PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

WHAT'S INSIDE: **May 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**

Update: Professional Liability (Malpractice) Coverage Requirements

(P1R1-19, published 5/1/19)

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**.

Reminder: Change to TPA Business and Submitting Claims for TPA Plan Members

(P50-19, published 5/1/19)

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

Client/ Group Name	Old Group Number
Ely Bloomensen	5MN05990
Flandreau Santee Sioux Tribe	5BL05900
Fond du Lac CHS	5MN03960
Fortune Bay Casino Resort	5MN02810
Genesis Publishing	5MN05740
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

Client/ Group Name	Old Group Number
Torgerson Properties, Inc	5MN03460
Transit Team	5MN06060
Treasure Island Resort & Casino	5BL05920
Tuohy Furniture Corporation	5MN02050
Upper Lakes Foods, Inc	5MN03380
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.

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

2019 Renewal Changes Summary for Aware Professional Providers

(P45-19, published 5/1/19)

The purpose of this Blue Cross and Blue Shield of Minnesota, Blue Plus, and Affiliates (Blue Cross) Bulletin is to communicate substantive changes to the 2019 Aware Provider Service Agreement. The complete Provider Service Agreement (Agreement) is modified periodically to reflect the most current regulatory changes and other clarifications necessary to properly administer the Agreement. The minor changes and clarifications to the Agreement effective July 1, 2019 are detailed below. The summary items are listed in order of appearance in the Agreement.

Provider Service Agreement Changes

1) **Article II.B. The definition of "Agreement"** has been revised to more clearly reference Medical and Behavioral Health Policies (available at bluecrossmn.com) as components of an Agreement.
2) **Article II.H. The definition of "Minnesota Health Care Programs"** has been expanded to include Families and Children as a prepaid public program.
3) **Article IV.J. Subscriber Liability** provision has been clarified to reflect that the Provider shall abide by all applicable statutes and requirements with respect to collection and return of deductibles and coinsurance amounts.
4) **Article VII.A. Insurance** provision has been expanded to further clarify that evidence of coverage requirements for Providers is detailed in the Credentialing Policy and Procedure Manual.
5) **Article VIII.B. Termination.** The third sentence in the opening paragraph has been revised to indicate that written notice of termination must be sent "via certified mail" to Blue Cross.
6) **Article X.A. Confidentiality Requirements.** (Section 3) has been further clarified to include reference to Minnesota Statutes 62J.81.
7) **Article XI.N. Provider Merger or Acquisition.** The following sentence has been added to support prompt notification of material changes: "Notification of any material business transactions such as a merger or acquisition must be provided to Blue Cross no later than 60 days prior to the finalization of the transaction."

No changes have been made to the Medicare Amendment.

Disclosure of Ownership
A Disclosure of Ownership form must be completed and submitted **annually** to Blue Cross per Minnesota Department of Human Services requirements. Information about the requirement and an electronic version of the form are available at bluecrossmn.com.

Questions?
If you have any questions about the changes made in 2019, please call provider services at **651-662-5200** or **1-800-262-0820**. If you would like to receive a comprehensive copy of a new Agreement that reflects these changes, please email a request to the following address: Request.Contract.Renewal@bluecrossmn.com

2019 Renewal Changes Summary for Blue Plus Referral Health Professional Providers

(P46-19, published 5/1/19)

The purpose of this Blue Cross and Blue Shield of Minnesota, Blue Plus, and Affiliates (Blue Plus) Bulletin is to communicate substantive changes to the 2019 Blue Plus Referral Health Professional Provider Service Agreement (Agreement). The complete Agreement is modified periodically to reflect the most current regulatory changes and other clarifications necessary to properly administer the Agreement. The minor changes and clarifications to the Agreement effective July 1, 2019 are detailed below. The summary items are listed in order of appearance in the Agreement.

