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**

Please reference the Payer Spaces tab on Availity.com for a comprehensive list of services that require prior authorization.

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.

bright SM HEALTH

What is the turnaround time for prior authorization decisions?

Utilization Review Timelines (Calendar Days) — Individual & Family Plans				
Category	**Standard**	**Urgent**	**Concurrent**	**Retrospective**
Alabama, Arizona, Ohio, Tennessee, Florida, Nebraska, Oklahoma	15 days	72 hours	24 hours	30 days
Colorado	5 days	less of 2 business days/72 hours	24 hours	30 days
North Carolina	3 business days	3 business days	3 business days	30 days
South Carolina	2 business days	2 business days	1 business day	2 business days

Utilization Review Timelines (Calendar Days) — Medicare Advantage				
Category	**Pre-Service Standard**	**Expedited/Urgent**	**Concurrent**	**Retrospective**
CMS Standard	14 days	72 hours	24 hours (URAC)	30 days
With extension	28 days	17 days	N/A	N/A

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.

bright SM HEALTH