of Tennessee
1 Cameron Hill Circle
Chattanooga, Tennessee 37402
bcbst.com

Medical Necessity, Prior Authorization Time Frames and Enrollee Responsibilities

BlueCross BlueShield of Tennessee provides services to help manage your care including performing prior authorization of certain services to ensure they are medically necessary, concurrent review of hospitalization, discharge planning, low-risk condition management, care coordination, complex and chronic care management, and specialty care programs such as transplant case management. BlueCross also provides medical policies.

BlueCross does not make medical treatment decisions under any circumstances. You may always elect to receive services that do not comply with BlueCross's care management requirements or medical policy, but doing so may affect the coverage of such services.

Prior Authorization

Some covered services must be authorized by BlueCross in advance in order to be paid at the maximum allowable charge without penalty. Obtaining prior authorization is not a guarantee of coverage. All provisions of the policy must be satisfied before coverage for services will be provided.

Services that require prior authorization include, but are not limited to:

1. Inpatient hospital stays (except maternity admissions);
2. Skilled nursing facility and rehabilitation facility admissions;
3. Certain outpatient surgeries and/or procedures;
4. Certain specialty drugs;
5. Certain prescription drugs;
6. Advanced radiological imaging services;
7. Certain durable medical equipment (DME);
8. Certain prosthetics;
9. Certain orthotics;
10. Certain genetic testing;
11. Non-emergency Air Ambulance transport;
12. Certain musculoskeletal procedures (including, but not limited to, spinal surgeries, spinal injections, and hip, knee and shoulder surgeries);
13. Other services not listed at the time of publication may be added to the list of services that require prior authorization. Visit bcbst.com or call Member Service at the number on the back of your Member ID card to find out which services require prior authorization.
    Network providers in Tennessee will get prior authorization for you. Network providers outside of Tennessee are responsible for obtaining prior authorization for any inpatient hospital (facility only) stays requiring prior authorization. In these situations, the member is not responsible for any penalty or reduced benefit when prior authorization is not obtained.

You are responsible for obtaining prior authorization when using network providers outside Tennessee for physician and outpatient services, or payments may be reduced or services denied.

If prior authorization is required and not obtained, and services are medically necessary, benefits may be reduced for network providers outside Tennessee. If the reduction results in liability to you greater than $2,500 above what you would have paid had prior authorization been obtained, then you may contact our consumer advisors to have the claim reviewed and adjusted and the reduction will be limited to $2,500. Services that are not determined to be medically necessary are not covered.

Prior Authorization Request Time Frames

Scheduled admissions/services must be authorized at least 24 hours prior to admission. Emergency inpatient admissions/services must be authorized within 2 business days of an admission. We typically decide on requests for prior authorization for medical services within 72 hours of receiving an urgent request or within 15 days for non-urgent requests.