PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

WHAT'S INSIDE: **June 3, 2019**

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**

Update: Professional Liability (Malpractice) Coverage Requirements

(P1R1-19, published 5/1/19 and 6/3/19)

The information in this Provider Bulletin replaces Professional Liability (Malpractice) Coverage Requirements Bulletin P1-19 published on January 2, 2019.

In Bulletin P1-19, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) announced that effective July 1, 2019, professional liability (malpractice) insurance coverage requirements were changing for participating providers. Blue Cross has since made the decision to postpone any changes to these requirements until further review on the topic.

Therefore, the current requirements for all participating providers to continuously maintain professional liability (malpractice) coverage in the amount of $1 million per incident and $3 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 remain. Common Carrier and Special Transportation providers are required to carry automobile insurance liability coverage of no less than $1 million per incident and $3 million aggregate.

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

Provider Reimbursement Calculation for Legacy Platform Runout Claims

(P52-19, published 6/3/19)

As previously communicated in Provider Bulletin P24-19, the decommissioning of Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) legacy claims processing systems will be initiated during the third quarter of 2019. Decommissioning impacts the system's ability to fully function as it currently does and therefore a change to the methodology in which to calculate reimbursement is necessary. Providers may see runout claims processed using an alternate reimbursement methodology as early as August 1, 2019.

Runout claims will begin to process according to a percent of charge methodology beginning August 1, 2019. Blue Cross will determine the percent of charge reimbursement level at an amount equal to or greater than the Provider's current aggregate billed to charge ratio for 2018 health services. These rates are calculated by evaluating one year's worth of Provider specific claims data to determine an aggregate percent of charges for each provider by line of business (commercial, Medicare, and Medicaid) and type of claim (professional, facility inpatient, and facility outpatient) submitted.

The impacted decommissioning claims and appeals are primarily for Minnesota Health Care Programs (Families and Children, MNCare, MSC+, MSHO) with dates of service prior to 2019, but may also include claims and appeals from other lines of business for earlier dates of service. Providers are encouraged to submit claims, including replacement claims, and appeals as promptly as possible according to claim submission guidelines to ensure efficient and timely claim payment. All claims are subject to all other payment terms as outlined in the Agreement.

All actively participating Providers will receive a letter with their calculated percent of charges reimbursement in the mail no later than June 10, 2019.

Questions?

If providers do not receive a letter regarding reimbursement arrangement information by June 10, 2019 or have additional questions regarding this reimbursement, please provide your NPI and or Internal Reference Number from your contract and email decommission.reimbursement@bluecrossmn.com.

If providers have any questions about overall reimbursement or the new operating system they can contact provider services at **(651) 662-5200** or **1-800-262-0820**.

Update: Provider Telephone Number Added - Change to TPA Business and Submitting Claims for TPA Plan Members (P50R1-19, published 5/1/19 and 6/1/19)

The information in this Provider Bulletin replaces the previous Bulletin (P50-19) that was published on May 1, 2019. A telephone number has been added for providers to contact if they need assistance.

As previously communicated (Provider Bulletins P14-19, P35-18, P41-18 and P76-18), Independence Health Group 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).

As of January 1, 2019, all these members were transferred to AHA systems. Between October 1, 2018, and January 1, 2019, the plan members received ID cards with the BlueLink TPA* name and logo; they access the BlueCard® program of network providers.

Submitting claims with dates of service in 2018 or prior for your patients who carry a BlueLink TPA ID card:

For patients carrying an ID card with the following groups numbers – electronic claims submission will be turned off by June 15, 2019.

