PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

WHAT'S INSIDE: **July 1, 2020**

Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association.

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**

CERiS Review of High Dollar Claims (P49-20, published 7/1/20)

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) has engaged CERiS for itemized bill review of high dollar institutional claims. Effective September 1, 2020, CERiS will be performing a review and comparative analysis of itemized billing statements against national and Blue Cross payment standards. This includes a review of charge utilization, appropriateness of charges and billing behavior to verify accurate reimbursement of claims.

Out-of-state members

Facility claims that are reimbursed under a percent of charge methodology allowing $200,000 or greater will be reviewed on a pre-payment basis with the exception of Medicare Advantage groups. Medicare Advantage groups will be reviewed based on $200,000 charge rather than allowed amount. Blue Cross requests that the itemized bill be attached to the claim submission. If the itemized bill is not attached, CERiS will reach out to obtain the itemized bill. Upon receipt of the itemized bill from the provider, a line-item review will be conducted to determine charges that are appropriately billed. All appropriately billed charges will be processed, and in the majority of cases, charges found to be inappropriately billed will be denied as **CO 97 - M80: These charges are not covered. This service is considered part of another service.**

Minnesota members

Facility claims that are reimbursed under a percent of charge methodology allowing $200,000 or greater will be reviewed on a post-payment basis. Blue Cross requests that the itemized bill be attached to the claim submission. If the itemized bill is not attached, CERiS will reach out to obtain the itemized bill. Upon receipt of the itemized bill from the provider, a line-item review will be conducted to determine charges that are appropriately billed. All appropriately billed charges will be processed, and in the majority of cases, charges found to be inappropriately

billed will be denied as **CO 97 - M86: This service is considered to be an integral part of another service. Therefore, a separate payment cannot be made for this service.**

When the requested itemized bill cannot be obtained by CERiS within 7 to 10 days, the claim will be denied as **CO 252 - N26 In order to process this claim, additional information is required.** The claim should be resubmitted with an itemized bill for each date of service reported. Electronically enabled providers should resubmit electronically.

A findings letter will be sent to the provider upon completion of the review and adjudication of the claim. The standard appeal process should be used to dispute these reviews.

Minnesota Health Care Programs
Facility claims paid under APR-DRG methodology with a calculated outlier payment of $2,500 or greater will be reviewed. The calculated reimbursement for the base APR-DRG allowed will be reimbursed to the provider with one of the following remark codes:

- **(OA 133) Cost outlier calculated outlier charges under payment review.** This remark code will be included if the itemized bill has already been received from the provider. A line-item review will be conducted for the remaining outlier charges to determine that the charges were appropriately billed.
- When the requested itemized bill cannot be obtained by CERiS within 7 to 10 days, the outlier portion of the claim will be denied as **(CO 95*)* Base DRG Pymt made. For outlier review submit itemized bill to CERiS.** A line-item review will be conducted to determine that the charges were appropriately billed once received.
- Once the line-item review of the submitted itemized bill is completed, the outlier allowed will then be processed, excluding any charges determined to be billed in error, and any additional reimbursement will be released. The remark code on the final outlier payment will be **(CO 45) – Paid per CERiS review**.

Interim claims (discharge status 30) with billed charges of $25,000 or more will be reviewed. If an itemized bill has already been received, the remark code will be **(OA 133) Cost outlier calculated outlier charges under payment review**; otherwise, the provider will receive the remark code **(CO 252) Please submit with itemized bill for CERiS review.**

General information
Providers submitting claims that qualify for review are encouraged to submit the itemized bill as an attachment to the claim to expedite processing. A findings letter will be sent to the provider upon completion of the review and adjudication of the claim. The standard appeal process should be used to dispute these reviews.

