PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

WHAT'S INSIDE: **November 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**

CONTRACT UPDATES

CMS Changing Payment Classification System for Home Health Effective January 1, 2020 (P76-19, published 11/1/19)

Effective January 1, 2020, the Centers for Medicare & Medicaid Services (CMS) is transitioning to the Patient Driven Groupings Model (PDGM). PDGM is a new payment model for Home Health Prospective Payment System (HH PPS) that relies more heavily on clinical characteristics and other patient information to place home health periods of care into meaningful payment categories and eliminates the use of therapy service thresholds. In accordance with Article XIII, B. of the Amendment to the Agreement - Medicare Programs, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross), effective January 1, 2020 will also begin utilizing the PDGM payment rate classification system to determine reimbursement for Medicare Health Services (for SecureBlue (MSHO) and Medicare Advantage products) provided and billed by a Home Health Agency for those services that qualify.

Transition Scenarios

- For 60-day episodes that begin on or before December 31, 2019 and end on or after January 1, 2020 (i.e., episodes that span the January 1, 2020 PDGM implementation date), payment will be the calendar year (CY) 2020 national, standardized 60-day episode payment amount
- For HH periods of care that begin on or after January 1, 2020, the unit of payment will be the calendar year (CY) 2020 national, standardized 30-day payment amount
- Under the PDGM, recertification for home health services, updates to the comprehensive assessment and updates to the HH plan of care will continue on a 60-day basis

Providers should submit the PDGM for Health Services using the Health Insurance Prospective Payment System (HIPPS) code that is generated from assessments with an Assessment Reference Date (ARD) on or after January 1, 2020. Blue Cross will publish additional information to assist providers as more details become available.

Products Impacted
This change only applies to:

- SecureBlue (MSHO)
- Medicare Advantage
- Platinum Blue

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

2020 Renewal Changes Summary for Primary Care Clinic Providers

(P80-19, published 11/1/19)

Blue Cross and Blue Shield of Minnesota, Blue Plus, and Affiliates (Blue Plus) has simplified the annual renewal process and is communicating the substantive changes to the 2020 Blue Plus Provider Care Clinic 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 January 1, 2020 are detailed below. The summary items are listed in order of appearance in the Agreement.

Article III.E. Clinical Coding Requirements has been amended to include reimbursement information for unlisted codes and is hereby replaced and superseded by the following:

Coding Requirements. Provider shall place all appropriate diagnosis and procedure codes and other necessary codes on each claim prior to submission to Blue Cross or Plan Sponsor. Provider is required to submit a written description, the manufacturer's suggested retail price for the item(s) and an itemization of the Regular Billed Charges for such item(s), health care service or supply whenever submitting an unlisted procedure code such as K0108 or E1399 for such services. Claims submitted to Blue Cross with an unlisted procedure code without a written description and manufacturer's suggested retail price will be denied. Provider agrees to use unlisted procedure codes only when no code exists for the service being provided. The reimbursement process for unlisted procedures can be found at https://www.bluecrossmn.com/providers/reimbursement-policies

Article VIII.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.

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 Cross.

Article XII.N. Provider Merger provision has been updated to include reference to practice expansions and additional new locations.

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.

Questions?
If you have any questions about these changes, 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 your request to the following address: Request.Contract.Renewal@bluecrossmn.com

Blue Cross Discontinues Vendor Relationship with Magellan (P83-19, published 11/1/19)

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) is providing behavioral health providers an update regarding the status of the second phase of its transition with Magellan.

Blue Cross had delayed the second phase of transition to Magellan. A decision has now been made to discontinue this transition entirely. Effective January 1, 2020, the functionality that Magellan was managing for behavioral health (Case Management, Disease Management and Utilization Management) will be managed by Blue Cross.

All prior authorizations reviewed by Magellan prior to December 31, 2019 will be transferred to Blue Cross and approved authorizations will be honored. Concurrent reviews submitted for dates of service January 1, 2020 and after will be reviewed by Blue Cross staff. Providers should continue to submit prior authorizations via the Availity Provider Portal at Availity.com.

Prior Authorizations for Minnesota Health Care Program members will continue to be reviewed by Amerigroup.

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

Payment Change for all Medicare Supplement Products (P78-19, published 11/1/19)

Effective January 1, 2020, Blue Cross and Blue Shield of Minnesota (Blue Cross) will be making a change to reimbursement for enhanced services allowed by a Medicare Supplement plan that are not covered by Medicare.

