PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

WHAT'S INSIDE: **March 1, 2022**

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**

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATES

Medical Policy Updates: Coupe Health and Self-Funded Benefit Plans Managed by Blue Cross and Blue Shield of Alabama (P15-22, published 3/1/22)

Participating providers are invited to submit for consideration scientific, evidence-based information, professional consensus opinions, and other information supported by medical literature relevant to our draft policies for Coupe Health and Self-Funded benefit plans managed by Blue Cross and Blue Shield of Alabama.

The draft policies are available for physician comment for 45 days from the posting date found on the document. Make sure your voice is heard by providing feedback directly to us.

How to Submit Comments on Draft Medical Policies
Complete our medical policy feedback form online at https://mn-policies.exploremyplan.com/portal/web/mn-policies/feedback or send comments and supporting documentation to us by mail or fax:

Birmingham Service Center
Attn: Health Management - Medical Policy
P.O. Box 10527
Birmingham, AL 35202

Fax: 205-220-0878

Draft Medical Policies
Draft medical policies can be found at Policies & Guidelines (exploremyplan.com)

Policy #	Policy Title
MP-746	Maternal Serum Biomarkers for Prediction of Adverse Obstetric Outcomes

Policy #	Policy Title
MP-744	Cryoablation, Radiofrequency Ablation, and Laser Ablation for the Treatment of Chronic Rhinitis
MP-312	Suprachoroidal Delivery of Pharmacological Agents
MP-208	Laparoscopic, Percutaneous, and Transcervical Techniques for the Myolysis of Uterine Fibroids
MP-513	Genetic Testing for Hereditary Breast and/or Ovarian Cancer
MP-719	Surgical Treatments for Lymphedema
MP-745	Radiofrequency Coblation Tenotomy for Musculoskeletal Conditions

Draft Provider-Administered Drug Policies

Draft provider-administered drug policies can be found at Policies & Guidelines (exploremyplan.com) and Policies & Guidelines (exploremyplan.com)

Policy #	Policy Title
PH-90091	Orencia® (abatacept)
PH-90513	Adakveo® (crizanlizumab-tmca)
PH-90027	Cerezyme® (imiglucerase)
PH-90421	Gamifant™ (emapalumab-lzsg)
PH-90079	Luxturna® (voretigene neparvovec-rzyl)
PH-90512	Scenesse® (afamelanotide)
PH-90525	Tepezza® (teprotumumab-trbw)
PH-90131	Trelstar® (triptorelin)
PH-90105	Elelyso™ (taliglucerase alfa)
PH-90141	VPRIV® (velaglucerase alfa)

Update: Introducing Coupe Health (P16-22, published 3/1/22)

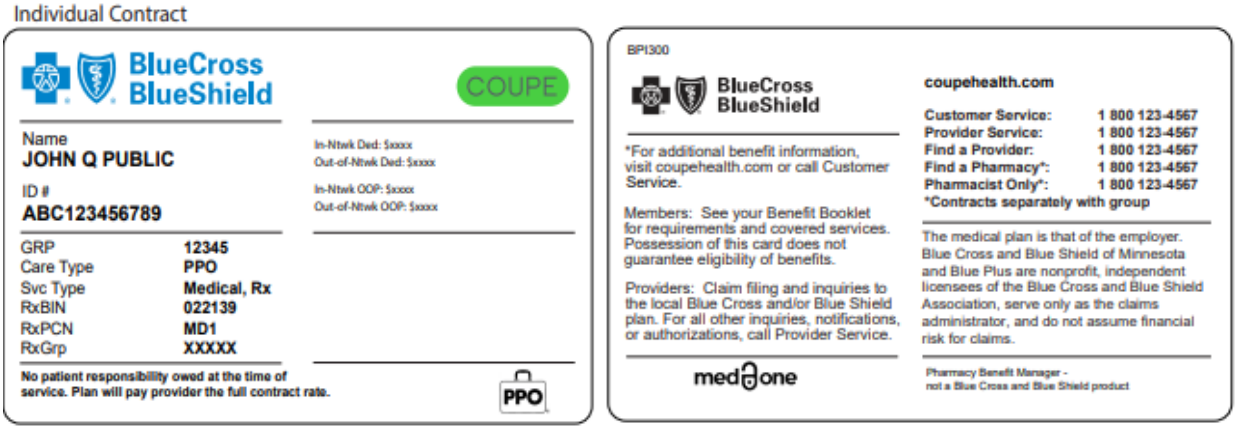
Updating Provider Bulletin P72-21, published on 11/1/2021 because the claim submission for participating providers in counties that border Minnesota has changed. All other information remains the same.

