PROVIDER QUICK POINTS
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

March 27, 2024

Appeal Submission Timeframe Alignment

Blue Cross and Blue Shield of Minnesota (Blue Cross) has been made aware of confusion regarding the timely filing requirement of appeals when a claim has been denied for no prior authorization on file. Prior to the COVID-19 pandemic, an appeal was required to be submitted within 60 days of the claim's remit when the denial was for no prior authorization. During the pandemic, Blue Cross moved the timely filing requirement of all appeals to 180 days. Blue Cross published Provider Bulletin P74-22 on December 1, 2022, that announced a return to a timely filing requirement of 90 days for all appeals on February 1, 2023, and no specific timeframe was provided for claims denied for no prior authorization. Provider references, such as the Provider Policy and Procedure Manual, continued to state that an appeal for no prior authorization must be submitted within 60 days.

In order to reduce confusion and to simplify the appeals process, Blue Cross will maintain a timely filing of 90 days for all first-level appeals and provider resources have been updated with this information. The required submission time for second-level appeals will remain unchanged and must be submitted within 60 days of the notification of the uphold determination of the first-level appeal.

As a reminder, an appeal is only accepted for a service denied for no prior authorization if the following criteria is met. If this criteria is not met, the appeal will be closed and returned to the submitter.

Exception Criteria:

- 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).

QP25-24
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- 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.
- Federal Employee Program (FEP) members.

Products Impacted
All, except FEP.