PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

September 1, 2021

Updated Minnesota Health Care Programs and Minnesota Senior Health Options (MSHO) Prior Authorization and Medical Policy Requirements

Effective November 1, 2021, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be updating its government program's 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 MSHO products.

As stewards of healthcare 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.

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

Policy #	Policy Name	New Policy	Prior Authorization Required	
			Medicaid	MSHO
CG-SURG-111	Open Sacroiliac Joint Fusion	Yes	No	No
ING-CC-0196	Zynlonta (loncastuximab tesirine-lpyl)	Yes	Yes	Yes
ING-CC-0197	Jemperli (dostarlimab)	Yes	Yes	Yes
ING-CC-0198	Relizorb (immobilized lipase) cartridge	Yes	Yes	Yes
MHCP	Cochlear Implants	No	Yes	Yes
JO-04	Musculoskeletal- Small Joint Surgery	Yes	No	No
ING-CC-0201	Rybrevant (amivantamab-vmjm)	Yes	Yes	Yes

The following policies have changes in clinical criteria and **will be applicable** to subscriber claims on or after **July 5, 2021**.

Policy #	Policy Name	Prior Authorization Required	
		Medicaid	MSHO
CG-SURG-01	Colonoscopy (Note: criteria changed from age 50 to age 45)	No	No

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

Policy #	Policy Name	Prior Authorization Required	
		Medicaid	MSHO
Blue Cross II-29	Intra-Articular Hyaluronan Injections for Osteoarthritis	Yes	Yes
Blue Cross IV-123	Gender Affirming Procedures for Gender Dysphoria	Yes	Yes
ANC.00007	Cosmetic and Reconstructive Services: Skin Related	Yes	Yes
ANC.00009	Cosmetic and Reconstructive Services of the Trunk and Groin	Yes	Yes
Blue Cross IV-152	Transcatheter Mitral Valve Repair	Yes	Yes
CG-MED-57	Cardiac Stress Testing with Electrocardiogram	No	No
CG-GENE-11	Genotype Testing for Individual Genetic Polymorphisms to Determine Drug-Metabolizer Status	Yes	Yes
CG-GENE-13	Genetic Testing for Inherited Diseases	Yes	Yes
CG-MED-70	Wireless Capsule Endoscopy for Gastrointestinal Imaging and the Patency Capsule	Yes	Yes
CG-SURG-12	Penile Prosthesis Implantation	Yes	Yes
CG-SURG-24	Functional Endoscopic Sinus Surgery (FESS)	Yes	Yes
CG-SURG-31	Treatment of Keloids and Scar Revision	Yes	Yes
CG-SURG-55	Intracardiac Electrophysiological Studies (EPS) and Catheter Ablation	Yes	Yes
CG-SURG-59	Vena Cava Filters	No	No
CG-SURG-71	Reduction Mammaplasty	Yes	Yes
CG-SURG-84	Mandibular/Maxillary (Orthognathic) Surgery	Yes	Yes
CG-SURG-89	Radiofrequency Neurolysis and Pulsed Radiofrequency Therapy for Trigeminal Neuralgia	Yes	Yes
CG-SURG-93	Angiographic Evaluation and Endovascular Intervention for Dialysis Access Circuit Dysfunction	Yes	Yes
MED.00004	Technologies for the Evaluation of Skin Lesions (including Dermatoscopy, Epiluminescence Microscopy, Videomicroscopy, Ultrasonography)	No	No
MED.00090	Wireless Capsule for the Evaluation of Suspected Gastric and Intestinal Motility Disorders	No	No
MED.00132	Adipose-derived Regenerative Cell Therapy and Soft Tissue Augmentation Procedures	Yes	Yes
SURG.00010	Treatments for Urinary Incontinence	Yes	Yes

Policy #	Policy Name	Prior Authorization Required	
		Medicaid	MSHO
SURG.00095	Viscocanalostomy and Canalplasty	No	No
SURG.00129	Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea or Snoring	Yes	Yes
SURG.00143	Perirectal Spacers for Use During Prostate Radiotherapy	No	No
SURG.00145	Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts)	Yes	Yes
SURG.00155	Cryoneurolysis	No	No
ING-CC-0137	Cablivi (caplacizumab-yhdp)	Yes	Yes
ING-CC-0002	Colony Stimulating Factor Agents	Yes	Yes
ING-CC-0192	Cosela (trilaciclib)	Yes	Yes
ING-CC-0099	Abraxane (paclitaxel, protein bound)	Yes	Yes
ING-CC-0098	Doxorubicin Liposome (Doxil, Lipodox)	Yes	Yes
ING-CC-0107	Bevacizumab for Non-Opthalmologic Indications (for Avastin, Mvasi, and Zirabev only)	Yes	Yes
ING-CC-0175	Proleukin (aldesleukin)	Yes	Yes
ING-CC-0142	Somatuline Depot (lanreotide)	Yes	Yes
ING-CC-0114	Jevtana (cabazitaxel)	Yes	Yes
ING-CC-0120	Kyprolis (carfilzomib)	Yes	Yes
ING-CC-0151	Yescarta (axicabtagene ciloleucel)	Yes	Yes
ING-CC-0150	Kymriah (tisagenleleucel)	Yes	Yes
ING-CC-0052	Dihydroergotamine (DHE) Injection	No	No
ING-CC-0057	Krystexxa (pegloticase)	Yes	Yes
ING-CC-0102	GnRH Analogs for Oncologic Indications	Yes	Yes
ING-CC-0061	GnRH Analogs for the Treatment of Non-Oncologic Indications	Yes	Yes
ING-CC-0087	Gamifant (emapalumab)	Yes	Yes
ING-CC-0194	Cabenuva (cabotegravir extended-release; rilpivirine extended-release) Injection	Yes	No

The following prior authorization requirements will be removed and **will not be applicable** under the medical benefit plan to subscriber claims on or after **November 1, 2021**. However, the policies will remain in effect.

Policy #	Policy Name	Prior Authorization Required	
		Medicaid	MSHO
ING-CC-0072	Selective Vascular Endothelial Growth Factor (VEGF) Antagonists (Avastin only)	Yes	Yes

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

Policy #	Policy Name	Prior Authorization Required	
		Medicaid	MSHO
CG-SURG-34	Diagnostic Infertility Surgery	No	No
DME.00024	Transtympanic Micropressure	Yes	Yes
LAB.00027	Selected Blood, Serum, and Cellular Allergy and Toxicity Tests	No	No
GENE.00042	Genetic Testing for Cerebral Autosomal Dominant Arteriopathy with Subcortical Infarcts and Leukoencephalopathy Syndrome	Yes	Yes

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 **www.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 **www.bluecrossmn.com**

- Under Tools & Resources, select **Minnesota Health Care Programs site**
- Under Resources, select **Manuals and Guides**
- Click on **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

Please note that the Precertification Look-Up Tool is not available for prior authorization look up.

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