PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

June 1, 2023

Ancillary and Facility Claim Processing when Prior Authorization is Not Obtained

As previously communicated, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) implemented an appeal policy related to the existing requirement of a prior authorization (PA) submission in Provider Bulletin P35R1-19. Blue Cross is expanding that policy to include all ancillary and facility claims for non-authorized services. If a service is performed without a PA on file, or a PA was denied for medical necessity, all associated facility and ancillary (anesthesia, professional services, etc..) claims will be denied as well.

Providers should continue to follow applicable Prior Authorization and Notification requirements for inpatient stays. Inpatient claims, even with an approved Pre-Admission Notification/Precertification, and outpatient facility claims will be denied and ineligible for reimbursement if the services provided require a PA and an approved PA is not obtained.

The policy will go into effect with dates of service beginning August 1, 2023.

When a PA is required for a service, procedure or item, the ordering health care provider must submit the clinical information ***in advance*** to Blue Cross via the Availity Portal. Before performing a service that requires a PA, the rendering health care provider must validate that the ordering health care provider completed the authorization process and was issued a final determination on the authorization. If the rendering health care provider provides a service before an authorization was completed, the claim(s) for both the ordering health care provider and the rendering health care provider will be denied for lack of prior authorization and the provider will be held liable. The claim denial will be administrative and cannot be appealed for medical necessity.

Rendering health care providers can verify if a prior authorization was obtained through the Availity Portal. You will need the member identification number, the ordering provider's NPI, and the service dates used on the submission:

1. Log in at **Availity.com/essentials**
2. Select Patient Registration, choose **Authorizations & Referrals,** then **Authorization/Referral Inquiry**

Certain circumstances may make obtaining a PA prior to rendering the service difficult. Retrospective clinical review will be considered by Blue Cross and eviCore (specialty UM vendor, see Bulletin P25-18) 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. Retrospective authorization requests can be submitted online at Availity.com.

Note: Retrospective authorization requests will not be accepted for chemotherapy – reviewed by eviCore. Genomic and Molecular Lab services will be accepted for up to 60 days from the date of specimen collection - reviewed by eviCore.

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

Other exemptions from this policy are:

- Emergency and urgent care services that are performed in the emergency room do not require prior authorization and will be considered at the in-network benefit level.
- Maternity delivery admissions when level of care is delivery only.
- Inpatient admissions
- Medicaid lines of business
- Federal Employee Program (FEP) members
- PT/ST/OT/Chiropractic – beginning June 3, 2019, Blue Cross will no longer require providers to submit prior authorizations for these services (see Provider Bulletin P34-19, for additional information).

Products Impacted

- Commercial
- Medicare Advantage
- Medicare Platinum Blue

Questions?
Please contact provider services at (651) 662-5200 or 1-800-262-0820.