PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

May 1, 2019

Update: Appeals Policy for no Prior Authorization Effective June 3, 2019

The information in this Bulletin replaces Provider Bulletin P35-19, which was published on April 1, 2019. Clarification has been made to state "Medically emergent services do not require a PA. Medical emergent services are defined in the Reimbursement Policy – Evaluation and Management – Medical Emergency."

In order to best support the coordination of care for our members, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will implement a new appeals policy related to the existing requirement of a prior authorization (PA) submission. The policy will go into effect with dates of service beginning June 3, 2019, for all providers across the following lines of business:

- Commercial (All except FEP)
- Medicare (Advantage, Platinum Blue)

When a PA is required for a service, procedure or item, the provider must submit the clinical information in advance to Blue Cross via the Availity Portal (beginning May 1, 2019, see Bulletin P27-19). The Utilization Management team reviews the clinical information and determines if the request meets medical necessity criteria based on the current Medical Policy and accepted standards of care. PAs must be completed before the service is rendered. Medically emergent services do not require a PA. Medical emergent services are defined in the Reimbursement Policy – Evaluation and Management – Medical Emergency.

If a PA is not submitted prior to the service, the claim will be denied for lack of prior authorization and the provider will be held liable. **The claim denial will be administrative and cannot be appealed for medical necessity.**

Certain circumstances may make obtaining a PA prior to rendering the service difficult. Retrospective clinical review will be considered by Blue Cross and eviCore (specialty UM vendor, see Bulletin P25-18) for up to 14 days after the date of service and prior to the claim being submitted in consideration of scenarios such as after-hours urgent situations. Retrospective authorization requests can be submitted online at Availity.com.

Note: Retrospective authorization requests will **not** be accepted for chemotherapy – reviewed by eviCore. Genomic and Molecular Lab services will be accepted for up to 60 days from the date of specimen collection - reviewed by eviCore.

Exceptions/Exemptions:
If a claim is administratively denied for no PA, an appeal for medical necessity will not be accepted, but an **administrative appeal may be submitted for limited situations**. These exceptions are listed below, and must be supported by submitted documentation:

- Blue Cross is the subscriber's secondary coverage and PA is not required (e.g. Medicare is primary).
- Another insurance company is identified as the payer and a claim was submitted to the other payer within the timely filing guidelines with Blue Cross subsequently identified as the patient's primary coverage.

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- The patient is identified as the payer and is billed for the service, but later the patient reports Blue Cross coverage for the date of service. Appeals for this exception must include notes about accounts receivable actions. For example, include notes documenting calls with the Blue Cross Service Center or notes that the subscriber was sent to collections within 120 days after date of service.
- The subscriber was enrolled in the plan retrospectively, after the service was provided.
- A previously prior-authorized service unexpectedly changed for medically necessary reasons, or it was determined that an unforeseen additional service was necessary.
- Extenuating circumstances beyond the control of the rendering provider or facility that make it impractical to obtain or validate the existence of a precertification of coverage prior to rendering the service (e.g. natural disaster or Availity outage).

Other exemptions from this policy are:

- Emergency and urgent care services that are performed in the emergency room do not require prior authorization and will be considered at the in-network benefit level
- Maternity delivery admissions when level of care is delivery only
- Inpatient admissions
- Medicaid lines of business
- Federal Employee Program (FEP) members
- PT/ST/OT/Chiropractic – beginning June 3, 2019, Blue Cross will no longer require providers to submit prior authorizations for these services (See Provider Bulletin P34-19, for additional information)

New PA Lookup Tool via Availity:
Blue Cross is currently working with Availity to develop a new online tool that will help providers quickly determine if a PA is required for any service, streamlining the process and creating less administrative burden. If an authorization is required, users can easily redirect to the Authorization tool on Availity to complete the request. The tool will be ready for use prior to Appeals Policy for No PA go live. Additional information will be included in upcoming provider communications and trainings.

Prior Authorization Requirements:
Prior Authorization Lists are updated to reflect current PA requirements on the effective date of the management change, including applicable codes. To access Prior Authorization Lists for all lines of business, go to providers.bluecrossmn.com:

- Under Tools & Resources, select “Medical Policy”, and read/accept the Blue Cross Medical Policy Statement
- Select the “+” (plus) sign next to “Utilization Management” to access the current Prior Authorization Lists.

Summary:

[NOT NEW] If PA is submitted via Availity Portal prior to service:	**[NOT NEW] If PA is submitted after service was rendered:**	**[NEW] If PA is not submitted within 14 days of service and prior to claim submission:**
PA is reviewed by UM, and then approved or denied. If approved, the service claim will process according to the member’s benefits.	Retrospective PA submission is possible for up to 14 days from date of service, and before a claim is submitted. PA is reviewed by UM, and then approved or denied. If approved, the service claim will process according to the member’s benefits.	Claims review is completed to confirm whether a required PA was submitted. If PA has not been received, claim payment will be denied. No appeals for medical necessity will be accepted – this is an administrative denial, not a medical necessity review.

Questions? If you have questions, please contact provider services at **(651) 662-5200** or **1-800-262-0820**.