCare, & TennCareSelect. The Quick Reference Guides are now located under "Demos, Tutorials & FAQ" in the Service Center.

More

BlueCard / FEP

Coverage, eligibility, claims status inquiries, and pre-service review for out-of-state BCBS & FEP plans. If no electronic option is available for pre-service review for the member’s plan, you will be provided with contact information that can be used to obtain prior authorization.

Electronic Provider Access (EPA) Out-of-Area Pre-service Review

Real Time Claim Estimation/Adjudication

Enables claim submission & claim estimation to gain member liability for Commercial, BlueCare/TennCareSelect and BlueAdvantage.

View tutorial

More

CHOICES

TennCare CHOICES in Long-Term Care is TennCare's program for long-term care services.

More

BCBST Musculoskeletal Program
Online Authorizations

Provider Home

What you can do

e-Health services

Announcements:

DME authorizations may now be submitted online. You can attach medical records, invoices, certificates of medical necessity as required by CMS, etc to the DME authorizations and on the Clinical Update form.

Effective January 7, 2015, you are now able to search for BlueCare members pharmacy claim information if you are listed as their PCP. Note: This is specific to BlueCare members.

Prior Authorization Search by Code will be coming in 2015.

Specialty Pharmacy Authorizations

Please note for the following Specialty Pharmacy drug Unetuxim (denutuximab) a prior authorization is required web at this time. Providers can obtain a prior authorize specialty drugs by calling 1-800-934-7141 and for self-calling Express Scripts at 1-877-918-2271.

Pre Service Review for Out of Area Members

Did you know that authorizations for out of area members online through the BlueCard/FEP application? Click the "Area Members" link to begin.

For COMMERCIAL members

Prior authorization is NOT required for 24 hour observation ER. If your request pending for nurse review and you request that is elective, direct admit from ER office. If the request is denied, please document this clearly in the comment section to be able to cancel.

e-Health Services Provider Demos & Tutorials

- Web Authorization Guidelines
- BCBST Web Authorization Quick Reference Guide
- HRA Quick Reference
- Web Authorization - Updated Guidelines
- Global OB Quick Reference Guide
- Specialty Pharmacy Quick Reference Guide
- Milliman Care Guidelines
- Disclaimer
- BlueCare PCP Quick Reference Guide
Why is BlueCare Different?

• The Grier Consent Decree governs members’ rights and responsibilities related to denials and ensures a timely and fair appeals process.

• An appeal is the process when a member wants to pursue a reconsideration of an adverse action (e.g., delay, denial, reduction or termination of services).

• Grier ensures members are notified of their appeal rights by requiring:
  – Notification in a timely manner after any adverse action of a TennCare service.
  – Notices or other written member communication is no higher than a sixth grade level reading level.
TennCare Rules define medical necessity determinations according to five components:

1. Recommended by a health care provider (is there an order for the service requested?)
2. Required to diagnose or treat the medical condition.
3. Safe and effective.
4. Not experimental or investigational.
5. Least costly alternative.
Peer-to-Peer
• Arrange a Physician-to-Physician discussion with a BlueCare Medical Director by calling Utilization Management (simply call 1-888-423-0131).
  – Only applicable at the time of the initial denial.
  – Only available when the ordering or attending physician requests (not applicable for service providers or facilities).

Reconsideration
• Submit additional information through the prior authorization process.

Member Appeal or Provider Appeal
• Provider Appeals can be used if Reconsideration or Peer-to-Peer resulted in an adverse determination and member already received services.
• Member Appeals can be used if member has not received services (this request is made through TennCare Solutions).
BlueCare Tennessee (BCT) Appeals

• Types of Appeals:

  – Member Appeals – An adverse action occurred and services have not been rendered (filed through TennCare Solutions within 30 days of denial notification).

  – Standard Provider Appeals – A denial of a service occurred and the services have been rendered with no adverse action to the member (filed through BlueCare Tennessee for processing within 60 days of the denial notification).

