PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

WHAT'S INSIDE: **March 1, 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**

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**

Medicare Advantage PPO Network Sharing Frequently Asked Questions

(P25-19, published 3/1/19)

What is Blue Cross and Blue Shield of Minnesota (Blue Cross) Medicare Advantage PPO Network Sharing?

All Blue Medicare Advantage PPO Plans participate in reciprocal network sharing. This network sharing allows all Blue MA PPO members to obtain in-network benefits when traveling or living in the service area of any other Blue MA PPO Plan as long as the member sees a participating MA PPO provider.

What does Blue Cross Medicare Advantage (MA) PPO Network Sharing mean to me?

Per the Blue Cross and Blue Shield Association (BCBSA) rules, effective with dates of service of January 1, 2019, if you are a participating MA PPO provider with Blue Cross in the Group Medicare Advantage network and you see MA PPO members from other Blue Plans, these members will be extended the same contractual access to care and

will be reimbursed in accordance with your Medicare Advantage rate in your Blue Cross contract. These members will receive in-network benefits in accordance with their member contract.

If you are not a participating MA PPO provider with Blue Cross and you provide services for any Blue Medicare Advantage members, you will receive the Medicare allowed amount for covered services. For Urgent or Emergency care, you will be reimbursed at the member's in-network benefit level. Other services will be reimbursed at the out-of-network benefit level.

How do I recognize an out-of-area member from one of these Plans participating in the BCBS MA PPO network sharing?

The *"MA"* in the suitcase indicates a member who is covered under the MA PPO network sharing program. Members have been asked not to show their standard Medicare ID card when receiving services; instead, members should provide their Blue Cross and/or Blue Shield member ID.

Do I have to provide services to Medicare Advantage PPO members from these other Blue Plans?

If you are a participating Medicare Advantage provider with Blue Cross, you should provide the same access to care as you do for Blue Cross Blue MA PPO members. You can expect to receive the same contracted rates for such services.

If you are not a Medicare Advantage participating provider, you may see a Blue Medicare Advantage member, however you are not required to. Should you decide to provide services to Blue Medicare Advantage members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member's out-of-network benefits. For Urgent or Emergency care, you will be reimbursed at the in-network benefit level.

Where do I submit the claim?

You should submit the claim to Blue Cross, under your current billing practices. Do not bill Medicare directly for any services rendered to a Medicare Advantage member.

What is the member cost sharing level and co-payments?

Out of area MA PPO members who see MA PPO participating providers in Minnesota, Blue Cross will pay the same cost sharing level (in-network cost sharing) they would pay if they received covered benefits from any MA PPO in-network providers in Minnesota. You may collect the co-payment amounts from the member at the time of service.

May I balance bill the member the difference in my charge and the allowance?

No, you may not balance bill the member for this difference. Members may be billed for any applicable deductibles, co-insurance, and/or co-pays in accordance with the provision of your Provider Service Agreement.

Blue Cross to Decommission Legacy Claims System (P24-19, published 3/1/19)

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) has completed the migration of members and groups off the legacy platform as of January 1, 2019. The Legacy system was Blue Cross' claims system in use prior to migration to our new claims system that began in the third quarter of 2015. With all members and groups now migrated, Blue Cross will decommission the legacy claims system in Quarter 3 of 2019.

While providers must submit claims, including replacement claims, and appeals as promptly as possible for efficient and timely processing in accordance with the provisions of their Provider Service Agreement, Blue Cross would like to emphasize the particular importance of submitting claims that process on the legacy operating system as promptly as possible. The impacted 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.

Medicare Crossover Process Change During Second Quarter 2019

(P31-19, published 3/1/19)

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) has completed the migration of members and groups off the legacy platform as of January 1, 2019. The Legacy system was Blue Cross' claims system in use prior to migration to our new claims system that began in the third quarter of 2015. With all members and groups now migrated, Blue Cross will decommission the legacy systems.

As part of the migration to the new platform, Blue Cross established Medicare Crossover agreements specific to our new claims system. With this, the decommission will also include the discontinuation of the legacy Medicare crossover agreements during the second quarter of 2019. Claims that are not automatically crossed over by Medicare should be submitted promptly by the provider to Blue Cross once Medicare has finalized the processing of the claims; the secondary claims should be sent with COB information providing all of the Medicare Payment information.

How to determine if a claim has crossed over from Medicare:

837P Crossover Information	837I Crossover Information
A note associated with the ANSI remark code indicates which payer will receive the claim information. Provider will continue to see MA18 and the name of the payer on the Medicare Remittance Advice (RA) when the payment information is forwarded to a single payer. However, code N89 will be used when the payment information is forwarded to multiple payers; only one of those payers will be named on the RA even though the payment information is forwarded to multiple payers.	The current message indicating the claim was sent to Blue Cross will continue to be displayed on the *Subscriber's Medicare Summary Notice (MSN)* or on the *Explanation of Medicare Benefits (EOMB)*. Medicare will indicate on Provider's Remittance Advice (RA), claim status codes of 19, 20 or 21 indicate that the claim was crossed over.