Blue Cross and Blue Shield of Minnesota (Blue Cross) began offering a new product, Coupe Health administered by Blue Cross and Blue Shield of Alabama, to self-insured employers and their employees effective January 1, 2022. Coupe Health provides an efficient and guided experience that allows members to select a high-quality provider, know the cost of service ahead of time and receive one consolidated bill. This streamlined and straightforward experience can save the member time and money.

How is Coupe Health different than other products and networks?

Coupe Health leverages the Aware network, and then tiers providers based upon four attributes: quality, relationships, experience, and cost. Members search for providers through a phone or web-based application that reviews each provider's quality rating, location, and co-pay option. The member will receive one simplified bill at the end of the month from Coupe Health and providers will not be responsible for collecting member out of pocket costs. Providers will be reimbursed 100% of the allowed amount by the Plan.

Sample ID Card:



For members accessing Minnesota providers, **including participating providers in counties that border Minnesota,** providers should submit the claims to Minnesota as a BlueCard claim. Minnesota will price the claims based on the Minnesota provider agreement and will send claims to Blue Cross and Blue Shield of Alabama to apply the benefits.

For members accessing providers outside Minnesota, **excluding participating providers in counties that border Minnesota**, claims should be submitted to the local Blue Plan as a BlueCard claim. The local plan will price the claims based on the provider agreement and will send claims to Blue Cross and Blue Shield of Alabama to apply the benefits.

Blue Cross and Blue Shield of Alabama will be providing all functions of claim management including but not limited to, medical policy, prior authorizations, pre-certifications and appeals. Providers must include the three-digit prefix when checking benefits, eligibility, and authorization requirements in order to be routed to the correct application.

Appeals

Pre-service appeals should be submitted to Coupe Health directly by following the instructions on the prior authorization denial notification.

Post-service appeals should be faxed to Blue Cross and Blue Shield of Alabama at 1-833-374-0220.

Medical Policy and Prior Authorization Requirements

Providers will be able to see medical policies and the categories of services that require prior authorization for this product at https://mn-policies.exploremyplan.com/.

Draft medical policies are available for physician comment for 45 days from the posting date found on the policy. Instructions for submitting comments are on the draft policies pages on the website. Blue Cross will include language in the monthly bulletins that are posted the first business day of the month for new draft policies that may have been posted after the bulletin posted the previous month.

Draft medical drug policies are posted on the first business day of each month and can be viewed on the website https://mn-policies.exploremyplan.com/. These will also be included in the monthly provider bulletin.

Prior Authorizations/Precertification

Providers who use the Authorization Portal in Availity® to check to see if a prior authorization is required will be directed to skip this step and submit an authorization. Once the member identification number is entered, the provider will be routed to submit the request in the appropriate application for this product. When submitting requests online, providers can attach multiple document attachments with medical records but cannot attach additional records electronically once the authorization request is submitted. If necessary, additional records can be faxed to 1-866-713-6516. Precertification requests can also be submitted via phone by calling 1-833-749-1967.

Requests for outpatient physical, occupational and speech therapy cannot be submitted online and should be faxed to the appropriate fax number below.

- Physical Therapy 1-833-719-1608
- Occupational Therapy 1-833-719-1607
- Speech Therapy 1-833-731-1511

Requests for chiropractic, home health care and hospice services and inpatient hospital and long-term acute care admission should be faxed to the appropriate fax number below.

- Chiropractic 1-833-719-1601
- Home Health 1-888-295-3005
- Hospice 1-833-719-1609
- Inpatient Hospital 1-866-713-6516
- Long-Term Acute Care 1-833-719-1602

If requests for these services are submitted online, the provider will be advised to send the request via fax.

To prevent delays, do not submit prior authorization requests or medical records for this product to fax numbers used for other Blue Cross and Blue Shield of Minnesota products.

Provider Service Questions
Providers that may have questions can call **1-833-749-1974**.

eviCore Healthcare Specialty Utilization Management (UM) Program – Medical Oncology Drug Prior Authorization Updates (P13-22, published 3/1/22)

The eviCore Healthcare Utilization Management Program will be making the following updates to the Medical Oncology Current Procedural Terminology (CPT) Prior Authorization (PA) Code List.