  – Expedited Provider Appeals – A denial of service occurred and the provider thinks the adverse determination could jeopardize a member’s life or health and the ability to regain maximum function or subject the member to severe pain that cannot be managed without care or treatment.
• Members (or their representatives) have 30 calendar days from the date on the denial notice to submit an appeal to the Bureau of TennCare.
  – To continue existing services, the appeal must be filed within 20 calendar days.

• Providers can appeal on behalf of the member by filing an appeal with TennCare Solutions if services have not been rendered.
  – Phone: TennCare Solutions: 1-800-878-3192
  – Fax: TennCare Solutions: 1-888-345-5575
  – Mail: TennCare Solutions
    P.O. Box 000593
    Nashville, TN 37202-0593
Member Appeals

• Service Appeal
  – Requesting a covered or non-covered service that has been denied, delayed, terminated, reduced or suspended.
    • Standard Appeal: 14 calendar days from date of receipt in the organization to respond to the appeal.
    • Expedited Appeal: five calendar days from date of receipt in the organization to respond to the appeal.

• Reimbursement Appeal
  – Requesting to be reimbursed for an out-of-pocket expense or the member received bills from a health care provider.
Member Appeals - Useful Links

• Bureau of TennCare – Home Page:  
  http://www.tn.gov/tenncare

• TennCare Rules:  

• TennCare Medical Appeal Form:  
  http://www.tn.gov/assets/entities/tenncare/attachments/medappeal.pdf

• Link to the Grier Consent Decree:  
  http://www.tn.gov/assets/entities/tenncare/attachments/grier020508.pdf
• Expedited Provider Appeals for denied services:
  Call Utilization Management
  – BlueCare: 1-888-423-0131
  – TennCareSelect: 1-800-711-4104

• Standard Provider Appeals for denied services must be received within 60 calendar days from the date of the initial denial notice:
  – Fax: BlueCare Tennessee UM Appeals 1-888-357-1916
  – Mail: BlueCare Tennessee
    Attention: BlueCare/TennCareSelect Provider Appeals Supervisor
    1 Cameron Hill Circle, Ste. 0020
    Chattanooga, TN 37402-0020
What to Include in the Provider Appeal Submission

- A copy of the denial letter
- A completed appeal form (located at bcbst.com and in the BlueCare Tennessee Provider Administration Manual) indicating reasons for the appeal.
- Pertinent clinical information
Provider Appeal Turnaround Times

- **Expedited Provider Appeal:**
  - A determination will be sent to the Provider and Member within 72 hours of receipt of request (clinical circumstances will help to determine the speed of the response).

- **Standard Provider Appeal:**
  - A determination will be sent to the Provider and Member within 30 calendar days the receipt of the request for appeal; if the 30 day timeline cannot be met, notification will be sent to the provider.

- **Still dissatisfied with the decision?**
  You may appeal according to our Provider Dispute Resolution Procedure described in the BlueCare Tennessee Provider Administration Manual.
BlueCare Tennessee Appeals Contacts

- Rafielle Freeman, MSL, RN, BSN, CPHQ
  Director, Quality Improvement
  - (423) 535-7302
  - Rafielle_Freeman@bcbst.com

- Leanne Rodgers, RN, MSN, CCM, CPHQ
  Manager, BlueCare Appeals
  - (423) 535-8024
  - Leanne_Rodgers@bcbst.com

- Pat White, Supervisor, BlueCare Appeals
  - (423) 535-7671
  - Pat_White@bcbst.com

- Julie Sledge, Clinical Supervisor, BlueCare Appeals
  - (423) 535-3608
  - Julie_Sledge@bcbst.com
Objective: Collaborate with facilities, providers and members to transition our members to appropriate levels of care for better health outcomes.

A dedicated on-site or telephonic TOC nurse liaison will:

- Assist facility discharge planners, physicians and members to understand benefits and options for discharge.
- Expedite necessary authorizations to prevent delays in discharge.
- Collaborate with multifunctional hospital teams to address any identified barriers to a safe and successful discharge.
The TOC nurse is responsible for:

- Monitoring daily census and referrals for assigned hospital.
- Contacting members and/or family to assess risks, assess discharge needs and educate.
- Working with hospital discharge planners to collaborate on an appropriate plan of care.
- Expediting authorization requests as needed.
- Coordinating with home health, skilled nursing facility, rehab and LTAC as needed.
- Collaborating with Population Health team as needed.
- Following-up after discharge.
Skilled Nursing Facility and Rehab are not a covered services for BlueCare members (always pended to physician for review).

