PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

June 1, 2023

WHAT'S INSIDE:

L08R04 (12/13)

ADMINISTRATIVE UPDATES

Reminder: Medicare Requirements for Reporting Provider Demographic Changes

(published in every summary of monthly bulletins)

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) collaborates with providers to ensure accurate information is reflected in all provider directories. In accordance with Medicare requirements, Blue Cross is required to maintain accurate provider network directories for the benefit of our Subscribers.

- 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

The appropriate form for each of these changes or updates can be located on the Blue Cross website at bluecrossmn.com/providers/provider-demographic-updates

Providers are obligated, per federal requirements, to update provider information contained in the National Plan & Provider Enumeration System (NPPES). Updating provider information in NPPES will provide organizations with access to a current database that can be used as a resource to improve provider directory reliability and accuracy. Providers with questions pertaining to NPPES may reference NPPES help at https://nppes.cms.hhs.gov/webhelp/nppeshelp/HOME%20PAGE-SIGN%20IN%20PAGE.html

Questions?
Please contact provider services at **(651) 662-5200** or **1-800-262-0820.**

Ancillary and Facility Claim Processing when Prior Authorization is Not Obtained | P41-23

As previously communicated, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) implemented an appeal policy related to the existing requirement of a prior authorization (PA) submission in Provider Bulletin P35R1-19. Blue Cross is expanding that policy to include all ancillary and facility claims for non-authorized services. If a service is performed without a PA on file, or a PA was denied for medical necessity, all associated facility and ancillary (anesthesia, professional services, etc..) claims will be denied as well.

Providers should continue to follow applicable Prior Authorization and Notification requirements for inpatient stays. Inpatient claims, even with an approved Pre-Admission Notification/Precertification, and outpatient facility claims will be denied and ineligible for reimbursement if the services provided require a PA and an approved PA is not obtained.

The policy will go into effect with dates of service beginning August 1, 2023.

When a PA is required for a service, procedure or item, the ordering health care provider must submit the clinical information ***in advance*** to Blue Cross via the Availity Portal. Before performing a service that requires a PA, the rendering health care provider must validate that the ordering health care provider completed the authorization process and was issued a final determination on the authorization. If the rendering health care provider provides a service before an authorization was completed, the claim(s) for both the ordering health care provider and the rendering health care provider will be denied for lack of prior authorization and the provider will be held liable. The claim denial will be administrative and cannot be appealed for medical necessity.

Rendering health care providers can verify if a prior authorization was obtained through the Availity Portal. You will need the member identification number, the ordering provider's NPI, and the service dates used on the submission:

1. Log in at **Availity.com/essentials**
2. Select Patient Registration, choose **Authorizations & Referrals,** then **Authorization/Referral Inquiry**

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

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

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

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

Other exemptions from this policy are:

- Emergency and urgent care services that are performed in the emergency room do not require prior authorization and will be considered at the in-network benefit level.
- Maternity delivery admissions when level of care is delivery only.
- Inpatient admissions
- Medicaid lines of business
- Federal Employee Program (FEP) members
- PT/ST/OT/Chiropractic – beginning June 3, 2019, Blue Cross will no longer require providers to submit prior authorizations for these services (see Provider Bulletin P34-19, for additional information).

Products Impacted
- Commercial
- Medicare Advantage
- Medicare Platinum Blue

Questions?
Please contact provider services at (651) 662-5200 or 1-800-262-0820.

Diagnosis Coding Edits in Availity Essentials for Acute Stroke & Myocardial Infarction | P43-23

Blue Cross and Blue Shield of Minnesota (Blue Cross) will be implementing coding edits in Availity Essentials that will impact claims submitted on or after August 2, 2023. These coding edits are related to the submission of claims with an acute stroke or myocardial infarction diagnosis in an office place of service (place of service 11). The edits are being implemented to reduce incorrect diagnosis coding that currently results in medical record requests from the Blue Cross Risk Management Program.