Provider Service Agreement Changes

1) **Article II.B. The definition of "Agreement"** has been revised to more clearly reference Medical and Behavioral Health Policies (available at bluecrossmn.com) as components of an Agreement.
2) **Article II.H. The definition of "Minnesota Health Care Programs"** has been expanded to include Families and Children as a prepaid public program.
3) **Article IV.I. Subscriber Liability** provision has been clarified to reflect that the Provider shall abide by all applicable statutes and requirements with respect to collection and return of deductibles and coinsurance amounts.
4) **Article VII.A. Insurance** provision has been expanded to further clarify that evidence of coverage requirements for Providers is detailed in the Credentialing Policy and Procedure Manual.
5) **Article X.B. Termination.** The third sentence in the opening paragraph has been revised to indicate that written notice of termination must be sent "via certified mail" to Blue Plus.
6) **Article XII.A. Confidentiality Requirements.** (Section 3) has been further clarified to include reference to Minnesota Statutes 62J.81.
7) **Article XIII.N. Provider Merger or Acquisition.** The following sentence has been added to support prompt notification of material changes: "Notification of any material business transactions, such as a merger or acquisition, must be provided to Blue Plus no later than 60 days prior to the finalization of the transaction."

No changes have been made to the Medicare Amendment.

Disclosure of Ownership
A Disclosure of Ownership form must be completed and submitted **annually** to Blue Plus per Minnesota Department of Human Services requirements. Information about the requirement and an electronic version of the form are available at bluecrossmn.com.

Reimbursement
Participating Providers may request a list of applicable rate allowances by emailing a request to Fee.Schedule.Allowance.Request@bluecrossmn.com up to twice annually. Your request must include the participating provider's NPI(s) and Blue Plus Internal Reference Number(s).

Questions?
If you have any questions about the changes made in 2019, please call Provider Services at **651-662-5200** or **1-800-262-0820**. If you would like to receive a comprehensive copy of a new Agreement that reflects these changes, please email a request to the following address: Request.Contract.Renewal@bluecrossmn.com

2019 Renewal Changes Summary for Suppliers of Durable Medical Equipment

(P47-19, published 5/1/19)

The purpose of this Blue Cross and Blue Shield of Minnesota, Blue Plus, and Affiliates (Blue Cross) Bulletin is to communicate substantive changes to the 2019 Provider Service Agreement with Suppliers of Durable Medical Equipment (DME). The complete Provider Service Agreement with Suppliers of Durable Medical Equipment (Agreement) is modified periodically to reflect the most current regulatory changes and other clarifications

necessary to properly administer the Agreement. The minor changes and clarifications to the Agreement effective July 1, 2019 are detailed below. The summary items are listed in order of appearance in the Agreement.

Provider Service Agreement Changes

1) **Article II.C. The definition of "Agreement"** has been revised to more clearly reference Medical and Behavioral Health Policies (available at bluecrossmn.com) as components of an Agreement.
2) **Article II.K. The definition of "Minnesota Health Care Programs"** has been expanded to include Families and Children as a prepaid public program.
3) **Article IV.M. Subscriber Liability** provision has been clarified to reflect that the Provider shall abide by all applicable statutes and requirements with respect to collection and return of deductibles and coinsurance amounts.
4) **Article VII.A. Insurance** provision has been expanded to further clarify that evidence of coverage requirements for Providers is detailed in the Credentialing Policy and Procedure Manual.
5) **Article IX.B. Termination.** The third sentence in the opening paragraph has been revised to indicate that written notice of termination must be sent "via certified mail" to Blue Cross.
6) **Article XI.A. Confidentiality Requirements.** Section 3) has been further clarified to include reference to Minnesota Statutes 62J.81.
7) **Article XII.N. Provider Merger or Acquisition.** The following sentence has been added to support prompt notification of material changes: "Notification of any material business transactions such as a merger or acquisition must be provided to Blue Cross no later than 60 days prior to the finalization of the transaction."

No changes have been made to the Medicare Amendment.

Disclosure of Ownership
A Disclosure of Ownership form must be completed and submitted **annually** to Blue Cross per Minnesota Department of Human Services requirements. Information about the requirement and an electronic version of the form are available at bluecrossmn.com.

Questions?
If you have any questions about the changes made in 2019, please call Provider Services at **651-662-5200** or **1-800-262-0820**. If you would like to receive a comprehensive copy of a new Agreement that reflects these changes, please email a request to the following address: Request.Contract.Renewal@bluecrossmn.com

Update: Appeals Policy for no Prior Authorization Effective June 3, 2019

(P35R1-19, published 5/1/19)

The information in this Bulletin replaces Provider Bulletin P35-19, which was published on April 1, 2019. Clarification has been made to state "Medically emergent services do not require a PA. Medical emergent services are defined in the Reimbursement Policy – Evaluation and Management – Medical Emergency."