CONTRACT UPDATES

Genetic/Molecular Lab Test Coding Reimbursement Policy (P46-20, published 7/1/20)

Advancements in the science of genetics and genomics have led to remarkable new options for medical professionals to diagnose, treat, and prevent disease. As increases in genetic and molecular testing continue, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) is committed to improving the sustainability of care by ensuring high-quality, appropriate care is delivered at a fair price.

Beginning October 1, 2020, Blue Cross will expand the requirements for billing of genetic and molecular testing. In accordance with the new Blue Cross Reimbursement Policy for Genetic and Molecular Test Coding, all providers billing for genetic and molecular testing services will be required to adhere to the coding recommendation from Concert Genetics, our industry-leading genetic testing technology partner. Billing integrity requirements in the reimbursement policy will be administered on a post-payment review basis by Concert Genetics.

The provider portal can be accessed here: join.concertgenetics.com/bcbsmn

List of Impacted Tests Included in Reimbursement Policy (sections in CPT/HCPCS manual):

- Molecular Pathology
- Genomic Sequencing Procedures and Other Molecular Multianalyte Assays
- Multianalyte Assays with Algorithmic Analyses

Products Impacted

This program only applies to fully-insured and self-insured commercial lines of business. Please check the subscriber's benefits and confirm the **in-network** site of service.

Next Steps for Providers:

- Register with Concert Genetics and implement self-reporting quality metrics
- Verify accuracy of test catalog and review coding recommendations and fee schedule
- Utilize Concert Genetics' recommended codes when billing for genetic and molecular tests

Registration:

Please visit the Concert Genetics website (see link above) and submit a registration request. Labs will receive a welcome packet via email from Concert Genetics with an invitation to the Concert Genetics platform, where labs can review and validate the accuracy of their test catalog data and complete the quality questionnaire.

During onboarding, Concert Genetics will work with labs to gather the necessary information to calculate coding recommendations and self-reporting quality metrics. Labs will use the "Report as Inaccurate" feature to report specific test corrections. To assist providers:

- Concert Genetics will provide training materials and other documentation to assist labs with registration
- Concert Genetics will provide online, email, and phone support during and after registration
- For general inquiries, labs are encouraged to connect with a Concert Genetics representative
    - help@concertgenetics.com
    - (855) 435-7643

Reporting and Post-Payment Reviews

Detailed reports will be provided to labs beginning with August 1, 2020 dates of service to help determine where billing adjustments are required.

Beginning with October 1, 2020 dates of service, claims will be reviewed by Concert Genetics on a post-payment basis. Claims that are identified as being billed incorrectly will be denied and recouped by Blue Cross. Providers will be asked to resubmit appropriate claims. Providers may appeal any/all determinations through the standard Blue Cross appeals process.

Pass-Through Billing

Blue Cross currently allows pass through billing for laboratory services but clinics/facilities are strongly encouraged to only bill for laboratory services they provide. If a clinic/facility does bill for a genetic or molecular test performed by an independent laboratory, they should bill in accordance with Concert Genetics' coding recommendation for the performing laboratory and append the 90 modifier. See the Laboratory Services General Guide policy for additional information on the appropriate transaction loops that should be completed.

Reminder Regarding Reimbursement Policies:

This is not a change in medical policy or member benefits, but a change in reimbursement policy. Reimbursement policies are updated on an ongoing basis and used by Blue Cross to define if and how certain claims will be paid for various health care services.

Blue Cross requires that all providers billing for genetic and molecular testing services bill according to the coding recommendation in the Concert Genetics portal. Non-compliance with this policy may result in a written notification from Blue Cross. Continued non-compliance may result in a denied payment or termination of the provider's contract per the terms of the Provider Services Agreement.

To access the reimbursement policy:
Go to providers.bluecrossmn.com

- Under Tools & Resources, select "Reimbursement Policies"
- Locate "Genetic/Molecular Lab Test Coding"

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

Additional Information (About Concert Genetics):
Concert Genetics (formerly NextGxDx, Inc.) launched in 2010 as a technology company dedicated to enhancing the transparency and efficiency of genetic testing for clinicians, hospitals, laboratories and health insurers. Concert Genetics' mission is to provide tools that connect, unify & simplify the world of genetic testing. To learn more, visit https://www.concertgenetics.com/.