Client/ Group Name	Old Group Number
Action Floor Systems	5MN04690
Activar	5MN03730
AG Partners	5MN04910
Aicota Health Care	5MN05980
Albert Lea Select Foods	5MN03810
Appleton Hospital	5MN05970
Arrow Tank	5MN06080
Arrowhead Promotion & Fulfillment	5MN04920
Artisans Inc	5MN04890
Austin Public Schools	5MN04940
BendTec Inc	5MN04540
Bois Forte Reservation Tribal Council	5MN04610
Brenny Transportation Inc	5MN05830
Capstan Corporation	5MN05530
Carl Bolander	5MN04300
Catholic Charities Bureau	5MN04500
Cedar Corporation	5MN04780
City of Austin	5MN05760
Community Memorial Hospital	5MN02000
Davasee Enterprises	5MN03090
Design Electric, Inc.	5MN05570
Diocese of Superior	5MN04490
Direct Fulfillment	5MN05630
Douglas Corporation	5MN01370
Ely Bloomensen	5MN05990
Flandreau Santee Sioux Tribe	5BL05900
Fond du Lac CHS	5MN03960
Fortune Bay Casino Resort	5MN02810
Genesis Publishing	5MN05740

Client/ Group Name	Old Group Number
Grand Forks Public Schools	5MN05610
Grand Portage	5MN03610
Grandmas Inc	5MN04750
Hank's Specialties	5MN06040
Hiawatha Rubber Company	5MN05470
Human Development Center	5MN06010
Jackpot Junction Casino Hotel	5MN05700
Javens Mechanical Contracting Co	5MN06070
Jeff Foster Trucking	5MN04820
Lower Sioux Indian Community	5MN05690
Marine Credit Union	5MN05440
Minnco Credit Union	5MN05560
Modernistic	5MN03370
National Bank of Commerce	5MN05880
North Shore Bank of Commerce	5MN03740
Northeast Regional Corrections Center	5MN03050
Northwood Children's Services	5MN03910
NRI Electronics	5MN06010
Nystrom & Associates, Ltd.	5MN05720
OB-GYN & Assoc	5MN05430
OSI Environmental	5MN03940
PACA (Apex International)	5MN03130
Prairie Island	5BL05910
Quality Pork Processors, Inc	5MN04140
Randy's Sanitation	5MN04370
Red Lake Nation	5MN03300
Red Wing Publishing	5MN03870
Republic Bank, Inc.	5MN04640
Shakopee Mdewakanton Sioux Community	5BL05820
Southern Minnesota Regional Legal Services, Inc.	5MN05850
Specialty Manufacturing	5MN03410
Spectro Alloys	5MN04100
St. Croix Chippewa Indians of WI	5MN05930
St. Louis County Jail	5MN02590
St. Paul Stamp	5MN06050
Sterling State Bank	5MN03820
Torgerson Properties, Inc	5MN03460
Transit Team	5MN06060
Treasure Island Resort & Casino	5BL05920
Tuohy Furniture Corporation	5MN02050
Upper Lakes Foods, Inc	5MN03380

Client/ Group Name	Old Group Number
Upper Sioux Community	5MN05940
Wells Concrete	5MN04860
White Earth Band of Chippewa Indians/National Tribal Claims Center	5MN05950
Woodland Centers	5MN03510

For adjustments or claims for services you performed prior to December 31, 2018
Providers have until the end of day of June 14, 2019 to electronically submit claims through the Blue Cross and Blue Shield of Minnesota provider portal (Availity). Electronic submissions will no longer be available after this date. Should you have any questions, please call **1-833-803-4459**.

Providers will need to submit paper claims to:

BlueLink TPA
c/o Processing Center
P.O. 21974
Eagan, MN 55121

Claims will be processed following the applicable terms for timely submission. Electronic submission will no longer be available for such claims only because of the decommissioning of the Blue Cross and Blue Shield of Minnesota Legacy claims system which requires that an alternative solution be implemented for the very few claims that are impacted due to this claims system change.

*BlueLink TPA is a product of QCC Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association.

CONTRACT UPDATES

Precertification for Commercial Inpatient Admissions Effective September 1, 2019

(P54-19, published 6/3/19)

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 policy requiring a precertification submission for all planned, acute, inpatient admissions for commercial members. Concurrent review will also be required for continued stays to ensure medical appropriateness and assist with transition of care.

While pre-admission notification (PAN) has been required for all Blue Cross members since early 2016, precertification is currently only required for Medicaid, Medicare Advantage and Federal Employee Program (FEP) members. This new policy will go into effect for dates of admission on or after **September 1, 2019**.