The following drug has been added to the Medical Oncology program and will require prior authorization for oncologic reasons **beginning May 1, 2022.**

Drug Name	Brand Name	Code(s)
tebentafusp-tebn	Kimmtrak	C9399, J3490, J3590, J9999

Prior authorization requests will be reviewed based on eviCore clinical guideline criteria. Providers can view the list of 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 **"See all tools and resources"** under *Tools and Resources*
- Select **"See medical policy and prior authorization info"** under *Medical policy and prior authorization*, read and accept the Blue Cross Medical Policy Statement
- Click on the **"Medical policies"** tab, then scroll down and click on the **"eviCore healthcare clinical guidelines"** link, which is located under *Other evidence-based criteria and guidelines we use and how to access them*
- Select **"Solution Resources"** and then click on the appropriate solution (ex: Medical Oncology)
- 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 **"See all tools and resources"** under *Tools and Resources*
- Select **"See medical policy and prior authorization info"** under *Medical policy and prior authorization*, read and accept the Blue Cross Medical Policy Statement
- Click on the **"Medical policies"** tab, then scroll down and click on the **"eviCore healthcare clinical guidelines"** link, which is located under *Other evidence-based criteria and guidelines we use and how to access them*

- Click on the **"Resources"** dropdown in the upper right corner
- Click **"Clinical Guidelines"**
- Select the appropriate solution: i.e., Medical Oncology
- 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:

- Individual subscribers
- Fully insured commercial subscribers
- Self-insured commercial subscribers (Select Groups)
- 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/Essentials**
2. Select **Patient Registration**, choose **Authorization & 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 request 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.

eviCore Healthcare Specialty Utilization Management (UM) Program – Radiation Oncology Clinical Guideline Updates (P14-22, published 3/1/22)

eviCore has released clinical guideline updates for the Radiation Oncology program. Guideline updates will become **effective May 1, 2022:**

Please review all guidelines when submitting a prior authorization request.

Guidelines with substantive changes:

- Selective Internal Radiation Therapy (SIRT)

Prior authorization request will be reviewed based on eviCore clinical guideline criteria. Providers can view the list of Current Procedural Terminology (CPT) codes that require prior authorization, 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 **"See all tools and resources"** under *Tools and Resources*
- Select **"See medical policy and prior authorization info"** under *Medical policy and prior authorization*, read and accept the Blue Cross Medical Policy Statement
- Click on the **"Medical policies"** tab, then scroll down, and click on the **"eviCore healthcare clinical guidelines"** link, which is located under *Other evidence-based criteria and guidelines we use and how to access them*
- Select **"Solution Resources"** and then click on the appropriate solution (ex: Sleep Management)
- 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 **"See all tools and resources"** under *Tools and Resources*
- Select **"See medical policy and prior authorization info"** under *Medical policy and prior authorization*, read and accept the Blue Cross Medical Policy Statement
- Click on the **"Medical policies"** tab, then scroll down, and click on the **"eviCore healthcare clinical guidelines"** link, which is located under *Other evidence-based criteria and guidelines we use and how to access them*
- Click on the **"Resources"** dropdown in the upper right corner
- Click **"Clinical Guidelines"**
- Select the appropriate solution: i.e., Sleep Management
- 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:

- Individual subscribers
- Fully insured subscribers
- Self-insured commercial subscribers (Select Groups)
- 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/Essentials**
2. Select **Patient Registration**, choose **Authorization & 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 request 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 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. Subscribers 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.

New Medical, Medical Drug and Behavioral Health Policy Management Updates — Effective May 2, 2022 (P12-22, published 3/1/22)

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 May 2, 2022:

Policy #	Policy Title/ Service	New Policy	Prior Authorization Requirement	Line(s) of Business
II-257	Triamcinolone Acetonide Suprachoroidal Injection (Xipere™)	Yes	New	Commercial
L33394	Drugs and Biologicals, Coverage of, for Label and Off-Label Uses • Triamcinolone Acetonide Suprachoroidal Injection (Xipere™) • Spesolimab*	No	New	Medicare Advantage
II-173	Accepted Indications for Medical Drugs Which are not Addressed by a Specific Medical Policy • Spesolimab*	No	New	Commercial