These services may be approved for unique member situations if the service is a least cost alternative to a covered service.

Fax SNF, rehab or LTAC service requests to (423) 535-7790 using the BlueCare SNF/Rehab request form located in the BlueCare Tennessee Provider Administration Manual and BlueCare website.
Hospital Case Management and Transition of Care Partnership

- This unique relationship offers:
  - Quality care for members
  - Prevents discharge delays

- The partnership decreases:
  - Denials for days not medically necessary while discharge decisions are being made.
  - Duplication of services
  - Readmissions

- The partnership increases:
  - Cost savings for all parties involved
  - Member education opportunities
  - Increase coordination for referrals to post discharge programs for ongoing health care needs such as Population Health or Behavioral Health programs.
Medicare Advantage
Medicare Advantage Authorization Submission Options

• Phone
  – 1-800-924-7141
  (Monday – Friday, 9 a.m. to 6 p.m. ET)

• Fax
  1-888-535-5243

• Online
  - bcbst.com
  - 24/7 access
The Centers for Medicare and Medicaid Services (CMS) requires all MA plans to use the following hierarchy in medical necessity determinations:

- Title 18 of the Social Security Act
- Title 42 CFR part 422 and 476
- CMS Interpretive Manuals, including sub-manuals Pub. 100-04 Claims Processing, Pub 100-08 Program Integrity Manual, Pub. 100-10 QIO manual and Pub. 100-16 Medicare Managed Care Manual
- Medicare Coverage Database (http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx) including:
  - National Coverage Determinations (NCD) (Pub 100-03 of the Interpretive Manuals)
  - Local Coverage Determinations (LCD) (http://www.cms.hhs.gov/mcd/search.asp)
  - DMEMAC associated PSC LCDs
- MCG guidelines for most inpatient services
- BlueCross Modified MCG guidelines (http://www.bcbst.com/providers/UM_Guidelines/)
- BlueCross Medical Policy
- Peer reviewed clinical literature
Medicare Advantage Care Management

- Authorization Requirements:
  - All inpatient admissions.
  - Skilled nursing facility admissions.
  - Acute rehabilitation and long-term acute-care admissions.
  - Home-based skilled nursing and speech therapy.
  - Durable Medical Equipment (DME) over $500.
  - Orthotic and prosthetics over $200.
  - Specific Part B Specialty Drugs (see attachment).
  - Specific Part D Specialty Drugs bcbst.com/providers/pharmacy.
  - Chiropractic services – external vendor.
  - Physical therapy services (home health and free standing) – external vendor.
  - Pain injections - external vendor.
  - High-tech imaging - external vendor.
Medicare Advantage Care Management

- **Acute and Sub-Acute Inpatient Services**
  - All authorizations will be assigned an initial expected length of stay/service.
  - Additional clinical information is required to extend the length of stay.

- **Concurrent Review**
  - After an initial DRG approval, frequent clinical updates may be requested to help coordinate services for the member and ensure MCG acute inpatient or CMS SNF criteria’s are met for ongoing medical necessity.
Medicare Advantage Inpatient Services Programs

- Readmission Reduction Program:
  - BlueAdvantage℠ (PPO) and the BlueChoice℠ (HMO) plans implemented two readmission programs on Sept. 1, 2014, that apply to same or similar diagnosis readmissions to acute care hospitals that occur within 31 days from the index admission discharge:
    - Admission within 48 hours of discharge – the readmission is not reimbursed
      - Defined as the same or similar diagnosis from a complication of the original hospital stay or admission from a modifiable cause of the original hospital stay.
      - Both admissions must occur at the same facility or a facility operating under the same contract.
      - BlueCross will follow for discharge planning needs only (i.e., no clinical updates).
    - Admission within three to 31 days of discharge – only the higher weighted DRG pays.
      - Defined as the same or similar diagnosis from a complication of the original hospital stay or admission from a modifiable cause of the original hospital stay.
      - Both admissions must occur at the same facility or a facility operating under the same contract.
      - Reimburse a single DRG (the higher weighted of the two admissions), and all other days will be reimbursed based on DRG outlier methodology.
      - Subject to inpatient medical review based on MCG criteria.

