Pre-authorization for professional providers

Pre-authorization is a prospective determination performed by licensed health care professionals. It helps determine medical necessity and appropriateness of the proposed treatment, level-of-care assessment and treatment setting.

Pre-authorization does not guarantee payment of procedures or services that depend on our clinical edits and members' eligibility and benefits. Services that require pre-authorization and their associated medical policies are listed in the Pre-authorization section of our provider website at **regence.com**.

Failure to obtain required pre-authorization will result in an administrative denial, claim non-payment and provider and facility write-off. Our members may not be balance billed. Charges for services and supplies that are not medically necessary are denied as provider write-off.

Medical policies

Our medical policies are a guide to coverage in accordance with our members' contract terms. Benefit determinations are based on the contract language. If there is a conflict between the medical policy and contract language, the contract language will apply.

Medical policies are based upon scientific evidence of merit for a particular medical technology. Technology determinations are made using criteria developed by the Blue Cross Blue Shield Association's Technology Evaluation Center and are approved by our Medical Policy Workgroup. Medical policies **do not** determine a member's benefits. Medical policies are simply used to determine whether a service may be medically necessary or investigational.

Medically necessary services

Medically necessary services are defined as a health care service or supply that a physician or other health care professional exercising prudent clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. They are:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease
- Not primarily for the convenience of the patient, facility or provider, and are not more costly than an alternative service or sequence of services or supplies at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease

Generally accepted standards of medical practice refers to standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the medical community. This includes physician specialty society recommendations, the views of providers practicing in relevant clinical areas and other relevant factors.

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Service definitions

Elective

A patient receives an elective procedure or admission for care or treatment which, in the opinion of the treating provider, is necessary and admission can be delayed for at least 24 hours.

Expedited

When the patient or their physician believes that waiting for a decision under the standard time frame could place the patient's life, health or ability to regain maximum function in serious jeopardy.

Note: Issues with scheduling a procedure or service do not constitute an "expedited" pre-authorization.

Routine

Care or treatment for which the request is made in advance of the patient obtaining medical care or services and the services do not fall into the "expedited" or "emergency services" definition.

Cosmetic services

Services provided to improve physical appearance nd that do not repair or improve physical function. Typically these services are contract exclusions, are ineligible for payment and are denied as member write-off.

Emergency services

Services to treat a sudden, serious and unexpected acute illness, injury or condition that it is reasonable to believe could endanger the member's health if treatment is not received immediately. Emergency services do not require pre-authorization; however, they are subject to hospital admission notification requirements.

Other definitions

Administrative services only (ASO) groups

An employer group that self funds their group plan and establishes its own benefits.

Regence is the third-party administrator for these groups and provides administrative services only, including claims processing. These groups customize their plans and may not be subject to our administrative guidelines.

Electronic Provider Access (EPA)

EPA is a tool which allows facilities to access an out-of-area member's Home Plan provider portal and electronic pre-service review capabilities. The EPA tool is available in the Availity Portal.

Experimental and cosmetic services (Medicare Advantage)

Experimental and cosmetic services and supplies are typically contract exclusions for Medicare Advantage members and are ineligible for payment. Experimental procedures and items are defined by the Centers for Medicare & Medicaid Services (CMS) as those items and procedures determined by our plan and original Medicare to not be generally accepted by the medical community.

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Investigational services and supplies

Services and supplies may be considered investigational if they do not meet our medical policy technology assessment criteria. All services associated with investigational technology (including, but not limited to, associated procedures, treatments, supplies, devices, equipment, facilities or drugs) are also considered investigational. For investigational services and supplies:

- Charges are denied as member responsibility. We encourage members to verify benefit coverage for proposed services.
- We encourage you to notify the member that they may be financially responsible for the charges before these services are provided.

View services and supplies we consider to be investigational on the *Clinical edits by code list* on our website: Claims and Payment>Claims Submission>Coding Toolkit.

AIM Specialty Health℠

We partner with AIM to administer our Radiology and Sleep Medicine programs. Codes that require an order number are listed on our pre-authorization lists.

eviCore healthcare

We partner with eviCore to administer our Physical Medicine program. Codes that require authorization from eviCore are listed on our pre-authrozation lists.

Notification of admission and discharge

Notification of admission and discharge is required through electronic medical record. Fax notifications are accepted if electronic medical records are not available. If your facility submits electronic admission and discharge data to Collective Medical Technologies, we will receive it through PreManage/EDIE.

Notification can also refer to requirements for the Physicial Medicine program.

Pre-service appeal process

Pre-service appeals (e.g., pre-authorization denials) follow our member appeal policy and procedures. Refer to the Member Appeals section of our Administrative Manual for information on how a pre-service pre-authorization denial can be appealed. The Administrative Manual is located on our website: Library>Administrative Manual.

Pre-authorization reminders

Each pre-authorization list includes reminders to help when requesting and rendering services to our members. Carefully review the important pre-authorization reminders before requesting a pre-authorization.

Requesting pre-authorization

Pre-authorization requests and supporting documentation may be submitted online through the Availity Portal between 4 a.m. and 9 p.m., Pacific Time. Outside of this time, requests may be submitted using our online form or by fax.

- Physical Medicine program authorizations should be obtained from eviCore.
- Radiology and Sleep Medicine program order numbers can be obtained or verified from AIM.

Review all of our pre-authorization lists for details.

Program participation list

Our *Program participation list* outlines requirements of our radiology, sleep and Physical Medicine programs, and the members who particpate in each program. The *Program participation list* is linked from our pre-authorization lists on our website: Pre-authorization.

Contact information

Phone and fax numbers for pre-authorization differ by each product we offer. View our pre-authorization lists and the contact information on our website: Pre-authorization.

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