PROVIDER BULLETIN
PROVIDER INFORMATION

November 1, 2019

Updated Bulletin: Alignment of Start Date for Prior Authorization Requests

The information in this document clarifies content published on October 1, 2019, in Provider Bulletin P23R1-19, adding the following clarifications:

- The eviCore healthcare process for retrospective review for commercial and Medicare Advantage subscribers is not impacted by this policy change. EviCore healthcare will continue to accept retrospective review requests when PA cannot be obtained prior to the service being rendered for the following programs: DME, Radiology, Cardiology, Musculoskeletal, and Sleep Management.
- EviCore healthcare will also continue to date authorizations for Radiation Therapy and Molecular and Genomic Lab as described below. This policy is not changing.

In an ongoing effort to simplify and ease provider administration related to the prior authorization processes, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be implementing changes to better align the Utilization Management process across vendors and lines of business. The following changes will be implemented for commercial (fully and self-insured and FEP) and Medicare (Medicare Advantage and Platinum Blue) subscribers for Prior Authorization (PA) requests received on or after December 1, 2019:

- PA requests that are approved will begin the date the request was received by Blue Cross or eviCore, rather than the date of determination.

  Exceptions (below is current process and will not change):
  - Radiation therapy authorizations: start date will include the initial SIM (within 14 days prior to start of radiation therapy)
  - Molecular lab authorizations: start date will include the specimen collection date (within 60 days of the molecular lab)

  Important note: The PA process is in place to determine when services meet medical necessity guidelines and are contractually eligible for coverage, prior to being rendered. Evidence based medical policy criteria and subscriber contract language are used to determine if benefits are available for the requested services. Providers who render a service that requires PA after the PA is submitted but before a determination is made are financially liable if the service is found to be not medical necessary. **Claims for denied services rendered after a PA is submitted but prior to the date of determination will be rejected and will not be billable to the subscriber.**

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- Effective December 1, 2019, Blue Cross will no longer accept requests for retrospective review for procedures, services or DME that require PA, except where specified below. There are no changes at this time to retrospective review policy for requests reviewed by eviCore healthcare or Amerigroup.

  Exception:
  - Retrospective review requests will only be accepted by Blue Cross for home health care services. When medically necessary and approved, the authorization for home health care will align with the proposed treatment plan. Retrospective review requests should only be submitted when PA cannot be done prior to the start of care and must be made prior to the date of claim submission.

Services found to be not medically necessary upon retrospective review will be denied and **rejected claims for these services will not be billable to the subscriber.**

Effective December 1, 2019:

	Commercial and Medicare (Administered by Blue Cross)	**Minnesota Health Care Programs**	**Commercial, Medicare (Administered by eviCore)**
PA Start Date for Approved Services	Date of receipt	Date of receipt*	Date of receipt
Pre-claim Retrospective Review	Limited to home care	Not available*	Limited to DME, Radiology, Cardiology, Musculoskeletal, and Sleep Management*

*No policy change

Inpatient admissions processes are not impacted by this change.

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