CONTRACT UPDATES

Required Use of Authorization Portal to Submit Preservice Inpatient and Outpatient Prior Authorization and PAN Requests (P27-19, published 3/1/19)

Effective May 1, 2019, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) providers will be required to go to the Availity® Provider Portal to submit preservice inpatient and outpatient prior authorization requests, including Pre-Admission Notifications (PANs) for all Commercial, Medicare Advantage, Medicare Cost and Federal Employee Program (FEP) lines of business. **Faxes and phone calls for these requests will no longer be accepted by Blue Cross (eviCore process is not changing).** Providers can create and inquire on the status of utilization management authorization requests electronically by logging in to **www.Availity.com**.

Submitting an authorization to BCBSMN in the Availity Portal is easy. Using the Availity portal for submission of prior authorization and PAN requests allows providers to:

- Determine if an authorization or PAN is required
- Determine if a request was received
- Route requests to the appropriate reviewer
- Electronically attach required clinical documentation
- Determine the status of all requests through a dashboard
- Receive real-time approval (for certain services)

If providers experience a technical issue when submitting a request, Availity Client Services at (**1-800-Availity** or **1-800-282-4548**) is available for assistance Monday through Friday from 7am to 6pm. If providers receive an error message, a prior authorization will be accepted by fax if a screen shot with a copy of the error message is included as the second page of the faxed request. If a copy of the error message is not included with the faxed request, the prior authorization will not be processed, and the provider will receive a faxed response redirecting them to the portal.

The following sections provide helpful tips and information about training, as well as how to use the portal to enter, search for, and update your Authorizations.

Training Opportunities
Providers can access the Blue Cross Authorization training demo and common question training guides from the Availity portal:

1. Click **Help & Training** | **Get Trained** (Availity Learning Center (ALC) opens a new tab)
2. Go to the very top of the ALC screen, search with the keyword “BCBSMN”
3. Click on the training document you want to access **or** click on the coarse title you want to enroll in **and**
4. Click **Enroll** in the top right corner and confirm that you want to enroll
5. Click **Start** to view the training

Webinar Trainings: Several live webinar trainings are scheduled for providers to get training and ask questions about how to most effectively use the portal for submitting authorizations.

How to Register:
Log onto Availity.com (Call Availity Client Services at **1-800-Availity** or **1-800-282-4548** if you need help)

1. Click **Help & Training | Get Trained** (Availity Learning Center (ALC) opens a new tab)
2. At the top center of the page, click **Sessions**
3. On the calendar, scroll to April or May to view all the live training sessions offered
4. Click **View Course** next to the date and time you want
5. Click **Enroll** at the top right corner of the screen
5. You will receive an email with information about the training immediately, one week before the training and the day of the training with a link to the webinar

Training Date	Training Time
4/8/19	2:30-4:00 PM
4/16/19	9:00-10:30 AM
4/18/19	1:00-2:30 PM
4/22/19	8:30-10:00 AM
4/24/19	1:00-2:30 PM
4/30/19	8:30-10:00 AM
5/2/19	1:00-2:30 PM
5/7/19	9:00-10:30 AM
5/9/19	12:30-2:00 PM
5/13/19	1:00-2:30 PM
5/15/19	10:00-11:30 AM

Authorization Process on Availity Portal
Use the Authorization process in the Availity Portal for all required preservice inpatient and outpatient prior authorization requests and for PANs.

Once you have successfully submitted an authorization request on Availity, you will receive an immediate response with a reference number and one of the following statuses:

- Approved
- Pending for Review
- Cancelled – No PA Required or Medicare is Primary or PPO Opt. Out
- Denied – Not a Covered Benefit or Experimental/Investigative

When a request is pended for review, you will be immediately prompted to attach supporting medical records. The request will not be processed until medical records are attached.

After submission is complete, you can access the Auth/Referral Dashboard where you can review requests you submitted in Availity and the current status of each request. When a pended request is completed, your Auth/Referral Dashboard will be updated with the final status and reason and the normal determination fax and letter will be generated.

Providers can also:

- Request a concurrent review authorization for additional days on an existing inpatient authorization
- Add discharge details on existing inpatient authorizations
- Attach additional medical records electronically during the clinical review process
- Inquire on the status of any utilization management request completed in the last year

Create an Authorization Request on Availity

1. Log in at **Availity.com**
2. Select **Patient Registration**, choose **Authorizations & Referrals**, then **Authorizations**
3. Select Payer BCBSMN, your Organization and you'll be redirected to the Authorization application
4. Select Inpatient Authorization or Outpatient Authorization
5. Complete the required fields in steps 1-3, then review and submit your authorization
   - If your Authorization is a specialty authorization, you may be routed to a vendor between steps 1 and 2 to complete the authorization process. As much data as possible will be sent to limit the need for re-entry.
6. Receive and print your confirmation for your records
   - If your submission was pended for clinical review, you must attach supporting medical records or your authorization request will not be processed

Inquire on an Authorization Request Entered in the Last Year

1. Log in at **Availity.com**
2. Select **Patient Registration**, choose **Authorizations & Referrals**, then **Auth/Referral Inquiry**
3. Select Payer BCBSMN, your Organization and you'll be redirected to the Inquiry application
4. Select Inpatient Authorization or Outpatient Authorization
5. Complete the required fields, then submit your Inquiry
6. Select the specific request from the inquiry results
7. Review the details returned in your inquiry. At this point, you will have the option to update the request. When you click the "Update" button, you will be taken to a portal to complete the update process. You can:
   - Request a concurrent review authorization for additional days on an existing inpatient authorization
   - Add discharge details on existing inpatient authorizations
   - Attach additional medical records electronically during the clinical review process

View the Status of Authorizations Submitted in Availity Using the Authorization & Referral Dashboard: The last 90 days of requests are on the dashboard, to view an older authorization perform an inquiry first.

