PROVIDER QUICK POINTS
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

April 14, 2021

Reminders Related to the Submission of Prior Authorizations and Subsequent Claims

The following are answers to frequently asked questions about the Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) prior authorization process.

What is a prior authorization?

A prior authorization is a preservice review of a specific health care service, procedure, medical drug, item or supply (health service) to determine if the health service is eligible for coverage. Contract language, medical necessity criteria, and individual needs are evaluated during the review process. All requests for services that do not meet medically necessary and appropriate criteria are reviewed through the physician peer review process. Procedure codes submitted with prior authorization requests are not assessed for coding appropriateness.

Why does Blue Cross require prior authorization?

The prior authorization process helps to promote effective, appropriate, and efficient use of medical and behavioral health care resources for our subscribers.

What procedure codes should be included with a request for prior authorization?

Submit the code that most accurately identifies the service(s) requested. Documentation in the patient's medical record must support the codes submitted.

- Prior authorization requests should only include procedure codes that require prior authorization. Codes for incidental or related services that do not require prior authorization should not be included on the prior authorization request.
- Unlisted codes should only be used if no code exists to describe the procedure, service or supply. Requests submitted with unlisted codes require a complete narrative description.

How can I support efficient and effective prior authorization review?

A medical necessity determination can only be made once all the necessary medical information is received. Providers can ensure this process is not delayed by submitting documentation from the member's medical record that supports the medical necessity of the requested health service based on the applicable medical policy criteria. The prior authorization team will contact the provider if additional information is needed. For the request to be considered for approval, it is critical that the provider return all requested information as soon as possible and before the authorization review timeframe expires.

What if the planned procedure changes after I get prior authorization?

If the procedure performed is different than the procedure approved, contact us (or the appropriate UM vendor) prior to submitting a claim and ask for the request to be updated. The updated procedure will be reviewed for medical necessity when appropriate. Note: Pre-claim retrospective review requests are generally limited to radiology, cardiology and musculoskeletal due to the propensity of additional procedures potentially identified

during a procedure. If a claim has been submitted and rejected, an administrative appeal may be allowed when an explanation of the extenuating situation is provided with the appeal request. A medical necessity review will be completed during the appeal review process.

Does an approved prior authorization guarantee payment of specific procedure codes?

Prior authorization does not in itself guarantee coverage, but notifies the provider and member that as described, the health service, device or drug meets the criteria for medical necessity and appropriateness at the time the review is completed.

- The provider submitting the prior authorization request should always verify the subscriber's coverage is active and check the subscriber's contract benefits before requesting a prior authorization.
- Claim payments are conditioned upon the provider's submission of the most appropriate billing/procedure code(s) for the service(s) performed.
- Claims for health services that are determined medically necessary and appropriate **must be coded in the most cost-effective manner when more than one coding option exists**. Submitting an incorrect or inappropriate code may result in a denial of the claim, and/or audit and recoupment.
- The member must continue to meet all applicable clinical criteria for the requested health service and is subject to audit and recoupment if the member's medical diagnosis or condition changes before the services is provided and the service or item requested is no longer medically necessary on the date of service.

What if I have additional questions?

If you have questions for a member enrolled in a Minnesota Health Care Programs (MHCP) plan, please contact provider services at **1-866-518-8448**. Please contact provider services at **(651) 662-5200** or **1-800-262-0820** for all other questions.