PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

WHAT'S INSIDE: **December 1, 2020**

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**

CONTRACT UPDATES

New Reimbursement Policy - Cellular and Gene Therapy Products (P89-20, published 12/1/20)

Effective February 1, 2021, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will implement a new Reimbursement Policy: Cellular and Gene Therapy Products Reimbursement. The policy is available in the provider section of the Blue Cross website located at **providers.bluecrossmn.com.** Go to the section titled, "Tools and Resources" and select "Reimbursement Policies".

This policy defines reimbursement of new medical treatments for cellular and gene therapy products as they are approved by the Food and Drug Administration (FDA) and enter the market. While not required, Providers may choose to bill the gene therapy code separately on a professional claim form for expedited reimbursement.

Additionally, effective February 1, 2021, Blue Cross will be updating the reimbursement methodologies of unlisted procedure codes in Reimbursement Policy: General Coding 005 – Unlisted Procedure Code Policy.
Reimbursement for unlisted codes will be determined by one of the following methodologies:

- 85% of the Average Wholesale Price (AWP) (drug codes); or
- Percentage of Provider's Regular Billed Charge (55% of charge for Commercial and 35% of charge for Medicare); or
- Invoice amount.
- Allowance of similar code (procedure/item); or
- Wholesale Acquisition Cost (WAC) for gene therapy products – see Cellular and Gene Therapy Product reimbursement policy.

Reminder Regarding Reimbursement Policies
This is not a change in medical policy, member benefits, or prior authorization (PA) requirements for cellular and gene therapy products. Reimbursement policies are updated on an ongoing basis and used by Blue Cross to define if and how certain claims will be paid for various health care services. Blue Cross will not be denying claims or recouping payment as a result of this reimbursement policy at this time. Note: If authorization of a cellular or gene therapy is required before service and the treatment needs to be administered in an in-patient setting, providers should submit the PA request and receive determination of review for cellular or gene therapy treatment prior to submitting an inpatient notification.

Products Impacted
This change only applies to commercial lines of business.

Coding Requirements Reminder
All coding and reimbursements are subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (e.g. HCPCS, CPT, ICD, Revenue), only valid codes for the date of service may be submitted or accepted.

Questions?
If you have questions, please contact provider services at **(651) 662-5200** or **1-800-262-0820**.

HCPCS stands for Healthcare Common Procedure Coding System
CPT® (Current Procedural Terminology) is a registered trademark of the American Medical Association

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATES

New Medical, Medical Drug and Behavioral Health Policy Management Updates—Effective February 1, 2021 (P87-20, published 12/1/20)

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be expanding utilization management requirements, including 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 February 1, 2021:

Policy #	Policy Title/ Service	New Policy	Prior Authorization Requirement	Line(s) of Business
L33394	Coverage for Drugs & Biologics for Label & Off-Label Uses: • Aducanumab* • Casimersen (Amondys 45)* • Evinacumab* • Idecabtagene vicleucel* • Pegunigalsidase alfa (PRX-102)*	No	New	Medicare Advantage

* PA will be required upon FDA approval.

Products Impacted
The information in this bulletin applies **only** to subscribers who have coverage through Medicare Advantage lines of business.

Submitting a PA Request when Applicable

- **Providers may submit PA requests for any treatment in the above table starting January 25, 2021.**
- Providers must check applicable Blue Cross policy and **attach all required clinical documentation** with the PA request. PA requests will be reviewed when patient-specific, relevant medical documentation has been submitted supporting the medical necessity of the service**.** Failure to submit required information may result in review delays or a denial of the request due to insufficient information to support medical necessity. 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.
- Current and future PA requirements can be found using the *Is Authorization Required* tool in the Availity® portal prior to submitting a PA request. Prior Authorization Lists are also updated to reflect additional PA requirements on the effective date of the management change and includes applicable codes. To access the pdf 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.

Prior Authorization Requests

- Participating providers must submit PA requests online via our free Availity® provider portal
- 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 fax form located under the Forms & Publications section on the Blue Cross website, or their own PA form.

