

PROVIDER BULLETIN

PROVIDER INFORMATION

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April 1, 2019

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Minnesota Health Care Programs (MHCP) Updates

- No Bulletins regarding MHCP Updates were published for the month of April

ADMINISTRATIVE UPDATES

Reminder: Medicare Requirements for Reporting Provider Demographic Changes (article is published in every monthly Bulletin)

In accordance with Medicare requirements, Blue Cross is required to maintain accurate provider network directories for the benefit of our Subscribers. Blue Cross is hereby reminding all providers to submit a form to us whenever any of the following changes occur:

- Accepting new patients
- Demographic address and phone changes
- Office hours or other changes that affect availability
- Tax ID changes
- Practitioner additions or terminations
- Branch additions

Forms Location

Based on what change has occurred, submit the appropriate form located on our website at **providers.bluecrossmn.com**. Select “Administrative Updates” in the “What’s Inside” section to obtain instructions on completing the various forms or access the link below:

<https://www.bluecrossmn.com/healthy/public/personal/home/providers/admin-updates>.

How do we submit changes?

Send the appropriate form via fax as indicated below:

Fax: 651-662-6684, Attention: Provider Data Operations

Professional Liability (Malpractice) Coverage Requirements

(article is published in every monthly Bulletin, through July 2019)

Effective July 1, 2019, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) requires that all participating providers continuously maintain professional liability (malpractice) coverage in the amount of \$2 million per incident and \$4 million aggregate, unless the practitioner or provider is covered by a State or Federal Tort Claim liability statute, i.e., Minnesota State Statute Section 3.736. Common Carrier and Special Transportation providers are required to carry automobile insurance liability coverage of no less than \$2 million per incident and \$4 million aggregate.

Practitioners must provide evidence of malpractice coverage (or Federal Tort coverage letter), or provide proof that they have the required amounts through a binder, a copy of which must be provided to Blue Cross via email:

Malpractice.Ins@bluecrossmn.com

Reminder: Change to TPA Business

(P14-19, published 2/1/19)

As previously communicated in Provider Bulletins P35-18, P41-18 and P76-18, Independence Health Group (Independence) subsidiary AmeriHealth Administrators, Inc. (AHA) completed an asset purchase May 1, 2018 that included self-insured customer contracts from Blue Cross and Blue Shield of Minnesota's (Blue Cross) third-party administrator (TPA).

Blue Cross informed providers that:

- AHA's platform will manage eligibility, benefits, claims processing and health management services for the purchased customer accounts;
- After transition to the AHA platform, members will carry an ID card with the BlueLink TPA name and logo and access the BlueCard provider network;
- Customer contracts that were part of the purchase migrated to the AHA technology platform over a span of four months beginning October 1, 2018 through January 1, 2019.

As groups were migrated, AHA began providing all functions of claim management including, but not limited to, medical policy, pre-authorizations (PA's), pre-certifications, preadmission notifications (PAN's) and appeals.

- For convenient, online PA or pre-certification requests, providers can access AHA's iExchange portal. Go to www.ahatpa.com, select the provider tab, then locate the "New to iExchange" link to register. Choose the Independence Administrators plan when registering.
- Providers may also send PA or pre-certification requests via FAX to 215-784-0672
- Provider Pre-Certification calls should be directed as follows:
Mental Health /Substance Abuse.....**1-800-778-2119**
Other Admissions.....**1-888-234-2393**
- For all other inquiries.....**1-888-234-2393**

CONTRACT UPDATES

Change to Prior Authorization Requirements for Outpatient Therapies and Chiropractic Services for Commercial and Medicare Products (P34-19, published 4/1/19)

Blue Cross and Blue Shield of Minnesota (Blue Cross) will remove the prior authorization (PA) requirements for outpatient therapies, including physical, occupational, and speech therapy, and chiropractic services beginning June 3, 2019 for most commercial and Medicare products. Blue Cross has contracted with SecureCare to provide network management services for physical therapy and chiropractic services. Please note the following:

Self-Insured Groups may have benefits that require a PA for outpatient therapy or chiropractic services. These services may be managed as a PA or a retrospective review.