1. Log in at **Availity.com**
2. Select **Patient Registration**, choose **Authorizations & Referrals**, then **Auth/Referral Dashboard**
   - The status is shown for each authorization request in the dashboard
   - Each authorization request will also show the name of the UM entity reviewing the request - BCBSMN or BCBSMN (vendor name)
3. Click on any request card in the dashboard. Additional authorization details will display.
4. Additionally, when selecting request card from the dashboard, you will be able to:
   - View details
   - Print details
   - Request a concurrent review authorization for additional days on an existing inpatient authorization
   - Add discharge details on existing inpatient authorizations
   - Attach additional medical records electronically during the clinical review process
5. From the dashboard, you can navigate to perform the following:
   - Inquiry
   - Create New Authorization or Referral
   - Find Referral – Additional for referrals ONLY

- BCBSMN will have a proprietary inquiry (FindRef) where the user will be taken to a new screen, and a call out to BCBSMN will occur with user entered information such as NPI and a date range.

InterQual® Level of Care Criteria for Authorizations

Submitting authorizations in the Availity Portal for hospital, acute rehabilitation and long-term acute care (LTAC) admission.

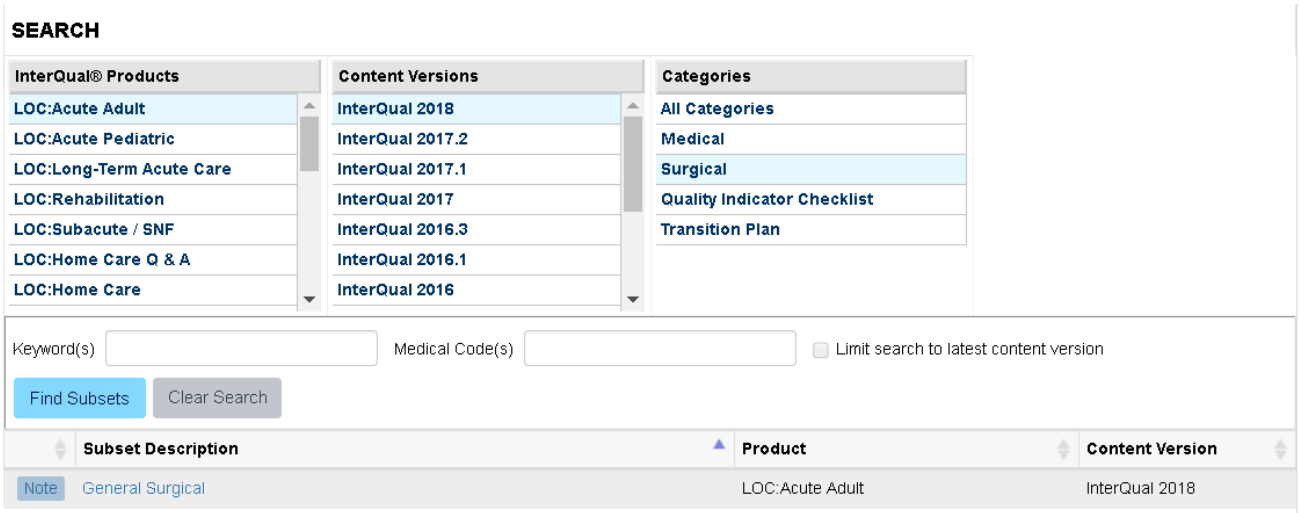
Providers submitting requests for these types of admissions will have the ability to complete the InterQual® Level of Care Criteria questionnaire prior to attaching medical records to the request.

Note: InterQual® Level of Care Criteria questionnaires are not available for preadmission notifications.

How to complete an InterQual® questionnaire from Availity

When a questionnaire is required, you will see the following screen after submitting the request. Select the "Click Here to Launch InterQual" link.

A new window will open with the questionnaire. Select the appropriate InterQual® Product, the current version, and the appropriate category for the type of admission requested. Click the blue link below the search box to begin the questionnaire.



In the next screen, select the Criteria from the menu on the left side of the screen and enter the information relevant to the patient in the panel on the right side until the questionnaire is complete.

When finished, click "Save" at the top of the screen, and close the window.

After Completing a Questionnaire
When InterQual® admission criteria are met for the level of care requested, the request will be approved immediately, and no further action will be required.

When criteria for admission are not met or not enough information is available to complete the questionnaire, the provider can continue the request submission process by saving the survey and then following the prompts to attach medical records to support the admission. The request will then be pended to a Care Manager for review.

