Effective June 15, 2020

Changes to Utilization Review Requirements

Changes are a result of continued developments with COVID-19

Overview of Changes to Bright Health's Utilization Review Requirements

In March 2020 Bright Health suspended a subset of authorization requirements to support Care Partners in the care and safety of members during the COVID-19 pandemic.

- On May 1, 2020, Bright Health reimplemented authorization requirements for select services as providers began to perform non-emergent medical and surgical procedures.
- **On June 15, 2020, Bright Health will reimplement the final phase of authorization requirements for Individual and Family Plan (IFP) and Medicare Advantage (MA) lines of business.**

Individual and Family Plan (IFP): Effective 06/15/2020, authorization requirements include the following:

- **Network Validation:** Providers not contracted (out-of-network) with Bright Health need to submit an authorization for ALL services and procedures.
- **Inpatient and Post-Acute Care Stays:** ALL inpatient and post-acute care stays require authorizations for payment. COVID-19 related stays will have limited concurrent review.
- **Outpatient Services:** CPT/HCPC codes that require an authorization are updated on our website, brighthealthplan.com and on Availity.com.
    - Except for a limited subset of CPT/HCPC codes, contracted (in-network) providers are no longer required to submit an authorization for services/procedures that previously required a Level 1 (network validation) review.
    - **For this limited subset of CPT/HCPC codes, authorization review will ONLY consist of a network validation review.**

Medicare Advantage (MA): Effective 06/15/2020, authorization requirements include the following:

- **Network Validation:** Providers not contracted (out-of-network) with Bright Health need to submit an authorization for ALL services and procedures.
- **Hospital and Post-Acute Care Inpatient Stays:** ALL inpatient and post-acute care stays will return to normal utilization review process using appropriate criteria to determine medical necessity and length of stay and require authorization for payment. COVID-19 related stays will have limited concurrent review.
- **Outpatient Services:** CPT/HCPC codes that require an authorization are updated on our website, brighthealthplan.com and on Availity.com.
    - Contracted (in-network) providers are no longer required to submit an authorization for services/procedures that previously required a Level 1 (network validation) review.

As we continue to support you and our members, Bright Health will provide updates that reflect any additional changes to our Utilization Management review requirements.

What Providers Need to Know - Changes to Authorization Requirements

1. What are the authorization requirements for any COVID-19-related services and procedures?

Bright Health has suspended authorization requirements and/or is auto-approving authorizations that are COVID-19 related. It is important on the authorization request to be clear that the services/procedures being requested are COVID-19 related. Follow the appropriate CDC guidance on diagnosis coding for the dates of services, linked below.

- CDC guidance on diagnosis coding for dates of service prior to April 1, 2020
- CDC guidance on diagnosis coding for dates of service beginning April 1, 2020
  - ICD-10-CM Official Coding and Reporting Guidelines
  - ICD-10-CM Code for the 2019 Novel Coronavirus (COVID-19)
- CMS Definitions of COVID-19 Related Codes

2. What changes has Bright Health made to its utilization review requirements for services and procedures NOT related to COVID-19?

	Individual and Family Plan (IFP) For 06/15/2020	Medicare Advantage (MA) For 06/15/2020
Inpatient Services - Hospital Inpatient, LTAC, and Inpatient Acute Rehabilitation	Inpatient Hospital: Emergent admissions notification within 48 hours of admission. Planned admissions require prior authorization. LTAC, Inpatient Acute Rehabilitation: prior authorization required before admission. Admissions will be reviewed for medical necessity on the normal concurrent review cycle using MCG or other appropriate criteria.	Inpatient Hospital: Emergent admissions notification within 48 hours of admission. Planned admissions require prior authorization. LTAC, Inpatient Acute Rehabilitation: prior authorization required before admission. Admissions will be reviewed for medical necessity on the normal concurrent review cycle using NCD/LCD or other appropriate criteria.
Outpatient Services	CPT/HCPCs codes that require an authorization are updated on our website at Brighthealthplan.com and on Availity.com. Except for a limited subset of CPT/HCPC codes, contracted (in-network) providers are no longer required to submit an authorization for services that previously required a Level 1 (network validation) review.	CPT/HCPCs codes that require an authorization are updated on our website at Brighthealthplan.com and on Availity.com. Contracted providers are no longer required to submit authorization requests for services that previously required a Level 1 (network validation) review.
Network Validation	Network validation is completed for ALL authorization requests for the servicing provider and facility. For the limited subset of CPT/HCPC codes, authorization review will be a network validation review.	Network validation is completed for ALL authorization requests for the servicing provider and facility. Contracted (in-network) providers do NOT need to submit an authorization for services that previously required Level 1