Emergency Department Level of Service Coding Reimbursement Policy

(P52-20, published 7/1/20)

As the cost of health care continues to rise, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) is committed to improving the sustainability of care by ensuring high-quality, appropriate care is delivered at a fair price and billed appropriately for the services provided to our members.

Beginning September 1, 2020, Blue Cross will implement a new reimbursement policy to help ensure Emergency Department (ED) providers are reimbursed accurately based on the level of services provided.

In order to reduce the administrative and financial impact to providers, Blue Cross will not initially deny or recoup ED claims as a result of this reimbursement policy. Instead, level 4 and 5 ED visit claims data will be reviewed on a post-payment basis and shared with providers that have a higher utilization of these codes compared to peer providers. The expectation is that this additional clarity and information will support improved coding to most accurately reflect the level of ED care delivered. In the event that such corrections are not made after a period of time, Blue Cross retains the right to deny improper charges or recover payments made. Blue Cross will work with providers in support of ongoing efforts to assure compliance with accurate coding.

Products Impacted
This policy only applies to subscribers who have Commercial and Federal Employee Program (FEP) lines of business.

Next Steps for Providers:

- Review the reimbursement policy, including the criteria Blue Cross will use to determine the appropriate level of reimbursement as applicable for ED services.
- Adjust internal policies and procedures to ensure alignment with this policy.
- Review data reports from Blue Cross on utilization of levels 4 and 5 ER codes and readjust billing practices accordingly.

Reporting and Post-Payment Reviews
Following post-payment review, detailed reports will be shared with ED providers beginning with September 1, 2020 dates of service to help determine where billing adjustments are required.

Reminder Regarding Reimbursement Policies:
This is not a change in medical policy or member benefits, but a change in reimbursement policy. Reimbursement policies are updated on an ongoing basis and used by Blue Cross to define if and how certain claims will be paid for various health care services.

Blue Cross will not be denying claims or recouping payment as a result of this reimbursement policy at this time.

To access the reimbursement policy:
Go to providers.bluecrossmn.com
- Under Tools & Resources, select "Reimbursement Policies"
- Locate "Emergency Department Level of Service Coding"

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

New Reimbursement Policy: Inpatient Non-Reimbursable Unbundling
(P53-20, published 7/1/20)

Effective September 1, 2020, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will implement a new Reimbursement Policy: Inpatient Non-Reimbursable Unbundling. The policy is available in the provider section of the Blue Cross website located at **providers.bluecrossmn.com**. Go to the section titled, "Tools and Resources" and select "Reimbursement Policies".

This policy defines inpatient services, items and/or supplies that should not be unbundled and/or inappropriately charged.

Blue Cross will request medical records and an itemized bill post-payment for certain inpatient claims reimbursed using a percent of charge payment methodology. Charges found to be billed not in compliance with this policy will be recouped.

Products Impacted
This policy only applies to subscribers who have Commercial and Federal Employee Program (FEP) lines of business.

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, Revenue), 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**.

HCPCS stands for Healthcare Common Procedure Coding System
CPT® (Current Procedural Terminology) is a registered trademark of the American Medical Association

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATES

New Medical, Medical Drug and Behavioral Health Policy Management Updates—Effective August 31, 2020 (P47-20, published 7/1/20)

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be expanding utilization management requirements, including prior authorization (PA) requirements.