When admission criteria are not met, the provider may elect to order an observation stay for the patient rather than moving forward with the request for admission. **If the patient will not be admitted, we ask providers to withdraw the request from the Auth/Referral Dashboard in Availity** (See Provider Quick Point QP97-18 for more detail).

Questions?
If you have questions regarding the use of Availity or a technical issue within Availity, please contact Availity Client Services at (**1-800-Availity** or **1-800-282-4548**) for assistance Monday through Friday from 7am to 6pm. For all other questions contact provider services at (**651) 662-5200 or 1-800-262-0820.**

Prior Authorization Start Date for Urgent and Non-Urgent Preservice Requests
(P23-19, published 3/1/19)

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) use the prior authorization (PA) process to review services **prior to being rendered** to help subscribers and providers determine when services are medically necessary and contractually eligible for coverage. Evidence based medical policy criteria and member contract language are used to assist in determining if benefits are available for the requested services.

Effective May 1, 2019, in order to ensure subscribers can make informed care decisions, Blue Cross will no longer include “planned” dates of service in the authorization approved date span if the planned date is prior to the date of determination. The approved date span will begin the date the approval determination is made. Providers submitting a request for prior authorization should wait to provide the service until a determination has been made. If the service is provided prior to the approved date span, the claim will deny for lack of prior authorization.

This change does not impact requests for services with a prescribed treatment plan or the retrospective review process described below.

PA requests for services that are provided over time as part of prescribed treatment plan, such as home health care, outpatient therapies, chiropractic service, and ongoing drug renewals, are reviewed and determined based on the patient’s medical condition and contract benefits available on the first date of service. If the treatment plan is medically necessary and approved, the authorization date span will align with the proposed treatment plan and will include the first date of service. These requests should be submitted within 14 days from the first date of service.

A retrospective review request is accepted when prior authorization is required, but the provider did not obtain the authorization prior to the service being rendered. Retrospective review requests should be submitted to Blue Cross within 14 days of the date of service and prior to the claim being submitted and should include a comment with the actual date the service was performed. Retrospective review will be completed based on the patient’s medical condition on the date of service and are processed and completed within 30 calendar days of receipt.

Please note:

- Retrospective review requests will not be accepted for chemotherapy requests reviewed by eviCore
- Genomic and Molecular Lab services will be accepted for up to 60 days from the date of specimen collection
- Retrospective authorization requests and pre-admission notifications for facility admissions must be submitted within one business day from the date of admission

As a reminder, services provided in an emergency room to treat an emergency medical condition[2] **do not** require prior authorization.

Questions?
If you have any questions, please contact provider services:

- For Federal Employee Program (FEP) Subscribers call **(651) 662-5044** or **1-800-859-2128**.
- For Minnesota Health Care Programs (MHCP) Subscribers call **1-866-518-8448**.
- For all other Subscribers call **(651) 662-5200** or **1-800-262-0820**.

[1]An urgent (expedited) determination is completed as the enrollee's medical condition requires. Requests not meeting the conditions for an urgent request will be considered non-urgent and processed accordingly. Both urgent and non-urgent requests will be reviewed and completed within current state and federal timelines. A request is considered urgent when, "The attending health care professional believes that a standard decision time frame could seriously jeopardize the member's life, health or ability to regain maximum functioning, based on a prudent layperson's judgment, or in the opinion of the treating physician, would subject the individual to severe pain that cannot be adequately managed without the treatment being requested. An urgent condition is a situation that has the potential to become an emergency in the absence of treatment."

[2]An emergency medical condition is defined as "a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health (or the health of an unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs."

Update: Delay in Process Change for Requesting Precertification for Skilled Nursing Facility, Long Term Acute Care and Inpatient Rehabilitation Admissions

(P6R1-19, published 3/1/19)

Note: The effective date of March 1, 2019, that was previously published in Provider Bulletin P6-19 is being delayed. A new timeline for implementation, that provides a 60 day notification will be announced at a later date.

In order to better assist our members with post-acute level of care transitions, Blue Cross and Blue Shield of Minnesota (Blue Cross) will be changing the process for reviewing Skilled Nursing Facility (SNF), Inpatient Rehabilitation (IRF/ACR), and Long Term Acute Care (LTAC) admissions for **commercial and Federal Employee Program (FEP) members**. At a later date, Blue Cross will communicate via a Provider Bulletin the effective date for only accepting requests for post-acute level of care admissions from the **discharging hospital**/facility and will no longer accept them from the admitting facility.

Post-acute admissions for Medicare Advantage members will continue to be managed by eviCore healthcare.

This process change is designed to align the member's discharge planning decisions with the facility's clinical team recommendations, to ensure the member's safety, to maximize use of in-network benefits, and to reduce preventable readmissions.

Blue Cross will accept extended stay (concurrent) requests, if needed, from the admitting facility after the initial admission has been approved.