- Provider Appeals:
  - Standard provider appeal remedies are the same as usual for administrative service denials.
Medicare Advantage Inpatient Services Programs

• Inpatient DRG Day Outlier Management Program:
  • BlueAdvantage℠ (PPO) and the BlueChoice℠ (HMO) plans implemented the DRG day outlier management program on Sept. 1, 2014, consistent with the criteria in MCG (formerly Milliman Care Guidelines). BlueCross reviews acute inpatient hospitalization days outside of the initial Diagnosis Related Group (DRG) initial day approval as follows:
    - MCG will be used relative to the concurrent information provided from the acute care facility to determine if the care and services provided are consistent with acute inpatient service provision.
    - This review is performed by a Plan Medical Director.
    - This review will occur after the DRG days have elapsed and are subject to the facility providing concurrent clinical information for review.
    - All admissions are approved for eight days, but as staffing increases this will be expanded to an expected length of stay based on admission diagnosis.
    - Standard provider appeal remedies are available.
Ancillary Service Reviews:

DME and Home Health are assigned a date span for the authorization based upon:

- Item
- Treatment
- Services required by the member

If additional services are required, additional clinical information supporting the need for the care/item must be submitted:

- Phone: 1-800-924-7141
- Fax: 1-888-535-5243
- Online: www.bcbst.com
Medicare Advantage Care Management

• Predeterminations:
  • Can be obtained on any treatment that does not require an authorization, but for which there is a question about Medicare coverage.
  • Examples:
    - Items considered investigational (e.g., J2001 - lidocaine infusion for pain)
    - Cosmetic surgeries (e.g., blepharoplasty, dermatochalasis, xanthelasma and spider veins)
    - Glucometers and testing strips are covered under the Part B benefit that the member can obtain through the local pharmacy or by mail order.
    - DME items under $500 not covered by Original Medicare.
Turnaround times (TAT):

- CMS turnaround times take precedence over any other review entity.
  - Standard review: 14 days
  - Urgent review (member’s life is in jeopardy): 72 hours
  - Our 2015 Medicare Advantage GOAL is three days for 90 percent of requests.
Medicare Advantage Care Management

- **Retrospective Reviews:**
  - Any item requiring authorization that was not obtained (must be received within 30 days of the denial of the reconsideration).
  - Services that require authorization but not obtained by non-par provider.
  - Large Bill items ($95,000 or greater allowed amount)
  - Provider chart appeal review
  - Turnaround time is 30 days
Reconsideration:

• Provider appeal options:
  - CMS requires all Provider appeals, reconsiderations and peer-to-peers to be reviewed by a different physician reviewer other than who made the original organizational determination.

• Peer-to-Peer discussion (MD to MD)
  - Must be requested within two days of fax notification of adverse determination.
  - Supply two dates and times of availability.
  - Phone number 1-800-924-7141
Medicare Advantage Care Management
Provider Appeals

• Reconsideration:
  - Need continued hospitalization or service was denied?
  Fax additional details to 1-888-535-5243.
  - Information must be received within 10 days of fax notification of adverse determination.
Medicare Advantage Care Management Provider Appeals

- If Peer-to-Peer (MD to MD) or additional clinical information was received and the organization determination remains denied, it goes to Provider Dispute Resolution (see our Provider Manual Medicare Advantage Section XXIV).

