2023

Utilization Management Updates

Presented by BlueCross BlueShield of Tennessee for members of the Tennessee Hospital Association
February 28, 2023

Commercial

Authorization Submission Options and Requirements

Options:

- **Online**
  - -- Register for the web via **Availity.com**
  - -- 24/7 access
  - -- Automated approvals on certain guidelines when criteria is met
  - --Need assistance? Call: (423) 535-5717, option 2
- **Phone**
  - --1-800-924-7141
- **Fax** –Forms located at:
  - -- https://provider.bcbst.com/tools-resources/documents-forms
  - -- Select appropriate form based on services being requested

- **Commercial Authorization Requirements**
  - -- https://www.bcbst.com/docs/providers/Commercial-Prior-Auth-Requirements.pdf

  Additional UM Resources:
  - -- https://provider.bcbst.com/tools-resources/authorizations-appeals

Medical Policy Criteria Hierarchy

Commercial

1. Evidence of Coverage (EOC) / Benefit Plan
2. BlueCross Medical Policy (https://www.bcbst.com/mpmanual/!SSL!/WebHelp/mpmprov.htm)
3. BCBST UM Guidelines (http://www.bcbst.com/providers/UM_Guidelines/default.htm)
4. MCG Guidelines (Not used for pharmaceutical/specialty medication agents)
5. If applicable, a Vendor Program Policy (e.g., eviCore) is used by the vendor in the absence of a BlueCross or MCG document addressing a given topic.

Durable Medical Equipment:

1. BlueCross Medical Policy
2. MCG Guidelines
3. DMEMAC (Durable Medical Equipment Medicare Administrative Contractor)

Note: All requests/claims for oral pharmaceutical / specialty medication agents are adjudicated using the PBM's policies.

BlueCare

1. Contractor Risk Agreement (CRA) / TennCare Rules
2. BCBST Medical Policy (MPM)
3. MCG Guidelines
4. Center for Medicare / Medicaid Services (CMS) / Local Coverage Determinations (LCD's)
   - Durable Medical Equipment Only
5. Clinical Judgment

MedAdvantage

- The law (Title 18 of the SSA);
- The Regulations (Title 42 Code of Federal Regulations (CFR) parts 422 and 476);
- National Coverage Determinations (Pub 100-03 of the Internet Only
- http://www.cms.gov/mcd/search.asp;
- MA Benefit Policy Manual (IOM 100-02);
- Local Coverage Determinations http://www.cms.gov/mcd/search.asp;
- Coverage guidelines in Interpretive Manuals (Internet Only Manual (IOM), sub manuals Pub 100-04 Claims Processing, Pub 100-08 Program Integrity Manual, Pub 100-10 QIO manual, Pub 100-16 Medicare Managed Care Manual;
- Durable Medical Equipment Medicare Administrative Contractor (DMEMAC)
- https://www.cms.gov/medicare-coverage-database/indexes/contacts-durable-medical-equipment-medicare-administrative-contractor-index.aspx?bc=AgAAAAAAAAAA%3d%3d&);
- Program Safeguard Contractor (PSC) local coverage determinations;
- MCG criteria;
- BlueCross Utilization Guidelines (http://www.bcbst.com/providers/UM_Guidelines/);
- BlueCross Medical Policy;
- Supplemental Benefits and Limitations as outlined in the Member's Evidence of Coverage;
- U.S. F.D.A Approved Indications for Medications;
- Other major payer policy and peer reviewed literature.

Cite Guideline Transparency (CGT)

- Cite Guideline Transparency allows providers, members, prospective members, etc., access to view the MCG guidelines and is located at the following link: https://bcbst.access.mcg.com/index

- Simply go to the site, accept Terms and Conditions, obtain an access code via Text, Email, or Telephone. Choose the contact method of choice and enter the information (email address, phone number, etc.

- Once the access code is received and entered, access to review MCG guidelines is available.