Summary of changes

- For members in an acute care facility, the hospital will be responsible for submitting the initial inpatient precertification request for SNF, IRF and LTAC admissions
- SNF, IRF and LTAC facilities will submit concurrent review requests
- SNF, IRF and LTAC facilities will submit precertification requests when a patient admits directly from the community

Note: Home Health Care agencies will continue to submit prior authorization (PA) requests for direct hospital discharges and community referrals. Discharging SNF, IRF and LTAC facilities may also submit Home Health PA requests.

How to submit a request to Blue Cross for SNF, IRF or LTAC admissions

Blue Cross accepts precertification and prior authorization requests from providers in any of the following ways:

- **Availity.com** is the quickest way to create prior authorizations and check existing case status.
  - If the admitting facility is not yet known at the time the authorization request is created in Availity, use the discharging facility as the "facility" on screen three. When the member is discharged, contact Blue Cross to update the admitting facility's information.
  - **Admitting facilities should obtain the authorization number from the discharging facility at the time of admission.** Admitting facilities can request concurrent reviews on Availity using Authorization Inquiry to find the initial approval and selecting the "Update" option. Validate the authorization is approved for the correct facility before adding a concurrent review request.
- Fax the request with supporting clinical records to **(651) 662-1004**
- Telephone – Call Blue Cross at **1-800-711-9868** to start the request and discuss the patient's discharge needs with our clinical review team.

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATES

New Medical, Medical Drug and Behavioral Health Policy Management Updates for Commercial & Medicare Advantage Lines of Business (P26-19, published 3/1/19)

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 • 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: • 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: • Ravulizumab (Ultomiris™)	No	New	Commercial
L37808	Water Vapor Thermal Therapy for LUTS/BPH	No	New	Medicare Advantage
IV-166	Penile Prosthesis	Yes	New	Commercial
NCD 230.4 & IV-166	Penile Prosthesis	Yes	New	Medicare Advantage
IV-158	Surgical Treatments of Lymphedema	Yes	New	Commercial & Medicare Advantage
NCD 20.15	Electrocardiographic Services	No	New	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

eviCore Healthcare Utilization Management (UM) Program Prior Authorization Updates for Fully Insured Commercial and Medicare Advantage Members

(P29-19, published 3/1/19)

The eviCore Healthcare UM Programs will be making the following updates to their CPT Code List.

Starting April 30, 2019, the following codes will require prior authorization(PA):

Program	Code	Description
Lab Management	0036U	Exome (ie, somatic mutations), paired formalin-fixed paraffin-embedded tumor tissue and normal specimen, sequence analyses

Program	Code	Description
Lab Management	0037U	Targeted genomic sequence analysis, solid organ neoplasm, DNA analysis of 324 genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden
Radiation Therapy	79101	Radiopharmaceutical therapy, by intravenous administration

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

To access the link to eviCore's 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**"
- Click on the **'eviCore healthcare Specialty Utilization Management Clinical Guidelines'** link. This will bring you to BCBS MN's landing page. Here you will be able to access training materials, job aids, checklists, forms, etc.
  - To access the Lab Management guidelines:
    - Scroll down to the "**Lab Management**" topic
    - Click on the "**BCBSMN Lab Resources Page**" link to locate guidelines and CPT code lists.
  - To access all other program guidelines:
    - Click on the "**Clinical Guidelines and Forms**" link in the upper right corner
    - **Select the desired program** from the solution dropdown box
    - Here you will find the current guidelines and any posted future guidelines

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 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

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.

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 member's benefit plan. Member benefit plans vary in coverage and some plans may not provide coverage for certain services discussed 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 and Medicare Advantage Members – eviCore Healthcare UM Program

(P28-19, published 3/1/19)

The eviCore Healthcare Utilization Management (UM) Program will be making the following updates to the **Medical Oncology** program.

The following medication is awaiting FDA approval. When approved, the medication will automatically be added to the prior authorization (PA) list for oncologic reasons effective immediately. CPT® code(s) will be assigned closer to the approval date.

Drug Name	Brand Name(s)
larotrectinib	Vitrakvi®

Prior authorization requests will be reviewed based on eviCore clinical guideline criteria available for review on the Blue Cross and Blue Shield of Minnesota (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
- Click on the **"eviCore healthcare Specialty Utilization Management Clinical Guidelines"** link
- Scroll down to the **"Medical Oncology"** section

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 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

To submit a Medical Oncology Drug Prior Authorization (PA) Request to eviCore
Providers began submitting 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 member's benefit plan. Member benefit plans vary in coverage and some plans may not provide coverage for certain services discussed 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 is required for a drug for non-oncology use, please refer to the Prior Authorization Lists posted on the Blue Cross website. To access the Pre-Authorization 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

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

(P30-19, published 3/1/19)

Effective May 1, 2019, 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, MNCare, and MSC+) and Minnesota Senior Health Options (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.

Reminder: Submit requests for self-administered medications to Prime Therapeutics and consult prior authorization requirements under the pharmacy benefit plan.