If a claim is submitted with an acute stroke diagnosis with an office place of service (place of service 11), the claim will be rejected with the message: *The claim was denied because it was billed with an acute stroke diagnosis in POS 11. This diagnosis code is reserved for the initial (first) episode of care for the acute stroke/cerebrovascular accident.* The claim will not be accepted for processing and providers must correct and resubmit the claim.

If a claim is submitted with a myocardial infarction diagnosis with an office place of service (place of service 11), the claim will be accepted and processed; however, a message will be returned stating: *The claim has been submitted with an acute myocardial infarction diagnosis in POS 11. Per ICD 10 guidelines, this diagnosis code can only be reported 4 weeks (28 days) or less from onset. If the myocardial infarction occurred more than 4 weeks ago, the appropriate aftercare or history code should be assigned.* Providers that receive this message should review medical records to determine if the appropriate diagnosis was submitted. Correcting the diagnosis code will require the submission of a replacement claim once the claim has been remitted.

Lines of Business Impacted
Commercial and Medicare

Questions?
Please contact provider services at **(651) 662-5200** or **1-800-262-0820**.

List Payer ID for Blue Plus Minnesota Health Care Programs Claims (MHCP) Will Change January 1, 2024 | P45-23

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be migrating the processing of Minnesota Health Care Program (MHCP) transactions back to Blue Cross on January 1, 2024. As a result of this migration, the payer ID will change from 00562 to 00726 for transaction submission dates starting January 1, 2024, regardless of date of service.

Blue Cross requests that providers and clearinghouses prepare for this change and submit with the appropriate payer ID beginning January 1, 2024. A crosswalk will be in place for claims submitted with the prior payer ID and outreach will occur to notify providers that continue to submit with an incorrect payer ID.

Products Impacted
- Families and Children [formerly known as Prepaid Medical Assistance Program (PMAP)]
- MinnesotaCare (MNCare)
- Minnesota Senior Care Plus (MSC+)
- Minnesota Senior Health Options (MSHO)

Questions?
Contact provider services at **(651) 662-5200** or **1-800-262-0820**.

CONTRACT UPDATES

Updated Reimbursement Policies, Effective August 7, 2023 | P39-23

Blue Cross and Blue Shield of Minnesota (Blue Cross) will implement the following changes to the identified reimbursement policies, effective August 7, 2023:

Policy #	Policy Title/Service
Commercial General Coding - 038	Injection and Infusion Services • Commercial products to follow NCCI PTP code edits. • Additional supply codes added to services not reimbursed separately. • Additional codes added to services not reimbursed separately in facility or home place of service.
Medicare Evaluation and Management -002	Same Day Same Service • A 50% reduction will be applied to evaluation and management services (99202-99380 and 99401-99498) submitted with modifier 25 for Medicare Advantage claims only.
Commercial General Coding - 025	Maternity • Revised to align with the American College of Obstetricians and Gynecologists (ACOG) guidelines. • Examples are provided to address the correct reporting of multiple gestation deliveries.

Products Impacted
Commercial, Medicare Advantage.

Questions?
Please contact provider services at **(651) 662-5200** or **1-800-262-0820**.

Penalty will Apply to Non-Timely Notice of Admission (NOA) Claims | P44-23

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) began requiring a Notice of Admission (NOA) claim with type of bill 32A effective with episodes of care for dates of service January 1, 2022. Blue Cross did not implement a penalty at that time for NOA claims that were not received within the required timeframe. Effective July 14, 2023, Blue Cross will be applying a penalty aligned with CMS guidance for any non-timely NOA claim submissions. Blue Cross must receive the NOA claim within 5 calendar days of the admit date to be considered timely.

Blue Cross requires a NOA claim be submitted for all Medicare-eligible Home Care services rendered to Medicare members. Providers must submit the NOA claim for episodes of care for dates of service January 1, 2022, and after to receive reimbursement on the final episode of care claim.

Blue Cross will not require the correct HIPPS code to be submitted on the NOA claim. Final episode of care claim submission must include the correct HIPPS code in order to reimburse correctly.