DRG Threshold Reviews

Clinical is requested every 8 days if patient remains inpatient

- Helps coordinate discharge planning needs
- Referrals to Transition of Care
- Medical necessity review is not done during the threshold review process. Cases that hit outlier/stoploss are subject to a medical necessity review (based on facility contract)

Discharge Dates

- One comprehensive list per facility per day.
- May incorporate all lines of business on same list with indicators for the line of business.
- Coversheets should include:
  1. Facility name
  2. NPI number

Options:

Fax: 423-591-9501

Email: dcdates@bcbst.com

Web: Entries for individual cases

Timeliness Guidelines

- Elective (planned) admissions must be authorized at least 24 hours before admission.
- Notification must occur within two (2) business days of an emergent admission.
- Notification of conversions from observation to inpatient should occur within one (1) business day.
  - 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.

After-Hours Needs

- 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 management on call.
  - Prior authorizations available via the web 24/7.

Adverse Determinations

- **Reconsideration (Prior to or during services)**
  - 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 Appeals

- Provider Reconsiderations and Appeals forms with instructions are located at the following link

- https://provider.bcbst.com/tools-resources/authorizations-appeals

Helpful guide

http://www.bcbst.com/docs/providers/Provider_Reconsideration_and_Appeals_presentation_REVISED_1_30_17.pdf

Reconsideration process map

http://www.bcbst.com/docs/providers/Reconsideration_Mapping_12_9_2016.pdf

Appeals process map

http://www.bcbst.com/docs/providers/Appeal_Mapping_12_14_2016.pdf

Transition of Care (TOC) Programs

- 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.
- 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

MedAdvantage

Medicare Advantage

Medicare Advantage Authorization Submission Options

MedAdvantage

Authorizations may be submitted through these modalities:

- **Online via Availity** ***(preferred method)***
  - 24/7 access
  - https://www.bcbst.com
- **Phone**
  - Monday – Friday, 9 a.m. to 6 p.m. ET
  - **1-800-924-7141**
- **Fax**
  - **1-888-535-5243**
  - MA specific fax forms can be found on the BCBST.com website @ https://provider.bcbst.com/tools-resources/documents-forms
- **Clinical Vendor related authorizations**
  (High-Tech Imaging and Specialty Rx)
  - **Call 1-888-258- 3864**

Medicare Advantage Inpatient Services

All inpatient admissions require a prior authorization and are reviewed for medical necessity.

Elective services are planned procedures and require an authorization to be submitted at least 24 hours prior to admission.

Emergency (unplanned) admissions require notification within twenty-four (24) hours or the next business day after services have started.

Observation stays do not require prior authorization though any associated elective service may require an authorization. Any conversion to an inpatient admission will require a notification within 24 hours of the admission.

Reference prior authorization lists, and additional information can be found at https://www.bcbst.com/providers/utilizationmanagement.page

Lack of timely notification is considered non-compliant and may result in a denial. Retrospective reviews are rendered under specific circumstances:

- Member did not provide Medicare Advantage insurance information at the time of service.
- Member ID card was not issued.
- There was a coverage issue.
- The Provider submits a valid copy of fax transmittal as evidence that an attempt to meet prior authorization timeframe requirements was made.

Medicare Advantage Clinical Decision Structure

MedAdvantage

The Centers for Medicare and Medicaid Services (CMS) requires all MA plans to use the following hierarchy in medical necessity determinations:

- The law (Title 18 of the SSA);
- The Regulations (Title 42 Code of Federal Regulations (CFR) parts 422 and 476);
- National Coverage Determinations (Pub 100-03 of the Internet Only
- http://www.cms.gov/mcd/search.asp;
- MA Benefit Policy Manual (IOM 100-02);
- Local Coverage Determinations http://www.cms.gov/mcd/search.asp;
- Coverage guidelines in Interpretive Manuals (Internet Only Manual (IOM), sub manuals Pub 100-04 Claims Processing, Pub 100-08 Program Integrity Manual, Pub 100-10 QIO manual, Pub 100-16 Medicare Managed Care Manual;
- Durable Medical Equipment Medicare Administrative Contractor (DMEMAC)
- https://www.cms.gov/medicare-coverage-database/indexes/contacts-durable-medical-equipment-medicare-administrative-contractor-index.aspx?bc=AgAAAAAAAAAA%3d%3d&);
- Program Safeguard Contractor (PSC) local coverage determinations;
- MCG criteria;
- BlueCross Utilization Guidelines (http://www.bcbst.com/providers/UM_Guidelines/);
- BlueCross Medical Policy;
- Supplemental Benefits and Limitations as outlined in the Member's Evidence of Coverage;
- U.S. F.D.A Approved Indications for Medications;
- Other major payer policy and peer reviewed literature.

