Update on Authorization Processes

In December, Florida Blue implemented a new system to support our utilization management process. As a result of the migration to the new system, we have experienced unforeseen issues with authorization requests and authorization inquiry status submissions. This has resulted in a higher volume of calls to our authorization precertification line than we expected. That, coupled with the normal increase of calls for new membership in January, has extended our telephone hold times. We sincerely apologize for any inconvenience this is causing you or your patients. Please be assured we continue working aggressively to resolve these issues in an expedited manner.

The following list summarizes issues/action items currently being addressed:

- <u>Fewer visits/days and date spans than previously authorized (examples include radiation oncology, chemotherapy and physical therapy</u>) - A system fix was implemented on February 3, 2015, to correct this issue and authorization requests are now being approved at the appropriate unit and time levels.
- <u>Concerns related to phone accessibility</u> - Due to high call volumes, providers are experiencing longer than usual phone hold times and, in some cases when an extremely high call volume occurs, blocked access to phone lines. Florida Blue continues to work to address this issue through increased staffing and other means. We continue to make our automated tools available through Availity®[1] and Blue Express and expect providers to attempt automated entry before requesting authorization telephonically.
- <u>Regulatory turnaround time for an authorization is 10-14 days for non-urgent authorizations depending on the product type</u> - Providers experiencing delays to patient care or needing to escalate a specific scenario should continue to escalate by sending an email to JIVAAuthResearch@bcbsfl.com. This mailbox should be used as your primary escalation point and will be active until March 31, 2015. All non-authorization related inquiries will be returned to the submitter unanswered with a standard response. Unresolved issues can also be escalated to your network management representative. Please note that providers should submit the certificate of medical necessity by fax if one exists for services pended in the authorization process.
- <u>Florida Blue identified impacted claims that are denying for no prior authorization on file and will continue reprocessing these claims per employee benefit plans until such time we are comfortable all impacted claims have been addressed</u> - Because of the ongoing issues and Florida Blue's commitment to our members and providers, Florida Blue will honor the Availity *reference* number in addition to existing authorization information for claims processing. This means that on an interim basis, claims will not deny for failure to obtain an authorization if you receive an error message, as long as you have an Availity *reference* number documenting the attempt. There is no need to contact Florida Blue at this time to obtain an authorization number if you have the Availity reference number. Since this

reference number is <u>not</u> an authorization, claim payments will remain subject to the member's eligibility and benefits (which can still be verified through Availity) and we reserve the right to perform post-service audit of medical records, if needed. Florida Blue will now honor the Availity reference number (as outlined above) through February 28, 2015. We anticipate the current issues to be resolved before this date. We will continue to monitor progress, and if needed, will revisit the end date, if issues continue.

- <u>The IVR process is not recognizing the Availity reference number and is disconnecting the call</u> - It was clarified that the transaction ID should be used when using the IVR and not the reference number. The transaction ID is currently working for inpatient services only. Florida Blue is researching this issue to determine why outpatient transaction IDs continue not to function properly.

- <u>The authorization update function is currently not working correctly</u> - Providers should continue to call to update an existing authorization. Duplicate authorizations should not be entered.

- Any transaction entered in the authorization entry screen is considered a request for a preservice medical necessity review. Currently, the system will accept authorization requests for all product lines and services regardless of whether or not an authorization is required. Providers should utilize the member eligibility screen for authorization requirements versus entering an authorization request in the entry screen.

- <u>Authorization request is automatically pended for medical review</u> – An authorization request is automatically pended and authorization results will be available in Availity when completed. Requests for additional information will be mailed or faxed to the provider within 48 hours. The overall timeline for authorization approval may be longer than before, but still within regulatory timelines. Providers should consider appropriate timeframes when scheduling services.

You will be notified via the Availity transaction response once our existing issues are corrected.

We thank you for your patience and truly appreciate the service you provide to our members.