- If Peer-to-Peer or receipt of additional clinical information was NOT completed:
  - The medical record is required for review upon discharge to appeal.
    - What we need for review:
      - MD orders
      - Progress notes
      - History and physical
      - Discharge summary
      - Consultant dictation
      - Pertinent lab and imaging results
  - Turnaround time is 30 days from receipt of records
Medicare Advantage Member Appeal vs. Provider Appeal

- **Member Appeals:** Can be filed if a member or appointed representative disagrees with a pre-service denial or claim payment decision. The PCP or treating physician can file on a member’s behalf for pre-service denials within 60 days of the determination notice.

- **CMS required review timeline:**
  - 72 hours for expedited appeals (pre-service)
  - 30 days for pre-service appeals
  - 60 days for claims/payment appeals

- **A 14-day extension can be granted if:**
  - The member has a justifiable reason for filing late
  - The plan needs to request information to support the member’s appeal
  - The member wants to submit additional information

- **If a case is upheld (fully or partial):**
  - The appeal requestor is notified of the decision, and the case is reviewed by the Independent Reviewer Entity (IRE). After the IRE makes a decision, the plan updates the case accordingly.

- **If a case is overturned:**
  - The case is updated to approve or pay (effectuate), and the requestor is notified before the case is closed.
Medicare Advantage Member Appeal vs. Provider Appeal

- Provider Appeals: Per CMS guidelines, contract providers do not have appeal rights. However, BlueCross has a contractual provider appeals process if a provider disagrees with a determination post-service or payment.

Medicare Advantage Care Management

- Authorization Contact Information:
  - Phone: 1-800-924-7141
  - Fax: 1-888-535-5243
  - Web: www.bcbst.com

- For escalated issues:
  - Becky Williams, RN Manager Inpatient Services:
    (423) 535-6706
  - LaShonda Swoope, RN, PAHM, Manager Precertification Services/ Home Health, DME, Pre D:
    (423) 535-3102
  - Sandra Young, RN, Manager Quality and Reporting:
    (423) 535-3047
# CARE MANAGEMENT CONTACTS

## Commercial
- **Care Management Contacts**  
  - 1-888-515-7141
  - Fax: 1-888-728-5572

## CareKids
- **Care Management Contacts**  
  - 1-888-225-9688
  - Fax: 1-888-728-5572

## BlueCare
- **Care Management Contacts**  
  - 1-888-416-3625
  - Fax: 1-888-728-5572

## BlueChoice (PPD)**
- **BlueChoice (PPD)**  
  - 1-800-351-3930
  - Fax: 1-800-351-3930

## BlueChoice (HMO)**
- **BlueChoice (HMO)**  
  - 1-800-351-3930
  - Fax: 1-800-351-3930

## BlueChoice Plus (HMO SNP)**
- **BlueChoice Plus (HMO SNP)**  
  - 1-877-715-9630
  - Fax: 1-888-728-5572

## Transition of Care
- **Transition of Care**  
  - 1-888-515-7141
  - Fax: 1-888-728-5572

## Population Health
- **Population Health**  
  - 1-888-225-9688
  - Fax: 1-888-728-5572

## Recommendations
- **Recommendations**  
  - 1-800-351-3930
  - Fax: 1-800-351-3930

## Plan-to-Pair Discussion
- **Plan-to-Pair Discussion**  
  - 1-800-351-3930
  - Fax: 1-800-351-3930

## Appointments
- **Appointments**  
  - 1-888-416-7141
  - Fax: 1-888-416-7141

## Care Coordination
- **Care Coordination**  
  - 1-800-351-3930
  - Fax: 1-800-351-3930

## Behavioral Health Referrals
- **Behavioral Health Referrals**  
  - 1-888-225-9688
  - Fax: 1-888-351-3930

## C/E Outpatient
- **C/E Outpatient**  
  - 1-800-351-3930
  - Fax: 1-800-351-3930

## Customer Service/Provider Services
- **Customer Service/Provider Services**  
  - 1-888-351-3930
  - Fax: 1-888-351-3930

## Web Services
- **Web Services**  
  - 615-526-5747

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**Notes:**
- To use as a referral source, please contact the appropriate BlueCross BlueShield of Tennessee contact number.
- Additional information for active authorizations related to services may be obtained, faxed, or sent via website for non-certification of referrals.
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