Medicare Advantage Concurrent Reviews

Concurrent Reviews

Initial admission requests are currently spanned for five days. Services needed past the initial date span will require an extension request. This allows for collaboration of care between facilities, providers and members to ensure appropriate levels of care and best health outcomes. Medicare Advantage has several supports to assist members.

- Social Workers
- Case Managers
- Nurses
- Pharmacists
- Behavioral Health
- Physicians

Assistance is readily available to support facility CM / discharge planners. We appreciate collaboration with discharge plans, discharge summaries, and discharge dates.

Discharge dates can be submitted

- One comprehensive list per facility per day
- May incorporate all lines of business on same list indicating the line of business
- Facility name and NPI number need to be included on the cover sheet

Submit to any of these:
Fax: 423-591-9501
Email: dcdates@bcbst.com
Web: Entries for individual cases

Medicare Advantage Post-Acute Inpatient Services

MedAdvantage

Post-acute inpatient services are a covered benefit for Medicare Advantage members. These include Long-Term Acute Care Hospitals (LTACH), Inpatient Rehabilitation Facilities (IRF), and Skilled Nursing Facilities (SNF). All these services require prior authorization and are reviewed for medical necessity based on CMS guidelines.

Clinical information, including the evaluation and plan of care, are needed for these reviews. The Skilled Nursing Fax form is a great guide to ensure all information is submitted. It can be found at **http://www.bcbst.com/docs/providers/16PED78364.pdf**

Requests may be submitted the same as acute care requests and are now able to be submitted via the web.

Members facing discharge barriers, who have unrealistic discharge ideas, or complex family situations may benefit from additional services through the Population Health team. This team is comprised of nurse case managers, social workers, behavioral health clinicians, and dieticians who can help coordinate care for members, caregivers, and providers. Please make Population Health referrals by calling **1-800-611-3489.**

Medicare Advantage Turnaround Times

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Turnaround times (TAT):

CMS turnaround times take precedence over any other review entity.

- Standard review: 14 days
- Post Service review: 30 days
- *Expedited (Urgent) review: 72 hours

MD must attest that applying the standard timeframe for making a determination would seriously jeopardize the life, or health of the member, or their ability to regain maximum function. If the member is already receiving the care, the request is non-urgent.

While we have standard TAT requirements outlined, the Medicare Advantage GOAL is to complete requests as timely as possible to best meet our member needs.

Medicare Advantage Readmissions

MedAdvantage

Readmission Quality Program

The Centers for Medicare & Medicaid Services (CMS) recognizes the growing challenge of readmissions for the Medicare population. Medicare Advantage plans are held to an All-Cause Readmissions measure that differs from the Original Medicare Hospital Readmissions Reduction Program. Because of this, BlueCross has developed a same or similar diagnosis readmissions program to more closely align with how CMS evaluates our Plan.

Readmissions are categorized in two ways, 48-hour readmissions and 3-31 day readmissions. The details are provided in the Provider Administration Manual. Some of the highlights are:

The date of discharge from the original acute inpatient admission (called the Index Admission) is the start of the readmission window.

This readmission program is limited to same or similar diagnoses between the Index Admission and the Readmission and has a modifiable cause as determined by a plan Medical Director. Observation stays and member in active chemotherapeutic treatment are exempt from the program.

Only readmissions that occur as an acute inpatient admission to the same or similar facility, or facility operating under the same contract are included in this program.

3-31 day readmissions have the admissions bundled together and pay the higher weighted DRG.

48 hour readmissions will not be reimbursed regardless of the readmission length of stay. This penalty is because CMS considers a short-term readmission for the same or similar diagnosis to generally be due to a process failure in discharge planning or due to the Member not being clinically stable for discharge at the time of the original discharge.