Providers will be reimbursed up to the amount allowed by the Centers for Medicare & Medicaid Services (CMS) if there is a rate available. For those services that Medicare does not establish a rate for, Blue Cross will allow 35% of Regular Billed Charge.

Products Impacted
This change **only** applies to:

- All Medicare Supplement Products

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

New Medicare Benefit for Opioid Treatment Programs – Effective January 1, 2020 (P79-19, published 11/1/19)

The Centers for Medicare & Medicaid Services (CMS) is implementing a new Medicare Part B benefit for opioid use disorder (OUD) treatment services, beginning January 1, 2020.

CMS will reimburse Opioid Treatment Programs (OTPs) for OUD treatment services provided to Medicare Part B Subscribers, including medications, toxicology testing and counseling, through bundled payments.

To be eligible for payment by CMS, OTP Providers must be enrolled in Medicare, certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) and accredited by a SAMHSA-approved accrediting body.

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) requires that Providers participate in the Blue Cross Medicare Network to be eligible to participate in the Opioid Treatment Program. All eligible Providers were mailed an offer to participate in the Blue Cross Medicare Network on October 8, 2019, with a request to sign and return the Medicare Amendment.

For more information on the new Medicare benefit, including additional guidance and updates, refer to the CMS OTP webpage.

https://www.cms.gov/Center/Provider-Type/Opioid-Treatment-Program-Center.html

Questions?
If you have any questions about the Blue Cross Medicare Amendment or contracting with Blue Cross, please contact provider services at (**651**) **662-5200** or **1-800-262-0820**.

2020 Renewal Changes Summary for Institutional Providers (P81-19, published 11/1/19)

Blue Cross and Blue Shield of Minnesota, Blue Plus, and Affiliates (Blue Cross) has simplified the annual renewal process and is communicating the substantive changes to the 2020 Institutional 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 January 1, 2020 are detailed below. The summary items are listed in order of appearance in the Agreement.

Language Changes:

Definition of "Custodial Care" (formerly Article II.E.). This definition in the Agreement has not changed but has been moved to Chapter 9 of the Blue Cross Provider Policy and Procedure Manual.

Article III.F. Clinical Coding Requirements has been amended to include reimbursement information for unlisted codes and is hereby replaced and superseded by the following:

Coding Requirements. Provider shall place all appropriate diagnosis and procedure codes and other necessary codes on each claim prior to submission to Blue Cross or Plan Sponsor. Provider is required to submit a written description, the manufacturer's suggested retail price for the item(s) and an itemization of the Regular Billed Charges for such item(s), health care service or supply whenever submitting an unlisted procedure code such as K0108 or E1399 for such services. Claims submitted to Blue Cross with an unlisted procedure code without a written description and manufacturer's suggested retail price will be denied. Provider agrees to use unlisted procedure codes only when no code exists for the service being provided. The reimbursement process for unlisted procedures can be found at https://www.bluecrossmn.com/providers/reimbursement-policies

Article V.D. Prior to Coverage has been expanded to further clarify that Subscriber's prior coverage, if any, is responsible for Health Services for an admission that began prior to the effective date of the Subscriber contract, until after the Subscriber is discharged.

Article IX.A. Insurance has been further clarified to state that evidence of coverage requirements for Providers is detailed in the Credentialing Policy and Procedure Manual.

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 Cross.

Article XIV. N. Provider Merger provision has been updated to include reference to practice expansions and additional new locations.

Reimbursement:

Items not covered under Medicare Supplement, but are covered as an additional benefit, will be reimbursed at the lesser of the appropriate Medicare rate, if available, or 35% of Regular Billed Charge.

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 these changes, 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 your request to the following address: Request.Contract.Renewal@bluecrossmn.com

Reimbursement Policy Clarification to Unlisted Codes for Commercial and Medicare Products (P82-19, published 11/1/19)

Effective January 1, 2020 Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be clarifying the reimbursement of unlisted procedures in the Reimbursement Policies: *General Coding 005 – Unlisted Procedure Code Policy* and *DME 001 – DME and Supplies*.

Reimbursement for unlisted codes will be determined by one of the following methodologies:

- Allowance of similar code (procedure/item); or
- 85% of the Average Wholesale Price (AWP) (drug codes); or
- Percentage of Provider's Regular Billed Charge (55% of charge for Commercial and 35% of charge for Medicare); or
- Invoice amount.

