Prior Authorization Program for Blue Cross Blue Shield of Illinois, Montana, New Mexico, Oklahoma, Texas Commercial members, Blue Cross Centennial Community℠ Medicaid members, and Medicaid members with Blue Cross and Blue Shield of Illinois, which includes Blue Cross Community Health Plans℠

Frequently Asked Questions

About the Prior Authorization Program

1. What is the Prior Authorization Program?

Prior Authorization Program is a utilization management program that requires providers to request prior authorization for certain services. The requests are evaluated against evidence-based, Carelon Medical Benefits Management Clinical Guidelines, located here; select Genetic Testing, Joint, Spine and Pain Management services will be evaluated against the health plan's medical policy, located at HCSC's medical policy website.

2. Which members require prior authorization through Carelon?

Please check member benefits and eligibility to determine whether prior authorization is required. Blue Cross and Blue Shield (BCBS) of Illinois, Montana, New Mexico, Oklahoma and Texas commercial members, Blue Cross Centennial Community (BCCC) Medicaid, and Blue Cross Community Health Plan (BCCHP) members will require clinicians ordering services to request prior authorization for the following lines of business:

- Commercial PPO, EPO, HMO, HPN members
- Medicaid members with Blue Cross Centennial Community (BCCC) and Blue Cross Community Health Plan (BCCHP).

3. How is the program administered?

The program is administered by Carelon on behalf of BCBS of Illinois, Montana, New Mexico, Oklahoma and Texas, Blue Cross Centennial Community (BCCC) Medicaid members, and Blue Cross Community Health Plan (BCCHP) Medicaid members. Carelon collaborates with payors to help improve health care quality and manage costs for some of today's complex tests and treatments, promoting patient care that is appropriate, safe, and affordable.

4. What services require prior authorization?

Prior authorization programs are in place for the following care categories for BCBS of Illinois, Montana, New Mexico, Oklahoma, and Texas commercial members, BCCC Medicaid members, and BCCHP Medicaid members as indicated by the tables below.

When selecting a service that does not require prior authorization from Carelon, the provider will be notified via a message on the Carelon provider portal or by a representative in the Carelon Contact Center that Carelon prior authorization is not required. Providers should contact the health plan to verify prior authorization requirements. Reference each care category for more details on the applicable services that require prior authorization.

Care Category	BCBSIL	BCBSMT	BCBSNM	BCCC	BCBSOK	BCBSTX	BCCHP
Advanced Imaging	•	•	•	•	•	•	
Cardiology	•				•	•	
Sleep Medicine	•		•	•		•	
Joint and Spine Surgery	•		•	•	•	•	•
Pain Management	•		•	•	•	•	•
Genetic Testing	•	•	•	•	•	•	•
Radiology	•	•	•	•	•	•	•
Rehabilitation (PT/OT/ST)							•
Medical Oncology	•	•	•	•	•	•	•
Radiation Therapy	•	•	•	•	•	•	•