Medical Necessity Review at Point of Claim

As stewards of healthcare expenditures for our members, we are charged with ensuring they receive the highest quality, evidence-based care. This is accomplished through expanded development of medical policies and through management of these policies to include the medical necessity review of services. The primary purpose of the review process is to ensure that evidence-based care is provided to our members, driving quality, safety, and affordability. While PA will no longer be required for these services, claims may be monitored to verify appropriate care is being delivered through a retrospective review process.

SecureCare does not contract with facilities that provide physical therapy services. In addition, they do not contract any occupational or speech therapy services. Blue Cross will be pending claims for retrospective medical necessity review for outpatient therapy and chiropractic claims submitted by providers not contracted with SecureCare.

The number of visits outlined below provides an example of when Blue Cross would typically begin reviewing therapies for medical necessity at point of claim.

Commercial

- Physical Therapy – 40 visits
- Occupational Therapy – 40 visits
- Speech Therapy – 50 visits
- Chiropractic Services – 30 visits

Medicare Advantage

- Physical Therapy – 10 visits
- Occupational Therapy – 10 visits
- Speech Therapy – 10 visits
- Chiropractic Services – 10 visits

If claims do not meet medical necessity guidelines upon review of the medical records, claims will be denied as provider liability. Providers may submit medical records as claim attachments to expedite the claim processing. The following guidelines apply based on the line of business:

- Medicare Advantage – Medicare guidelines apply for PT/OT/ST and Chiropractic Services
- Commercial – Chiropractic Services, Medical Policy III-04, effective 5/6/19. InterQual criteria prior to 5/6/19.
- Commercial – InterQual guidelines apply for PT/OT/ST

All services are subject to the member's benefits and medical necessity guidelines. Guidelines applied are based upon the member's product.

Appeals Policy for no Prior Authorization Effective June 3, 2019 (P35-19, published 4/1/19)

In order to best support the coordination of care for our members, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will implement a new appeals policy related to the existing requirement of a prior authorization (PA) submission. The policy will go into effect with dates of service beginning June 3, 2019, for all providers across the following lines of business:

- Commercial (All except FEP)
- Medicare (Advantage, Platinum Blue)

When a PA is required for a service, procedure or item, the provider must submit the clinical information in advance to Blue Cross via the Availity Portal (beginning May 1, 2019, see Bulletin P27-19). The Utilization Management team reviews the clinical information and determines if the request meets medical necessity criteria based on the current Medical Policy and accepted standards of care. PAs must be completed before the service is rendered. Medically emergent services do not require a PA, per the Reimbursement Policy – General Coding – 046.001-Medical Emergency.

If a PA is not submitted prior to the service, the claim will be denied for lack of prior authorization and the provider will be held liable. The claim denial will be administrative and cannot be appealed for medical necessity.

Certain circumstances may make obtaining a PA prior to rendering the service difficult. Retrospective clinical review will be considered by Blue Cross and eviCore (specialty UM vendor, see Bulletin P25-18) for up to 14 days after the date of service and prior to the claim being submitted in consideration of scenarios such as after-hours urgent situations. Retrospective authorization requests can be submitted online at Availity.com.

Note: Retrospective authorization requests will **not** be accepted for chemotherapy – reviewed by eviCore. Genomic and Molecular Lab services will be accepted for up to 60 days from the date of specimen collection – reviewed by eviCore.

Exceptions/Exemptions:

If a claim is administratively denied for no PA, an appeal for medical necessity will not be accepted, but an **administrative appeal may be submitted for limited situations**. These exceptions are listed below, and must be supported by submitted documentation:

- Blue Cross is the subscriber's secondary coverage and PA is not required (e.g. Medicare is primary).
- Another insurance company is identified as the payer and a claim was submitted to the other payer within the timely filing guidelines with Blue Cross subsequently identified as the patient's primary coverage.
- The patient is identified as the payer and is billed for the service, but later the patient reports Blue Cross coverage for the date of service. Appeals for this exception must include notes about accounts receivable actions. For example, include notes documenting calls with the Blue Cross Service Center or notes that the subscriber was sent to collections within 120 days after date of service.
- The subscriber was enrolled in the plan retrospectively, after the service was provided.
- A previously prior-authorized service unexpectedly changed for medically necessary reasons, or it was determined that an unforeseen additional service was necessary.
- Extenuating circumstances beyond the control of the rendering provider or facility that make it impractical to obtain or validate the existence of a precertification of coverage prior to rendering the service (e.g. natural disaster or Availity outage).

