# Utilization Management and Prior Authorizations

Why does Bright Health have a utilization management program?

Bright Health has a utilization management program to promote evidence-based, cost-effective use of healthcare resources, and to identify and connect members to care management programs.

## What is prior authorization?

Prior authorization determines coverage on certain services and products by confirming in-network status of the provider or facility and/or medical necessity based on clinical review. Not all prior authorizations require a medical necessity review.

### When is a prior authorization required?

- **In-network inpatient admission**
- **In-network labor/delivery**
- **In-network transplant services**
- **Out-of-network medical and behavioral admissions**
- **Out-of-network medical and behavioral services**

### What are the levels of review when I submit a prior authorization?

Service requests based on CPT code either require a network validation review (Level 1) or medical necessity review (Level 2).

**Network Validation (Level 1)**

Level 1 reviews seek to confirm that services are being delivered by in-network providers in an in-network setting.

**Medical Necessity Review (Level 2)**

Level 2 reviews seek to complete a network validation, ensure that the service being requested is a covered service per member’s benefit, and pass a medical necessity review.

Please reference the Payer Spaces tab on Availity.com for a comprehensive list of services that require prior authorization.
What is the turnaround time for prior authorization decisions?

### Utilization Review Timelines (Calendar Days) — Individual & Family Plans

<table>
<thead>
<tr>
<th>Category</th>
<th>Standard</th>
<th>Urgent</th>
<th>Concurrent</th>
<th>Retrospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama, Arizona, Ohio, Tennessee, Florida, Nebraska, Oklahoma</td>
<td>15 days</td>
<td>72 hours</td>
<td>24 hours</td>
<td>30 days</td>
</tr>
<tr>
<td>Colorado</td>
<td>5 days</td>
<td>less of 2 business days/72 hours</td>
<td>24 hours</td>
<td>30 days</td>
</tr>
<tr>
<td>North Carolina</td>
<td>3 business days</td>
<td>3 business days</td>
<td>3 business days</td>
<td>30 days</td>
</tr>
<tr>
<td>South Carolina</td>
<td>2 business days</td>
<td>2 business days</td>
<td>1 business day</td>
<td>2 business days</td>
</tr>
</tbody>
</table>

### Utilization Review Timelines (Calendar Days) — Medicare Advantage

<table>
<thead>
<tr>
<th>Category</th>
<th>Pre-Service Standard</th>
<th>Expedited/Urgent</th>
<th>Concurrent</th>
<th>Retrospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS Standard</td>
<td>14 days</td>
<td>72 hours</td>
<td>24 hours (URAC)</td>
<td>30 days</td>
</tr>
<tr>
<td>With extension</td>
<td>28 days</td>
<td>17 days</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

How do I submit a prior authorization?

**Online**
Electronically via Availity.com

**Phone**
Prior authorization forms, which include the number to submit via phone are located on Availity.com under the Payer Spaces tab and on BrightHealthPlan.com/Provider.

**Fax**
Prior authorization forms, which include the number to submit via fax are located on Availity.com under the Payer Spaces tab and on BrightHealthPlan.com/Provider.

How do I submit a pharmacy prior authorization?

**Online**
Electronically via Surescripts or CoverMyMeds.

**Phone**
Pharmacy prior authorization forms, which include the number to submit via phone, as well as a complete drug formulary, can be found online on Availity.com under the Payer Spaces tab and on BrightHealthPlan.com.

**Fax**
Pharmacy prior authorization forms, which include the number to submit via fax, as well as a complete drug formulary, can be found online on Availity.com under the Payer Spaces tab and on BrightHealthPlan.com.