All unplanned emergency admissions (including detox and labor and delivery admissions) will not require clinical review at the time of admission but will require notification to the plan. These admissions must be medically necessary and are subject to retrospective review or audit. Concurrent reviews will be required for continued stays longer than two days for emergency admissions, two days for vaginal delivery, four days for cesarean delivery, or three days for detox.

Precertification requests must be submitted via the Availity Authorization Portal (see Bulletin P27-19) prior to the admission and should include all relevant clinical information to support the medical necessity for inpatient level of care. If the service or procedure planned during the inpatient admission requires a Prior Authorization (PA), the PA must be obtained prior to submitting the precertification. For specific details on precertification decision and notification timeframes, please refer to chapter four of the Provider Policy and Procedure Manual (PPPM).

While precertification will be required prior to the service being rendered, certain circumstances may make this difficult. Retrospective clinical review will be considered by Blue Cross in these circumstances for up to 48 hours from the time of inpatient admission and prior to the claim being submitted.

Admissions for newborns less than 30 days old that are not yet added to the subscriber's policy, observation stays, and outpatient procedures/services do not require inpatient precertification or notification.

Beginning January 1, 2020, if a precertification is not submitted prior to the admission, the claim for the entire stay will be denied and the provider will be held liable. **The claim denial will be administrative and cannot be appealed for medical necessity. Medical necessity appeals *will* be accepted for dates of admission between September 1, 2019 and December 31, 2019, allowing additional time for providers to adjust.**

Exceptions/Exemptions:
Beginning January 1, 2020, an appeal may be submitted for **limited administrative situations** when a claim is denied due to lack of precertification. These exceptions are listed below and must be supported by submitted documentation:

- Blue Cross is the subscriber's secondary coverage and precertification is not required
- 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 date of admission
- Extenuating circumstances beyond the control of the 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)

Summary:

CURRENT PROCESS (Commercial)	EFFECTIVE SEPTEMBER 1, 2019 (Commercial)	EFFECTIVE JANUARY 1, 2020 (Commercial)
A pre-admission notification must be submitted to Blue Cross when a member is admitted to an inpatient facility. No clinical review process is required.	Precertification must be submitted prior to planned inpatient admission. If approved, the claim will process according to the member's benefits. If no precertification is submitted, the claim will deny, and medical necessity appeal will be allowed.	Precertification must be submitted prior to planned inpatient admission. If approved, the claim will process according to the member's benefits. If precertification has not been received, claim payment will be denied. Limited administrative appeals will be accepted.

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

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATES

Musculoskeletal Program Updates for Fully Insured Commercial and Medicare Advantage Subscribers – eviCore Healthcare Specialty Utilization Management Program (P51-19, published 6/3/19)

eviCore has released clinical guideline updates for their Musculoskeletal program. Updates to these programs will become **effective beginning August 1, 2019:**

Musculoskeletal guideline updates will post on June 1, 2019.

The following interventional pain and large joint guidelines have updated:

- CMM-200: Epidural Steroid Injections
- CMM-203: Sacroiliac Joint Injections
- CMM-208: Radiofrequency Ablation
- CMM-210: Implantables Intrathecal Drug Delivery Systems
- CMM-211: Spinal Cord Stimulators
- CMM-308: Thermal Intradiscal Procedures
- CMM-312: Knee Arthroscopic and Open Procedures
- CMM-313: Hip Replacement/Arthroplasty
- CMM-314: Hip Surgery Arthroscopic and Open
- CMM-400: Anesthesia Services for Interventional Pain Procedures

The following spine guidelines have updated:

- CMM-600: Preface to Spine Surgery Guidelines
- CMM-601: Anterior Cervical Discectomy and Fusion
- CMM-602: Cervical Total Disc Arthroplasty
- CMM-603: Electrical and Low Frequency Ultrasound Bone Growth Stimulation (Spine)
- CMM-604: Posterior Cervical Decompression (Laminectomy/Hemilaminectomy/ Laminoplasty) with or without Fusion
- CMM-605: Cervical Microdiscectomy
- CMM-606: Lumbar Microdiscectomy (Laminotomy, Laminectomy, or Hemilaminectomy)
- CMM-607: Primary Vertebral Augmentation (Percutaneous Vertebroplasty/ Kyphoplasty) and Sacroplasty
- CMM-609: Lumbar Fusion (Arthrodesis)
- CMM-611: Sacroiliac Joint Fusion or Stabilization
- CMM-612: Grafts

e**viCore's Musculoskeletal clinical guidelines are available on the Blue Cross website** at **providers.bluecrossmn.com**

