PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

November 2, 2020

Appeals Policy for no Prior Authorization for Minnesota Health Care Programs

In an effort to provide more consistency across lines of business, 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 January 1, 2021 for Minnesota Health Care Programs (MHCP) subscribers and is applicable to services that currently require PA.**

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 Interactive Care Reviewer (ICR) portal or by faxing the applicable form to the appropriate area. An authorization must be obtained prior to the provider performing the service. Same-day requests will be reviewed and the provider will be subject to the medical necessity determination.

Certain circumstances may make obtaining an approval prior to rendering the service difficult. Retrospective clinical review will be considered by Blue Cross 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). Pre-claim retrospective review exceptions to post-service requests are limited to radiology, cardiology and musculoskeletal due to the propensity of additional procedures potentially identified during a procedure.

Retrospective PA requests should be submitted via the applicable forms and fax numbers located here: https://provider.publicprograms.bluecrossmn.com/minnesota-provider/resources/prior-authorization

If a request is received post-service, only approved exceptions will receive a review; all others will be returned to the provider indicating that late requests are not allowed and will not be reviewed. The Utilization Management (UM) 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. If incomplete documentation is submitted, UM may request additional information to complete the review. Providers must submit the requested documentation in a timely manner or may receive a medical necessity denial. If a denial is received, the provider has 60 days to submit an appeal to the medical necessity denial with additional documentation. Medically emergent services do not require a PA.

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

Appeal exceptions/exemptions

If a claim is administratively denied for no authorization, 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 member's secondary coverage and authorization 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.
- 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 member was sent to collections within 120 days of the date of service.
- The member was enrolled in the plan retrospectively, after the service was provided.
- A previously 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 made it impractical to obtain or validate the existence of an authorization prior to rendering the service (e.g., natural disaster or Availity outage).

Other exemptions from this policy:

- Emergency and urgent care services that are performed in the emergency room do not require authorization and will be considered at the in-network benefit level.
- Inpatient admissions, including those that require pre-certification or notification, are exempt from this administrative Appeals Policy.

PA requirements

PA lists are updated to reflect current PA requirements on the effective date of the management change, including applicable codes. To access PA lists for MHCP subscribers go to:
https://provider.publicprograms.bluecrossmn.com/minnesota-provider/resources/prior-authorization

Products impacted:

- Families and Children (F&C)
- Minnesota Senior Care Plus (MSC+)
- Minnesota Senior Health Options (MSHO)
- MinnesotaCare (MNCare)

Questions?

If you have questions, please contact provider services at **1-866-518-8448**.