Medicare Advantage Peer to Peer

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Peer-to-Peer discussion (MD to MD)

A peer-to-peer occurs BEFORE a written appeal has been submitted.

One (1) peer-to-peer conversation and one (1) level of **provider** appeal are permitted during this process. This is followed by binding arbitration.

Peer-to-peer may be scheduled even if, the member has discharged.

To initiate and schedule call 1-800-924-7141

Medicare Advantage Provider Appeal

MedAdvantage

Provider Appeals:

These are considered Post-Service medical necessity appeals.
If the service has not been rendered *you may appeal on behalf of the member by following the member appeal process.*

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.

Please reference your provider Determination Notice for instructions on your appeal options and how to submit a provider appeal.

Requests for a Provider Appeal must be received in writing **within 60 days from date on the Determination Notice**

Provider appeal determinations are made within 30 days from receipt of the appeal.

Medicare Advantage Member Appeal

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Member Appeals:

These are considered **Pre-Service** medical necessity 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.

Reference: Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance

Member Appeal review timeframes depend on the member's needs :

- 72 hours for expedited appeals with a statement that supports the need for an urgent review
- 30 days for standard pre-service appeals

A 14-day extension can be granted if:

- 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, and the requestor is notified before the case is closed.

Medicare Advantage Population Health

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Population Health Management Team

- Fully integrated, multi-disciplinary medical and behavioral care team
- Licensed clinicians with case management certification
- Specialized support (Social Work, Dietitian, Clinical Pharmacist, Nurses)
- Health Navigators

Targeted Interventions

- Identification of barriers affecting adherence with the plan of care
- Coaching and support for behavior change, goal setting, and medication adherence
- Education and resources to empower patients through increased knowledge of their health condition
- Coordination with primary care, specialists and community resources
- Assistance with navigating complex health situations

Call 1-800-611-3489

Medicare Advantage Contacts

MedAdvantage

Contact Information for escalated issues:

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Bethany Young, BSN, RN
Manager In-Patient Services
(423)-208-4842
Bethany_Young@bcbst.com

Cynthia Garmany, BSN, RN
Manager Out-Patient Services, Correspondence, Provider Appeals
(423)-535-7730
Cynthia_Garmany@bcbst.com

LaShonda Swoope, BSN, RN
Director of MedAdvantage Medical Management
(423)-535-3102
Lashonda_Swoope@bcbst.com

Janice Holland, RN, CCM
Manager Population Health
(615) 348-3062
Janice_Holland@bcbst.com

Ryan Scherer
Manager Operations and Care Management
(423) 298-7906
Ryan_Scherer@bcbst.com

BlueCare Tennessee

BlueCare

Our Goal

Assure the provision of medically necessary and appropriate health care to all BlueCare and TennCare*Select* members in the most cost-effective manner within the TennCare benefit structure.

Inpatient Admission

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 from when the inpatient admission order is determined.

- 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)

- **Standard requests (non-urgent)** – A decision is made within 14 calendar days of the request.

Note: Even though inpatient requests are considered non-urgent, they're internally assigned an urgent priority. This means acute care requests are generally worked on within 1-2 business days.

- **Expedited requests (urgent)** – A decision is made within 72 hours of the receipt of the request.

Note: Requests are considered urgent when following the standard time frame could seriously jeopardize the member's life or health. When a member is currently in an acute-care setting, they're getting the care they need, so the request is non-urgent.

- **Retrospective requests (the service has already been provided)** – A decision is made within 30 calendar days of the request.

Contacts for Submitting Requests

Urgent

- Online: bcbst.com
- Call:
  - BlueCare
    1-888-423-0131
  - TennCare*Select*
    1-800-711-4104
  - CHOICES
    1-888-747-8955

Non-Urgent

- Online
- Call
- Fax:
  BlueCare or TennCare*Select*
  1-800-292-5311

Why is BlueCare Different?

- The Division of TennCare 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).
- 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 reading level.

Components of Medical Necessity

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.

I've Received a Denial. What are My Options?

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 the Appeals Processing Unit (APU) formally known as 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 60 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.
  - filed by phone only through BlueCare Tennessee Utilization Management

Member Appeal Submission Information

- Members (or their representatives) have 60 calendar days from the date on the denial notice to submit an appeal to the Division of TennCare.
  - To continue existing services, a request for continuation of benefits must be filed within 10 calendar days.