Detail list of services within each care category includes

Advanced Imaging	Sleep Medicine	Pain Management
• Computed Tomography (CT), including CT angiography, structural CT, and quantitative evaluation of coronary calcification • Magnetic Resonance Imaging (MRI), including functional MRI (fMRI) • Magnetic Resonance Angiography (MRA) • Magnetic Resonance Spectroscopy (MRS) • Nuclear Imaging (PET, SPECT)	• Home Sleep Test (HST) • In-lab Sleep Study, Polysomnography (PSG) • Multiple Sleep Latency Testing (MSLT) • Maintenance of Wakefulness Testing (MWT) • Titration Study • Initial treatment orders and supplies (APAP, CPAP, BPAP) • Ongoing treatment orders and supplies (APAP, CPAP, BPAP) • Oral Appliances	• Epidural adhesiolysis • Epidural injections (interlaminar/caudal and transforaminal) • Facet joint injections/ medial branch blocks • Facet joint radiofrequency nerve ablation • Implanted spinal cord stimulators • Regional sympathetic blocks • Sacroiliac joint injections • Prolotherapy • Thermal intradiscal procedures
Joint and Spine Surgery	**Genetic Testing**	**Radiation Therapy**
Spine surgery • Cervical, thoracic, lumbar, sacral, and sacroiliac joint fusion • Automated percutaneous and endoscopic discectomy • Bone grafts • Bone growth stimulators • Cervical/lumbar spinal fusions • Cervical/lumbar spinal laminectomy • Cervical/lumbar spinal discectomy • Cervical/lumbar spinal disc arthroplasty (replacement) • Sacroiliac joint fusion • Spinal deformity (scoliosis/kyphosis) • Vertebroplasty/ kyphoplasty **Joint surgery** (including all associated revision surgeries) • Total hip replacement • Total knee replacement • Shoulder arthroplasty • Hip arthroscopy • Knee arthroscopy • Shoulder arthroscopy	• Reproductive Carrier Screening • Prenatal Testing • Preimplantation Genetic Diagnosis / Preimplantation Genetic Screening (PGD/PGS) • Rare Disease Testing • Whole Exome/Genome Sequencing • Hereditary Cancer Testing • Tumor Markers • Hereditary Cardiac Testing • Neurogenetic and Neuromuscular Testing • Pharmacogenomics and Thrombophilia Testing • Susceptibility Testing for Common Diseases • Transplant Testing (limited to the following CPT codes: 81595, 0055U, 0087U, 0088U and 0118U)	• Brachytherapy • Intraoperative Radiation Therapy (IORT) • Intensity Modulated Radiation Therapy (IMRT) • Proton Beam Radiation Therapy (PBRT) • Stereotactic Radiosurgery (SRS) / Stereotactic Body Radiotherapy (SBRT) • 2D/3D Conformal Therapy • (EBRT) for bone metastases, breast cancer and non-small cell lung cancer • Image Guidance Radiation Therapy (IGRT) • Special Physics Consult, Special Treatment Procedure and Hydrogel Spacer • Radiopharmaceuticals; including Zevalin, Xofigo, Lutathera, Azedra, Sodium Iodide 131
Cardiology	**Rehabilitation**	**Medical Oncology**
• Computed Tomography (CT), including CT angiography, structural CT, and quantitative evaluation of coronary calcification • Magnetic Resonance Imaging (MRI) • Nuclear Imaging (PET, MPI, MUGA and First Pass, Infarct avid imaging)	• Physical Therapy • Occupational Therapy • Speech Therapy	• Chemotherapy and supportive drugs

5. How can providers find/look up services requiring prior authorization?

For some care categories providers can request prior authorization for individual CPT codes, while for other care categories providers they can select a service/procedure which may include a group of CPT codes. See table below for details:

Care Category	Providers request prior authorization for
Advanced Imaging Cardiology Sleep Genetic Testing	Procedure/Service/Test (most often includes a group of codes, but may include one code) Or Individual CPT codes
Rehabilitation (PT/OT/ST) Radiation Therapy	Therapy/Modality (Grouper CPT Codes and/or Individual Adjunctive CPT Codes)
Joint and Spine Surgery Interventional Pain Management	Individual CPT codes
Medical Oncology	Individual HCPCS

6. What place of service setting requires authorization from Carelon?

Solution	Physician's Office	Home	Outpatient Hospital	Inpatient Hospital	Free Standing Facility	Genetic Testing Laboratory	Ambulatory Surgical Center
Advanced Imaging / Cardiology	✓		✓		✓		
Sleep	✓	✓	✓				
Pain Management	✓		✓				✓
Joint and Spine Surgery			✓	See note below			✓
Medical Oncology	✓	✓	✓		✓		
Genetic Testing						✓	
Radiation Therapy			✓		✓		
Rehabilitation (PT, OT, ST)			✓		✓		

***Inpatient hospital:** For commercial and BCCC Medicaid members, medical necessity will be reviewed by Carelon while the level of care and length of stay will be reviewed by the health plan.

7. When should providers submit prior authorization requests to Carelon?

Providers are strongly encouraged to obtain prior authorization before initiating, scheduling, and performing services.

8. What happens if providers do not call Carelon and do not enter information through the ***Provider****Portal*?

Providers are encouraged to request prior authorization before the start of services. Retrospective authorization requests may be initiated up to two business days after the treatment start date. Failure to contact Carelon and obtaining prior authorization may result in a claim denial.

9. Where can I find a list of CPT codes for the above services?

To access the current CPT code list, please refer to the appropriate BCBS health plan provider page.