Products Impacted
Medicare Advantage

Questions?
Contact provider services at **(651) 662-5200** or **1-800-262-0820**.

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 | P36-23

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. At the conclusion of the 45 days, policies will go into effect. 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-356	Ambulatory Event Monitors and Mobile Cardiac Outpatient Telemetry
MP-561	Transcutaneous Mitral Valve Repair and Replacement
MP-755	Digital Health Technologies: Therapeutic Applications
MP-225	Balloon Ostial Dilation
MP-215	Bariatric Surgery

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-90697	Syfovre® (pegcetacoplan)
PH-90018	Berinert (C1 Esterase Inhibitor, Human)
PH-90052	Alpha-1-Proteinase Inhibitors: Aralast NP®, Glassia®, Prolastin-C®, Zemaira®
PH-90017	Benlysta® (belimumab)
PH-90693	Briumvi® (ublituximab-xiiy)
PH-90098	Denosumab: Prolia®, Xgeva®
PH-90346	Mepsevii (vestronidase alfa-vjbk)
PH-90503	Reblozyl® (luspatercept-aamt)
PH-90614	Saphnelo® (anifrolumab-fnia)

New Medical, Medical Drug and Behavioral Health Policy Management Updates: Effective July 31, 2023 | P37-23

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 July 31, 2023:

Policy #	Policy Title/ Service	New Policy	Prior Authorization Requirement	Line(s) of Business
II-277	Pegcetacoplan (Syfovre™)	Yes *(Moving from Policy II-173)*	Continued	Commercial
II-278	Velmanase alfa (Lamzede®)	Yes *(Moving from Policy II-173)*	Continued	Commercial
II-173	Accepted Indications for Medical Drugs Which are Not Addressed by a Specific Medical Policy: • Natalizumab biosimilar (PB006)*	No	New	Commercial
L33394	Coverage for Drugs & Biologics for Label & Off-Label Uses: • Voretigene neparvovec (Luxturna®) • Natalizumab Biosimilar (PB006)* • Delandistrogene moxeparvovec (SRP-9001)* • Epcoritamab*	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 July 24, 2023.**
- 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
  - Select “See Medical and Behavioral Health Policies” then click “Search Medical and Behavioral Health 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 include 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 https://www.bluecrossmn.com/providers/medical-management
- Select "See Medical and Behavioral Health Policies" then click "See Upcoming Medical and Behavioral Health Policy Notifications."

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

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eviCore Healthcare Specialty Utilization Management (UM) Program: Laboratory Management Clinical Guideline Updates | P40-23

eviCore has released clinical guideline updates for the Laboratory Management program. Guideline updates will become **effective August 1, 2023**.

Please review all guidelines when submitting a prior authorization request.

New Guideline:
- Multi-Cancer Early Detection Screening

Guidelines with substantive changes:
- Immunohistochemistry (IHC)
- Investigational and Experimental Laboratory Testing
- Molecular Respiratory Infection Pathogen Panel (RIPP) Testing
- Somatic Mutation Testing-Hematological Malignancies
- Special Circumstances Influencing Coverage Determinations
- Somatic Mutation Testing-Solid Tumors
- Whole Genome Sequencing

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. Laboratory 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., Laboratory 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.

To Provide Feedback on Future Guidelines:

Participating providers are invited to submit for consideration scientific, evidence-based information, professional consensus opinions, and other information supported by medical literature relevant to future guidelines managed by eviCore.

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

To submit feedback, complete the Provider feedback form for third-party clinical policies/guidelines/criteria PDF via https://www.bluecrossmn.com/providers/medical-management/medical-and-behavioral-health-policies.

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 the Authorization application to complete 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.

Services Removed from the Commercial Prior Authorization List | P46-23

Blue Cross and Blue Shield of Minnesota (Blue Cross) will not conduct medical necessity reviews for Home Health Aides and Unlisted DME over $500 for dates of service beginning July 1, 2023.

