NEWS Brief business information and news from Premera Blue Cross Blue Shield of Alaska

Sept. 9, 2013

Prior Authorization

As part of our efforts to maintain a sustainable healthcare system and help our members receive high-quality, cost-effective care consistent with clinical best practices, Premera Blue Cross Blue Shield of Alaska (Premera) is implementing prior authorization. Prior authorization streamlines the claims payment process by having the service reviewed for medical necessity before it occurs. By requesting prior authorization, providers receive confirmation of patient benefits, timely claims processing, and potential avoidance of a member penalty or provider financial liability for the claim.

Note: Providers are financially liable for rendering services that are not medically necessary. We are providing this reminder to be consistent with the terms of our provider agreements, which require providers to write off charges in the absence of a written waiver from our member.

When will prior authorization be implemented?

Beginning Jan. 1, 2014, certain services will require prior authorization (or pre-service review). As employer groups and individuals enroll or renew with Premera, they will begin moving to prior authorization.

What is the impact to my practice?

- Providers will be accountable for requesting prior authorization on some services for their patients.
- Premera is encouraging members to ask their providers to check their benefits before scheduled medical services. Depending on the terms of the specific member contract, members may receive a financial penalty if prior authorization is not completed. Your patients depend on you to contact us on their behalf to request prior authorization.
    - A preliminary list of the procedures and services requiring prior authorization is posted at **premera.com/ak/provider**. Under Utilization Review on the left menu, select the Prospective Review link.
    - Facilities should make sure that prior authorization has been received before admitting Premera members for scheduled services.
- When a prior authorization is not completed for a medically necessary service, the member financial penalty is processed as member liability. The amount of the member financial penalty, along with other charges for which the member is responsible (copay/deductible), will be noted in the member liability section on the Explanation of Payment (EOP). The provider is responsible for collecting the member liability that will be withheld from the EOP.

- When a prior authorization is not completed for a non-medically necessary service, the claim will be denied and providers will be financially liable for the claim.

What action do I need to take? What do I need to know?

- Request prior authorization from Premera in advance of certain procedures and services. This prospective (or pre-service) review must be completed before the service is rendered.
    - We recommend checking with Premera for *all* planned or scheduled services to determine what the patient's benefits will cover. A list of services that require a review for medical necessity can be found on the Clinical Review Code list, posted at **premera.com/ak/provider**. Under Utilization Review on the left menu, select the Prospective Review link.
- Save time on the phone and use the online Prospective Review Tool at **premera.com/ak/provider** (under Utilization Review on the left menu, select Prospective Review, then the "Get Started Now" button) to:
    - Determine if a review is required or recommended
    - Submit a new review request
    - Check the status of an existing review

To avoid provider financial liability for non-medically necessary services, the patient must sign a waiver *prior to rendering the service,* and it must include **all of** the following information:

1) The waiver must be specific to the service; it cannot be a general waiver;
2) The waiver must include the cost of proposed services;
3) The waiver must be signed by the patient/member stating that they agree to self-pay for the service in the event the health plan determines the service is not medically necessary.

In addition, we follow the Centers for Medicare & Medicaid Services guidelines, which require billing non-medically necessary services with a GA modifier to indicate a valid signed waiver is on file with the provider.

Why the change to prior authorization?

- It promotes predictable coverage, timely claims processing, and prompt payment for our providers.
- It allows us to help our members and providers avoid unnecessary financial liability, and to get an estimate of costs ahead of time.
- It facilitates predictable coverage and helps identify those members who may benefit from additional Premera services, such as case and disease management.
- Employer groups have requested prior authorization to help ensure that their employees are receiving high-quality, cost-effective care.

Additional Support:

- For questions about this News Brief, call Physician and Provider Relations at 877-342-5258, option 4, and ask to be connected to your provider network representative.
- Visit our provider website at **premera.com/ak/provider** to use the Prospective Review Tool and for the latest news and updates.
- For claims-related questions, call the number on the back of the member's ID card.