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

The following prior authorization changes will be effective August 31, 2020:

Policy #	Policy Title/ Service	New Policy	Prior Authorization Requirement	Line(s) of Business
II-173	Accepted Indications for Medical Drugs Which are Not Addressed by a Specific Medical Policy: • Abicipar pegol* • Lisocabtagene carleucel (Breyanzi®)* • Remestemcel-L (Ryoncil®)*	No	New	Commercial
L33394	Coverage for Drugs & Biologics for Label & Off-Label Uses: • Abicipar pegol* • Lisocabtagene carleucel (Breyanzi®)* • Remestemcel-L (Ryoncil®)*	No	New	Medicare Advantage

* PA will be required upon FDA approval.

Products Impacted

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

Submitting a PA Request when Applicable

- Providers may submit PA requests for any treatment in the above table starting August 24, 2020.
- 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 to support medical necessity. 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.
- Current and future PA requirements can be found using the *Is Authorization Required* tool in the Availity® portal prior to submitting a PA request. Prior Authorization Lists are also updated to reflect additional PA requirements on the effective date of the management change and includes applicable codes. To access the 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.

Prior Authorization Requests

- Participating providers must submit PA requests online via our free Availity® provider portal
- 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 fax form located under the Forms & Publications section on the Blue Cross website, or their own PA form.

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**.

CMS Issued Prior Authorization Requirements for Certain Hospital Outpatient Department (OPD) Services—Effective July 1, 2020 Retraction: CMS mandate does not apply to Medicare Advantage or Platinum Blue lines of business. Please disregard this bulletin.

The Centers for Medicare & Medicaid Services (CMS) is implementing a prior authorization program for certain hospital outpatient department (OPD) services for dates of service on or after July 1, 2020. CMS believes prior authorization for certain hospital OPD services will ensure that Medicare beneficiaries continue to receive medically necessary care while protecting the Medicare Trust Fund from improper payments and keeping the medical necessity documentation requirements unchanged for providers.

The following prior authorization changes will be effective July 1, 2020:

Policy #	Policy Title/ Service	New Policy	Prior Authorization Requirement	Line(s) of Business
Medicare (A52837)	Blepharoplasty	No	New	Medicare Platinum Blue
Medicare (L33646 & A52837)	Botulinum Toxin Injections	No	New	Medicare Platinum Blue
BCBSMN IV-24	Panniculectomy/Excision of Redundant Skin or Tissue	No	New	Medicare Platinum Blue
BCBSMN IV-82	Liposuction	No	New	Medicare Advantage & Medicare Platinum Blue
Medicare (Benefit Policy Manual 100.2) & IV-73	Rhinoplasty and related services	No	New	Medicare Advantage & Medicare Platinum Blue
Medicare (L33575 & A52870)	Vein Ablation	No	New	Medicare Platinum Blue

For more information on these changes, see CMS Prior Authorization for Certain Hospital Outpatient Department (OPD) Services.

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

Submitting a PA Request when Applicable
- Providers may submit PA requests for any treatment in the above table starting June 26, 2020**.**
- 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 to support medical necessity. 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.
- Current and future PA requirements can be found using the *Is Authorization Required* tool in the Availity® portal prior to submitting a PA request. Prior Authorization Lists are also updated to reflect additional PA requirements on the effective date of the management change and includes applicable codes. To access the 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.

Prior Authorization Requests
- Participating providers must submit PA requests online via our free Availity® provider portal
- 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 fax form located under the Forms & Publications section on the Blue Cross website, or their own PA form.

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, please contact provider services at (**651**) **662-5200** or **1-800-262-0820**.

eviCore is Changing Prior Authorization Guidelines used to Review Durable Medical Equipment (DME), Home Health Care (HHC), and Post-Acute Care (PAC) Services for Medicare Advantage Subscribers (P50-20, published 7/1/20)

eviCore will transition to using Milliman Care Guidelines (MCG) for Durable Medical Equipment (DME), Home Health Care (HHC), and Post-Acute Care (PAC) services. This will ensure our members receive the highest quality of evidence-based care.

eviCore will begin applying Milliman Care Guidelines (MCG) to the following services **effective September 1, 2020:**

- Home Health Care (HHC)
- Inpatient Rehabilitation Facility (IRF)
- Skilled Nursing Facility (SNF)

eviCore will extend the use of Milliman Care Guidelines (MCG) to the following services **effective November 1, 2020:**

- Durable Medical Equipment (DME)
- Long Term Acute Care (LTAC) Facility

Prior authorization requests will be reviewed based on eviCore clinical guideline criteria. Providers can view the list of Current Procedural Terminology (CPT) codes that require prior authorizations, eviCore clinical guidelines, and other provider resources on the eviCore Implementation Resources website.