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

Policy #	Policy Name	New Policy	Prior Authorization Required	
			Medicaid	MSHO
ING-CC-0057	Krystexxa (pegloticase)	Yes	Yes (existing)	Yes (existing)
ING-CC-0082	Onpattro (patisiran)	Yes	Yes	Yes
ING-CC-0083	Aristada Initio (aripiprazole lauroxil)	Yes	Yes	Yes
MHCP	Crysvita (burosumab-twza)	No	Yes	Yes
MHCP	Akynzeo (netupitant and palonosetron)	No	Yes	Yes
MHCP	Male Circumcision	No	Yes	Yes
MHCP	**Home Care Nursing (HCN) (Private Duty Nursing)** *****Not covered by BluePlus for PMAP and MNCare.	No	No (not covered by MCO)	Yes
MHCP	**Home Health Care (Skilled Nursing Visit & Home Health Aide)** *PMAP & MNCare Members: Home Care Visits: after 20 visits (Skilled Nursing and/or Home Health Aide) *Secure Blue / MSC+ Members: Pre-Certification/ Pre-Authorization not required for Medicare PPS Episodes. Home Care agencies should coordinate visits and need for Prior Authorization with the Member's Care Coordinator. All home care requests must come from the Care Coordinator.	No	Yes	Yes (see note)
MHCP	**Personal Care Assistant (PCA)** *Secure Blue / MSC+ Members: PCA agencies should coordinate visits and need for Prior Authorization with the Member's Care Coordinator. All PCA requests must come from the Care Coordinator. *Not covered by BluePlus for PMAP and MNCare.	No	No (not covered by MCO)	Yes (see note)

The following Amerigroup policies have transitioned to new policy numbers, with changes in clinical criteria, and **will be applicable** to subscriber claims on or after **May 1, 2019**.

New Policy #	Prior Policy #	Policy Name	Prior Authorization Required	
			Medicaid	MSHO
ING-CC-0002	CG-DRUG-16	Colony Stimulating Factor Agents	Yes	Yes

New Policy #	Prior Policy #	Policy Name	Prior Authorization Required	
			Medicaid	MSHO
ING-CC-0003	CG-DRUG-09	Immunoglobulins	Yes	Yes
ING-CC-0008	DRUG.00031	Testopel (testosterone subcutaneous implant)	Yes	Yes
ING-CC-0016	CG-DRUG-21	Vivitrol (extended-release, injectable naltrexone) Injection	Yes	Yes
ING-CC-0017	CG-DRUG-27	Xiaflex (clostridial collagenase histolyticum) injection	Yes	Yes
ING-CC-0018	CG-DRUG-28	Lumizyme (alglucosidase alfa)	Yes	Yes
ING-CC-0019	CG-DRUG-41	Zoledronic Acid Agents	Yes	Yes
ING-CC-0021	CG-DRUG-54	Fabrazyme (agalsidase beta)	Yes	Yes
ING-CC-0023	CG-DRUG-56	Naglazyme (galsulfase)	Yes	Yes
ING-CC-0024	CG-DRUG-57	Elaprase (idursufase)	Yes	Yes
ING-CC-0025	CG-DRUG-58	Aldurazyme (laronidase)	Yes	Yes
ING-CC-0026	CG-DRUG-59	Testosterone, Injectable	Yes	Yes
ING-CC-0030	CG-DRUG-89	Implantable and ER Buprenorphine Containing Agents	Yes	Yes
ING-CC-0035	CG-DRUG-108	Duopa (carbidopa and levodopa enteral suspension)	Yes	Yes
ING-CC-0040	DRUG.00027	Prialt (ziconotide)	Yes	Yes
ING-CC-0045	DRUG.00086	Increlex (mecasermin)	Yes	Yes
ING-CC-0050	DRUG.00111	Monoclonal Antibodies to Interleukin-23	Yes	Yes
ING-CC-0051	CG-DRUG-08	Enzyme Replacement Therapy for Gaucher Disease	Yes	Yes
ING-CC-0061	CG-DRUG-61	GnRH Analogs for the treatment of non-oncologic indications	Yes	Yes
ING-CC-0070	CG-DRUG-86	Jetrea (ocriplasmin)	Yes	Yes
ING-CC-0072	CG-DRUG-90	Selective Vascular Endothelial Growth Factor (VEGF) Antagonists	Yes	Yes
ING-CC-0073	CG-DRUG-92	Alpha-1 Proteinase Inhibitor Therapy	Yes	Yes
ING-CC-0075	CG-DRUG-94	Rituxan (rituximab) for Non-Oncologic Indications	Yes	Yes
ING-CC-0052	CG-DRUG-14	Dihydroergotamine (DHE) Injection	No	No
ING-CC-0056	CG-DRUG-33	Selected Injectable 5HT3 Antiemetic Agents	Yes	Yes

New Policy #	Prior Policy #	Policy Name	Prior Authorization Required	
			Medicaid	MSHO
ING-CC-0039	DRUG.00013	GamaSTAN [(immune globulin (human)]	Yes	Yes
ING-CC-0058	CG-DRUG-45	Octreotide Agents	Yes	Yes
ING-CC-0059	CG-DRUG-46	Selected Injectable NK-1 Antiemetic Agents	Yes	Yes
ING-CC-0065	CG-DRUG-78	Antihemophilic Factors and Clotting Factors	Yes	Yes
ING-CC-0067	CG-DRUG-82	Prostacyclin Infusion and Inhalation Therapy	Yes	Yes

The following policies and prior authorization requirements will be archived and **will not be applicable** under the medical benefit plan to subscriber claims on or after **May 1, 2019**.