- To access the link, 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**"
  - Scroll down to locate the "**Medical Policy Supporting Documents**" section
- Click on "**eviCore healthcare Specialty Utilization Management Clinical Guidelines**" link
  - Click on the "**Resources**" dropdown in upper right corner
  - Click "Clinical Guidelines"
  - Select **"Musculoskeletal Advanced Procedures"** solution
  - Type "**BCBS MN**" (space is important) in *'Search by Health Plan'*
  - Click on "**Future**" tab
  - Select desired document

Products Impacted
This change only applies to:

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

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

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

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 PA Request to eviCore
Providers submit eviCore PA requests via our free **Availity** provider portal.

Instructions on how to utilize this portal are found on the Availity website. Providers need to reference the eviCore clinical guideline criteria, submit prior authorization request 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.

Questions?
If you need to submit a PA by phone or need to speak to an eviCore representative call **844-224-0494**, 7:00 a.m. to 7:00 p.m. CST, Monday - Friday.

Update: eviCore Medicare Advantage DME Prior Authorization Code List Update
(P411R1-19, published 6/3/19)

The information in this Provider Bulletin replaces Bulletin P41-19, published on May 1,2019. The only change is in reference to bullet point number five, providers select "Durable Medical Equipment" not "Post-Acute Care".

Effective May 31, 2019, the prior authorization (PA) requirement will be removed for several CPT® codes on the eviCore Medicare Advantage Durable Medical Equipment (DME) Prior Authorization code list. Removed codes relate to accessories or features of wheelchairs and wheelchair repair as well as low cost items such as canes, crutches, orthoses and certain prostheses.

The updated code list is 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
- Click on **"Solution Resources"** tab
- Select **"Durable Medical Equipment"**
- Click on **"CPT Codes"**

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

New Medical, Medical Drug and Behavioral Health Policy Management Updates

(P53-19, published 6/3/19)

Effective August 5, 2019, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be expanding utilization management requirements for commercial 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 August 5, 2019 for commercial lines of business:

Policy #	Policy Title/ Service	New Policy	Prior Authorization Requirement	Line(s) of Business
II-228	Caplacizumab (Cablivi®)	Yes *(Replacing policy II-173)*	Continued	Commercial
II-229	Ravulizumab (Ultomiris™)	Yes *(Replacing policy II-173)*	Continued	Commercial
II-69	Amino Acid-Based Elemental Formulas	No	Removed	Commercial

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) 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 July 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

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

Change to Prior Authorization Requirements for Radiology Program for Fully Insured Commercial and Medicare Advantage Subscribers – eviCore HealthCare Specialty Utilization Management (UM) Program (P55-19, published 6/3/19)

eviCore will remove the prior authorization (PA) requirements applicable to the Radiology Program for radiology reads only (professional component submitted with a 26-modifier) when billed by an entity **other than** the facility performing the service for fully insured commercial and Medicare Advantage subscribers. The system is anticipated to be updated mid-June 2019. Radiology claims that include the technical component (claims billed globally, or claims billed with a TC-modifier) will continue to be subject to the prior authorization requirements.

Radiology reads denied for no prior authorization on file at the time the claim was processed will be reprocessed and overturned without an appeal from the provider. Radiology reads denied previously for not meeting medical necessity will not be reprocessed or overturned.

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

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

MINNESOTA HEALTH CARE PROGRAMS (MHCP) UPDATES

Updated Minnesota Health Care Programs and Minnesota Senior Health Options Prior Authorization, Notifications, and Medical Policy Requirements (P56-19, published 6/3/19)

Effective August 1, 2019, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be updating its government programs medical policy and prior authorization/precertification/notification lists. The lists clarify medical policy, prior authorization, and notification requirements for the Minnesota Health Care Programs (Prepaid Medical Assistance Program, MinnesotaCare, and Minnesota Senior Care Plus) and Minnesota Senior Health Options (MSHO) products.