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

Questions?

If you have questions, please contact provider services at (**651**) **662-5200** or **1-800-262-0820**.

New Medicare Advantage Part B Step Therapy Program and Medical Policy (P88-20, published 12/1/20)

Effective February 1, 2021, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will implement a new step therapy program and medical policy for Part B outpatient medical drugs for our Medicare Advantage (MA) subscribers. This program applies to Medicare Advantage subscribers who are beginning medical drug therapy (new starts).

As stewards of healthcare expenditures for our subscribers, we are charged with ensuring they receive the highest quality, evidence-based care. The purpose of the policy is to encourage use of safe, cost-effective (preferred drugs) to treat medical conditions when multiple versions of the same drug exist or before progressing to other drug therapies, when medically necessary.

Part B drugs addressed in the policy will not be covered unless a subscriber meets applicable drug-specific medical necessity criteria and step therapy requirements.

The following new medical policy will be effective February 1, 2021 for Medicare Advantage lines of business along with the following preferred drugs under the Part B medical benefit.

Policy #	Policy Title	Will Apply to Service Drug Class	Preferred Part B Drug Products (Covered)			Non-Preferred Drug Alternatives (Not Covered)*		
			Brand Name	NDC Codes	HCPCS Codes	Brand Name	NDC Codes	HCPCS Codes
II-247	Medicare Advantage Part B Step Therapy	Intra-articular hyaluronan injections for osteoarthritis (*existing prior authorization requirement will continue*)	SynVisc-One	58468-0090-xx	J7325	Durolane	89130-2020-xx	J7318
			Synvisc	58468-0090-xx	J7325	GenVisc 850	50653-0006-xx	J7320
			Euflexxa	55566-4100-xx	J7323	Hyalgan	89122-0724-xx	J7321
						Supartz Fx	89130-4444-xx	J7321
						Hymovis	89122-0496-xx	J7322
						OrthoVisc	59676-0360-xx	J7324
						Gel-One	50016-0957-xx	J7326
						MonoVisc	59676-0820-xx	J7327
						Gelsyn 3	89130-3111-xx	J7328
						Trivisc	50653-0006-xx	J7329
						Synojoynt	57844-0181-xx	J7331
						Triluron	89122-0879-xx	J7332
						Visco-3	50016-0957-xx	J7333
							87541-0301-xx	

***Any newly approved drugs in this drug class will be considered non-preferred until determined otherwise.**

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 option" Upcoming Medical Policy Notifications" under the "Medical and Behavioral Health Policies" section

We encourage providers to review the Medicare Advantage Part B Step Therapy policy frequently, as the preferred drug list in the policy is subject to change as new drug formulations and products are approved by the Food and Drug Administration (FDA) and enter the market. To review Blue Cross criteria after the policy goes into effect:

- Go to **providers.bluecrossmn.com**
- Under 'Tools and Resources' select 'Medical policy' and then acknowledge the Acceptance Statement
- Select the option "Blue Cross and Blue Shield of Minnesota Medical Policies" to access policy criteria

Products Impacted
The information in this Bulletin applies only to subscribers who have coverage through Medicare Advantage lines of business.

Questions?
If you have questions, please contact provider services at **(651) 662-5200** or **1-800-262-0820**.

eviCore Healthcare Specialty Utilization Management Program – Sleep Management Clinical Guideline Updates for Fully Insured Commercial and Medicare Advantage Subscribers (P91-20, published 12/1/20)

eviCore has released clinical guideline updates for the Sleep Management program. Guideline updates will become **effective February 1, 2021**:

Please review all guidelines when submitting a prior authorization request.

Guidelines with substantive changes:

- Actigraphy Guideline
- Indications/Diagnostic Testing Guideline
- Pediatric Sleep Guideline

Prior authorization requests will be reviewed based on eviCore clinical guideline criteria. Providers can view the list of Current Procedural Terminology (CPT) codes that require prior authorizations, eviCore clinical guidelines, and other provider resources on the eviCore Implementation Resources website.