- Providers can appeal on behalf of the member by filing an appeal with the Appeals Processing Unit if services have not been rendered. These are considered member appeals.
    - Members must include a signed consent form for the provider to submit an appeal on the member's behalf

  - Phone: TennCare Member Medical Appeals: 1-800-878-3192
  - Fax: TennCare Member Medical Appeals: 1-888-345-5575
  - Mail: TennCare Member Medical Appeals
    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: 24 hours for expedited, or 72 hours for reconsideration 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 requesting relief of billing when the member receives bills from a health care provider.

Member Appeals - Useful Links

- Division of TennCare– Home Page:

http://www.tn.gov/tenncare

- TennCare Rules:

http://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-13.20180116.pdf

- TennCare Medical Appeal Form:

https://www.tn.gov/tenncare/members-applicants/how-to-file-a-medical-appeal.html

Provider Appeal Submission Information

- Expedited Provider Appeals for denied services:

  Call Utilization Management
  - BlueCare: 1-888-423-0131
  - TennCare*Select*: 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 Appeals (888) 357-1916
  - Mail: BlueCare Tennessee

    Attention: BlueCare/TennCare*Select* Provider Appeals Manager

    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 Provider Dispute 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 submit according to our Provider Dispute Resolution Procedure described in the BlueCare Tennessee Provider Administration Manual http://www.bcbst.com/providers/manuals/BCT_PAM.pdf.

BlueCare Tennessee Appeals Contacts

- Rafielle Freeman, MSL, RN, BSN, CPHQ
  Director, Quality Improvement
  - (423) 535-7302
  - Rafielle_Freeman@bcbst.com
- Leanne Rodgers, MSN, RN, CCM, CPHQ, CPPS
  Manager, Quality of Care Oversight & Appeals
  - (423) 535-8024
  - Leanne_Rodgers@bcbst.com
- Pat White, LSSGB
  Manager, Member & Provider Appeals
  - (423) 535-7671
  - Pat_White@bcbst.com

  LeeAnn Steed, MBA, BSN, RN, PAHM
  Manager, Member & Provider Appeals
  - (423) 535-8020
  - M_Steed@BCBST.com

Discharge Planning

- Objective: Collaborate with facilities, providers and members to transition our members to appropriate levels of care for better health outcomes.

- A dedicated UM Discharge Planning nurse 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.

Discharge Planning Actions

- The DC Planning nurse is responsible for:
  - Monitoring daily census and referrals for assigned hospital.
  - 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 care management as needed.
  - Obtain hospital discharge plan for follow-up after discharge.

SNF, Rehab and LTAC Authorizations

- Skilled Nursing Facility stays aren't covered services for any BlueCare Tennessee members, and Inpatient Rehab isn't a covered service for members age 21 and older. Authorization requests for these services are always pended for physician review.

- These services may be approved on a case-by-case basis if the service is a cost-effective alternative to a covered service.

- Please submit SNF, Inpatient Rehab and LTAC service requests by web, phone (1-888-423-0131) or by faxing the Skilled Nursing Facility and Inpatient Rehabilitation Fax Form to (423) 591-9398. You can find the form online at: bluecare.bcbst.com/providers/forms/

Hospital and MCO Discharge Planning 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 programs.

Unique BlueCare Services

- Population Health
  - Integrated Care Management
  - Care Coordination
- MLTSS programs
- Enhanced Respiratory Services
- DCS Collaboration
- Home Visits
- Transportation
- Behavioral Health Integration

BlueCare Tennessee UM Contacts

Contact Information for escalated issues:

Kate McLendon, BSN, RN
Manager Inpatient and Outpatient Services
(423)-535-4351
Kate_McLendon@bcbst.com

Kelly Allison, RN
Manager DME and Home Health Services
(423)-535-7527
Kelly_Allison@bcbst.com

Amber Casteel, BSN, RN, CCM
BlueCare Director of Clinical Effectiveness
(423)-535-4201
Amber_Casteel@bcbst.com

Questions?

THANK YOU