REQUIREMENTS AND PROCESS FOR A RETROSPECTIVE PRIOR APPROVAL REQUEST

Date: August 1,2025

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.
bluecrossvt.org

-

Prior Approval (PA) should always be secured prior to the service(s) being rendered. Contracted providers and facilities are held financially responsible if PA is required and not obtained. Providers are not able to file an appeal for lack of PA. 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 PA as required. The provider must contact us within a reasonable time, not to exceed 60 calendar days from the date of service, unless otherwise noted below.

Act 111 – Blueprint Primary Care Provider (BP PCP) waiver of Prior Authorization

- A claim submitted identifying the ordering provider on the claim form (see Section 12 of our on-line Provider Handbook for details) denies for lack of PA and the rendering provider had believed the ordering provider and member qualified for a waiver of PA. However, later learned that the provider was not a BP PCP, and/or the member did not qualify.

  Note: Retrospective PA consideration will not be given to claims that did not report the ordering provider information correctly (or at all) on the claim form or electronic submission. See Section 12 of our on-line Provider Handbook for submission details. In these cases, a correct claim must be submitted with the ordering BP PCP information.

Ambulance Non-Emergent Transportation

- All instances where PA was not requested before services were rendered. The provider must contact us within a reasonable time, not to exceed 90 calendar days.

Chiropractic Services

- Chiropractic services rendered within three (3) days of visit following the 12th visit or any previously granted chiropractic treatment extension through the PA process (e.g. 18th, 24th, etc.)
- A claim denies for lack of PA because the member's benefit has been exhausted, but the provider took sufficient steps to verify benefits before providing the services to the member. Sufficient steps include verifying member benefits through a call to customer service or eligibility accumulator inquiry AND asking the member whether they have received other chiropractic care and receiving an answer that they have not.

Coverage Unknown, Changed or Incorrect—the 60 days starts from the date the provider was notified of the active coverage.

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

Change in Primary Insurance Processing—the 60 days starts from the date of the other carrier's reporting.

- Denial or recovery of primary insurer's processing—other carriers' information must be included in the request for retrospective review.

Discharge Planning

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

Durable Medical Equipment (DME) Continuation - continuation requests greater than 30 calendar days from the last covered authorization day will be reviewed for future services only and must include documentation supporting 60 days of member compliance.

- Continuation requests within 30 calendar days of the last covered day of the trial PA 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

- We quoted that a service, procedure, or supply did not require PA when it is on an applicable PA list and the retroactive request is received within 60 days from the first denial.

Monitored Anesthesia

- Requests received within 5 business days of the date of service.

Physical, Speech or Occupational Therapy Services

- A claim denies for lack of PA, but the provider took sufficient steps to verify benefits before providing the services to the member. Sufficient steps include verifying member benefits through a call to customer service or eligibility accumulator inquiry AND asking the member whether they have received other physical, speech or occupational therapy care and receiving an answer from the member that the member has not received such care.

Treatment Plan Change

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

Unable to Reach Blue Cross VT and/or Delegated Vendor Partners

- Provider attempted to obtain PAI, but was unable to reach Blue Cross VT due to extenuating circumstances (natural disaster, power outage).

Requesting a Retrospective Review

If a provider identifies a service that qualifies for a retrospective review, they must submit a PA approval form noting it is a retrospective review and include documentation that:

1. Supports the procedure provided, and
2. Provides details of why PA 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.