Health Plan	CPT code list available on
BCBS of Illinois - Commercial	https://www.bcbsil.com/provider/claims/um_commercial.html
BCBS of Montana	https://www.bcbsmt.com/provider/claims-and-eligibility/predetermination- and-preauthorization
BCBS of New Mexico – Commercial	https://www.bcbsnm.com/provider/claims/preauth.html
Blue Cross Centennial Community (BCCC) - New Mexico Medicaid	https://www.bcbsnm.com/provider/network/medicaid.html
BCBS of Oklahoma	https://www.bcbsok.com/provider/clinical/precertification_req.html
BCBS of Texas	https://www.bcbstx.com/provider/clinical/preauthorization.html
Blue Cross Community Health Plan (BCCHP) – Illinois Medicaid	https://www.bcbsil.com/bcchp

10. Where can I find medical necessity criteria (medical policies) for each of the care categories?

Carelon Clinical Guidelines for each of the care categories are available here. Carelon Clinical Guidelines are developed through a rigorous process integrating evidence-based literature with expert physician review.

In addition, select Genetic Testing, Joint, Spine and Pain Management services will be evaluated against the health plan's medical policy located at HCSC's medical policy website. Carelon will use HCSC Medical Policy for the following codes related to the following care categories.

Care category	CPT code
Genetic Testing	81490
Joint and Spine Surgery	20975, 22867, 22868, 22869, 22870, 62380, 27280, E0749, S2118
Pain Management	22526, 22527, 62263, 62264, 62287, 0274T, 0275T, 62350, 62351, 62360, 62361, 62362, M0076

As always, providers should check benefits and eligibility to determine the member's benefits and prior authorization requirements.

11. Do inpatient services require prior authorization through Carelon?

No, advanced imaging, cardiology, sleep, pain management, genetic testing, radiation therapy, Rehabilitation (PT, OT, ST), and joint and spine surgery (BCCC Medicaid members only) services performed as part of an inpatient admission will not be reviewed by Carelon and will be reviewed by the health plan, if applicable.

For joint and spine surgery prior authorizations, if an inpatient facility stay is requested, providers will contact Carelon first for medical necessity determination, then contact the health plan for final determination of length of stay & the level of care.

13. How far in advance can a provider request prior authorization for services?

Providers should contact Carelon and obtain prior authorization for any services on or after the program effective date.

This includes ongoing Sleep Medicine treatment of supplies/machine.

For sleep medicine treatment, Carelon will:

- Validate the diagnosis to determine the treatment is needed
- Request the treatment start date to determine member's treatment timeline
- Approve appropriate machine per member's treatment needs

If a provider has a current prior authorization for dates of service that extend past the effective date, providers will not need to obtain a new prior authorization with Carelon until the authorized units or time has expired on the prior authorization.

Advanced Imaging and Cardiology	Prospective requests can be created up to **30 calendar days** prior to the Treatment Start Date but not prior to the Program Start Date.
Sleep Medicine	Prospective requests can be created up to **30 calendar days** prior to the Treatment Start Date but not prior to the Program Start Date.
Joint and Spine Surgery	Prospective requests can be created up to **60 calendar days** prior to the Treatment Start Date but not prior to the Program Start Date.
Pain Management	Prospective requests can be created up to **30 calendar days** prior to the Treatment Start Date but not prior to the Program Start Date.
Genetic Testing	Prospective requests can be created up to **90 calendar days** prior to the Test Initiation Date but not prior to the Program Start Date.
Medical Oncology	Prospective requests can be created up to **30 calendar days** prior to the Treatment Start Date but not prior to the Program Start Date.
Radiation Therapy	Prospective requests can be created up to **90 calendar days** prior to the Treatment Start Date and the Planning Start Date but not prior to the Program Start Date.
Rehabilitation (PT, OT, ST)	Prospective requests can be created up to **30 calendar days** prior to the Treatment Start Date but not prior to the Program Start Date.

14. How does the program benefit providers and patients?

When providers prescribe test or treatment for a patient and submits it to Carelon for review, it is compared against evidence-based Carelon Clinical Guidelines in real time, so the provider knows medical necessity criteria is met.

15. How do providers request prior authorization with Carelon?

Providers can request prior authorization in one of the three ways:

- Through the Availity accessible on the health plan's provider website (links you directly to the provider portal).
- Directly via the Carelon provider portal at www.providerportal.com

  Note: Providers already registered for the provider portal can add the applicable health plan through Manage My Groups.
- Call the Carelon contact center using the health plan specific number in the table below.

