Capital BlueCross

Preauthorization Program

Traditional, Comprehensive, PPO

To receive the highest level of benefits it is sometimes necessary to obtain preauthorization for services.

SERVICES REQUIRING PREAUTHORIZATION

The following services, regardless of whether they are performed as an inpatient or outpatient, require preauthorization:

- All non-emergency inpatient admissions including acute care, long-term acute care, skilled nursing facilities, rehabilitation hospitals and mental health care and substance abuse treatment facilities, including partial hospitalization. Emergent admissions require notification within 48 hours;
- Non-emergent air and ground ambulance transports;
- Behavioral health (mental health care/substance abuse) - intensive outpatient programs (Behavioral health phone numbers are listed on the member's ID card);
- Diagnostic assessment and treatment for autism spectrum disorder;
- Bio-engineered or biological wound care products.
- Category IDE Trials;
- Clinical Trials (including cancer related trials);
- Durable medical equipment (DME), orthotic devices and prosthetic appliances for all purchases and repairs greater than or equal to $500 dollars. All DME rental items that are on the preauthorization list, regardless of price per unit, require preauthorization;
- Enhanced external counterpulsation (EECP)
- All testing for genetic disorders except; standard chromosomal tests, such as Down Syndrome, Trisomy, and Fragile X, and state mandated newborn genetic testing;
- Home health care;
- Home infusion therapy;
- Hyperbaric Oxygen Therapy (non-emergent);
- Intraocular injection for retinal pathology when performed in a facility;
- All potentially investigational and reconstructive/cosmetic therapies and procedures;
- Laser treatment of skin lesions
- Office surgical procedures that are performed in a facility, including, but not limited to:
  - Arthrocentesis;
  - Aspiration of a joint;
  - Colposcopy;
  - Electrodessication condylomata (complex);
  - Excision of a chalazion;
  - Excision of a nail (partial or complete);
  - Enucleation or excision of external thrombosed hemorrhoids
  - Injection of a ligament or tendon;
  - Oral surgery;
  - Pain management (including facet joint injections, trigger point injections, stellate ganglion blocks, peripheral nerve blocks, SI joint injections, and intercostals nerve blocks);
  - Proctosigmoidoscopy/flexible Sigmoidoscopy;
  - Removal of partial or complete bony impacted teeth (if a benefit);
  - Repair of lacerations, including suturing (2.5 cm or less);
  - Vasectomy;
  - Wound care and dressings (including outpatient burn care)
- Outpatient surgeries - All potentially reconstructive/cosmetic and investigational surgeries/procedures;
- Outpatient rehabilitation therapies including physical medicine, occupational therapy, respiratory therapy and manipulation therapy. Pulmonary rehabilitation programs;
- Sleep Studies for the diagnosis and medical management of obstructive sleep apnea syndrome
- Specialty Medical Injectable Medications
- Transplant evaluation and services. Preauthorization will include referral assistance to the Blue Quality Centers for Transplant network if appropriate.

Preauthorization requirements do not apply to services provided by a hospital emergency room provider. If an inpatient admission results from an emergency room visit, notification must occur within forty-eight (48) hours or two (2) business days of the admission. If the hospital is a participating provider, the hospital is responsible for performing the notification. If the hospital is a non-participating provider, the member or the member's responsible party acting on the member's behalf is responsible for the notification.

HOW TO OBTAIN REQUIRED PREAUTHORIZATION

The member's identification card will show if preauthorization is required before receiving the listed services or supplies.

If preauthorization is required, members should present their identification card to their health care provider when medical services or supplies are requested. The member's participating provider will be asked to provide medical information on the proposed treatment to Capital's Clinical Management Department by calling **1-800-471-2242**.

If members use a non-participating provider or a BlueCard participating provider, it is their responsibility to obtain preauthorization. Members should call Capital's Clinical Management Department toll-free at **1-800-471-2242** to obtain the necessary preauthorization. A non-participating provider may call on the member's behalf. However, it is ultimately the member's responsibility to obtain preauthorization.

Capital's Clinical Management Department will notify the member's health care provider and the member of the authorization or denial of the requested procedures, services, and/or supplies within fifteen (15) days after Capital receives the request for preauthorization. Capital may extend the fifteen (15)-day time period one (1) time for up to fifteen (15) days for circumstances beyond Capital's control. Capital will notify the member prior to the expiration of the original time period if an extension is needed. The member and Capital may also agree to an extension if the member or Capital requires additional time to obtain information needed to process the member's preauthorization.

Preauthorization of elective admissions and selected services should be obtained at least seven (7) days prior to the date of service. Maternity admissions require notification within two (2) business days of the date of admission.

PREAUTHORIZATION OF MEDICAL SERVICES INVOLVING URGENT CARE

Special rules apply to preauthorization of urgent care medical services.

If the member's request for preauthorization involves urgent care, the member or the member's provider should advise Capital of the urgent medical circumstances when the member or the member's provider submit the request to Capital's Clinical Management Department. Capital will respond to the member and the member's provider no later than seventy-two (72) hours after Capital's Clinical Management Department receives the preauthorization request.

Members who are dissatisfied with an adverse preauthorization determination regarding an urgent care claim may submit an appeal. Urgent care appeals may be submitted orally by contacting Capital's Customer Service Department, toll-free, at **1-800-962-2242**. Capital will notify the member's health care provider and the member of the outcome of the appeal via telephone or facsimile no later than seventy-two (72) hours after Capital receives the appeal.

PREAUTHORIZATION PENALTY

When a procedure is not preauthorized when required, there may be a preauthorization penalty.

If the member presents his/her ID card to a participating provider in the 21-county area and the participating provider fails to obtain or follow preauthorization requirements, the allowable amount will not be subject to reduction.

When members undergo a procedure requiring preauthorization and fail to obtain preauthorization (when responsible to do so), benefits will be provided for medically necessary covered services. However, in this instance, the allowable amount may be reduced by the dollar amount or the percentage established in the Certificate of Coverage.

PLEASE NOTE: This listing identifies those services that require preauthorization only as of the date it was printed. This listing is subject to change. Members should call Capital at **1-800-962-2242** (TDD number at **1-800-242-4816**) with questions regarding the preauthorization of a particular service.

This information highlights the standard Preauthorization Program. *Members* should refer to their *Certificate of Coverage* for the specific terms, conditions, exclusions and limitations relating to their *coverage*.