To view CPT Code lists:

- Access the 'Provider Section' of the Blue Cross website at **providers.bluecrossmn.com**
- Select "**Medical Policy**" under *Tools and Resources*, read and accept the Blue Cross Medical Policy Statement
- Under "Medical and Behavioral Health Policies" scroll down and click on the "**eviCore healthcare Specialty Utilization Management Clinical Guidelines**" link
- Select "**Solution Resources**" and then click on the appropriate solution (ex: Sleep Management)
- Select "**CPT Codes**" to view the current CPT code list that require a prior authorization

To view Clinical Guidelines:

- Access the 'Provider Section' of the Blue Cross website at **providers.bluecrossmn.com**
- Select "**Medical Policy**" under *Tools and Resources*, read and accept the Blue Cross Medical Policy Statement
- Under "Medical and Behavioral Health Policies" scroll down and click on the "**eviCore healthcare Specialty Utilization Management Clinical Guidelines**" link
- Click on the "**Resources**" dropdown in upper right corner
- Click "**Clinical Guidelines**"
- Select the appropriate solution: i.e. Sleep Management
- Type "**BCBS MN**" (space is important) in 'Search by Health Plan'
- Click on the "**Current**", "**Future**", or "**Archived**" tab to view guidelines most appropriate to your inquiry

Products Impacted
This change only applies to:

- Individual subscribers
- Fully insured commercial subscribers
- Medicare Advantage subscribers

Prior Authorization Look Up Tool

Providers should use the Prior Authorization Look Up Tool on the Availity Provider Portal to quickly determine if an authorization is required. By entering Member Group Number, Date of Service and Procedure Code, the tool will indicate whether an Authorization is required. If an Authorization is not required, the tool will allow the user to print the results for their records. If an Authorization is required, the user will move directly into the next field in Authorization application to complete the request.

This feature is accessible for lines of business managed by Blue Cross and will advise providers if Blue Cross or eviCore will review the request.

To access the Prior Authorization Look Up Tool:

1. Log in at **Availity.com**
2. Select **Patient Registration**, choose **Authorizations & Referrals**, then **Authorizations**
3. Select Payer **BCBSMN**, your Organization, Transaction Type **Outpatient** and you will be redirected to the Authorization Look Up Tool application

To submit a Prior Authorization (PA) Request to eviCore

Providers submit eviCore PA requests via our free **Availity** provider portal. There is no cost to the provider for using the portal.

Instructions on how to utilize this portal are found on the Availity website. Providers should reference the eviCore clinical guideline criteria, submit prior authorization requests via Availity, and submit 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 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.

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.

Questions?

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

Update: eviCore Healthcare Specialty Utilization Management – Durable Medical Equipment (DME) for Medicare Advantage Subscribers (P94-20, published 12/1/20)

Effective February 1, 2021 the eviCore DME prior authorization (PA) list will be revised with multiple codes being added and/or removed from the list. Providers can determine what Healthcare Procedure Coding System codes (HCPCS) require PA by visiting the Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) website at **providers.bluecrossmn.com** (see below for details).

To view CPT/HCPCS Code lists:

- Access the 'Provider Section' of the Blue Cross website at **providers.bluecrossmn.com**
- Select "**Medical Policy**" under *Tools and Resources*, read and accept the Blue Cross Medical Policy Statement
- Under "Medical and Behavioral Health Policies" scroll down and click on the "**eviCore healthcare Specialty Utilization Management Clinical Guidelines**" link
- Select "**Solution Resources**" and then click on the appropriate solution (ex: Cardiology)
- Select "**CPT Codes**" to view the current CPT code list that require a prior authorization

To view Clinical Guidelines:

- Access the 'Provider Section' of the Blue Cross website at **providers.bluecrossmn.com**
- Select "**Medical Policy**" under *Tools and Resources*, read and accept the Blue Cross Medical Policy Statement
- Under "Medical and Behavioral Health Policies" scroll down and click on the "**eviCore healthcare Specialty Utilization Management Clinical Guidelines**" link
- Click on the "**Resources**" dropdown in upper right corner
- Click "**Clinical Guidelines**"
- Select the appropriate solution: i.e. Cardiology & Radiology
- Type "**BCBS MN**" (space is important) in 'Search by Health Plan'
- Click on the "**Current**", "**Future**", or "**Archived**" tab to view guidelines most appropriate to your inquiry

Products Impacted
This change only applies to Medicare Advantage subscribers.

