BlueCross BlueShield of Texas

Process for Standard Utilization Management (Prior Authorization) with Incomplete or Insufficient Documentation

Blue Cross and Blue Shield of Texas (BCBSTX) will issue coverage determinations for Incomplete Prior Authorizations (PA) Requests according to the following timelines:

BCBSTX will notify the requesting provider and member, in writing, of missing information no later than three business days after the PA receive date. Additionally, BCBSTX is permitted to contact the provider by telephone and obtain the information necessary to resolve the incomplete PA request. BCBSTX's written request for additional information will include the following:

1. A statement that BCBSTX has reviewed the PA request and is unable to make a decision about the requested services without the submission of additional information.
2. A clear and specific list and description of missing/incomplete/incorrect information or documentation that must be submitted in order to consider the request complete.
3. An applicable timeline for the provider to submit the missing information.
4. Information on the manner through which a provider may contact BCBSTX.

Incomplete or Insufficient Documentation

If BCBSTX does not receive the information requested by the end of the third business day from the date that BCBSTX sent the notice to the provider and the PA request will result in an **Adverse Benefit Determination**, BCBSTX will refer the Incomplete PA Request for Medical Director review with all information received with the PA request. This referral must be no later than the seventh business day after the PA Receive Date.

Within three business days of the referral for Medical Director review, but no later than the 10th business day after the PA receive date, BCBSTX must make a final decision on the PA request.

A peer to peer consultation can occur at any time during the PA request process after a Medical Director review. BCBSTX must offer an opportunity for a peer to peer consultation to the requesting physician no less than one business day before an Adverse Benefit Determination is issued. Final determinations will be made within three business days after the date missing information is provided. If a holiday (e.g., Christmas) will result in the process exceeding the 14 calendar daytime limit, BCBSTX will adjust the timeline accordingly so that the prior authorization timeline does not exceed 14 calendar days.

Other clarifications:

Start of Care Date

The "Start of Care" (SOC) date is the date that care is to begin as listed on the PA request form. Exceptions to this SOC date may include PA requests for:

- home health skilled nursing
- aide services
- private duty nursing (PDN)

- physical therapy
- occupational therapy
- speech therapy services.

These services may require that the provider assess the member and initiate care prior to submitting a PA request. For example, PDN Providers must obtain PA within three business days of the SOC date for services that have not been prior authorized previously. During the PA process, Providers are required to deliver the requested services from the SOC date. The SOC date is the date agreed to by the physician, the PDN Provider, and the member or responsible adult and indicated on the submitted plan of care (POC) as the SOC date. The requested SOC date will be honored by BCBSTX when a Provider is able to submit additional information enough to classify a request as complete as described on the BCBSTX website.

Peer to Peer Consultations and Reasonable Opportunity

In accordance with Texas Government Code § 533.00284, BCBSTX must follow established timeframes to provide the requesting physician with a reasonable opportunity to discuss the member's treatment plan with a physician who is contracted by BCBSTX and who practices in the same or similar specialty, but not necessarily the same subspecialty, and has experience in treating the same category of population as the member on whose behalf the request is submitted. A peer to peer consultation is between a BCBSTX Medical Director and the requesting physician for a specified service. A BCBSTX Medical Director is permitted to determine that his/her clinical knowledge or experience is insufficient to accurately render a decision on a PA request. In this case, standard of care indicates that BCBSTX must seek and document, additional information from reference material, from the expertise of another physician associated with BCBSTX, or by employing an outside organization.

BCBSTX will document the time, date, name, and credentials of the individual consulted on a PA request and the substance of any verbal communication between the individual consulted and BCBSTX. A person may not review Health Care Services or make Adverse Benefit Determination or changes to a PA request if he or she, or a member of his or her family:

1. Participated in developing or executing the Member's treatment plan;
2. Is a part of the Member's family;
3. Is a governing body member, officer, partner, 5 percent or more owner, or managing employee in the health care organization where the services were or are to be furnished; or
4. A member of a reviewer's family is a spouse (other than a spouse who is legally separated under a decree of divorce or separate maintenance), child (including a legally adopted child), grandchild, parent, or grandparent.

Relating to Grievances, Fair Hearing Rights and Appeal Timelines

The process and timelines set forth in the timeframes for coverage determinations do not affect:

1. any related timeline, including the timeline for BCBSTX Internal Appeal, a State Fair Hearing, or a review conducted by an External Medical Reviewer;

2. any rights of a Member to appeal a determination made on a PA request.

Communication and Notices

Provider Notifications: After BCBSTX determines that a PA request is incomplete, it must use at least one of the following modes of communication to contact the provider: fax, electronic communication via secure provider portal, or postal mail.

BCBSTX is not required to mail notices to the provider if notice is sent by fax or electronic communication via secure provider portal. A date and time stamp must be properly documented by the BCBSTX if the notice is sent by fax or electronic communication via secure provider portal. Additionally, BCBSTX is permitted to contact the provider by telephone. If BCBSTX obtains the information necessary to complete the PA request during the phone call, BCBSTX will document the time, date, credentials, and name of the individual consulted during the phone call, and the substance of

their verbal communication. All clinical information must be received from a licensed physician, or other appropriately licensed and credentialed medical personnel. BCBSTX will send a written notice of final determination no later than the next business day after a determination is made on a PA request. This final notice must be dated the day the notice is sent.

Member Notifications

BCBSTX must allow members to choose a preferred method for receiving PA request notices to the extent practicable using existing resources, and provide members notice through their preferred methods. If a member does not choose a preferred method, BCBSTX is required to send notices via mail.

By clicking this link, you will go to a new website/app ("site"). This new site may be offered by a vendor or an independent third party. The site may also contain non-Medicare related information. In addition, some sites may require you to agree to their terms of use and privacy policy.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association