Carelon Contact Center

BCBS of Illinois - Commercial	1-866-455-8415	Monday through Friday – 7 AM to 7 PM CT
BCBS of Montana - Commercial	1-844-377-1285	Monday through Friday – 7 AM to 7 PM MT
BCBS of New Mexico – Commercial	1-866-745-1789	Monday through Friday – 7 AM to 7 PM MT
Blue Cross Centennial Community - New Mexico Medicaid	1-877-291-0513	Monday through Friday – 7 AM to 7 PM MT
BCBS of Oklahoma - Commercial	1-888-240-3085	Monday through Friday – 7 AM to 7 PM CT
BCBS of Texas – Commercial	1-800-859-5299	Monday through Friday – 6 AM to 6 PM CT Weekends and holidays – 9 AM to 12 PM CT
Blue Cross Community Health Plan - Illinois Medicaid	1-866-455-8415	Monday through Friday – 7 AM to 7 PM CT

Carelon will reply to voicemail messages after hours on the next business day.
Carelon Call Center is closed on the following holidays: Martin Luther King Jr. Day, Memorial Day, Juneteenth, Independence Day, and Labor Day, Thanksgiving Day, the day after Thanksgiving, Christmas Day, and New Year's Day.

16. Will providers be required to provide medical records or other clinical documents?

In most cases, medical records are not required, except for joint and spine surgery, pain management which often require upload of medical documentation. If medical records are needed to complete the review, Carelon clinical review team will notify provider's office or will message in the provider portal with the ability to upload documentation, when required.

Rehabilitation (PT, OT, ST) does not require a documentation upload for the initial and second requests; however, a documentation upload is required for the recurring (third) request and each request moving forward. Providers will be prompted in the provider portal for the documentation upload on the recurring request.

Providers should not send medical records proactively, unless specifically requested, and then send only what is requested (e.g., specific test result vs. full medical record). For most services, answers to clinical questions allow us to capture the relevant information to make a determination on the request. This delivers efficiency and eliminates the time and effort of submitting medical records that may not be needed.

17. Does Carelon only allow one diagnosis to be entered per request?

Carelon accepts prior authorization requests for a specific diagnosis. Only the primary diagnosis is needed. Users can enter additional clinical information after selecting a primary diagnosis. Multiple services, tests, modalities, or CPT codes can be requested per diagnosis.

18. How do I answer the clinical questions asked during the request process?

For most services, answers to clinical questions allow us to capture the relevant information to make a determination on the request. If you need assistance completing the clinical questions, please consult your clinical staff. They should be able to assist in where to find information in the patient's medical chart. Please also visit Carelon's website here for checklists to help gather all the clinical information necessary to submit a prior authorization request.

19. How will the requests be reviewed by Carelon?

For orders requiring prior authorization, Carelon will review requests against Carelon clinical guidelines.

If the request meets medical necessity criteria based on the information submitted by the ordering provider's office, the provider will receive an order number. If the request does not immediately meet criteria, the case will be forwarded to a Carelon clinician for additional clinical review. The clinical reviewer will request additional information regarding the case. If the additional information necessary confirms that the case is consistent with program guidelines, the provider will then receive an order number.

If, with additional information, the case still does not meet criteria, the case will be forwarded to a Carelon physician reviewer. Upon review, the physician reviewer may issue an order number or issue an adverse determination. The ordering provider will be notified of the final outcome for the request.

20. Once the provider submitted a request, how long will it take to receive a response from Carelon?

Requests that meet medical necessity criteria:
Requests that meet criteria receive a response immediately in the provider portal or on the phone with the Carelon contact center.

Requests that do not meet medical necessity criteria:
When an order request cannot be approved immediately, the provider has the option of discussing your case with one of Carelon clinical experts. A peer-to-peer discussion with one of Carelon physician reviewers is always offered before any adverse determination is made. No adverse determination is made until the case has been reviewed by a physician reviewer at Carelon.

It is important that when Carelon RN informs provider office (always via phone), that the case pends for peer-to-peer conversation, the ordering physician calls Carelon as soon as possible to discuss it with the Carelon physician. Until we receive a phone call back from the ordering physician (or their representative Physician Assistant or Nurse Practitioner), the case will continue to pend.

- Non-urgent commercial cases may pend for up to 15 business days, urgent commercial cases may pend for up to 72 hours of receipt. *Note: Timeframes vary by health plan and employer group.*
- Non-urgent BCCC Medicaid cases will pend up to 5 business days, urgent BCCC Medicaid requests will pend for up to 24 hours of receipt.
- Non-urgent BCCHP Medicaid cases will pend up to 5 calendar days, urgent BCCHP Medicaid requests will pend for up to 48 hours of receipt.