Resulting clarifying changes to the 2019 Provider Services Agreement with Suppliers of Durable Medical Equipment

Article III. F. Unlisted Codes Procedure of the 2019 Provider Service Agreement with Suppliers of Durable Medical Equipment has been removed. Article III. D. Clinical Coding Requirements has been amended to include reimbursement information for unlisted codes.

Article III. D. is amended as follows:

Coding Requirements. Provider shall place all appropriate diagnosis and procedure codes and other necessary codes on each claim prior to submission to Blue Cross or Plan Sponsor. Provider is required to submit a written description, the manufacturer's suggested retail price for the item(s) and an itemization of the Regular Billed Charges for such item(s), health care service or supply whenever submitting an unlisted procedure code such as K0108 or E1399 for such services. Claims submitted to Blue Cross with an unlisted procedure code without a written description and manufacturer's suggested retail price will be denied. Provider agrees to use unlisted procedure codes only when no code exists for the service being provided. The reimbursement process for unlisted procedure codes can be found at: https://www.bluecrossmn.com/providers/reimbursement-policies

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

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

New Colonoscopy Reimbursement Policy for Commercial Lines of Business
(P85-19, published 11/1/19)

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be publishing a new Colonoscopy Reimbursement Policy on January 1, 2020, which will allow the reimbursement of multiple colonoscopy procedures performed in the same session. This change will impact the reimbursement of claims with a date of service beginning January 1, 2020.

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

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

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATES

Updated Bulletin: Alignment of Start Date for Prior Authorization Requests
(P23R2-19, published 11/1/19)

The information in this document clarifies content published on October 1, 2019, in Provider Bulletin P23R1-19, adding the following clarifications:

- The eviCore healthcare process for retrospective review for commercial and Medicare Advantage subscribers is not impacted by this policy change. EviCore healthcare will continue to accept retrospective review requests when PA cannot be obtained prior to the service being rendered for the following programs: DME, Radiology, Cardiology, Musculoskeletal, and Sleep Management.
- EviCore healthcare will also continue to date authorizations for Radiation Therapy and Molecular and Genomic Lab as described below. This policy is not changing.

In an ongoing effort to simplify and ease provider administration related to the prior authorization processes, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be implementing changes to better align the Utilization Management process across vendors and lines of business. The following changes will be implemented for commercial (fully and self-insured and FEP) and Medicare (Medicare Advantage and Platinum Blue) subscribers for Prior Authorization (PA) requests received on or after December 1, 2019:

- PA requests that are approved will begin the date the request was received by Blue Cross or eviCore, rather than the date of determination.

  Exceptions (below is current process and will not change):
  - Radiation therapy authorizations: start date will include the initial SIM (within 14 days prior to start of radiation therapy)
  - Molecular lab authorizations: start date will include the specimen collection date (within 60 days of the molecular lab)

  Important note: The PA process is in place to determine when services meet medical necessity guidelines and are contractually eligible for coverage, prior to being rendered. Evidence based medical policy criteria and subscriber contract language are used to determine if benefits are available for the requested services.

Providers who render a service that requires PA after the PA is submitted but before a determination is made are financially liable if the service is found to be not medical necessary. **Claims for denied services rendered after a PA is submitted but prior to the date of determination will be rejected and will not be billable to the subscriber.**

- Effective December 1, 2019, Blue Cross will no longer accept requests for retrospective review for procedures, services or DME that require PA, except where specified below. There are no changes at this time to retrospective review policy for requests reviewed by eviCore healthcare or Amerigroup.

  Exception:
  - Retrospective review requests will only be accepted by Blue Cross for home health care services. When medically necessary and approved, the authorization for home health care will align with the proposed treatment plan. Retrospective review requests should only be submitted when PA cannot be done prior to the start of care and must be made prior to the date of claim submission.

  Services found to be not medically necessary upon retrospective review will be denied and **rejected claims for these services will not be billable to the subscriber.**

Effective December 1, 2019:

	Commercial and Medicare (Administered by Blue Cross)	Minnesota Health Care Programs	Commercial, Medicare (Administered by eviCore)
PA Start Date for Approved Services	Date of receipt	Date of receipt*	Date of receipt
Pre-claim Retrospective Review	Limited to home care	Not available*	Limited to DME, Radiology, Cardiology, Musculoskeletal, and Sleep Management*

*No policy change

Inpatient admissions processes are not impacted by this change.

