PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

June 1, 2016

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

Services on the MN Government Programs Pre-Certification/Pre-Authorization List require prior authorization. Beginning with August 1, 2016 dates of service, if a provider does not obtain **a required** prior authorization (PA) for a Government programs subscriber before rendering services, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will deny claims as provider liability for lack of a PA. For these claims, the submitting provider will have **60** days to file an appeal. This requirement applies to the Government products listed below and is consistent with other Minnesota payer guidelines. A PA enforcement policy was implemented for our commercial lines of business effective November 1, 2015.

- This change impacts subscribers that have coverage through Blue Plus Blue Advantage (PMAP, MinnesotaCare, and MSC+), and SecureBlue℠ (HMO SNP).

Federal Employee Program® (FEP), Platinum Blue (Medicare Cost), Medicare Supplement (Senior Gold, Basic Medicare Blue and Extended Basic Blue) subscribers **are not** impacted.

When a PA 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. The PA must be completed **before** the service is rendered.

For Government programs subscribers only the services on the MN Government Programs Pre-Certification/Pre-Authorization List require PA. Do not request PA for services not on the list.

Follow these steps to determine if a procedure for a Government programs subscriber requires PA:

1. Access the 'Provider Section' of the Blue Cross website at **providers.bluecrossmn.com**.
2. Under 'Tools and Resources' select 'Medical policy' then acknowledge the Acceptance Statement.
3. Click on the '+' next to 'Utilization Management' and under the 'Precertification Lists' select 'MN Government Programs Pre-Certification/Pre-Authorization List.'

Appeals

For appeals submitted after the service was rendered and within the 60 day requirement, 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**.

Distribution: All participating providers
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