Prior Authorization Look Up Tool
Providers should use the Prior Authorization Look Up Tool on the Availity Provider Portal to quickly determine if an authorization is required. By entering Member Group Number, Date of Service and Procedure Code, the tool will indicate whether an Authorization is required. If an Authorization is not required, the tool will allow the user to print the results for their records. If an Authorization is required, the user will move directly into the next field in Authorization application to complete the request.

This feature is accessible for lines of business managed by Blue Cross and will advise providers if Blue Cross or eviCore will review the request.

To access the Prior Authorization Look Up Tool:

1. Log in at **Availity.com**
2. Select **Patient Registration**, choose **Authorizations & Referrals**, then **Authorizations**
3. Select Payer **BCBSMN**, your Organization, Transaction Type **Outpatient** and you will be redirected to the Authorization Look Up Tool application

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Providers submit eviCore PA requests via our free **Availity** provider portal. There is no cost to the provider for using the portal.

Instructions on how to utilize this portal are found on the Availity website. Providers should reference the eviCore clinical guideline criteria, submit prior authorization requests via Availity, and submit 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 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.

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.

Questions?

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

Skilled Nursing Facility Prior Authorization Waiver (P92-20, published 12/1/20)

Due to the increasing number of COVID-19 cases, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) has suspended the prior authorization requirement for admissions from an Acute Care Facility to a Skilled Nursing Facility (SNF).

The waiver applies for SNF admission dates November 12, 2020 through December 31, 2020 for commercial and Medicare Advantage subscribers.

The waiver applies for SNF admission dates November 17, 2020 through December 31, 2020 for Minnesota Health Care Programs.

Providers must continue to submit notifications of admissions, so the admission can be approved, tracked, and followed up on throughout the length of stay. Admissions to a SNF will be approved for the first 7 days to help free up hospital beds.

Questions?
If you have questions for a member enrolled in a Minnesota Health Care Programs (MHCP) plan, please contact provider services at **1-866-518-8448**. Please contact provider services at **(651) 662-5200** or **1-800-262-0820** for all other questions.

MINNESOTA HEALTH CARE PROGRAMS (MHCP) UPDATES

Updated Minnesota Health Care Programs and Minnesota Senior Health Options (MSHO) Prior Authorization and Medical Policy Requirements (P93-20, published 12/1/20)

Effective February 1, 2021, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be updating its government programs medical policy and pre-authorization/pre-certification/notification lists. The lists clarify medical policy, prior authorization, and notification requirements for the Minnesota Health Care Programs (Families and Children, MinnesotaCare, and Minnesota Senior Care Plus) and Minnesota Senior Health Options (MSHO) products.

As stewards of health care expenditures for our members, we are charged with ensuring they receive appropriate, quality care while also maintaining overall costs. The prior authorization process ensures that the health service or drug being proposed is medically necessary, and reflective of evidence-based medicine and industry standards, prior to treatment. This process helps us manage the cost and quality of care appropriately for our members.

The following **new** policies and/or prior authorization requirements **will be applicable** to member claims on or after **February 1, 2021**.