As stewards of health care expenditures for our subscribers, 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.

Durable Medical Equipment (DME) Prior Authorization Update

The following new prior authorization requirements **will be applicable** to subscriber claims on or after August 1, 2019.

Code	Code description	Policy source	Prior authorization required	
			Medicaid	MSHO
A6509	Compression burn garment, upper trunk to waist including arm openings (vest), custom fabricated	MHCP	Yes	Yes
A6511	Compression burn garment, lower trunk including leg openings (panty), custom fabricated	MHCP	Yes	Yes
A6549	Gradient compression stocking, not otherwise specified	MHCP	Yes	Yes
A9277	Transmitter; external, for use with interstitial continuous glucose monitoring system	MHCP	Yes	Yes
A9278	Receiver (monitor); external, for use with interstitial continuous glucose monitoring system	MHCP	Yes	Yes
A9999	Miscellaneous DME supply or accessory, not otherwise specified or HIPPS code Default Code - used for informational-only	MHCP	Yes	Yes
E0619	Apnea monitor, with recording feature	MHCP	Yes	Yes
E0625	Patient lift, bathroom or toilet, not otherwise classified	MHCP	Yes	Yes
E0641	Standing frame system, multi-position (e.g., 3-way stander), any size including pediatric, with or without wheels.	MHCP	Yes	Yes
E2300	Power wheelchair accessory, power seat elevation system	MHCP	Yes	Yes
E2301	Wheelchair accessory, power standing system, any type	MHCP	Yes	Yes
E2331	Power wheelchair accessory, attendant control, proportional, including all related electronics and fixed mounting hardware	MHCP	Yes	Yes
E2510	Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access	MHCP	Yes	Yes
E2512	Accessory for speech generating device, mounting system	MHCP	Yes	Yes
E2609	Custom fabricated wheelchair seat cushion, any size	MHCP	Yes	Yes
E2617	Custom fabricated wheelchair back cushion, any size, including any type mounting hardware	MHCP	Yes	Yes
E8000	Gait trainer, pediatric size, posterior support, includes all accessories and components	MHCP	Yes	Yes
E8001	Gait trainer, pediatric size, upright support, includes all accessories and components	MHCP	Yes	Yes

Code	Code description	Policy source	Prior authorization required	
			Medicaid	MSHO
E8002	Gait trainer, pediatric size, anterior support, includes all accessories and components	MHCP	Yes	Yes
K0108	Wheelchair component or accessory, not otherwise specified	MHCP	Yes	Yes
K0884	Power wheelchair, group 4 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	MHCP	Yes	Yes
L0999	Addition to spinal orthotic, not otherwise specified	MHCP	Yes	Yes
L1499	Spinal orthotic, not otherwise specified	MHCP	Yes	Yes
L5999	Lower extremity prosthesis, not otherwise specified	MHCP	Yes	Yes
L8692	Auditory Osseointegrated Device, External Sound Processor, Used Without Osseointegration, Body Worn, Includes Headband	MHCP CG-SURG-82	Yes	Yes

Behavioral Health (BH) Prior Authorization (PA) Claims Denial Update

Blue Cross recently identified that certain codes, which should not have required a PA for BH services, have denied for no PA. The codes listed below have been **removed** from requiring PA effective **April 1, 2019**.

An update to the system is in progress, and any claims that denied incorrectly for no PA will be reprocessed.