Other exemptions from this policy are:

- Emergency and urgent care services that are performed in the emergency room do not require prior authorization and will be considered at the in-network benefit level
- Maternity delivery admissions when level of care is delivery only
- Inpatient admissions
- Medicaid lines of business
- Federal Employee Program (FEP) members
- PT/ST/OT/Chiropractic – beginning June 3, 2019, Blue Cross will no longer require providers to submit prior authorizations for these services (See Provider Bulletin P34-19, for additional information)

New PA Lookup Tool via Availity:

Blue Cross is currently working with Availity to develop a new online tool that will help providers quickly determine if a PA is required for any service, streamlining the process and creating less administrative burden. If an authorization is required, users can easily redirect to the Authorization tool on Availity to complete the request. The tool will be ready for use prior to Appeals Policy for No PA go live. Additional information will be included in upcoming provider communications and trainings.

Prior Authorization Requirements:

Prior Authorization Lists are updated to reflect current PA requirements on the effective date of the management change, including applicable codes. To access Prior Authorization Lists for all lines of business, go to providers.bluecrossmn.com:

- Under Tools & Resources, select “Medical Policy”, and read/accept the Blue Cross Medical Policy Statement
- Select the “+” (plus) sign next to “Utilization Management” to access the current Prior Authorization Lists.

Summary:

[NOT NEW] If PA is submitted via Availity Portal prior to service:	[NOT NEW] If PA is submitted after service was rendered:	[NEW] If PA is not submitted within 14 days of service and prior to claim submission:
<p>PA is reviewed by UM, and then approved or denied.</p> <p>If approved, the service claim will process according to the member’s benefits.</p>	<p>Retrospective PA submission is possible for up to 14 days from date of service, and before a claim is submitted.</p> <p>PA is reviewed by UM, and then approved or denied.</p> <p>If approved, the service claim will process according to the member’s benefits.</p>	<p>Claims review is completed to confirm whether a required PA was submitted.</p> <p>If PA has not been received, claim payment will be denied.</p> <p>No appeals for medical necessity will be accepted – this is an administrative denial, not a medical necessity review.</p>

Change to Outpatient Therapies Prior Authorization Requirements for Medicare Advantage Subscribers (P38-19, published 4/1/19)

As previously communicated in Provider Bulletin P64-18, Blue Cross and Blue Shield of Minnesota (Blue Cross) implemented a prior authorization (PA) requirement for outpatient therapy visits, including physical, occupational, and speech therapy, beginning on the first visit for Medicare Advantage subscribers for service dates beginning January 1, 2019. Based on provider feedback, Blue Cross will no longer require a PA for the first outpatient therapy visit. A prior authorization is required beginning with the second visit and is required for any additional subsequent visits. Claims will no longer deny for no PA for the first visit beginning with claims processing date March 18, 2019.

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATES

Update: New Medical, Medical Drug and Behavioral Health Policy Management Updates for Commercial & Medicare Advantage Lines of Business (P26R1-19, published 4/1/19)

The information in this Provider Bulletin replaces the New Medical, Medical Drug and Behavioral Health Policy Management Updates Bulletin P26-19, published on March 1, 2019. Information regarding the Penile Prosthesis policy (NCD 230.4) has been clarified, and the Electrocardiographic Services policy (NCD 20.15) has been removed.

Effective May 6, 2019, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be changing criteria for prior authorization of chiropractic care to medical policy III-04 for commercial lines of business. In addition, Blue Cross will be expanding utilization management requirements for commercial and Medicare Advantage lines of business. This includes both prior authorization (PA) requirements and the Medical Drug Prior Authorization Program.

As stewards of healthcare expenditures for our subscribers, we are charged with ensuring they receive the highest quality, evidence-based care. This is accomplished through expanded development and revision of medical policies and through management of these policies to include the PA process. The primary purpose of the PA process is to ensure that evidence-based care is provided to our subscribers, driving quality, safety, and affordability.