At that time, if the clinical information requested is not provided and peer-to-peer does not take place, the case will be denied. A denial letter will be sent to the member (via US mail) and provider (fax, if available or US mail). Denial rationale is included in every denial letter. If you have any questions regarding the denial, please call Carelon Contact Center at the numbers listed in Questions 14. In addition, for joint surgery, spine surgery and pain management, the denial rationale is visible on the provider portal when looking up the order.

21. What options do providers have if their review request does not meet medical necessity criteria?

Providers can contact Carelon to request a peer-to-peer discussion at any time before or after the determination. When there is a request for a peer-to-peer consultation, Carelon will make an effort to transfer the call immediately to an available Carelon physician reviewer. When a physician reviewer is not available, Carelon will offer a scheduled call back time that is convenient for the provider. Carelon's physicians with expertise in the specialty will discuss the case with the ordering physician or their representative Physician Assistant or Nurse Practitioner.

After the provider receives notice of a denial, the provider has two options for further review at Carelon:

- Providers may ask for reconsideration on a denied case for a period of up to 30 calendar days for commercial members for BCCC and 10 calendar days for BCCHP Medicaid members. This gives the provider an opportunity to provide additional information to one of our physician reviewers who will have the authority to overturn the denial.
- Providers may ask for provider documentation review (PDR) on a denied Rehabilitation (PT, OT, ST) case that required clinical documentation upload for a period of up to 10 calendar days for BCCHP Medicaid members. This gives the provider an opportunity to upload new clinical documentation that might impact the request's determination.
- If the provider chooses not to pursue a post determination option with Carelon, the other option is to submit an appeal. Appeals for commercial cases should be submitted to Carelon; appeals for BCCC and BCCHP Medicaid cases should be submitted to BCCC and BCCHP (details on how to file an appeal are included in the denial letters).

22. How do providers submit appeals for commercial cases to Carelon?

Providers should follow directions on how to submit an appeal as outlined in the denial letter. Appeals can be submitted for commercial cases in one of the three ways:

- Fax the appeal to 888-583-1005; please put "Attention: Appeals" on the cover sheet
- Call the Carelon contact center at the numbers listed in Questions 15 of the previous section.
- Mail the appeal to the following address:

  Carelon Medical Benefits Management
  Attention: Preauthorization Department HCSC Appeals
  540 Lake Cook Road
  Deerfield, IL 60015

23. How does the provider know when a peer-to-peer is needed?

When a case pends for review, it will go to an "In Progress" status. Carelon will call the ordering provider requesting a call- back for peer-to-peer review, should it be required.

24. Can providers request an urgent authorization?

Yes, providers should call Carelon using the specific phone number indicated for the health plan with urgent requests. Urgent commercial requests will receive a response as follows:

- BCBS Illinois, BCBS Oklahoma and BCBS Texas – within 72 hours of receipt
- BCBS Montana: within 48 hours of receipt
- BCBS New Mexico: within 24 hours of receipt
- Urgent BCCC Medicaid requests will receive a response within 24 hours of receipt.
- Urgent BCCHP Medicaid requests will receive a response within 24 hours of receipt.

25. How are reviewed requests communicated?

Carelon will include an order ID for reviewed procedures on an Order Request Summary in the provider portal, whether the order request was initiated in the provider portal or by phone. An approval letter will be sent to the member and the applicable physician(s) and/or sites.

Note: an order ID number will not be given if the request is denied. Denials are communicated by letter to the provider and member with appeals rights included as an attachment to the letter.

26. Should providers include the authorization number on the claim?

Please follow the specific health plan's claim filing guidelines.

27. How will the approval of services be communicated to providers?

Once the office staff has entered the required information into the provider portal, an immediate decision (in many of the cases) will be rendered. When your authorization is approved, the Order Request Summary will show:

- The name of the approved procedure(s) and the included CPT codes
- The quantity of CPT codes approved, applicable for genetic testing and radiation therapy only
- The number of approved visits (units for Rehabilitation PT, OT, ST)
- A valid date range
- An Order ID number

If Carelon needs more information to review the case, the system will indicate that it is pending review or "In Progress." Carelon clinical reviewer will call the ordering provider's office to obtain clarification or additional clinical records

28. How will the approval of services be communicated to the health plan?

The included CPT codes and quantity for each code will be shared with the health plan.
To avoid claims denials, physicians should use the provider portal to verify that an authorization is in place before the treatment is administered. Providers can share the Order Request Summary with their billing department; a copy may be printed, or a PDF may be created in the provider portal

29. How can providers appeal the denial decision?

Provider and first level member appeals are managed by Carelon for commercial cases. Denial letters include appeal instructions for both providers and members. For Medicaid members, member and provider appeals are managed by BCCC and BCCHP.

