



## FREQUENTLY ASKED QUESTIONS

### Authorizations

#### **What is a dollar threshold for durable medical equipment (DME)?**

Prior authorization requirements for DME can vary per plan. For this reason, it is important to verify eligibility and benefits.

#### **How can I check authorization requirements for out-of-state members?**

To check authorization requirements for out-of-state members, you can use the BlueCard® Prior Authorization Lookup Tool located on [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) or by calling the BlueCard® eligibility line at 800-676-BLUE (2583).

#### **What methods can be used to obtain prior authorization?**

Authorization requests can be submitted through My Insurance Manager<sup>SM</sup>. After selecting the appropriate option, you will be routed to the Cohere Health platform to initiate the request. Note: Cohere Health is just the platform used for requesting authorization. All clinical decisions are made by the health plan.

#### **What information is required when requesting prior authorization?**

When requesting prior authorization, the following information should be included:

- Patient details – Name, ID Number, and Date of Birth
- Service details – CPT/HCPCs codes with correct units, diagnosis codes, and MD orders
- Location details – Name of facility and rendering physician, address, and Tax ID/NPI
- Contact details – Call back number and fax number
- Date of service
- Clinical documentation – Including how long the problem has been occurring, attempted treatments, conservative medications, studies (e.g., labs, imaging, assessments, etc.)

#### **What are the guidelines for authorizations?**

The general guidelines for authorizations include:

- Submit elective requests prior to rendering services
- Submit requests once and allow time for review
- Services must be covered under the member's plan
- Member must have active coverage at the time of request

- Submit a notification of emergency admission within 24 to 48 hours of admission
- Mark requests as urgent ONLY when they are urgent

### **What can I do if an authorization request is denied?**

If authorization is denied, you can request an appeal or a peer-to-peer review. Peer-to-peer reviews are available if:

- A medical necessity adverse decision was received, along with health plan denial
- Requested within two business days of the denial for inpatient or continued stay requests or five days for all other denials
- Requested prior to an appeal

### **What partners or organizations are used for authorizations?**

Partners or organizations that manage authorization for certain benefits and plans include:

- **Avalon Healthcare Solutions**
  - Manages authorizations for lab services in the office, outpatient facility and independent laboratory.
- **Companion Benefit Alternatives (CBA)**
  - Manages authorization for behavioral health services such as psychological testing, behavioral health program admissions and repetitive transcranial magnetic stimulation.
- **Evolent**
  - Manages authorizations for radiation oncology, advanced radiology and musculoskeletal care.
- **Integrated Home Care Services (IHCS)**
  - Manages authorizations for DME in the home setting, home health and home infusion services for our Medicare Advantage plans.
- **OptumRx (MBMNow)**
  - Manages authorizations for certain specialty drugs.



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