The following prior authorization changes will be effective May 6, 2019 for commercial and Medicare Advantage lines of business:

Policy #	Policy Title / Service	New Policy	Prior Authorization Requirement	Line(s) of Business
III-04	Chiropractic Services	Yes (replacing InterQual criteria)	Continued <ul style="list-style-type: none"> • Fully Insured: After 30 visits • Self-Insured: After 30 visits or per Contract Requirement 	Commercial
L33394	Coverage for Drugs & Biologics for Label & Off-Label Uses: <ul style="list-style-type: none"> • Esketamine Nasal Spray (Spravato™) • Ravulizumab (Ultomiris™) 	No	New	Medicare Advantage
II-173	Accepted Indications for Medical Drugs Which are not Addressed by a Specific Medical Policy: <ul style="list-style-type: none"> • Ravulizumab (Ultomiris™) 	No	New	Commercial
L37808	Water Vapor Thermal Therapy for LUTS/BPH	No	New	Medicare Advantage
NCD 230.4	Diagnosis and Treatment of Impotence <ul style="list-style-type: none"> • Penile Prosthesis 	No	New	Medicare Advantage
IV-166	Penile Prosthesis	Yes	New	Commercial & Medicare Advantage

Policy #	Policy Title / Service	New Policy	Prior Authorization Requirement	Line(s) of Business
IV-158	Surgical Treatments of Lymphedema	Yes	New	Commercial & Medicare Advantage

Products Impacted

The information in this Bulletin applies **only** to subscribers who have coverage through commercial (excluding Federal Employee Program (FEP) which has separate requirements) and Medicare Advantage lines of business.

Submitting a PA Request when Applicable

- Before submitting a PA request, Providers are asked to check applicable Blue Cross policy and **attach all required clinical documentation** with the request. PA requests will be reviewed when patient-specific, relevant medical documentation has been provided supporting the medical necessity of the service. Failure to submit required information may result in review delays (if outreach is needed to obtain missing clinical information) or a denial of the request due to insufficient information. If a provider does not obtain the required PA before rendering services, Blue Cross will deny claims as provider liability for lack of prior authorization.
- PA approval will be based on the Blue Cross policy criteria. To review Blue Cross criteria:
 - Go to providers.bluecrossmn.com
 - Under Tools & Resources, select “Medical Policy”, and read/accept the Blue Cross Medical Policy Statement
 - Select the “+” (plus) sign next to Medical and Behavioral Health Policies, then select “Blue Cross Blue Shield of Minnesota Medical Policies” to access policy criteria.
- Prior Authorization Lists are updated to reflect additional PA requirements on the effective date of the management change and includes applicable codes. To access Prior Authorization Lists for all lines of business:
 - Go to providers.bluecrossmn.com
 - Under Tools & Resources, select “Medical Policy”, and read/accept the Blue Cross Medical Policy Statement
 - Select the “+” (plus) sign next to “Utilization Management” to access the Prior Authorization Lists.
- If a provider does not obtain the required PA before rendering services, Blue Cross will deny claims as provider liability for lack of prior authorization. The requirement applies to subscribers starting therapy and to those already being treated with a therapy noted above.
- Providers may submit PA requests for any treatment in the above table starting April 29, 2019.

Providers can Submit an Electronic Prior Authorization (ePA) Request

- Online via our free [Availity](#) provider portal – for Blue Cross to review.
- For Medical Drugs, PA’s can also be submitted using a [NCPDP](#) standard XML file feed to Blue Cross through CenterX, via an integrated Electronic Medical Record (EMR) system. To learn how to do this, providers should contact their EMR vendor for assistance.
- Out of state, non-contracted providers can submit a PA request to Blue Cross by either using the electronic processes above, the [Minnesota Uniform Form for PA Request and Formulary Exceptions](#) fax form located under the Forms section on the Blue Cross website, or their own PA form (secure fax: 651.662.2810).

Note: An approved PA does not guarantee coverage under a subscriber’s benefit plan. Subscriber benefit plans vary in coverage and some plans may not provide coverage for certain services discussed in the medical policies.