Policy #	Policy Name	Prior Authorization Required	
		Medicaid	MSHO
CG-DRUG-20	Enfuvirtide (Fuzeon®)	Yes	Yes
CG-DRUG-97	Rilonacept (Arcalyst®)	Yes	Yes
CG-DRUG-112	Abaloparatide (Tymlos™) Injection	Yes	Yes
DRUG.00096	Ibalizumab-uiyk (Trogarzo™)	Yes*	Yes*

***** Trogarzo will continue to require prior authorization under the medical benefit plan using MHCP policy.

As communicated previously (Bulletin P74-18), the following services are not subject to a medical necessity review for **behavioral health (BH) only**, but **notification is required**:

Code	Service Description	Notification Required	
		Medicaid	MSHO
H0038	Self-help/peer services, per 15 minutes — Level I	Yes	Yes
H0038 HA	Certified family peer specialist services / Family Peer Services	Yes	Yes
H0038 HA HQ	Certified family peer specialist services — Group setting	Yes	Yes
H0038 HQ	Self-help/peer services, per 15 minutes — Group	Yes	Yes
H0038 U5	Self-help/peer services, per 15 minutes — Level II	Yes	Yes
H0040	Assertive community treatment program, per diem	Yes	Yes
H0040 HA	Assertive community treatment program, per diem (Youth)	Yes	Yes
H0040 HK	Assertive community treatment program, per diem (Forensic)	Yes	Yes
H2015	Comprehensive community support services, per 15 minutes	Yes	Yes

Code	Service Description	Notification Required	
		Medicaid	MSHO
H2027	Psychoeducational service, per 15 minutes	Yes	Yes
H2027 HQ	Family psychoeducation — Recipient group (with multiple recipients)	Yes	Yes
H2027 HQ HR	Family psychoeducation — Family group (with multiple families with individuals present)	Yes	Yes
H2027 HQ HS	Family psychoeducation — Family group (with multiple families individuals not present)	Yes	Yes
H2027 HR	Family psychoeducation — Recipient and family (with a single recipient and their family)	Yes	Yes
H2027 HS	Family psychoeducation — Family (with a single family individual not present)	Yes	Yes

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

Go to **providers.bluecrossmn.com**

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

OR

Go to **providers.bluecrossmn.com**

- Under Tools & Resources, select "Migration of Minnesota Health Care Programs"
- Click on 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 **providers.bluecrossmn.com**

- Under Tools & Resources, select "Migration of Minnesota Health Care Programs"
- Click on 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
  AND
  https://www.anthem.com/pharmacyinformation/clinicalcriteria

How do I submit medical and drug prior authorization requests under the medical benefit?

Medical Prior Authorizations reviewed by Amerigroup should be submitted in one of the following ways:

- **Phone:** 866-518-8448
- **Fax:** PMAP, MSC+, MNCare (Medicaid) Fax: 844-480-6839. MSHO (Medicare): 866-959-1537
- **Web:** To access Interactive Care Reviewer (ICR) on Availity for the first time, contact your Availity Administrator and request to be assigned the Authorization and Referral Request role to create and submit a PA. Once you have the role assignment you can immediately access ICR by taking the following steps
  - From the Availity home page, select 'Patient Registration' from the top navigation.
  - Select 'Authorizations & Referrals', then select 'Authorizations'.
  - Select the 'Payer (BCBSMN Blue Plus Medicaid) and 'Organization' and submit.
  - The Interactive Care Reviewer (ICR) application will open. Use ICR to submit and manage (appeal) your medical prior authorizations.

- **Submit Medical and Medical Injectable Drug PAs using ICR accessed on the Availity Portal.**
  To access ICR on Availity for the first time, contact your Availity Administrator and request to be assigned the Authorization and Referral Request role to create and submit a PA. Once you have the role assignment you can immediately access ICR by taking the following steps:
  - Select **Patient Registration** from Availity's home page
  - Select **Authorizations and Referrals | Authorizations**
  - Choose **Payer - BCBSMN Blue Plus Medicaid** and your Availity **Organization** affiliated with the PA
  - Accept the ICR Disclaimer

  Medicaid Medical Injectables:
  Phone Number: **844-410-0752**
  Fax Number: 844-480-6837
  Hours of Operations: 8 AM to 8 PM, Monday through Friday

  Medicare Medical Injectables:
  Phone Number: **866-797-9884** (Option 5)
  Fax Number: MSC+: 800-964-3627. SecureBlue/MSHO: 866-959-1537
  Hours of Operation: 8 AM to 8 PM, Monday through Friday 7

- **Medical Drug PAs should be submitted electronically:**
  - Online via Availity.com
  - Using an 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.

How do I submit drug prior authorization requests under the pharmacy benefit?