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

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

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

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

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

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

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

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

Other exemptions from this policy are:

- Emergency and urgent care services that are performed in the emergency room do not require prior authorization and will be considered at the in-network benefit level
- Maternity delivery admissions when level of care is delivery only
- Inpatient admissions
- Medicaid lines of business
- Federal Employee Program (FEP) members

- PT/ST/OT/Chiropractic – beginning June 3, 2019, Blue Cross will no longer require providers to submit prior authorizations for these services (See Provider Bulletin P34-19, for additional information)

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

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

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

Summary:

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

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

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATES

Radiology Program Updates for Fully Insured Commercial and Medicare Advantage Subscribers – eviCore Healthcare Specialty Utilization Management (UM) Program

(P40-19, published 5/1/19)

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

Radiology guideline updates will post on June 1, 2019.

The following guidelines have substantive updates:

- Abdomen Imaging Policy
- Musculoskeletal Imaging Policy
- Oncology Imaging Policy
- Spine Imaging Policy
- Pediatric Abdomen Imaging Policy

e**viCore's Radiology 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 **"Cardiology & Radiology"** solution
    - Type "**BCBS MN**" (space is important) in *'Search by Health Plan'*
    - Click on "**Future**" tab to view guidelines becoming effective on July 1, 2019
    - 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.

eviCore Medicare Advantage DME Prior Authorization Code List Update

(P41-19, published 5/1/19)

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 & click on the "**eviCore healthcare Specialty Utilization Management Clinical Guidelines**" link
- Click on **"Solution Resources"** tab
- Select **"Post-Acute Care"**
- Click on **"CPT Codes"**

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

eviCore Lab Management Clinical Guidelines and Code Updates for Fully Insured Commercial and Medicare Advantage Subscribers – eviCore Healthcare Specialty Utilization Management (UM) Program (P42-19, published 5/1/19)

eviCore has released updates to the following Lab Management Clinical Guidelines and code updates becoming **effective on July 1, 2019:**

New guidelines and policies:

- MOL.CS.293.A Molecular Respiratory Infection Pathogen Panel (RIPP) Testing
- MOL.AD.304.A Medical Necessity Review Information Requirements
- MOL.TS.303.A FoundationOne CDx

Guidelines with Substantive Changes:

- MOL.CU.246.A Hereditary (Germline) Testing After Tumor (Somatic) Testing
- MOL.CU.117.A Investigational and Experimental Molecular and Genomic Testing
- MOL.CU.118.A Pharmacogenomic Testing for Drug Toxicity and Response
- MOL.CU.119.A Preimplantation Genetic Screening and Diagnosis
- MOL.TS.120.A 4Kscore for Prostate Cancer Risk Assessment
- MOL.TS.122.A Afirma Thyroid Cancer Classifier Test
- MOL.TS.123.A AlloMap Gene Expression Profiling for Heart Transplant Rejection
- MOL.TS.125.A Amyotrophic Lateral Sclerosis (ALS) Genetic Testing
- MOL.TS.129.A Ashkenazi Jewish Carrier Screening
- MOL.TS.240.A BCR-ABL Negative Myeloproliferative Neoplasm Testing
- MOL.TS.238.A BRCA Analysis
- MOL.TS.144.A CADASIL Testing
- MOL.TS.153.A ConfirmMDx for Prostate Cancer Risk Assessment
- MOL.TS.254.A DecisionDx Uveal Melanoma
- MOL.TS.159.A Dentatorubral-Pallidoluysian Atrophy Testing
- MOL.TS.160.Z DPYD Variant Analysis for 5-FU Toxicity
- MOL.TS.163.A EGFR Testing for Non-Small Cell Lung Cancer TKI Response
- MOL.TS.165.A Expanded Carrier Screening Panels
- MOL.TS.169.A Familial Hypercholesterolemia Genetic Testing
- MOL.CS.103.A Flow Cytometry
- MOL.CS.106.A Genitourinary Conditions Molecular Testing
- MOL.TS.194.A Liquid Biopsy Testing – Solid Tumors
- MOL.TS.199.A Lynch Syndrome Tumor Screening - Second-Tier
- MOL.CS.218.A Prenatal Aneuploidy FISH Testing
- MOL.TS.225.A Spinal Muscular Atrophy Testing

The following tests have always been Investigative/Experimental. However, they were previously addressed by a clinical use guideline. A test specific guideline has been created:

