PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

September 11, 2015

Providers will see a change in our Prior Authorization Process for Commercial Products

Beginning with November 1, 2015 dates of service, if a provider does not obtain a required prior authorization before rendering services, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will deny claims as provider liability for lack of prior authorization. For these claims, the submitting provider will have **60** days to file an appeal. This requirement applies to all our Commercial products. This change is consistent with other Minnesota payer guidelines.

This change does not impact members that have coverage through the PMAP, MinnesotaCare, SecureBlue (MSHO), MSC+, Federal Employee Program® (FEP), Platinum Blue, Senior Gold, Basic Medicare Blue or Extended Basic Blue.

As stewards of healthcare expenditures for our subscribers, we are charged with ensuring the highest quality, evidence based care for our members. One method for doing so is through the prior authorization process. The primary purpose is to ensure that evidence based care is provided to our members, driving quality, safety, and affordability.

When a prior authorization is required for a service, procedure or item, the provider must submit the clinical information in advance to Blue Cross. The Utilization Management team reviews the clinical information and determines if the request meets medical necessity criteria based on current Medical Policy and accepted standards of care. Prior Authorizations must be completed **before** the service is rendered.

Follow these steps to determine if a procedure requires prior authorization:

1. Access the 'Provider Section' of the Blue Cross website at **providers.bluecrossmn.com**
2. Click on the 'Medical Policy' link found under 'Tools and Resources'.
3. Follow the site instructions to the active policy section and then review the pre-certification/pre-authorization lists.

Only those services on the lists require prior authorizations. Do not request prior authorization for services not on the lists. The prior authorization requirements vary between Blue Cross' Commercial plans, Minnesota Health Care Programs plans and Medicare plans; therefore, please carefully review the applicable policy related to the member's plan.

What's changing for Commercial Products?

Beginning with November 1, 2015 dates of service, Blue Cross will deny claims as provider liability for lack of prior authorization for services which require prior authorization. The submitting provider will have **60** days in which to file an appeal.

The Consumer Service Center (CSC) team will review the medical records submitted with the appeal to determine the medical necessity of the service, based on current Medical Policy and accepted standards of care. Upon review, if the medical records support medical necessity of the service the denial will be over turned and the claim will be authorized for payment, subject to the members' contract benefits. However, upon review of the appeal, if the medical records do not support medical necessity, the denial will remain but the denial reason will be changed to "not medically necessary" and remain as provider liability.

Questions?

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

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