*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 April 25, 2022.**
- 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 bluecrossmn.com/providers/medical-management
  - Read and accept the Blue Cross Medical Management Disclaimer
  - Select the "Medical policies" tab then "Search Medical Policies" to access policy criteria
- Current and future PA requirements and related clinical coverage criteria can be found using the *Is Authorization Required* tool in the Availity Essentials® portal or at bluecrossmn.com/providers/medical-management 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 PDF prior authorization lists for all lines of business go to bluecrossmn.com/providers/medical-management

Prior Authorization Requests

- For information on how to submit a prior authorization please go to bluecrossmn.com/providers/medical-management

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 bluecrossmn.com/providers/medical-management
- Read and accept the Blue Cross Medical Management Disclaimer
- Select the Medical Policies tab, then click "See Upcoming Medical Policy Notifications"

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 (P10-22, published 3/1/22)

Effective May 1, 2022, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be updating its government programs medical policy and preauthorization/precertification/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 **May 1, 2022**.

Policy #	Policy Name	New Policy	Prior Authorization Required	
			Medicaid	MSHO
MED.00138	Wearable Devices for Stress Relief and Management	Yes	No	No
ING-CC-0204	Tivdak (tisotumab vedotin-tftv)	Yes	Yes	Yes
ING-CC-0195	Abecma (idecabtagene vicleucel)	Yes	Yes	Yes

The following policies have changes in clinical criteria and **will be applicable** to subscriber claims on or after **May 1, 2022**.

Policy #	Policy Name	Prior Authorization Required	
		Medicaid	MSHO
CG-MED-53	Cervical Cancer Screening Using Cytology and Human Papillomavirus Testing	No	No
CG-MED-81	Ultrasound Ablation for Oncologic Indications	Yes	Yes
CG-OR-PR-05	Myoelectric Upper Extremity Prosthetic Devices	Yes	Yes
CG-SURG-78	Locoregional and Surgical Techniques for Treating Primary and Metastatic Liver Malignancies	Yes	Yes
CG-SURG-106	Venous Angioplasty with or without Stent Placement or Venous Stenting Alone	No	No
GENE.00049	Circulating Tumor DNA Panel Testing (Liquid Biopsy)	No	No
GENE.00052	Whole Genome Sequencing, Whole Exome Sequencing, Gene Panels, and Molecular Profiling	Yes	Yes
MED.00099	Navigational Bronchoscopy	No	No
SURG.00010	Treatments for Urinary Incontinence	Yes	Yes
SURG.00011	Allogeneic, Xenographic, Synthetic, Bioengineered, and Composite Products for Wound Healing and Soft Tissue Grafting	Yes	Yes
SURG.00023	Breast Procedures; including Reconstructive Surgery, Implants and Other Breast Procedures	Yes	Yes
SURG.00026	Deep Brain, Cortical, and Cerebellar Stimulation	Yes	Yes
SURG.00037	Treatment of Varicose Veins (Lower Extremities)	Yes	Yes
SURG.00097	Scoliosis Surgery	No	No
CG-GENE-13	Genetic Testing for Inherited Diseases	Yes	Yes
ING-CC-0148	Agents for Hemophilia B	Yes	Yes
ING-CC-0149	Select Clotting Agents for Bleeding Disorders	Yes	Yes

Policy #	Policy Name	Prior Authorization Required	
		Medicaid	MSHO
ING-CC-0065	Agents for Hemophilia A and von Willebrand Disease	Yes	Yes
ING-CC-0168	Tecartus (brexucabtagene autoleucel)	Yes	Yes
ING-CC-0102	GnRH Analogs for Oncologic Indications	Yes	Yes
ING-CC-0001	Erythropoiesis Stimulating Agents	Yes	Yes
ING-CC-0170	Uplizna (inebilizumab-cdon)	Yes	Yes
ING-CC-0003	Immunoglobulins	Yes	Yes
ING-CC-0075	Rituximab Agents for Non-Oncologic Indications	Yes	Yes
ING-CC-0072	Selective Vascular Endothelial Growth Factor (VEGF) Antagonists	Yes	Yes
ING-CC-0107	Bevacizumab for Non-Ophthalmologic Indications	Yes	Yes
ING-CC-0061	GnRH Analogs for the Treatment of Non-Oncologic Indications	Yes	Yes
ING-CC-0106	Erbitux (cetuximab)	Yes	Yes
ING-CC-0105	Vectibix (panitumumab)	Yes	Yes

The following policies and/or prior authorization requirements will be archived and **will not be applicable** under the medical benefit plan to subscriber claims on or after **May 1, 2022**.

