Effective May 1, 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. As providers begin to schedule non-emergent medical and surgical procedures, Bright Health will reimplement authorization requirements over the next two months for the Individual and Family Programs (IFP) and Medicare Advantage (MA) lines of business.

Individual and Family Programs (IFP): The reimplementation of authorization requirements will be a phased approach.

- Effective 05/01/2020:
    - **Hospital and Post-Acute Care Inpatient Stays:** Inpatient initial/concurrent and prior authorization will return to normal utilization review process using MCG criteria to determine medical necessity and length of stay. This includes long-term acute care (LTAC), acute inpatient rehabilitation, and skilled nursing facility. Inpatient stays related to COVID-19 will continue to follow a "notification only" process.
    - **Outpatient Services:** Authorization required for a subset of Level 1 (network validation) and Level 2 (medical necessity) CPT/HCPC codes where authorization requirements were suspended in March 2020.
    - **Network Validation:** Providers not contracted with Bright Health (out of network) will need to submit an authorization for all services and procedures.
- Effective 06/01/2020:
    - Return to normal utilization management authorization requirements. Remaining authorization requirements for Level 1 (network validation) and Level 2 (medical necessity) CPT/HCPC codes that were suspended in March 2020 will be reimplemented beginning 06/01/2020.

Medicare Advantage (MA): The reimplementation of authorization requirements will occur on 06/01/2020.

- All changes to authorization requirements and initial/concurrent review that were suspended and/or relaxed in March 2020 will remain in effect till 05/31/2020. This includes non-contracted (out of network) providers not needing an authorization to provide services to members. Medical necessity review still applies on a subset of codes (i.e. surgery) so please validate before providing services
- Additional communication with more details will be released in the upcoming weeks for the authorization changes that will be reinstated on 06/01/2020.

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

What Providers Need to Know - Changes to Authorization Requirements

For all COVID-19 related services and procedures, Bright Health is suspending authorization requirements and/or auto-approving. It must be clear by the CPT/HCPC or diagnosis code that the services/procedures requested are COVID-19 related.

1. 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 05/01/2020	Medicare Advantage (MA) For 05/01/2020
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 criteria.	Auto-approve the first 7 days of an admission and check-in with provider on Day 8 and continue process until discharge. Notification required upon admission. Auto approval issued upon notification.
Outpatient Services	Level 2 (medical necessity) authorization review requirements reimplemented for majority of MRIs and CT scans. Providers will need to submit an authorization for claims payment. Select services will continue to have relaxed medical necessity review through 05/31/2020: i.e.; maternity, hospice, select Durable Medical Equipment (DME), and select screening/diagnostic services.	Continue with suspension of medical necessity review for select services provided through 05/31. No authorization is required for a subset of the following services; I.e.; maternity, hospice, select Durable Medical Equipment (DME), outpatient hospital, radiation treatment, select imaging/laboratory services and select screening/diagnostic services.
Network Validation (Level 1 authorization)	Subset of services will require a Level 1 (network validation) authorization review. Providers will need to submit an authorization for claims payment.	No authorization is required for services usually requiring a Level 1 (network validation) authorization review.
Non-Contracted Providers and Facilities	ALL providers and facilities not contracted with Bright Health ***are required*** to request an authorization for any services and/or procedures provided out of network.	Providers and facilities not contracted with Bright Health may provide services to members without an authorization. - Medical necessity review requirements still apply to a subset of codes. Please validate before providing services.
Skilled Nursing Facilities (SNF) Home Health Service - IFP ONLY	Level 1 (network validation) authorization is required prior to admission. Medical necessity review will occur: - SNF – on day 8 of admission - Home Health – after 6 total visits (SNV, HHA, or PT/OT/ST)	Approve first 7 days of admission and check-in with provider on Day 8 and continue process until discharge. Notification required upon admission. Auto approval will be issued upon notification.

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

2. **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

3. **How long will Bright Health take to reimplement the relaxed/suspended authorization requirements?**
   Bright Health will reimplement suspended authorization requirements over the next two months for both Individual and Family Plans (IFP) and Medicare Advantage (MA). 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.

4. **What can providers expect when calling Bright Health's Utilization Management (UM) team?**
   As we see Health Care systems begin to provide elective and preventive services, Bright Health will see 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 the authorization is no longer 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 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

7. **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.