	Individual and Family Plan (IFP) For 06/15/2020	Medicare Advantage (MA) For 06/15/2020
	- Contracted (in-network) providers do NOT need to submit an authorization if Place of Services (POS) is 11 – office	(network validation) review.
Non-Contracted (out-of-network) Providers and/or Facilities	ALL providers and facilities not contracted (out-of-network) with Bright Health ***are required*** to submit an authorization request for any services and/or procedures provided out of network. This includes when a contracted (in-network) provider performs the service/procedure at a non-contracted facility. Authorization request must be submitted due to the non-contracted facility. Redirection activities will be completed for non-contracted/out-of-network authorization requests.	ALL providers and facilities not contracted (out-of-network) with Bright Health ***are required*** to submit an authorization request for any services and/or procedures provided out of network. This includes when a contracted (in-network) provider performs the service/procedure at a non-contracted facility. Authorization request must be submitted due to the non-contracted facility. Redirection activities will be completed for non-contracted/out-of-network authorization requests.
Skilled Nursing Facilities (SNF) Home Health Service	Contracted (in-network) providers are required to submit an authorization request for medical necessity review: - SNF on day 8 of the admission - Home Health after a combined total of 6 visits of SNV, HHA, PT/OT/ST is met ALL non-contracted (out-of-network) SNF and Home Health Service providers need to submit an authorization prior to admission and/or initiation of service.	Contracted (in-network) providers are required to submit an authorization request for medical necessity review: - SNF on day 8 of the admission - Home Health Service on day 8 of admission ALL non-contracted (out-of-network) SNF and Home Health Service providers need to submit an authorization prior to admission and/or initiation of service.

Note: A list of services that require authorization is accessible on Availity.com and BrightHealthPlan.com.

3. **What can I do if I have an approved authorization, but the procedure and/or service was cancelled due to COVID-19 and closure of health care system, to perform the elective and/or non-essential services?**
   Verify the service end date of the authorization. If the non-emergent procedure and/or service date of service is beyond authorization end date, Bright Health will extend the approved authorization beyond the original service end date for an additional 60 days. This will be completed through the claim's payment process. You do not need to submit any additional forms and/or paperwork.

   Providers may also leverage the Change Request Form located on Availity.com or Brighthealthplan.com when needing to change other fields on an approved authorization. Select fields that can be changed include:
   - ✓ Servicing Provider or Facility Name
   - ✓ Dates of Service for an approved procedure and/or service
   - ✓ Number of days/units/visits needed for a specific procedure and/or service

4. **What can providers expect when calling Bright Health's Utilization Management (UM) team?**
   As we see Health Care systems again providing elective and preventive services, Bright Health is seeing an increase in inquiries for members needing care. ***Bright Health encourages you to use our Provider Portal at Availity.com to submit authorizations or submit them via fax.*** Please leverage non-telephonic submission on the Availity portal or via fax, and if you still need to speak with a Utilization Management team member, a team member will assist you.

5. **What happens to a submitted authorization request when an authorization is not required?**
   Providers will receive a notification letting them know that an authorization is not needed. As a reminder, authorizations are not a guarantee of payment as services are subject to member eligibility and benefit coverage.

6. **What happens if providers receive a no authorization required notice between 5/1/20-6/15/20 for services to be rendered after 6/15/20 (IFP & MA?)**
   Providers will need to review the prior authorization lists on our Provider Portal, Availity.com, and if services require authorization on 6/15/20 and after, an authorization will be required. If no authorization is received, claim payment will be denied.

7. **What is the best way to submit an authorization?**
   BEST: Request online via the Provider Portal, Availity.com
   Benefits to submitting authorizations electronically include:
   - Receive **immediate confirmation** that a request was submitted successfully.
   - Receive a **reference number and current status** for each authorization submitted.

   ACCEPTABLE: Request via Fax
   Fax Number for Prior Authorization Requests - 1-833-903-1067
   Fax Number for Concurrent Review Requests - 1-833-903-1068

8. **What is the best way to verify status of an authorization?**
   Visit the Provider Portal, Availity.com to verify authorization status of authorizations submitted electronically or via fax. Authorizations submitted via fax will take 24-48 hours to show authorization status in Availity.com.