To view CPT Code lists:

- Access the 'Provider Section' of the Blue Cross website at **providers.bluecrossmn.com**
- Select "**Medical Policy**" under *Tools and Resources,* read and accept the Blue Cross Medical Policy Statement
- Under "Medical and Behavioral Health Policies" scroll down and click on the "**eviCore healthcare Specialty Utilization Management Clinical Guidelines**" link
- Select "**Solution Resources**" and then click on the appropriate solution (ex: Cardiology)
- Select "**CPT Codes**" to view the current CPT code list that require a prior authorization

To view Clinical Guidelines:

- Access the 'Provider Section' of the Blue Cross website at **providers.bluecrossmn.com**
- Select "**Medical Policy**" under *Tools and Resources,* read and accept the Blue Cross Medical Policy Statement
- Under "Medical and Behavioral Health Policies" scroll down and click on the "**eviCore healthcare Specialty Utilization Management Clinical Guidelines**" link
- Click on the "**Resources**" dropdown in upper right corner
- Click "**Clinical Guidelines**"
- Select the appropriate solution: i.e. Cardiology & Radiology
- Type "**BCBS MN**" (space is important) in 'Search by Health Plan'
- Click on the "**Current**", "**Future**", or "**Archived**" tab to view guidelines most appropriate to your inquiry

Products Impacted

This change only applies to Medicare Advantage subscribers.

Prior Authorization Look Up Tool

Providers should use the Prior Authorization Look Up Tool on the Availity Provider Portal to quickly determine if an authorization is required. By entering Member Group Number, Date of Service and Procedure Code, the tool will indicate whether an Authorization is required. If an Authorization is not required, the tool will allow the user to print the results for their records. If an Authorization is required, the user will move directly into the next field in Authorization application to complete the request.

This feature is accessible for lines of business managed by Blue Cross and will advise providers if Blue Cross or eviCore will review the request.

To access the Prior Authorization Look Up Tool:

1. Log in at **Availity.com**
2. Select **Patient Registration**, choose **Authorizations & Referrals**, then **Authorizations**
3. Select Payer **BCBSMN**, your Organization, Transaction Type **Outpatient** and you will be redirected to the Authorization Look Up Tool application

To submit a Prior Authorization (PA) Request to eviCore

Providers submit eviCore PA requests via the free **Availity** provider portal. There is no cost to the provider for using the portal.

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

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.

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.

MINNESOTA HEALTH CARE PROGRAMS (MHCP) UPDATES

Updated Minnesota Health Care Programs and Minnesota Senior Health Options (MSHO) Prior Authorization and Medical Policy Requirements (P51-20, published 7/1/20)

Effective September 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 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 **September 1, 2020**.