Requests that are received through either Availity or fax Requests for Home Health Aides and Unlisted DME over $500 will be closed and returned with a message that no prior authorization is required. If there is an existing medical policy for a service, but prior authorization is not required, providers will be directed back to our medical policies to review our medical necessity criteria. If benefit coverage information is needed, providers will be guided to customer service for assistance with review of the member's benefits.

Please note, claims for services that are not on our prior authorization list will be processed through the claims system according to the subscribers' benefits.

Products Impacted

This information only applies to commercial lines of business.

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 (MHCP) & Minnesota Senior Health Options (MSHO) Prior Authorization & Medical Policy Requirements | P42-23

Effective August 1, 2023, 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 MHCP (Families and Children, MinnesotaCare, and Minnesota Senior Care Plus) and 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 **August 1, 2023**.

Policy #	Policy name	New policy	Prior authorization required	
			MHCP	MSHO
CC-0232	Lunsumio (mosunetuzumab-axgb)	Yes	Yes	Yes
Blue Cross II-274	Nadofaragene Firadenovec (Adstiladrin)	Yes	Yes	Yes
Blue Cross II-277	Pegcetacoplan (Syfovre)	Yes	Yes	Yes
Blue Cross II-278	Velmanase alfa (Lamzede)	Yes	Yes	Yes

The following policies have transitioned to new policy numbers, with changes in *Clinical Criteria*, and **will be applicable** to subscriber claims on or after **August 1, 2023**.

New policy #	Prior policy #	Policy name	Prior authorization required	
			MHCP	MSHO
MCG	CG-SURG-107	Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH)	Yes	Yes
MCG	CG-SURG-110	Lung Volume Reduction Surgery	Yes	Yes
MCG	SURG.00119	Endobronchial Valve Devices	No	No
CG-SURG-117	SURG.00151	Balloon Dilation of the Eustachian Tubes	No	No

The following policies have changes in *Clinical Criteria* and **will be applicable** to subscriber claims on or after **August 1, 2023**.

Policy #	Policy name	Prior authorization required	
		MHCP	MSHO
CC-0210	Enjaymo (sutimlimab)	Yes	Yes
CC-0116	Bendamustine agents (Bendeka, Treanda, Belrapzo and Vivimusta)	Yes	Yes
CC-0212	Tezspire (tezepelumab-ekko)	Yes	Yes
CC-0140	Zulresso (brexanolone)	Yes	Yes
CC-0125	Opdivo (nivolumab)	Yes	Yes
CC-0119	Yervoy (ipilimumab)	Yes	Yes
CC-0099	Abraxane (paclitaxel, protein bound)	Yes	Yes
CC-0093	Docetaxel (Taxotere)	Yes	Yes
CC-0094	Pemetrexed Agents (Alimta, Pemfexy)	Yes	Yes
CC-0130	Imfinzi (durvalumab)	Yes	Yes
CC-0118	Radioimmunotherapy and Somatostatin Receptor Targeted Radiotherapy (Azedra, Pluvicto and Zevalin only)	Yes	Yes
CC-0123	Cyramza (ramucirumab)	Yes	Yes
CC-0121	Gazyva (obinutuzumab)	Yes	Yes
CC-0096	Asparlas (calaspargase pegol-mknl), Oncaspar (pegaspargase), Rylaze (asparaginase, recombinant), and Asparaginase, not otherwise specified only	Yes	Yes