- MOL.TS.307.A AlloSure for Kidney Transplantation Rejection
- MOL.TS.305.A AssureMDx Testing for Bladder Cancer

The following tests have always been medically necessary when criteria are met; however, they were previously addressed by a clinical use guideline. A test specific guideline has been created:

- MOL.TS.302.A Legius Syndrome Genetic Testing
- MOL.TS.301.A Neurofibromatosis Type 1 Genetic Testing

Discontinued guidelines:

- BRCA Sequencing for Drug Treatment Response in Ovarian Cancer
  - This testing is addressed by the pharmacogenomic policy. The frequent additional FDA approved indications for this test made this policy redundant to the pharmacogenomic policy.
- Tumor Marker Testing-Solid Tumors
  - This guideline is now included in Foundation One CDx guideline.

The following CPT® Code has been deleted by the American Medical Association (AMA) **effective July 1, 2019:**

Code	Description
0057U	Oncology (solid organ neoplasia), mRNA, gene expression profiling by massively parallel sequencing for analysis of 51 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a normalized percentile rank

The following new Proprietary Laboratory Analyses CPT® Codes have been added by the AMA and will require prior authorization (PA) **beginning July 1, 2019:**

Code	Description
0084U	Red blood cell antigen typing, DNA, genotyping of 10 blood groups with phenotype prediction of 37 red blood cell antigens
0087U	Cardiology (heart transplant), mRNA gene expression profiling by microarray of 1283 genes, transplant biopsy tissue, allograft rejection and injury algorithm reported as a probability score
0088U	Transplantation medicine (kidney allograft rejection), microarray gene expression profiling of 1494 genes, utilizing transplant biopsy tissue, algorithm reported as a probability score for rejection
0089U	Oncology (melanoma), gene expression profiling by RTqPCR, PRAME and LINC00518, superficial collection using adhesive patch(es)
0090U	Oncology (cutaneous melanoma), mRNA gene expression profiling by RT-PCR of 23 genes (14 content and 9 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a categorical result (ie, benign, indeterminate, malignant)
0094U	Genome (eg, unexplained constitutional or heritable disorder or syndrome), rapid sequence analysis
0101U	Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with MRNA analytics to resolve variants of unknown significance when indicated (15 genes [sequencing and deletion/duplication], EPCAM and GREM1 [deletion/duplication only])
0102U	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with MRNA analytics to resolve variants of unknown significance when indicated (17 genes [sequencing and deletion/duplication])

Code	Description
0103U	Hereditary ovarian cancer (eg, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with MRNA analytics to resolve variants of unknown significance when indicated (24 genes [sequencing and deletion/duplication], EPCAM [deletion/duplication only])
0104U	Hereditary pan cancer (eg, hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with MRNA analytics to resolve variants of unknown significance when indicated (32 genes sequencing and deletion/duplication], EPCAM and GREM1 [deletion/duplication only])

eviCore 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**"
- Click on the **"eviCore healthcare Specialty Utilization Management Clinical Guidelines"** link
- Click on **"Solution Resources"** tab
- Click on the "**BCBS MN Lab Policy Book"**

To view the Lab prior authorization code list:

- Click on the **"Lab Management Code List"**

Products Impacted

This change only applies to:

- Individual subscribers
- Fully insured commercial subscribers
- 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

Group Number List

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

As a reminder, if a provider does not obtain a required prior authorization before rendering services, Blue Cross will deny claims as provider liability for lack of prior authorization.
To find a listing of all the group numbers that will be utilizing eviCore, the 2019 Commercial Network Guide has been updated with this information. To access the guide, go to providers.bluecrossmn.com and under "What's Inside" select "Education Center" then select "2019 Commercial Network Guide." You can also find it under "Tools and Resources", select "Medical Policy" and then acknowledge the Acceptance Statement, click on the "+" next to "Utilization Management", and select "see group numbers for members managed by eviCore" under the paragraph titled eviCore Healthcare Specialty Utilization Management.

To submit a Prior Authorization (PA) Request to eviCore
Providers should submit eviCore PA requests via our free **Availity** provider portal. Instructions on how to utilize this portal are found on the Availity website.

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.

Radiation Oncology Program Updates for Fully Insured Commercial and Medicare Advantage Subscribers – eviCore Healthcare Specialty Utilization Management (UM) Program (P43-19, published 5/1/19)

eviCore has released clinical guideline updates for the Radiation Oncology program. Guideline updates will become **effective July 1, 2019:**

Please review all guidelines when submitting a prior authorization request.