Reminder Regarding Medical Policy Updates & Changes:

Medical Policy changes are communicated in the Upcoming Medical Policy Notifications section of the Blue Cross Medical and Behavioral Health Policy website. The Upcoming Policies section lists new, revised, or inactivated policies approved by the Blue Cross Medical and Behavioral Health Policy Committee and are effective at minimum 45 days from the date they were posted. To access the website:

- Go to providers.bluecrossmn.com
- Under Tools & Resources, select “Medical Policy”, and read/accept the Blue Cross Medical Policy Statement
- Select the “+” (plus) sign next to “Medical and Behavioral Health Policies” to see the Upcoming Medical Policy Notifications section

New Medical, Medical Drug and Behavioral Health Policy Management Updates for Commercial & Medicare Advantage Lines of Business (P33-19, published 4/1/19)

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be expanding utilization management requirements for Commercial and Medicare Advantage lines of business. This includes prior authorization (PA) requirements.

As stewards of healthcare expenditures for our subscribers, we are charged with ensuring they receive the highest quality, evidence-based care. This is accomplished through expanded development of medical policies and through management of these policies to include the PA process. The primary purpose of the PA process is to ensure that evidence-based care is provided to our subscribers, driving quality, safety, and affordability.

The following prior authorization changes will be effective June 3, 2019 for Commercial and Medicare Advantage lines of business:

Policy #	Policy Title / Service	New Policy	Prior Authorization Requirement	Line(s) of Business
IV-27	Prophylactic Mastectomy	No	Continued <i>(No PA needed for prophylactic mastectomy related to breast cancer)</i>	Commercial & Medicare Advantage
Policy #	Policy Title / Service	New Policy	Prior Authorization Requirement	Line(s) of Business
II-173	Accepted Indications for Medical Drugs Which are Not Addressed by a Specific Medical Policy: <ul style="list-style-type: none">• Caplacizumab (Cablivi®)• Esketamine (Spravato™)	No	New <i>(Esketamine formerly not covered under policy II-174)</i>	Commercial
L33394	Coverage for Drugs & Biologics for Label & Off-Label Uses: <ul style="list-style-type: none">• Caplacizumab (Cablivi®)• Tocilizumab (Actemra®)	No	New <i>(Tocilizumab PA for non-oncologic indications only)</i>	Medicare Advantage

In addition, the following prior authorization changes will be effective April 1, 2019 for Medicare Advantage lines of business due to superseding NCD criteria:

Policy #	Policy Title / Service	New Policy	Prior Authorization Requirement	Line(s) of Business
NCD 20.32	Transcatheter Aortic Valve Replacement (TAVR)	No <i>(Replacing policy IV-149)</i>	Continued	Medicare Advantage
NCD 20.33	Transcatheter Mitral Valve Repair (TMVR)	No <i>(Replacing policy IV-152)</i>	Continued	Medicare Advantage
NCD 110.14	Apheresis (Therapeutic Pheresis) <ul style="list-style-type: none"> • Plasma Exchange 	No <i>(Used in addition to policy II-192)</i>	Continued	Medicare Advantage

Products Impacted

The information in this Bulletin applies **only** to subscribers who have coverage through commercial (excluding Federal Employee Program (FEP) which has separate requirements) and Medicare Advantage lines of business.

Submitting a PA Request when Applicable

- Before submitting a PA request, Providers are asked to check applicable Blue Cross policy and **attach all required clinical documentation** with the request. PA requests will be reviewed when patient-specific, relevant medical documentation has been provided supporting the medical necessity of the service. Failure to submit required information may result in review delays (if outreach is needed to obtain missing clinical information) or a denial of the request due to insufficient information. If a provider does not obtain the required PA before rendering services, Blue Cross will deny claims as provider liability for lack of prior authorization.
- PA approval will be based on the Blue Cross policy criteria. To review Blue Cross criteria:
 - Go to providers.bluecrossmn.com
 - Under Tools & Resources, select “Medical Policy”, and read/accept the Blue Cross Medical Policy Statement
 - Select the “+” (plus) sign next to Medical and Behavioral Health Policies, then select “Blue Cross Blue Shield of Minnesota Medical Policies” to access policy criteria.
- Prior Authorization Lists are updated to reflect additional PA requirements on the effective date of the management change and includes applicable codes. To access Prior Authorization Lists for all lines of business:
 - Go to providers.bluecrossmn.com
 - Under Tools & Resources, select “Medical Policy”, and read/accept the Blue Cross Medical Policy Statement
 - Select the “+” (plus) sign next to “Utilization Management” to access the Prior Authorization Lists.
- If a provider does not obtain the required PA before rendering services, Blue Cross will deny claims as provider liability for lack of prior authorization. The requirement applies to subscribers starting therapy and to those already being treated with a therapy noted above.
- **For PA requirements effective June 3, providers may submit PA requests for any treatment in the above table starting May 27, 2019.**