30. What does the Carelon order number look like?

Carelon's order numbers are nine (9) numeric digits for each of the care categories, with the exception of Rehabilitation (PT, OT, ST) where order numbers are alpha numeric.

31. How long is an order number valid?

Upon approval, Carelon will provide the ordering physician with an order number. Durations of the prior authorization are as follows:

Advanced Imaging and Cardiology	Order numbers are valid from the day the case was entered +**60 calendar days.** **For BCCHP,** Order numbers are valid from the day the case was entered +**6 months.**
Sleep Medicine	Order numbers are valid for **60, 90, or 365 calendar days** The timeframe is dependent on the sleep study, titration study, or equipment supplies selected within the case.
Joint and Spine Surgery	Order numbers are valid for **60 calendar days** from the date of service
Pain Management	Order numbers are valid for **10 business days** from the date of service
Genetic Testing	Order numbers are valid **90 calendar days** after the sample collection date.
Medical Oncology	Order numbers are valid from the dispensing date to the maximum treatment end date + 3-week cushion
Radiation Therapy	Order numbers are valid from the Planning Start Date until Treatment Start Date +90 Days NOTE: Radiopharmaceuticals may have valid date ranges longer than 90 days based on treatment so review the valid date ranges on the order summary; Xofigo - timeframe extended to cover the entire 6 months of treatment, Lutathera - timeframe extended to cover the entire 8 months of treatment and Azedra - timeframe extended to cover the entire 3 months of treatment.
Rehabilitation (PT, OT, ST)	BCCHP: Order numbers are valid for the timeframe listed on the order summary, which is based on an attestation of chronicity. Acute plans of care will have a valid timeframe of the service date plus six months. Chronic plans of care will have a valid timeframe of the service date plus twelve months.

32. What if the provider needs a longer treatment period than is indicated on the order request?

The order reflects an expected maximum duration of treatment. If treatment continues beyond the approved number of days, provider should call the Carelon Contact Center. Depending on the circumstances, Carelon will update the date range on the original prior authorization or issue a new prior authorization. Note: Providers are not able to update the date range of an existing prior authorization via provider portal.

Most users will find the most efficient way to track the order request time period is to save the order summary page that you receive from the Provider Portal, after completing your initial order in the patients' charts, so

that the information to report continuation of treatment is easily available.

33. How can providers determine whether an order number has been obtained for a member?

Ordering and servicing providers are able to contact Carelon to determine whether an order number has been obtained for a member.

34. How do I view order requests submitted by other users in my practice?

Provider portal users can view prior authorization requests entered by their colleagues if they use common provider identifier (TIN or NPI) for their requests. This eliminates the potential of entering duplicate requests by individuals in the same group. User profiles are linked by the provider identifier for a specific health plan, so each user should follow the steps below to add additional health plans and corresponding provider identifiers.

- Log in to www.providerportal.com.
- Click on *Manage Your Physician List*.
- Click on the *Manage Group List* button in the bottom right-hand corner.
- Then select a health plan from the drop-down menu.
- Enter in the requested provider identifier.
- Repeat steps for other health plans, as necessary.

35. Can providers enter referrals (waivers) for benefit exceptions via Carelon?

Yes, ordering physician will have an ability to attest to member having obtained a referral (waiver) for benefit exception from the health plan. BCBSIL Commercial members will not enter referral (waivers). Carelon will capture referrals/waiver information in the provider portal or via the call center as part of the case intake.