Policy #	Policy name	Prior authorization required	
		MHCP	MSHO
CC-0120	Kyprolis (carfilzomib)	Yes	Yes
CC-0126	Blincyto (blinatumomab)	Yes	Yes
CC-0132	Mylotarg (gemtuzumab ozogamicin)	Yes	Yes
CC-0097	Vidaza (azacitidine)	Yes	Yes
CC-0090	Ixempra (ixabepilone)	Yes	Yes
CC-0110	Perjeta (pertuzumab)	Yes	Yes
CC-0115	Kadcyla (ado-trastuzumab)	Yes	Yes
CC-0067	Prostacyclin Infusion and Inhalation Therapy	Yes	Yes
CC-0124	Keytruda (pembrolizumab)	Yes	Yes
Blue Cross IV-123	Gender Affirming Procedures	Yes	Yes
CG-SURG-106	Venous Angioplasty with or without Stent Placement or Venous Stenting Alone	No	No
CG-SURG-108	Stereotactic Radiofrequency Pallidotomy	Yes	Yes
CG-SURG-18	Septoplasty	Yes	Yes
CG-SURG-46	Myringotomy and Tympanostomy Tube Insertion	No	No
CG-SURG-86	Endovascular/Endoluminal Repair of Aortic Aneurysms, Aortoiliac Disease, Aortic Dissection and Aortic Transection	Yes	Yes
GENE.00049	Circulating Tumor DNA Panel Testing (Liquid Biopsy)	No	No
SURG.00011	Allogeneic, Xenographic, Synthetic, Bioengineered, and Composite Products for Wound Healing and Soft Tissue Grafting	No	No
SURG.00103	Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)	No	No

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 **August 1, 2023**.

Policy #	Policy name	Prior authorization required	
		MHCP	MSHO
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 • Prenatal Cell-Free DNA Screening	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
GT-05	Pharmacogenomic Testing and Genetic Testing for Thrombotic Disorders:	Yes	Yes

Policy #	Policy name	Prior authorization required	
		MHCP	MSHO
	• Pharmacogenomic Testing • Thrombophilia Testing		
RAD.00052	Positional MRI	No	No
SURG.00053	Unicondylar Interpositional Spacer	No	No

The following prior authorization requirements will be removed and **will not be applicable** to subscriber claims on or after **August 1, 2023**. However, the policies will remain in effect.

Code	Code description	Policy source
31574	Laryngoscopy, flexible; with injection(s) for augmentation (eg, percutaneous, transoral), unilateral	MED.00132
C1878	Material for vocal cord medialization, synthetic (implantable)	MED.00132
81243	FMR1 (fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	MHCP CG-GENE-13
81244	FMR1 (fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; characterization of alleles (eg, expanded size and promoter methylation status)	MHCP CG-GENE-13
81412	Ashkenazi Jewish associated disorders (eg, Bloom syndrome, Canavan disease, cystic fibrosis, familial dysautonomia, Fanconi anemia group C, Gaucher disease, Tay-Sachs disease), genomic sequence analysis panel, must include sequencing of at least 9 genes, including ASPA, BLM, CFTR, FANCC, GBA, HEXA, IKBKAP, MCOLN1, and SMPD1	MHCP GENE.00052
81403	MOLECULAR PATHOLOGY PROCEDURE LEVEL 4	MHCP CG-GENE-13
81335	TPMT (thiopurine S-methyltransferase) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3)	CG-GENE-11
81381	HLA Class I typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, B*57:01P), each	CG-GENE-11
81404	MOLECULAR PATHOLOGY PROCEDURE LEVEL 5	CG-GENE-14, CG-GENE-18, MHCP CG-GENE-13

MCG Care Guidelines 27th Edition

Effective **September 1, 2023,** Amerigroup Partnership Plan, LLC will upgrade to the 27th edition of MCG care guidelines for the following modules: Inpatient & Surgical Care (ISC). The below tables highlight new guidelines and changes.

Updates marked with an asterisk (*) notate that the criteria may be perceived as more restrictive.