Policy #	Policy Name	New Policy	Prior Authorization Required	
			Medicaid	MSHO
MED.00134	Non-invasive Heart Failure and Arrhythmia Management and Monitoring System	Yes	No	No
SURG.00156	Implanted Artificial Iris Devices	Yes	No	No
SURG.00157	Minimally Invasive Treatment of the Posterior Nasal Nerve to Treat Rhinitis	Yes	No	No
ING-CC-0170	Uplizna (inebilizumab)	Yes	Yes	Yes
ING-CC-0172	Viltepso (viltolarsen)	Yes	Yes	Yes

Policy #	Policy Name	New Policy	Prior Authorization Required	
			Medicaid	MSHO
ING-CC-0168	Tecartus (brexucabtagene autoleucel)	Yes	Yes	Yes
ING-CC-0171	Zepzelca (lurbinectedin)	Yes	Yes	Yes
ING-CC-0169	Phesgo (pertuzumab/trastuzumab/hyaluronidase-zzxf)	Yes	Yes	Yes
ING-CC-0179	Blenrep (belantamab mafodotin-blmf)	Yes	Yes	Yes
ING-CC-0180	Monjuvi (tafasitamab-cxix)	Yes	Yes	Yes

The following policies have transitioned to new policy numbers, with changes in clinical criteria, and **will be applicable** to member claims on or after **February 1, 2021**.

New Policy #	Prior Policy #	Policy Name	Prior Authorization Required	
			Medicaid	MSHO
ING-CC-0178	MHCP	Synribo (omacetaxine mepesuccinate)	Yes	Yes
ING-CC-0176	MHCP	Beleodaq (belinostat)	Yes	Yes
ING-CC-0175	MHCP	Proleukin (aldesleukin)	Yes	Yes
MHCP	ING-CC-0161	Sarclisa (isatuximab-irfc)	Yes	Yes
MHCP	ING-CC-0162	Tepezza (teprotumumab-trbw)	Yes	Yes
MHCP	ING-CC-0163	Durysta (bimatoprost implant)	Yes	Yes
MHCP	ING-CC-0165	Trodelvy (sacituzumab govitecan)	Yes	Yes
MHCP	ING-CC-0041	Ultomiris (ravulizumab-cwvz)	Yes	Yes

The following policies have changes in clinical criteria and **will be applicable** to member claims on or after **February 1, 2021**.

Policy #	Policy Name	Prior Authorization Required	
		Medicaid	MSHO
ADMIN.00006	Review of Services for Benefit Determinations in the Absence of a Company Applicable Medical Policy or Clinical Utilization Management (UM) Guideline	No	No
CG-DME-44	Electric Tumor Treatment Field (TTF)	Yes	Yes
CG-MED-51	Three-Dimensional (3-D) Rendering of Imaging Studies	Yes	Yes
CG-MED-63	Treatment of Hyperhidrosis	Yes	Yes
CG-MED-69	Inhaled Nitric Oxide	No	No
CG-SURG-01	Colonoscopy	No	No
CG-SURG-15	Endometrial Ablation	No	No

Policy #	Policy Name	Prior Authorization Required	
		Medicaid	MSHO
CG-SURG-59	Vena Cava Filters	No	No
CG-SURG-83	Bariatric Surgery and Other Treatments for Clinically Severe Obesity	Yes	Yes
GENE.00052	Whole Genome Sequencing, Whole Exome Sequencing, Gene Panels, and Molecular Profiling	Yes	Yes
LAB.00011	Analysis of Proteomic Patterns	No	No
SURG.00077	Uterine Fibroid Ablation: Laparoscopic, Percutaneous, or Transcervical Image Guided Techniques	No	No
SURG.00112	Implantation of Occipital, Supraorbital, or Trigeminal Nerve Stimulation Devices (and Related Procedures)	No	No
SURG.00128	Implantable Left Atrial Hemodynamic Monitor	No	No
ING-CC-0132	Mylotarg (gemtuzumab ozogamicin)	Yes	Yes
ING-CC-0104	Levoleucovorin Agents	Yes	Yes
ING-CC-0094	Alimta (pemetrexed disodium)	Yes	Yes
ING-CC-0061	GnRH Analogs for the Treatment of Non-Oncologic Indications	Yes	Yes
ING-CC-0141	Off-Label Drug and Approved Orphan Drug Use	No	No
ING-CC-0021	Fabrazyme (agalsidase beta)	Yes	Yes
ING-CC-0017	Xiaflex (collagenase clostridium histolyticum)	Yes	Yes
ING-CC-0023	Naglazyme (galsulfase)	Yes	Yes
ING-CC-0024	Elaprase (idursulfase)	Yes	Yes
ING-CC-0025	Aldurazyme (laronidase)	Yes	Yes

The following policies and/or prior authorization requirements will be archived and **will not be applicable** under the medical benefit plan to member claims on or after **February 1, 2021**.