36. How will Carelon incorporate the required New Mexico Uniform Prior Authorization form?

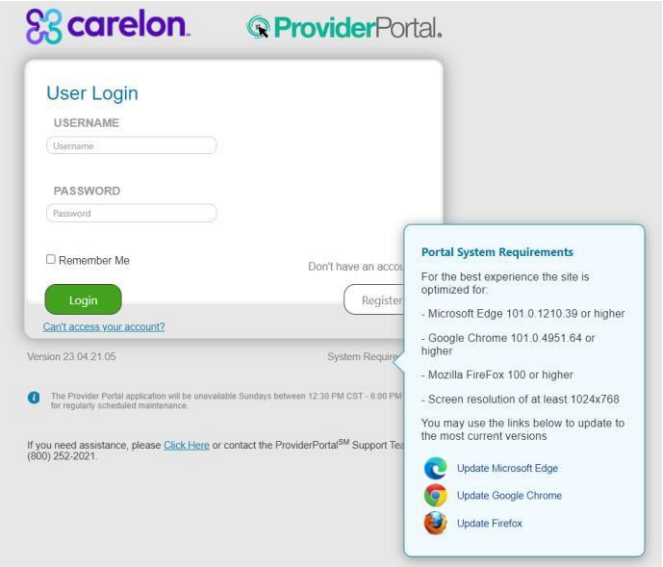
After selecting a New Mexico member in the provider portal, providers will have the ability to select the New Mexico Uniform Prior Authorization form by checking the box on the order type selection screen. After checking the box,

providers will be presented with a hyperlink to access the New Mexico Uniform Prior Authorization form. Once the form is completed by the provider, it can be uploaded as an attachment in the ProviderPortal. Please make sure you include all requested information, including contact name, phone number, and fax number. Carelon will contact you if more information is needed to process the request.

37. How can I learn more about the prior authorization programs?

Please visit here to view Carelon Clinical Appropriateness Guidelines.

About the *Provider*Portal



1. How do I access the *Provider*Portal?

Access provider portal at www.providerportal.com If you need assistance, please contact the provider portal support team at 800-252-2021, 7:00 am-6:00 pm CST

2. How do I register for the *Provider*Portal?

To begin the registration process, select the Register button located on the provider portal's home page at www.providerportal.com. Complete the required fields under the Details, Login Information and Health Plan Details tabs. Once registered, the user will receive an email requesting they validate their email to continue the registration process.

If you are already registered and need to add additional health plan(s) to your profile, please contact provider portal support team at 800-252-2021 (available weekdays between 7am-6pm CST) or via email here.

3. How often do I need to change my password to access *Provider*Portal?

You will be prompted to change your password every 90 days.

4. How can I look up prior authorization for a member?

To view the details of a prior authorization you will need to log into the provider portal and select *Check Order Status*. Select the member's Health Plan, Order Type and Search Type. After selecting *Find Order*, the *Order Request Summary* will display.

5. Can I look up prior authorizations for a member for all care categories at once?

Prior authorizations for a member cannot be looked up for all care categories at once. During the search process, the user will be prompted to select one care category/order type.

6. How can I look up letters that were sent to member/provider?

Letters for advanced imaging, cardiology, sleep, joint and pain surgery, pain management, genetic testing and radiation therapy can be accessed under the UM Mailbox located under Reference Desk. To search, select Health Plan, Order Type and Search Method. After selecting Find, search results will display. To view a letter, select the blue hyperlink. Letters for Rehabilitation (PT, OT, ST) requests can be accessed within the case itself in the letters section.

7. How can I enter a PSMNR/Post Claim Clinical Appropriateness (PCCA) review case?

If you have access to initiate a PSMNR request, you will have the option to select Start Your Request Here once logged into the provider portal. Note: PSMNR will not be permitted for BCCC and BBCHP Medicaid members.

8. Why is a Duplicate Order notification displayed on Order Request?

This notification will appear when a similar request is on file or the dates from one order to another overlap. A Carelon clinician will review these cases to verify no duplicate is being requested.

9. What if the provider is not available in the *Provider*Portal?

When locating a provider in the provider portal, you can search the following ways:

- Search for a servicing provider by facility name. Note: If you cannot find the facility you are looking for or the facility is showing as out of network, please search for and select the physician's last and first name as the rendering provider.
- Search by entering physician last name {space} physician first name in facility name field OR
- Search by NPI

If your provider is not available for selection, click Submit a Facility button to add a provider. These cases will be transferred to Carelon for further review.

10. What should providers enter as the date of service for the treatment?

The date of service is the actual date the treatment, or testing date for genetic testing, is likely to begin (cannot administer before that date).

11. Why is the physician showing as Out-of-Network?

If you believe your provider is in-network, check with your Network Provider representative at the health plan to see that your provider is entered into the system as in-network. Health plans send provider files to Carelon weekly and member files nightly.