Policy #	Policy Name	New Policy	Prior Authorization Required	
			Medicaid	MSHO
AI-01	Advanced Imaging of the Brain • PET Imaging of the Brain	Yes	Yes	Yes
AI-02	Advanced Imaging of the Chest • PET Imaging of the Chest	Yes	Yes	Yes
AI-03	Advanced Oncologic Imaging • PET Imaging for Oncologic Indications	Yes	Yes	Yes
AI-04	Advanced Imaging of the Extremities • PET Imaging of the Extremities	Yes	Yes	Yes
AI-05	Advanced Imaging of the Heart • Cardiac CT with Quantitative Evaluation of Coronary Calcification • Cardiac MRI • Myocardial Perfusion Imaging • Cardiac Blood Pool Imaging	Yes	Yes	Yes
GT-01	Genetic Testing for Hereditary Cancer Susceptibility • Lynch Syndrome • Hereditary Breast and Ovarian Cancer Syndrome (BRCA1, BRCA2) • Hereditary Paraganglioma-Pheochromocytoma Syndrome • PALB2 • Prostate Cancer • Von Hippel-Landau	Yes	Yes	Yes
GT-03	Genetic Testing for Reproductive Carrier Screen and Prenatal • Carrier Screening for Familial Disease • Fragile X • Cystic Fibrosis • Spinal Muscular Atrophy • Hemoglobinopathies • Ashkenazi Jewish Carrier Screening • Other Ethnicity Carrier Screening • Preimplantation Genetic Screening and Diagnostic Testing of Embryos • Prenatal Cell-Free DNA Screening	Yes	Yes	Yes
GT-04	Genetic Testing for Single Gene and Multifactorial Conditions • Genetic Testing for Germline Conditions • Multifactorial (Non-Mendelian Conditions) • Chromosomal Microarray Analysis	Yes	Yes	Yes
GT-05	Pharmacogenomic Testing and Genetic Testing for Thrombotic Disorders • Pharmacogenomic Testing • Thrombophilia Testing	Yes	Yes	Yes

Policy #	Policy Name	New Policy	Prior Authorization Required	
			Medicaid	MSHO
GT-06	Molecular Testing of Solid and Hematologic Tumors and Malignancies • Breast Cancer • Cell-Free Testing • Minimal Residual Disease (MRD) Testing • Targeted Molecular Testing for NTRK Fusions • Targeted Somatic Testing for PIK3CA • Prostate Cancer (symptomatic cancer screening)	Yes	Yes	Yes
GT-07	Whole Exome and Whole Genome Sequencing	Yes	Yes	Yes
IP-01	Interventional Pain – Epidural Injection Procedures	Yes	Yes	Yes
IP-02	Interventional Pain – Paravertebral Facet Injection/Nerve Block/Neurolysis	Yes	Yes	Yes
IP-03	Interventional Pain – Regional Sympathetic Nerve Block	Yes	Yes	Yes
IP-04	Interventional Pain – Sacroiliac Joint Injections	Yes	Yes	Yes
IP-05	Interventional Pain – Spinal Cord Stimulators	Yes	Yes	Yes
JO-01	Joint Surgery – Hip Procedures • Hip Arthroplasty • Hip Arthroscopy	Yes	Yes	Yes
JO-02	Joint Surgery – Knee Procedures • Knee Arthroplasty • Knee Arthroscopy and Open Procedures • Meniscal Allograft Transplantation of the Knee • Treatment of Osteochondral Defects	Yes	Yes	Yes
JO-03	Joint Surgery – Shoulder Procedures • Shoulder Arthroplasty • Shoulder Arthroscopy and Open Procedures	Yes	Yes	Yes
SP-01	Spine – Bone Graft Substitutes and Bone Morphogenic Proteins	Yes	Yes	Yes
SP-02	Spine – Cervical Arthroplasty	Yes	Yes	Yes
SP-03	Spine – Cervical Decompression	Yes	Yes	Yes
SP-04	Spine – Lumbar Arthroplasty	Yes	Yes	Yes
SP-05	Spine – Lumbar Discectomy, Foraminotomy, and Laminotomy	Yes	Yes	Yes
SP-06	Spine – Lumbar Fusion and Treatment of Spinal Deformity	Yes	Yes	Yes
SP-07	Spine – Lumbar Laminectomy	Yes	Yes	Yes
SP-08	Spine – Sacroiliac Joint Fusion	Yes	Yes	Yes

Policy #	Policy Name	New Policy	Prior Authorization Required	
			Medicaid	MSHO
SP-09	Spine – Vertebroplasty/Kyphoplasty	Yes	Yes	Yes
SDM-01	Sleep Disorder Management	Yes	Yes	Yes

The following policies will be archived and **will not be applicable** under the medical benefit plan to subscriber claims on or after **September 1, 2020**. However, prior authorization requirements will remain in effect per the new policies listed above.