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

New Medical, Medical Drug and Behavioral Health Policy Management Updates—Effective January 6, 2020 (P77-19, published 11/1/19)

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

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

The following prior authorization changes will be effective January 6, 2020 for Medicare Advantage, Platinum Blue, and Commercial lines of business:

Policy #	Policy Title/ Service	New Policy	Prior Authorization Requirement	Line(s) of Business
II-165	Lyme Disease: Diagnostic Testing and Intravenous Antibiotic Therapy	No	Removed .	Platinum Blue
II-203	Benralizumab (Fasenra®)	No	New	Medicare Advantage
II-176	Cerliponase alfa (Brineura™)	No	New	Medicare Advantage
II-145	Injectable Clostridial Collagenase for Fibroproliferative Disorders (Xiaflex®)	No	New	Medicare Advantage
L33394	Coverage for Drugs & Biologics for Label & Off-Label Uses: • Brolucizumab (Beovu®)	No	New	Medicare Advantage
II-173	Accepted Indications for Medical Drugs Which are Not Addressed by a Specific Medical Policy: • Brolucizumab (Beovu®)	No	New	Commercial

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

Submitting a PA Request when Applicable

- Providers must check applicable Blue Cross policy and **attach all required clinical documentation** with the PA request. PA requests will be reviewed when patient-specific, relevant medical documentation has been submitted supporting the medical necessity of the service**.** Failure to submit required information may result in review delays or a denial of the request due to insufficient information. 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 December 30, 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**.

Update: Precertification for Commercial Inpatient Admissions (P54R2-19, published 11/1/19)

Note: Precertification for Commercial Inpatient Admissions will not be implemented on January 1, 2020.

As previously communicated in Provider Bulletins P54-19 and P54R1-19, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) intended to implement a new policy requiring precertification/prior authorization for all planned, acute, inpatient admissions for commercial members, in order to help ensure medically necessary and appropriate care.

After careful consideration and discussions with various provider partners, a decision has been made to adjust the approach to this policy and further delay the implementation date in order to reduce administrative requirements for providers.

Blue Cross values the longstanding relationships we have with our provider partners and we're dedicated to creating a more seamless experience as we implement changes with the goal of better outcomes at a lower cost for our shared customers.

The adjusted policy and timeline will be published with further details in a future Provider Bulletin.

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 (P84-19, published 11/1/19)

Effective January 1, 2020, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be updating its government programs medical policy and pre-authorization/pre-certification/notification lists. The lists clarify medical policy, prior authorization, and notification requirements for the Minnesota Health Care Programs (Families and Children, MinnesotaCare, and Minnesota Senior Care Plus) and Minnesota Senior Health Options (MSHO) products.

As stewards of health care expenditures for our 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 **January 1, 2020**.

Policy #	Policy Name	New Policy	Prior Authorization Required	
			Medicaid	MSHO
MHCP	General Anesthesia for Dental Procedures	No	Yes	Yes

The following prior authorization requirements will be removed and **will not be applicable** under the medical benefit plan to subscriber claims on or after **January 1, 2020**. However, the policies will remain in effect.

Policy #	Policy Name	Prior Authorization Required	
		Medicaid	MSHO
MHCP	Transportation/ambulance services	Yes	Yes

Medical Prior Authorization (PA) Claims Denial Update
Blue Cross recently identified that certain codes, which should not have required a PA for medical services, have denied for no PA. The codes listed below have been removed from requiring PA effective **May 1, 2019**.

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

CPT Code	Code Description
L1820	Knee orthosis (KO), elastic with condylar pads and joints, with or without patellar control, prefabricated, includes fitting and adjustment

CPT Code	Code Description
L1831	Knee orthosis (KO), locking knee joint(s), positional orthosis, prefabricated, includes fitting and adjustment
L1850	Knee orthosis (KO), Swedish type, prefabricated, off-the-shelf

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 Medical Policy and UM Statement for Blue Cross
- 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 "Medical Policy," and read/accept the Medical Policy and UM Statement for Blue Cross
- Under 'Medical and behavioral health policies' select the 'MHCP Medical Policy Grid (PDF)'

OR

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?

- **Minnesota 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**.