Drugs that are self-administered (inclusive of self-injection) will continue to be managed by Prime Therapeutics. To submit a pharmacy prescription drug prior authorization, contact Prime at http://www.primetherapeutics.com or at the phone numbers below:

- MN Medicaid – **844-765-5939**
- MN SecureBlue – **888-877-6424**

Prescribers also can submit pharmacy prescription drug prior authorization requests by either submitting a request through the CoverMyMeds (CMM) free web portal or by sending an electronic NCPDP file to Prime through an integrated Electronic Medical Record (EMR) system during the e-prescribing process.

- To access CMM, go to www.covermymeds.com
- The first time you use the portal to submit a PA, you will need to create a CMM account.
- For help using the CMM site select Support (top of the web page) to view FAQs, CMM physician training webinar offerings, and support options to help you get started.

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**.

Update: Reminder Regarding Minnesota Health Care Programs and Minnesota Senior Health Options (MSHO) Pre-certification Requirements (P21R1-19, published 3/1/19)

The information in this Bulletin replaces Provider Bulletin P21-19, which was published on February 1, 2019. Information informing providers of approval of 48 hours for vaginal delivery and 96 hours for cesarean section delivery has been added.

As previously communicated, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross**) requires pre-certification for all inpatient admissions effective January 1, 2019**. Pre-certification prior to admission is required for all inpatient stays excluding urgent/emergent admissions and Obstetric Deliveries.

- **Inpatient admissions for MSHO members will remain notification only**

Claims for dates of service beginning March 1, 2019 will deny as provider liability without an approved authorization.
Planned Inpatient Admissions
Planned inpatient stays require pre-certification prior to admission.

- A medical necessity review will be conducted using MCG criteria
- Determinations will be communicated to the facility
  - For standard requests, a decision will be communicated as expeditiously as required by the subscriber's condition, not to exceed ten (10) calendar days**.**
  - For expedited/urgent requests, decisions will be communicated as expeditiously as required by the subscriber's condition, not to exceed 72 hours.

Urgent/Emergent Admissions and Obstetric Deliveries
Urgent/emergent inpatient admissions are defined as the unplanned, acute necessity of a member moving to a higher level of care. For example: Moving from the Emergency Room, Observation, or a Nursing Facility to an Inpatient hospital setting as required by their condition.

- An authorization request for urgent/emergent admissions or obstetric deliveries must be submitted within one business day following the admission.
- 48 hours is approved for vaginal delivery, and 96 hours is approved for cesarean section delivery.

- If the clinical documentation needed for certification is available at the time of notification the provider may submit to expedite the review process.
- All medical emergent inpatient hospital admissions will be reviewed within one business day of the facility notification to Amerigroup.
- Clinical information for the initial (admission) review will be requested by Amerigroup at the time of the admission notification.
- For medical admissions, the facilities are required to provide the requested clinical information within 24 hours of the request.
    - If the information is not received within 24 hours, a lack of information adverse determination (i.e., a denial) may be issued.
    - If the clinical information is received, a medical necessity review will be conducted using applicable nationally recognized clinical criteria. (MCG)
- Decisions are communicated verbally or via fax within 24 hours of determination.

Inpatient pre-certifications and clinical documentation should be submitted in one of the following ways:

- Phone: **1-866-518-8448**
- **Fax:**

Acute inpatient	For Blue Advantage Families and Children (F&C), MinnesotaCare, and Blue Advantage Minnesota Senior Care Plus (MSC+) members	**1-844-480-6839** Precertification **1-844-480-6840** Clinical or Discharge information
Planned elective admissions	For F&C, MinnesotaCare and MSC+ members	**1-844-480-6839** Precertification **1-844-480-6840** Clinical or Discharge information
Planned elective admissions	For MSHO members (Notification Only)	**1-866-959-1537**
Behavioral health	For MSHO members (Notification Only)	**1-877-434-7578**

- Web: To access the Interactive Care Reviewer (ICR) tool through Availity for the first time, contact your Availity administrator and request to be assigned the *Authorization and Referral Request* role. Once you have the role assignment, you can immediately access ICR by taking the following steps:
    - From the Availity home page (https://www.availity.com), select **Patient Registration** in the top navigation.
    - Select **Authorizations & Referrals**, then select Authorizations.
    - Select the Payer (BCBSMN Blue Plus Medicaid) and Organization and submit.

Additional information and training materials for the ICR tool are located at:
https://www.bluecrossmn.com/providers/migration-minnesota-health-care-programs

- Select Tools and Resources.
- Select Migration of Minnesota Health Care Programs, and then Training References.

Providers will find the following ICR training opportunities:

- Power Point presentation for the ICR tool
- A link out to individual recorded training videos for different topics within ICR
- A link to register for monthly live ICR webinar trainings as scheduled.

Inpatient Pre-Certification Requirements for Behavioral Health (BH) Inpatient Psychiatric and Substance Use Disorder (SUD) Hospitalization Admissions:

- Beginning February 1, 2019, all inpatient psychiatric and SUD hospitalization admissions will require pre-certification for Blue Advantage Families and Children (F&C) and Minnesota Senior Care Plus (MSC+) members.

- BH policies will be managed via MCG Guidelines as listed above and previously communicated in the December Behavioral Health Provider Bulletin.

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