Policy #	Policy Name	Prior Authorization Required	
		Medicaid	MSHO
RAD.00001	Computed Tomography to Detect Coronary Artery Calcification	Yes	Yes
Blue Cross V-14	Computed Tomography Angiography (CTA) for Evaluation of Coronary Arteries	Yes	Yes
Blue Cross V-27	Positron Emission Tomography (PET)	Yes	Yes
Blue Cross VI-48	Genetic Testing to Evaluate Patients with Developmental Delay/ Intellectual Disability, Autism Spectrum Disorder or Congenital Anomalies	Yes	Yes
CG-GENE-01	Janus Kinase 2, CALR, And MPL Gene Mutation Assays	Yes	Yes
CG-GENE-02	Analysis of RAS Status	Yes	Yes
CG-GENE-03	BRAF Mutation Analysis	Yes	Yes
CG-GENE-04	Molecular Marker Evaluation of Thyroid Nodules	Yes	Yes
CG-GENE-08	Genetic Testing for PTEN Hamartoma Tumor Syndrome	Yes	Yes
CG-GENE-12	PIK3CA Mutation Testing for Malignant Conditions	Yes	Yes
CG-GENE-14	Gene Mutation Testing for Solid Tumor Cancer Susceptibility and Management	Yes	Yes
CG-GENE-15	Genetic Testing for Lynch Syndrome, Familial Adenomatous Polyposis (FAP), Attenuated FAP and MYH-associated Polyposis	Yes	Yes
GENE.00009	Gene-Based Tests For Screening, Detection And Management Of Prostate Cancer	No	No
GENE.00023	Gene Expression Profiling of Melanomas	No	No
GENE.00026	Cell-free Fetal DNA-based Prenatal Testing	Yes	Yes
GENE.00046	Prothrombin (Factor II) Genetic Testing	No	No
CG-SURG-85	Hip Resurfacing	Yes	Yes
Blue Cross IV-74	Spinal Cord Stimulation	Yes	Yes

Policy #	Policy Name	Prior Authorization Required	
		Medicaid	MSHO
Blue Cross IV-95	Percutaneous Facet Joint Denervation	Yes	Yes
Blue Cross IV-87	Spinal Fusion: Lumbar	Yes	Yes
Blue Cross IV-126	Sacroiliac Joint Fusion	Yes	Yes

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

Go to https://provider.publicprograms.bluecrossmn.com/minnesota-provider/resources/prior-authorization

OR

Go to **providers.bluecrossmn.com**

- Under Tools & Resources, select "Minnesota Health Care Programs Site"
- Under Resources, select "Prior Authorization Requirements" and scroll down to "Related Information" to select "Prior Authorization Grid"

Where do I find the current government programs Medical Policy Grid?

Go to https://provider.publicprograms.bluecrossmn.com/minnesota-provider/resources/provider-manuals-and-guides

- Click on "Medical Policies and UM Guidelines"

OR

- Under Tools & Resources, select "Minnesota Health Care Programs Site"
- Under Resources, select "Manuals and Guides"
- Click on "Medical Policies and UM Guidelines"

Where can I access medical policies?

- **MN DHS (MHCP) Policies:**

  http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_157386

- **Blue Cross Policies:**

  https://www.bluecrossmn.com/providers/medical-policy-and-utilization-management

- **Amerigroup Policies:**

  https://provider.publicprograms.bluecrossmn.com/minnesota-provider/medical-policies-and-clinical-guidelines

  AND

  https://www.anthem.com/pharmacyinformation/clinicalcriteria

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

Questions?

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