Guidelines with substantive changes:

- Proton Beam Therapy
- Radiation Therapy for Soft Tissue Sarcomas
- Radiation Treatment with Lutathera

eviCore's Radiation Oncology 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 **"Radiation Oncology"** solution
- Type "**BCBS MN**" (space is important) in 'Search by Health Plan'
- Click on "**Future**" tab to view guidelines becoming effective on July 1, 2019
- 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.

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

New Medical, Medical Drug and Behavioral Health Policy Management Updates for Commercial and Medicare Advantage Lines of Business (P49-19, published 5/1/19)

Effective July 1, 2019, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be expanding utilization management requirements for Commercial and Medicare Advantage lines of business. This includes prior authorization (PA) requirements.

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

The following prior authorization changes will be effective July 1, 2019 for Commercial and Medicare Advantage lines of business:

Policy #	Policy Title/ Service	New Policy	Prior Authorization Requirement	Line(s) of Business
II-227	Enzyme Replacement Therapy for the Treatment of Adenosine Deaminase Severe Combined Immune Deficiency • Elapegademase (Revcovi™) • Pegademase bovine (Adagen®)	Yes *(Replacing policy II-173)*	New	Commercial
L33394	Coverage of Drugs & Biologics for Label & Off-Label Uses: • Pegademase bovine (Adagen®) • Sildenafil (Revatio®) injection • Golordirsen	No	New	Medicare Advantage
II-226	Esketamine (Spravato™)	Yes *(Replacing policy II-173)*	Continued	Commercial
II-204	Emapalumab (Gamifant®)	Yes *(Replacing policy II-173)*	Continued	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) 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 June 24, 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**.

Site of Service for Select Outpatient Procedures: XI-03 Medical Policy Update

(P48-19, published 5/1/19)

Effective July 1, 2019, an important update will be made to the Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) medical policy, XI-03: Site of Service for Selected Outpatient Procedures.

Selected outpatient ear, nose and throat (ENT) procedures (listed below) will be added to this medical policy and must be performed in a non-hospital outpatient setting – such as an Ambulatory Surgical Center (ASC) or physician's office – to be eligible for reimbursement, unless certain medical or geographic criteria are met for the procedure to be performed in a hospital outpatient facility. Many specialists in the Blue Cross network have already started redirecting patients to the ASC or office setting for these services when clinically appropriate. Groups performing these procedures outside the hospital have shown evidence of safe, high quality outcomes at a lower cost, while maintaining an excellent patient experience.

Procedures administered in a hospital outpatient facility that do not meet medical policy criteria will not be eligible for reimbursement. Post-service audits will be conducted for services taking place at an outpatient hospital setting using the following information to ensure policy criteria are met:

- Documentation of medical necessity to receive the procedure at an outpatient hospital setting.

Geographic exclusions for post-service audits include:

- Services for patients living greater than 25 miles from an in-network ASC or office performing these procedures are excluded from this program.
- Hospital outpatient facilities that do not have an in-network ASC or office performing these procedures within 25 miles of the outpatient hospital setting are excluded from this program.

Please check the subscriber's benefits and confirm the **in-network** site of service.

List of Impacted Procedures Added to Medical Policy (CPT Codes):

- **21320:** Closed treatment of nasal bone fracture; with stabilization
- **30140:** Submucous resection inferior turbinate, partial or complete, any method
- **30520:** Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
- **69436:** Tympanostomy (requiring insertion of ventilating tube), general anesthesia
- **69631:** Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction

Products Impacted

This program only applies to fully-insured and self-insured commercial lines of business. As a reminder for an Accountable Care Organization (ACO) subscriber, please have the subscriber call Blue Cross at **(651) 662-5200** or **1-800-262-0820.**

Predetermination Process for Providers:

If certain unforeseen clinical circumstances **not** outlined in the medical policy arise that dictate the member should receive care in an outpatient hospital setting, providers may submit a predetermination form via fax to verify if a service listed above will be deemed appropriate prior to treatment. Predeterminations are **not** required and do not guarantee payment.

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**.

MINNESOTA HEALTH CARE PROGRAMS (MHCP) UPDATES

Updated Minnesota Health Care Programs and Minnesota Senior Health Options (MSHO) Prior Authorization and Medical Policy Requirements (P44-19, published 5/1/19)

Effective July 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.