12. Does Carelon handle out-of-network provider requests?

Yes, Carelon manages prior authorization requests for in network and out of network providers.

13. Can both ordering and servicing providers request prior authorizations for patients?

Yes, provider portal users registered under either the ordering or servicing provider roles are able to submit authorizations on the ProviderPortal for advanced imaging, cardiology, sleep, radiation therapy, musculoskeletal therapies.

Users registered as servicing providers only will not be able to request prior authorizations for genetic testing, joint and spine surgery, or pain management services.

*If the ordering provider selection is not available for your provider portal user profile, it may be due to the specialty of the provider on behalf of whom you are submitting prior authorization request. Please contact Carelon with any questions.

14. When submitting a request, can I select any provider record as the ordering or servicing provider?

There are specific provider specialty or designation restrictions for the Sleep Medicine, Genetic Testing, Joint Surgery, Spine Surgery, Pain Management programs.

For example: Ordering Providers must be individual practitioners, not facilities. Certain provider types (e.g., midwives) are not able to place prior authorization requests. Each program has its own provider specialty restrictions. Please contact Carelon with any questions.

15. Can both ordering and servicing providers view required authorizations for patients?

Yes, users registered under either the ordering or servicing provider roles are able to view authorizations on the provider portal. Pending Requests: Providers can check the status of pending requests by selecting the member in the provider portal. All requests entered by the provider (approved, denied and pending) will display. To check order status, please follow these steps:

1. Log in to www.providerportal.com
2. Click on *Check Order Status*
3. Select the member's health plan
4. Select the *Order Type*
5. Enter the Member ID # and Name/DOB (or pending Order Number, only available for Musculoskeletal Therapies requests)
6. Click *"Find This Order"* button

In addition, providers can set up their User Profile to receive emails from Carelon when order status changes. An email is sent to the provider alerting them that the status of the order has changed (e.g., when status changes from pending to approved or denied).

16. What do the Case Status notifications on the Order Summary indicate?

Case Status indicates the overall determination of the request submitted for Carelon review:

- **In Progress/Open** – case is pending Carelon clinical review. The request will be reviewed by a Carelon clinician, including Carelon MD, if necessary, to clarify/collect additional clinical information via phone call to the provider's office. Peer-to- peer may be offered to gather additional clinical information to evaluate the request against medical necessity criteria.

    - Non-urgent commercial cases may pend for up to 15 business days and 5 calendar days for BCCHP Medicaid members. *Note: Timeframes vary by health plan and employer group.*

    - Urgent cases may pend for up to 72 hours for commercial members and up to 24 hours for BCCC and BCCHP members, giving the provider an opportunity to supply the missing information.

- **Completed/Closed** – Case has been reviewed by Carelon, and an order number has been given.

- **Authorized** –Requests requiring Carelon approval has/have been authorized.

- **Non-Authorized** – requests requiring Carelon approval do not meet medical necessity criteria and has not been authorized. The entire case is denied.

- **Multiple Decisions Rendered/Mixed Outcome** – The primary modality on the request has been approved, however the boost and/or associated treatments requested do not meet for medical necessity and are denied. This is applicable to Joint and Spine Surgery, Pain Management, Radiation Therapy, and Rehabilitation. This is not applicable to Advanced Imaging, Cardiology, Sleep Medicine, or Genetic Testing.

- **Voluntarily Cancelled** – the provider's office canceled/withdrew the case, following submission.

- **Not Reviewed/Error Entry** – the case was withdrawn (i.e., accidentally entered, duplicate case entry) prior to submission.

- **Duplicate** - the case was identified as a duplicate due to it being previously submitted.

17. What if the provider cannot find the procedure on the *ProviderPortal*?

For Advanced Imaging, Cardiology, Sleep, Joint and Spine Surgery, Pain Management, Radiation Therapy and Rehabilitation (PT, OT, ST), only procedures managed by Carelon can be submitted for review.

For Genetic Testing, providers can manually add a genetic test by entering the test name, CPT codes associated with the test, and, in some cases, the genes associated with the test.

If the provider selects a procedure or enters a code that is not managed by Carelon, the provider will receive a message notifying them it is not part of the Carelon program and to contact the health plan. To help find the diagnosis in the provider portal, providers may call Carelon Contact Center at the numbers listed in Questions 15 of the previous section or contact the health plan directly to verify if prior authorization is required.