Policy #	Policy Name	Prior Authorization Required	
		Medicaid	MSHO
MHCP	Hereditary Angioedema Agents	Yes	Yes
ING-CC-0035	Duopa (carbidopa and levodopa enteral suspension)	Yes	Yes
CG-SURG-74	Total Ankle Replacement	Yes	Yes
RAD.00062	Intravascular Optical Coherence Tomography (OCT)	No	No

Where do I find the current government programs Pre-Certification/Pre-Authorization/Notification list?

Go to **https://provider.publicprograms.bluecrossmn.com/minnesota-provider/resources/prior-authorization**.

OR

Go to **providers.bluecrossmn.com**

- Under *Tools & Resources*, select **Minnesota Health Care Programs site**.
- Under *Resources*, select **Prior Authorization Requirements** and scroll down to *Related Information* to select **Prior Authorization Grid**.

Where do I find the current government programs Medical Policy Grid?

Go to **https://provider.publicprograms.bluecrossmn.com/minnesota-provider/resources/provider-manuals-and-guides**.

- Select **Medical Policies and UM Guidelines**.

OR

Go to **providers.bluecrossmn.com**.

- Under *Tools & Resources*, select **Minnesota Health Care Programs site**.
- Under *Resources*, select **Manuals and Guides**.
- Select **Medical Policies and UM Guidelines**.

Where can I access medical policies?

- **MN DHS (MHCP) Policies:**

  http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_157386

- **Blue Cross policies:**

  https://www.bluecrossmn.com/providers/medical-policy-and-utilization-management

- **Amerigroup policies:**

  https://provider.publicprograms.bluecrossmn.com/minnesota-provider/medical-policies-and-clinical-guidelines

  AND

  https://www.anthem.com/pharmacyinformation/clinicalcriteria

Note: The Prior Authorization Lookup Tool (PLUTO) is not available for prior authorization look up.

Questions?
If you have questions, contact Provider Services at **1-866-518-8448**.

Urine Drug Testing (UDT) Limits and Prior Authorizations for Minnesota Health Care Programs (MHCP) (P90-20, published 12/1/20)

Effective February 1, 2021, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be enforcing presumptive urine drug testing (UDT) limits published by the Minnesota Department of Human Services (DHS). DHS guidelines on drug testing state that presumptive UDT is limited to 15 tests within a 12-month period. UDT after the identification of the patient's drugs use or abuse profile must be limited to the specific drugs present on the initial profile. Claims submitted for services that exceed the published guidelines will be denied.

In addition, Blue Cross will be implementing the following limits and prior authorization requirements effective February 1, 2021:

Limits
Limits will be enforced according to DHS/MHCP guidelines, including:

"The frequency of drug testing should be individualized to the treatment plan and should not exceed one every seven days at any time during the treatment."

Any presumptive UDT (CPT code 80307) with a date of service less than 7 days from the previous presumptive UDT will be subject to denial or recoupment. Also, any definitive UDT (HCPCS codes G0480-G0483) with a date of service less than 7 days from the previous definitive UDT will be subject to denial or recoupment.

Prior Authorization Requirements
Prior authorization will be required for the definitive UDT code G0483.

Prior authorization requests will be reviewed according to DHS guidelines, including: Drug or drug classes for which screening is performed, should only reflect those likely to be present based on the patient's medical history or current clinical presentation.

Products Impacted:

- Blue Advantage Families and Children (F&C)
- Minnesota Senior Care Plus (MSC+)
- SecureBlue (MSHO)
- MinnesotaCare (MNCare)

Click **here** to access DHS/MHCP guidelines on Drug Testing.

Questions?
If you have questions, please contact Provider Services at **1-866-518-8448**.