March 19, 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

As a result of COVID-19, there is increased use of healthcare services and resources across the nation. Bright Health is focused on supporting our Care Partners and Providers in the care of our members to keep members safe. As a result, we are temporarily relaxing select authorization requirements for a cohort of services, effective as of March 1, 2020 and until further notice.

As we continue to support you and our members navigating the health care system today, Bright Health will provide ongoing updates that reflect any additional changes to our Utilization Review requirements.

A Message from CMS about Elective Procedures

On March 18, 2020, CMS published recommendations to limit all non-essential planned surgeries and procedures, including dental, until further notice. This guidance is subject to change. More information can be found here and at cms.gov.

What Providers Need to Know About Temporary Changes to Authorization Requirements

1. **What changes has Bright Health made to its utilization review requirements?**
   Bright Health has temporarily suspended authorization requirements on select services summarized below:
   - **Hospital Inpatient Stays:** We will auto-approve the first 4 days of an inpatient admission and initiate concurrent review after day 4. Providers still need to submit authorizations for inpatient care.
   - **Outpatient Services:** We will temporarily suspend Level 2 (medical necessity) authorization review for select services: i.e.; maternity, hospice, select Durable Medical Equipment (DME), outpatient hospital, radiation treatment, select imaging/laboratory services and select screening/diagnostic services. At this time providers do not need to submit authorizations for these select services.
   - **Network Validation:** We will temporarily suspend Level 1 (network validation) authorization review for services requiring a Level 1 authorization review. At this time providers do not need to submit authorizations for these services. Please remember that services provided out of network may be more expensive for your patients.

   Note: List of services where changes to authorization requirement will be accessible on Availity.com and BrightHealthPlan.com.

2. How long will the relaxed authorization requirements be in place?
   Relaxed authorization requirements will be in place until further notice and are subject to change. Bright Health is committed to monitoring the progression of COVID-19 and will continue to communicate changes to authorization requirements in a timely manner through our Care Partners, fax notification, Availity.com and BrightHealthPlan.com.

3. What can providers expect when calling Bright Health's Utilization Management (UM) team?
   Just as providers are seeing an increase in members needing care and potential staffing constraints, Bright Health is seeing increased inquiries while working to provide optimal service. ***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.

4. What happens to a submitted authorization request when the authorization is no longer required?
   - Providers will receive a notification letting them know that an authorization is not needed.
   - For inpatient admissions, authorization approval will automatically be generated.

   As a reminder, authorizations are not a guarantee of payment as services are subject to member eligibility and benefit coverage.

5. 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

6. 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.

7. Where do I go for more information about Bright Health's Utilization Management program?
   Visit Bright Health's Provider Portal, Availity.com and BrightHealthPlan.com.

*** Please note that these changes to utilization review are temporary in response to COVID-19 and will continue to be monitored as COVID-19 evolves.*