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

Policy #	Policy Name	New Policy	Prior Authorization Required	
			Medicaid	MSHO
CG-ANC-07	Inpatient Inter-facility Transfers	Yes	No	No
CG-GENE-05	Genetic Testing for DMD Mutations (Duchenne or Becker Muscular Dystrophy)	Yes	Yes	Yes
CG-SURG-92	Paraesophageal Hernia Repair	Yes	Yes	Yes

Policy #	Policy Name	New Policy	Prior Authorization Required	
			Medicaid	MSHO
CG-SURG-93	Angiographic Evaluation and Endovascular Intervention for Dialysis Access Circuit Dysfunction	Yes	Yes	Yes
LAB.00036	Multiplex Autoantigen Microarray Testing for Systemic Lupus Erythematosus	Yes	No	No

The following policies have changes in clinical criteria and **will be applicable** to subscriber claims on or after **July 1, 2019**.

Policy #	Policy Name	Prior Authorization Required	
		Medicaid	MSHO
CG-DRUG-50	Paclitaxel, protein-bound (Abraxane®)	Yes	Yes
CG-MED-38	Inpatient Admission for Radiation Therapy for Cervical or Thyroid Cancer	No	No
CG-REHAB-02	Outpatient Cardiac Rehabilitation	No	No
CG-SURG-77	Refractive Surgery	Yes	Yes
CG-SURG-83	Bariatric Surgery and Other Treatments for Clinically Severe Obesity	Yes	Yes
GENE.00006	Epidermal Growth Factor Receptor (EGFR) Testing	No	No
LAB.00024	Immune Cell Function Assay	No	No
MED.00117	Autologous Cell Therapy for the Treatment of Damaged Myocardium	Yes	Yes
MED.00126	Fractional Exhaled Nitric Oxide and Exhaled Breath Condensate Measurements for Respiratory Disorders	Yes	Yes
SURG.00011	Allogeneic, Xenographic, Synthetic and Composite Products for Wound Healing and Soft Tissue Grafting	Yes	Yes
SURG.00037	Treatment of Varicose Veins (Lower Extremities)	Yes	Yes
SURG.00122	Venous Angioplasty with or without Stent Placement or Venous Stenting Alone	No	No
TRANS.00035	Mesenchymal Stem Cell Therapy for the Treatment of Joint and Ligament Disorders, Autoimmune, Inflammatory and Degenerative Diseases	No	No

The following policies have transitioned to new policy numbers, with no changes in clinical criteria, and **will continue to be applicable** to subscriber claims upon release.

New Policy #	Prior Policy #	Policy Name	Prior Authorization Required	
			Medicaid	MSHO
CG-GENE-06	GENE.00002	Preimplantation Genetic Diagnosis Testing	No	No
CG-GENE-07	GENE.00005	BCR-ABL Mutation Analysis	No	No
CG-GENE-08	GENE.00031	Genetic Testing for PTEN Hamartoma Tumor Syndrome	Yes	Yes
CG-GENE-09	GENE.00040	Genetic Testing for Charge Syndrome	No	No
CG-MED-81	MED.00119	High Intensity Focused Ultrasound (HIFU) for Oncologic Indications	Yes	Yes
CG-SURG-94	SURG.00115	Keratoprosthesis	Yes	Yes
CG-SURG-95	SURG.00117	Sacral Nerve Stimulation and Percutaneous Tibial Nerve Stimulation for Urinary and Fecal Incontinence; Urinary Retention	Yes	Yes
CG-SURG-96	SURG.00136	Intraocular Telescope	No	No
CG-SURG-98	RAD.00066	Prostate Multiparametric Magnetic Resonance Imaging	Yes	Yes
CG-MED-82	CG-DRUG-25	Intravenous versus Oral Administration in the Outpatient and Home Setting	No	No
ING-CC-0031	CG-DRUG-91	Intravitreal Corticosteroid Implants	Yes	Yes
ING-CC-0036	CG-DRUG-110	Naltrexone Implantable Pellets	Yes	Yes

The following policy 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-64	FDA-Approved Biosimilar Products	Yes*	Yes*

* FDA-approved biosimilar products will continue to require prior authorization under the medical benefit plan using drug-specific policies.

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

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**.