If additional information is needed because of lack of information submitted with the prior approval request, the Plan sends a written request for additional information within two business days of receipt of the request. The notice of extension specifically describes the required information. The member or provider has at least 45 calendar days from receipt of the notice within which to provide the specified information.

The Plan does not retroactively deny reimbursement for services that received prior approval, except in cases of fraud including material misrepresentation. See provider contracts for more complete details.

Note: Dental prior approval for (1) Health Exchange pediatric members or (2) members of an administrative services only (ASO) whose employer group has purchased dental coverage through BCBSVT and are eligible through the BCBSVT Dental Medical policy "Part B" are reviewed by CBA Blue. See Dental Care in Section 6 for more details.

Pharmacy prior approvals are reviewed by Express Scripts, Inc. (ESI). Note, however, not all members have pharmacy coverage through BCBSVT. Refer to our "Contact Information for Provider" sheet on our provider website under "Pharmacy Benefit Manager" for a list of exclusions.

Radiology prior approvals are reviewed by AIM Speciality Health.

Special Notes Related to Prior Approval for Ambulance Services

Refer to the current prior approval listing to determine which ambulance service(s) require prior approval.

We encourage the referring provider to obtain prior approval for ambulance services.

Ambulance providers cannot contract with BCBSVT and therefore, members are financially responsible for the services provided if prior approval is not obtained. In addition, the referring provider has the clinical information we need to make a decision.

When a rendering provider is requesting a prior approval for ambulance services, they need to know the ambulance service name, location and national provider identifier. No coding is necessary. BCBSVT uses an ambulance transport service code.

BCBSVT has two business days to review and make decisions on ambulance prior approval requests, unless they are marked urgent. Urgent requests have 48 hours to have a decision rendered. If you have enough time to file for prior approval before the transport, you should not mark the request as urgent.

Special Notes Related to Prior Approval/Referral Authorization:

- Home Health Agencies or Visiting Nurse Associations: a new authorization or an update/extension of an existing authorization does not need to be submitted or created should a member experience an inpatient admission during date spans for already approved services.

If the inpatient stay results in the need to adjust the date span of already approved services, or will result in services spanning a new calendar year, you need to contact our integrated health team at (800) 922-8778. We will adjust the existing authorization accordingly.

Retrospective review of prior approvals, and referral authorizations

Prior Approval and Referral Authorizations should always be secured prior to the service(s) being rendered. Providers and facilities are held financially responsible. However, we will conduct a retrospective review for medical necessity, when one of the applicable circumstances listed below occurs and the service was rendered without obtaining prior approval as required. Provider must contact BCBSVT within a reasonable time, not to exceed **60 calendar days from the date of service,** unless documentation provided,

Chiropractic Services

- Chiropractic services rendered within three (3) days of visit following visits 12th, 18th, 24th, etc. visits

Coverage Unknown, Changed or Incorrect

- Provider not aware member had BCBSVT coverage
- Provider not aware member had a change in BCBSVT coverage
- Provider advised member was not active through eligibility verification
- Provider received incorrect information about member's coverage (eligibility, benefits or Medicare status)

Discharge Planning

- Discharge planning occurred during the Plan's non-business operating hours

Durable Medical Equipment (DME) Continuation

- Continuation requests within 30 calendar days of the last covered day of the trial authorization for CPAP/BiPAP/TENS or any other continued DME

Genetic Testing

- Request received within 60 days of the specimen being collected and sent to the lab for processing

Misquote

- BCBSVT/AIM or ESI quoted that a service, procedure or supply did not require prior approval to a provider when it is on an applicable prior approval list

Treatment Plan Change

- Provider requests a new or different procedure or service when a change in treatment plan was necessary during a procedure/service
- Provider determines additional services that require prior approval are needed during a procedure/surgery
- Provider has an approved prior approval on file, but determines the need for other or additional services during a procedure or a change in treatment plan is required
- Provider received approval for a specific code(s), but when the procedure was rendered the code(s) changed by the National Coding Standards

Unable to reach BCBSVT and/or delegated vendor partners

- Provider attempted to obtain prior approval, but was unable to reach BCBSVT due to extenuating circumstances (natural disaster, power outage)

Requesting a Retrospective Review

If a provider identifies a service that qualifies for a retrospective review, he/she must submit a prior approval form noting it is a retrospective review and includes documentation that:

1. Supports the procedure provided and
2. Provides details of why prior approval was not originally requested.

We notify the provider of the outcome of the retrospective review within 30 days from receipt of request unless additional information is requested from the provider or it is not eligible for review.

Retrospective Reviews of Prior Approval Misquotes

If Provider contacts Customer Service and is erroneously informed that a service or procedure does not require prior approval or referral authorization (but the service or procedure is in fact listed on the applicable prior approval or referral authorization listing), Provider may request retrospective review for services or procedures billed in reliance on the Customer Service quote. Provider must contact BCBSVT within a reasonable time (not to exceed sixty (60) calendar days) after receiving the first remittance advice showing that the claim for the procedure or service was denied for lack of prior approval or referral authorization. BCBSVT will not consider requests for retrospective review for services or procedures if more than sixty (60) calendar days have passed since the Provider's receipt of the first remittance advice showing a denial for lack of prior approval or referral authorization. Quotes from Customer Service represent prior authorization or referral authorization requirements at the time of the quote, and Providers must verify prior approval or referral authorization requirements regularly by reviewing the listings available on BCBSVT's website.

Pre-notification of Admissions

Under the Plan's certificates of coverage, pre-notification of scheduled inpatient admission is required. Pre-notification enables the Plan's Integrated Health staff to assess the medical necessity of the requested procedure and the appropriateness of the requested setting of care (inpatient versus outpatient). Clinical information pertinent to the request is collected as needed. The information is reviewed in conjunction with nationally recognized health care guidelines and/or other data sources identified earlier in the description.