Code	Behavioral health prior authorization requirement
0362T	No Prior Auth required effective 04/01/2019
97151	No Prior Auth required effective 04/01/2019
99366	No Prior Auth required effective 04/01/2019
H0025	No Prior Auth required effective 04/01/2019
H0032	No Prior Auth required effective 04/01/2019
H0038	No Prior Auth required effective 04/01/2019
H0040	No Prior Auth required effective 04/01/2019
H0045	No Prior Auth required effective 04/01/2019
H0046	No Prior Auth required effective 04/01/2019
H2014	No Prior Auth required effective 04/01/2019
H2015	No Prior Auth required effective 04/01/2019
H2027	No Prior Auth required effective 04/01/2019
S5145	No Prior Auth required effective 04/01/2019
T1016	No Prior Auth required effective 04/01/2019
T2023	No Prior Auth required effective 04/01/2019

In addition, the BH notification requirement has been **removed** for the following codes effective **April 1, 2019**.

Code	Service description
H0038	Self-help/peer services, per 15 minutes — Level I
H0038 HA	Certified family peer specialist services / Family Peer Services
H0038 HA HQ	Certified family peer specialist services — Group setting
H0038 HQ	Self-help/peer services, per 15 minutes — Group
H0038 U5	Self-help/peer services, per 15 minutes — Level II
H0040	Assertive community treatment program, per diem
H0040 HA	Assertive community treatment program, per diem (Youth)
H0040 HK	Assertive community treatment program, per diem (Forensic)
H2015	Comprehensive community support services, per 15 minutes
H2027	Psychoeducational service, per 15 minutes
H2027 HQ	Family psychoeducation — Recipient group (with multiple recipients)
H2027 HQ HR	Family psychoeducation — Family group (with multiple families with individuals present)
H2027 HQ HS	Family psychoeducation — Family group (with multiple families, individuals not present)
H2027 HR	Family psychoeducation — Recipient and family (with a single recipient and their family)
H2027 HS	Family psychoeducation — Family (with a single-family individual not present)

Medical Prior Authorization (PA) Claims Denial Update

Blue Cross recently identified that certain codes, which should not have required a PA for services, have denied for no PA. The codes listed below have been **removed** from requiring PA effective **April 1, 2019**.

An update to the system is in progress, and any claims that denied incorrectly for no PA will be reprocessed.

Code	Medical prior authorization requirement
99511	No Prior Auth required effective 04/01/2019
S9123	No Prior Auth required effective 04/01/2019
S9124	No Prior Auth required effective 04/01/2019
S9338	No Prior Auth required effective 04/01/2019
S9353	No Prior Auth required effective 04/01/2019
S9379	No Prior Auth required effective 04/01/2019

Code	Medical prior authorization requirement
S9494	No Prior Auth required effective 04/01/2019
S9497	No Prior Auth required effective 04/01/2019
S9500	No Prior Auth required effective 04/01/2019
S9501	No Prior Auth required effective 04/01/2019
S9502	No Prior Auth required effective 04/01/2019
S9503	No Prior Auth required effective 04/01/2019
S9504	No Prior Auth required effective 04/01/2019
S9542	No Prior Auth required effective 04/01/2019
S9810	No Prior Auth required effective 04/01/2019
T1022	No Prior Auth required effective 04/01/2019

Where do I find the current government programs *Pre-Certification/Pre-Authorization/Notification List*?
Go to **https://www.bluecrossmn.com/providers**:

- Under *Tools & Resources*, select **Medical Policy**, and read/accept the Blue Cross *Medical Policy and UM Statement*.
- Select the + next to *Utilization Management*, and under the *Precertification Lists* select the ***MN Government Programs Pre-Certification/Pre-Authorization/Notification List***

OR

Go to **https://www.bluecrossmn.com/providers**:

- Under *Tools & Resources*, select **Migration of Minnesota Health Care Programs**
- Select the + next to *Prior Authorizations*, and select the ***Prior Authorization Grid*** (**PDF**)

Where do I find the current government programs medical policy grid?
Go to **https://www.bluecrossmn.com/providers**:

- Under *Tools & Resources*, select **Migration of Minnesota Health Care Programs**
- Select the + next to *Medical Policies* and select the ***MHCP Medical Policy Grid*** (**PDF**)

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://medicalpolicies.amerigroup.com/am_search.html**
    - **https://www.anthem.com/pharmacyinformation/clinicalcriteria**

Please note that the Precertification Look-Up Tool (PLUTO) will not be available for prior authorization look up.

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