Goal length of stay (GLOS) for inpatient & surgical care (ISC)

Guideline	MCG Code	26th Edition GLOS	27th Edition GLOS
*Electrophysiologic Study and Implantable Cardioverter-Defibrillator (ICD) Insertion	M157 [W0011]	Ambulatory or 1 day postoperative	Ambulatory
*Renal Failure, Acute	M-326	3 days	2 days
*Paraplegia, Acute	M-255	8 days	7 days

Guideline	MCG Code	26th Edition GLOS	27th Edition GLOS
*Tetraplegia, Acute	M-305	9 days	7 days
*Percutaneous Revascularization, Lower Extremity	S-1310 [W0121]	Ambulatory or 1 day postoperative	Ambulatory
*Splenectomy by Laparoscopy	S-1062	1 day postoperative	Ambulatory or 1 day postoperative
*Elbow Arthroplasty	S-420	Ambulatory or 1 day postoperative	Ambulatory
*Elbow Fracture, Open Treatment	S-424	Ambulatory or 1 day postoperative	Ambulatory
*Foot Fracture, Calcaneus or Talus, Open Reduction, Internal Fixation (ORIF)	S-490	Ambulatory or 1 day postoperative	Ambulatory
*Foot: Surgical Wound Care	S-495	Ambulatory or 1 day postoperative	Ambulatory
*Hip Resurfacing	S-565	2 days postoperative	Ambulatory or 1 day postoperative
*Knee Dislocation, Closed or Open Reduction	S-675	Ambulatory or 1 day postoperative	Ambulatory
*Shoulder Arthroplasty	S-634 [W0137]	1 day postoperative	Ambulatory or 1 day postoperative
*Appendectomy, without Abscess or Peritonitis, Pediatric	P-25	Ambulatory or 1 day postoperative	Ambulatory
*Hip: Congenital Dislocation, Open Reduction	P-590	1 day postoperative	Ambulatory or 1 day postoperative
*Renal Transplant, Pediatric	P-1015 [W0126]	6 days postoperative	5 days postoperative
*Slipped Upper Femoral Epiphysis, Closed Reduction	P-443	Ambulatory or 1 day postoperative	Ambulatory
*Tibial Osteotomy, Child or Adolescent	S-1131	Ambulatory or 1 day postoperative	Ambulatory
*Bladder Incision: Cystotomy	S-200	Ambulatory or 1 day postoperative	Ambulatory
*Ureterotomy, Nontransurethral for Stone	S-1150	1 day postoperative	Ambulatory or 1 day postoperative

New Guidelines for Inpatient & Surgical Care (ISC)

Body System	Guideline Title	MCG - Code
Hospital-at-Home	COVID-19: Hospital-at-Home	M-281-HaH
Hospital-at-Home	Viral Illness, Acute: Hospital-at-Home	M-280-HaH
Observation Care Guidelines	COVID-19: Observation Care	OC-068
Pediatrics	COVID-19, Pediatric	P-281
Thoracic Surgery and Pulmonary Disease	COVID-19	M-281

New Guidelines for Recovery Facility Care (RFC)

Body System	Guideline Title	MCG - Code
Cardiovascular Surgery	Percutaneous Revascularization, Lower Extremity	S-6310
Thoracic Surgery and Pulmonary Disease	COVID-19	M-5281

New Guidelines for Chronic Care (CCG)

Body System	Guideline Title	MCG - Code
Social Determinants of Health	Food Insecurity	C-1164
Social Determinants of Health	Housing Insecurity	C-1165

Where do I find the current government programs *Precertification/Preauthorization/Notification List*?

- Go to **https://provider.publicprograms.bluecrossmn.com/docs/inline/MNMN_CAID_PriorAuthorizationList.pdf?v=202203311948**.

or

- Go to **bluecrossmn.com/providers** > Tools & Resources > Minnesota Health Care Programs site > Prior Authorization > *Prior Authorization List*.

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

- Go to **https://provider.publicprograms.bluecrossmn.com/docs/gpp/MNMN_CAID_MedicalPolicyGrid.pdf?v=202203311949**.

or

- Go to **bluecrossmn.com/providers** > Tools & Resources > Minnesota Health Care Programs site > Resources > Manuals and Guidelines > Medical Policies and Clinical UM Guidelines > *Medical Policy Grid*.

Where can I access *Medical Policies*?

- 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** is not available for prior authorization look up.

Questions?

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