Providers can Submit an Electronic Prior Authorization (ePA) Request

- Online via our free [Availity](#) provider portal – for Blue Cross to review.
- For Medical Drugs, PA's can also be submitted using a [NCPDP](#) standard XML file feed to Blue Cross through CenterX, via an integrated Electronic Medical Record (EMR) system. To learn how to do this, providers should contact their EMR vendor for assistance.
- Out of state, non-contracted providers can submit a PA request to Blue Cross by either using the electronic processes above, the [Minnesota Uniform Form for PA Request and Formulary Exceptions](#) fax form located under the Forms section on the Blue Cross website, or their own PA form (secure fax: 651.662.2810).

Note: An approved PA does not guarantee coverage under a subscriber's benefit plan. Subscriber benefit plans vary in coverage and some plans may not provide coverage for certain services discussed in the medical policies.

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Reminder Regarding Medical Policy Updates & Changes:

Medical Policy changes are communicated in the Upcoming Medical Policy Notifications section of the Blue Cross Medical and Behavioral Health Policy website. The Upcoming Policies section lists new, revised, or inactivated policies approved by the Blue Cross Medical and Behavioral Health Policy Committee and are effective at minimum 45 days from the date they were posted. To access the website:

- Go to providers.bluecrossmn.com
- Under Tools & Resources, select "Medical Policy", and read/accept the Blue Cross Medical Policy Statement
- Select the "+" (plus) sign next to "Medical and Behavioral Health Policies" to see the Upcoming Medical Policy Notifications section

EviCore radiology Program Clinical Guideline Updates for Fully Insured Commercial & Medicare Advantage Subscribers (P32-19, published 4/1/19)

eviCore has released updates that will make the policy less restrictive for the following **eviCore Radiology Program** Clinical Guidelines:

- Oncology Imaging Guideline, Section 17: Renal Cell Cancer (RCC)

The clinical guideline updates become effective on April 5, 2019.

Directions on How to Access Clinical Guidelines

- select "Medical Policy" under **Tools and Resources**, read and accept the Blue Cross Medical Policy Statement
- Click on the "+" (plus) sign next to "**Medical and Behavioral Health Policies**" to expand the section
- Click on the '**eviCore healthcare Specialty Utilization Management Clinical Guidelines**' link.
- Scroll to the "**Need Help?**" section and click on "**Access Guidelines**"
- Click on the desired program
- Type "**BCBS MN**" in the "**Search by Health Plan**" search bar
- Select the current guideline

Products Impacted

This change only applies to:

- Individual
- Fully insured commercial
- Medicare Advantage subscribers

Products Not Impacted

Members who **do not require prior authorization through eviCore** are:

- Blue Cross Commercial Self-Insured Subscribers
- Blue Cross Federal Employee Program (FEP) Subscribers
- Blue Cross Minnesota Health Care Programs including Blue Advantage Families and Children (F&C), MinnesotaCare (MNCare), SecureBlue (MSHO), and Minnesota Senior Care Plus (MSC+)
- Blue Cross Platinum Blue and Senior Gold Subscribers

Group Number List

The 2019 Commercial Network Guide which includes a listing of the group numbers that will be utilizing eviCore, was updated on January 2, 2019. The list includes Medicare Advantage group numbers as well. The list will be updated on the second Tuesday of each month. However, due to new groups being added every month, providers should verify authorization requirements by using the Availity Authorization Portal for the most current and accurate information. If a group number is not on the list, the provider will need to verify PA requirements through the Availity Authorization Portal.

As a reminder, if a provider does not obtain a required prior authorization before rendering services, Blue Cross will deny claims as provider liability for lack of prior authorization.

