



# Prior Authorization FAQ's

## **? Does the prior authorization process include outpatient and inpatient admissions?**

Inpatient stays will need to be precertified like they are today. There is no change in that process. Outpatient services do not require precertification; however, outpatient procedures may need prior authorization.

## **? What is the expected turnaround time for approval once prior authorization has started and records are received?**

BCBSNE will do our best to make turnaround time a priority. You can anticipate a determination on the prior authorization request within 15 days of receipt of your request. Delays in the process can be avoided by ensuring the request is complete and the appropriate codes and supporting documentation are included.

## **? If a patient is hospitalized and a physician is consulted, is prior authorization required? For example, if a patient is hospitalized and a vascular doctor is consulted, is prior authorization necessary?**

If a patient is an inpatient and a surgery is needed during his or her stay or the surgery is needed emergently, BCBSNE would not require a prior authorization request.

## **? What is the Gold Card program?**

BCBSNE will offer a "Gold Card" program to physicians who meet predetermined denial metrics when submitting prior authorization data. BCBSNE is currently in the process of establishing those metrics.

## **? Will the new Gold Card program only be offered to physicians, or will this apply to mid-level providers?**

The Gold Card program will be offered to physicians and mid-level providers.

## **? Will Gold Card providers still need to submit a prior authorization request?**

Yes, Gold Card providers will still need to submit a request; however, no medical review will be required in order for the prior authorization team to issue an approval.

## **? How can I check to see if something will require a prior authorization?**

Reference the prior authorization list available at [nebraskablue.com](http://nebraskablue.com). Look at the "Prior Authorization and Pre Service Reviews" link in the Resource Center on the "For Providers" page. The Med Policy Blue tool will also advise if the medical policy will require a prior authorization: <https://medicalpolicy.nebraskablue.com>.

**?** **How will the prior authorization requirement work for out-of-state providers for Nebraska members (BlueCard)?**

BCBSNE will require that out-of-state providers submit prior authorization requests just as we do for in-state providers. If an out-of-state provider does not submit a prior authorization request before services are performed, services will be denied and may be the member's responsibility. Letters were sent to all out-of-state members as well as the covered family of members with a different address than the subscriber advising of this new prior authorization requirement. Out-of-state providers can use Med Policy Blue to determine if a procedure requires prior authorization: <https://medicalpolicy.nebraskablue.com>.

**?** **With the increased number of InterQual® Smartsheets, will providers be required to fill these out and submit?**

BCBSNE recommends that providers use InterQual® Smartsheets, but it will not be required. The provider may use the prior authorization form in Med Policy Blue and submit all the pertinent medical records for review. InterQual® criteria will still be used.

**?** **Will all medical policies require a prior authorization?**

There will be a handful of medical policies that will not require a prior authorization (e.g. HPV vaccines or Shingles vaccines). Each medical policy in the Med Policy Blue tool will include in the title of the policy whether it will require a prior authorization (e.g. "IV.72 Intensity Modulated Radiation Therapy (IMRT) (PREAUTHORIZATION IS REQUIRED)").

**?** **What will happen if a provider does not submit a prior authorization on a required procedure and a claim is submitted for the services?**

The claim and ancillary charges will be denied as no prior authorization was submitted and will be provider liability. The provider will not be able to balance bill the member.