PREMERA BLUE CROSS BLUE SHIELD OF ALASKA

NEWSFlash

OCTOBER 5, 2015

Frequently Asked Questions:
Prior Authorization and Provider Liability

On Oct. 1, 2015, we sent a News Brief about prior authorization and the change from member to provider liability if a provider does not secure a required prior authorization for services. This change is effective for dates of service on or after January 1, 2016.

Here are some frequently asked questions from providers on this topic.

Which codes require prior authorization?
Prior authorization is required for major procedures or services that could be a health and safety issue for our members. Prior Authorization requires review and approval before the service is performed.

The following non-exclusive list highlights some common services that require prior authorization:

- All planned inpatient stays
- Admission to a skilled nursing facility or rehabilitation facility
- Elective (non-emergent) air ambulance transport
- Some outpatient services
- Organ transplants
- Supplies, appliances, durable medical equipment (DME), and prosthetic devices over $500 (purchase)
- Provider-administered drugs

See the Clinical Review by Code List for all codes needing prospective review.

How do I get a prior authorization?
Requests for reviews can be submitted:

- Online with the Prospective Review Tool (log-in and member ID required)

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- By faxing a request form

For dental providers, the request should be faxed to Dental Review at 425-918-5956, or mailed to Dental Review, MS 173, P.O. Box 91059, Seattle, WA, 98111-9159.

Note: We require a fax of pertinent medical records to support a request. For supporting documentation requirements, see the Clinical Review by Code List.

How long will it take? How will I be notified?

After we receive all required materials, our goal is to respond with a decision in a timeframe that meets or exceeds state and federal guidelines for timely review. If your review is urgent, please call us so we can help expedite your request.

Once a decision is made on a pre-service review request, notification will be available via our Prospective Review Tool by entering the tracking number. We'll also fax a decision to you. For any service being denied or approved as a prior authorization, a detailed letter will be mailed to you and the member. For urgent requests, we'll notify you by phone.

What about emergencies or extenuating circumstances?

If an emergency exists that prevents you from obtaining prior authorization, Premera must be notified within 48 hours, following onset of treatment, or as soon as reasonably possible.

We recognize there are patient situations that may make it impossible for providers to obtain a pre-service before treating a patient, or to notify Premera within 24 hours of a patient's admission. In these situations, please contact us prior to submitting a claim and follow the recommended practices so that the claim will not be automatically denied. For more information, see our Extenuating Circumstances Policy.

For More Information

If you have questions about prior authorization, call Physician and Provider Relations at 800-722-4714, option 4, and ask to be connected to your provider network representative.