Policy #	Policy Name	Prior Authorization Required	
		Medicaid	MSHO
MED.00085	Antineoplaston Therapy	No	No
CG-MED-32	Ancillary Services for Pregnancy Complications	No	No
CG-MED-77	SPECT/CT Fusion Imaging	Yes	Yes
CG-MED-87	Single Photon Emission Computed Tomography Scans for Noncardiovascular Indications	Yes	Yes
GENE.00036	Genetic Testing for Hereditary Pancreatitis	Yes	Yes
GENE.00047	Methylenetetrahydrofolate Reductase Mutation Testing	No	No
MED.00095	Anterior Segment Optical Coherence Tomography	No	No
MED.00117	Autologous Cell Therapy for the Treatment of Damaged Myocardium	Yes	Yes

Medical prior authorization (pa) update

Blue Cross recently identified that certain codes should not have required a PA for medical services. The codes listed below have been removed from requiring PA effective **January 1, 2022**.

An update to the system is in progress.

CPT code	Code Description
J9356	Injection, trastuzumab, 10 mg and hyaluronidase-oysk
Q5112	Injection, trastuzumab-dttb, biosimilar, (Ontruzant), 10 mg
Q5113	Injection, trastuzumab-pkrb, biosimilar, (herzuma), 10 mg
Q5114	Injection, trastuzumab-dkst, biosimilar, (Ogivri), 10 mg
Q5116	Injection, trastuzumab-qyyp, biosimilar, (trazimera), 10 mg
Q5117	Injection, trastuzumab-anns, biosimilar, (kanjinti), 10 mg

Where do I find the current government programs precertification/preauthorization/notification list?

- Go to **https://provider.publicprograms.bluecrossmn.com/minnesota-provider/resources/prior-authorization**
- **Or** go to **https://www.bluecrossmn.com/providers**
- Under *Tools & Resources*, select **Minnesota Health Care Programs site**
- Under *Resources*, select **Prior Authorization Requirements** and scroll down to **Related Information** to select **Prior Authorization Grid**

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

- Go to **https://provider.publicprograms.bluecrossmn.com/minnesota-provider/resources/provider-manuals-and-guides**
- Select *Medical Policies and UM Guidelines* or
- Go to **https://www.bluecrossmn.com/providers**
- Under *Tools & Resources*, select Minnesota Health Care Programs site
- Under *Resources*, select **Manuals and Guides**
- Select **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 provider services at **1-866-518-8448**.

Billing Changes for Residential Treatment Centers and 1115 Waiver Providers for Minnesota Health Care Programs (P11-22, published 3/1/22)

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) is implementing billing changes for Residential Treatment Centers (RTC), 1115 Waiver and Withdrawal Management providers effective May 1, 2022. Blue Cross is updating the requirements to be consistent with the Minnesota Department of Human Services (DHS).

Effective May 1, 2022, inpatient RTC, 1115 Waiver and Withdrawal Management claims must be billed using the appropriate value code to indicate level of service as published by DHS on the **Residential 5-digit Value Codes for Billing Direct Access** (https://mn.gov/dhs/assets/res-value-codes-billing-direct-access_tcm1053-477386.pdf). Providers are advised that they should not bill with a HCPCS code/modifier combination beginning May 1, 2022, based on first date of service on the claim.

Inpatient services provided prior to May 1, 2022, must be billed using the HCPCS code/modifier combination to identify the level of intensity for accurate reimbursement. Residential Treatment Centers providing services to children and adolescents are advised that the use of modifier HA - Child/Adolescent program is defined as a member under the age of 18 for claims processing.

If claims have been submitted using the Value Codes prior to the effective date of May 1, 2022, providers are advised to submit replacement claims using the HCPCS code/modifier combination.

Outpatient services will continue to require the HCPCS code/modifier combination based on the services provided to the members.

Products Impacted
This information applies to the following Minnesota Health Care Programs:
• Families and Children (formerly Prepaid Medical Assistance Program)
• MinnesotaCare

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