To find a listing of all the group numbers that will be utilizing eviCore, the 2019 Commercial Network Guide has been updated with this information. To access the guide, go to providers.bluecrossmn.com and under “What’s Inside” select “Education Center” then select “2019 Commercial Network Guide.” You can also find it under “Tools and Resources”, select “Medical Policy” and then acknowledge the Acceptance Statement, click on the “+” next to “Utilization Management”, and select “see group numbers for members managed by eviCore” under the paragraph titled eviCore Healthcare Specialty Utilization Management.

To submit a Prior Authorization (PA) Request to eviCore

Providers should submit eviCore PA requests via our free **Availity** provider portal. Instructions on how to utilize this portal are found on the Availity website.

It is recommended that providers reference the eviCore clinical guideline criteria, submit PA requests via Availity, and include all applicable clinical documentation with the PA request. Failure to submit required information may result in review delays or denial of the request due to insufficient information.

Note: An approved PA does not guarantee coverage under a member’s benefit plan. Member benefit plans vary in coverage and some plans may not provide coverage for certain services in the medical policies.

Questions?

If you have questions or need to speak to an eviCore representative call **844-224-0494**, 7:00 a.m. to 7:00 p.m. CST, Monday - Friday.

Medical Oncology Drug Prior Authorization Updates for Fully Insured Commercial & Medicare Advantage Subscribers – eviCore Healthcare UM Program (P36-19, published 4/1/19)

The eviCore Healthcare Utilization Management Program will be making the following updates to the Medical Oncology CPT® Prior Authorization (PA) Code List.

The following drugs have been added to the Medical Oncology program and will require prior authorization for oncologic reasons beginning June 1, 2019:

Drug	Code(s)
Bortezomib (Not Otherwise Specified)	J9044
Trastuzumab and Hyaluronidase-oysk (Herceptin Hylecta)	J3490, J3590

Prior authorization requests will be reviewed based on eviCore clinical guideline criteria available for review on the Blue Cross website at providers.bluecrossmn.com:

- Select “**Medical Policy**” under Tools and Resources, read and accept the Blue Cross Medical Policy Statement
- Click on the “+” (plus) sign next to “**Medical and Behavioral Health Policies**” and locate the “**Medical Policy Supporting Documents**” section
- Scroll down and click on the “**eviCore healthcare Specialty Utilization Management Clinical Guidelines**” link
- Scroll to the “**Need Help?**” section and click on “**Access Guidelines**”
- Click on the **Medical Oncology** program
- Type “**BCBS MN**” in the “Search by Health Plan” search bar
- Select the current guideline

Products Impacted

This change only applies to **fully insured commercial** and **Medicare Advantage** subscribers.

The changes do not impact:

- Blue Cross Commercial Self-Insured Subscribers
- Blue Cross Platinum Blue and Senior Gold Subscribers
- Blue Cross Minnesota Health Care Programs including Blue Advantage Families and Children(F&C), MinnesotaCare (MNCare), SecureBlue (MSHO), and Minnesota Senior Care Plus (MSC+)
- Blue Cross Federal Employee Program (FEP) Subscribers

To submit a Prior Authorization (PA) Request to eviCore

Providers should submit eviCore PA requests via our free [Availity](#) provider portal. Instructions on how to utilize this portal are found on the Availity website.

It is recommended that providers reference the eviCore clinical guideline criteria, submit PA requests via Availity, and include all applicable clinical documentation with the PA request. Failure to submit required information may result in review delays or denial of the request due to insufficient information.

Note:

- An approved PA does not guarantee coverage under a member's benefit plan. Member benefit plans vary in coverage and some plans may not provide coverage for certain services in the medical policies.
- Some of the Medical Oncology Drugs listed above may be approved by the Food and Drug Administration (FDA) for use treating non-oncology indications. To identify if a prior authorization for a drug for non-oncology use, please refer to the PA Lists posted on the Blue Cross website. To access the PA Lists:
 - Go to providers.bluecrossmn.com
 - Select "Medical Policy" under Tools and Resources, read and accept the Blue Cross Medical Policy Statement
 - Click on the "+" (plus) sign next to "Utilization Management"

Questions?

If you have questions, please contact eviCore provider service at **844-224-0494**.

MINNESOTA HEALTH CARE PROGRAMS (MHCP) UPDATES

No Bulletins regarding MHCP Updates were published for the month of April