Blue Cross and Blue Shield of Minnesota and Blue Plus Commercial Prior Authorization/Admission Notification Requirements

Overview

Prior Authorization is required for various services, procedures, prescription drugs, and medical devices. This document contains the full list of services, procedures, prescription drugs, and medical devices[1] that require prior authorization/notification for Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) commercial products.

The prior authorization process determines whether services are medically necessary and appropriate based on clinical coverage criteria and is not a reflection of a member's benefits or eligibility. Benefits and eligibility must be verified each time a member seeks services. All applicable terms and conditions of the member's plan including exclusions, deductibles, copayments, and coinsurance provisions continue to apply with an approved prior authorization/notification.

A notification is a process whereby the provider or subscriber informs Blue Cross of a planned, unplanned or emergency service. All inpatient admissions require notification. Upon receipt of an admission notification, when prior authorization is required, the admission will be reviewed for medical necessity and appropriateness. As needed throughout an inpatient stay, we will review clinical records to determine medical necessity and appropriateness and to help the member when discharged.

Submitting Prior Authorizations/Notifications

Providers may submit prior authorization and notification requests on Availity.com. If unable to submit request using Availity, provider may submit request to Blue Cross Utilization Management Department using the appropriate form: Pre-Authorization/Pre-Certification/Notification Forms

When submitting a prior authorization or notification request, please ensure the following are available:

- The patient name (as it appears on the member's identification card)
- The patient subscriber ID, including alpha prefix, and group number
- The patient date of birth
- Name of ordering/admitting physician and NPI number
- Name of servicing/rendering physician and NPI number
- Diagnosis/CPT/HCPCS codes pertinent to the requested service and narrative description of service requested
- Clinical documentation to support the service request based on the relevant Medical Policy's documentation requirements
- Requestor's contact name, phone and fax number and location

To assure timely processing, please submit your request on Availity.com.

Access the Blue Cross and Blue Shield of Minnesota Medical and Behavioral Health Policies on our website. Change Healthcare's InterQual® criteria are available upon request.

[1] Services, procedures, prescription drugs and medical devices may be referred to as simply 'service(s)' in the remainder of this document.

A copy of any policy or other clinical criteria used to make a medical necessity determination may be requested by calling Provider Services at 1-800-262-0820 or (651) 662-5200.

The below list includes the standard prior authorization (PA)/notification requirements for Commercial products based on today's date. Upcoming changes to PA requirements can be found in the monthly Provider Bulletins published online at bluecrossmn.com/providers/forms-and-publications or by using the Authorizations tool in the Availity® provider portal. Additional PA requirements may also apply based on the member's group benefits.

The HCPCS/CPT/NUBC codes listed are included for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement.

Blue Cross and Blue Shield of Minnesota and Blue Plus Commercial Notifications	
Notification Only:	**Acute Medical and Acute Behavioral Health Inpatient Admissions** • Admission notification is required for all admissions • Continued stay notification is required if applicable, when the member is still in after the initially allowed days • Discharge details must be provided for every admission **Outpatient Dialysis Services** • Notification is required for all outpatient dialysis services • **Upon initiation of outpatient dialysis,** please complete Medicare CMS 2728 form and submit your request on Availity.com or fax to 651-662-2810. **The CMS 2728 form must be used for both Medicare and non-Medicare subscribers.** • If the subscriber is Medicare eligible, please complete entire form. • If the subscriber is not Medicare eligible, please complete only sections A-C.

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Blue Cross and Blue Shield of Minnesota and Blue Plus
Commercial Prior Authorization Requirements

Medical Policy Number or Criteria	Service Category	CPT/HCPCS/Revenue Codes
Radiology, Genetic Testing		
VI-16	**Genetic Testing for Hereditary Breast and/or Ovarian Cancer**	0102U, 0103U, 81162, 81163, 81164, 81165, 81166, 81167, 81212, 81215, 81216, 81217, 81432, 81433
Behavioral Health		
X-43	**Autism Spectrum Disorders: Assessment and Early Intensive Behavioral Intervention (EIBI) –** greater than 9 hours/week (MN and participating border county providers)	H0032, H2014, H2017, H2019, 0362T, 0373T, 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158
InterQual	**Eating Disorder Residential Services (MN providers)**	No specific coding
InterQual	**Mental Health Residential Admissions (MN providers)**	No specific coding
InterQual	**Partial Hospitalization (MN and participating border county providers)**	H0035 Revenue Codes: 0912, 0913
X-45	**Psychological & Neuropsychological Testing**	96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146
InterQual	**Substance Use Disorder Residential Admissions (MN providers)**	No specific coding

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Cosmetic Services *The list below is considered examples of cosmetic services and will not be covered unless BCBSMN considers the request eligible as reconstructive surgery under the terms of a member's contract. This list is not all inclusive.*		
IV-82	**Liposuction**	15876, 15877, 15878, 15879
Drugs & Injectables under the Medical Benefit *Electronic medical drug prior authorization requests can be submitted electronically to Blue Cross thru Availity.com or transmitted electronically through an integrated electronic medical record (EMR) system. See the Medical Drug Exclusion List for drug guidelines that apply.*		
II-161	**Abatacept (Orencia®)**	J0129
II-107	**Advanced Pharmacologic Therapies for Pulmonary Arterial Hypertension:** • Epoprestenol (Flolan® or Veletri ®) • Sildenafil (Revatio®) • Treprostinil (Remodulin®)	J1325, J3285
II-238	**Afamelanotide (Scenesse®)**	J7352
II-26	**Agalsidase beta (Fabrazyme®)**	J0180
II-184	**Alemtuzumab (Lemtrada®)**	J0202
II-186	**Alglucosidase alfa (Lumizyme®)**	J0221
II-206	**Alpha-1 Proteinase Inhibitors (Aralast NP™, Glassia®, Prolastin-C®, Zemaira®)**	J0256, J0257
II-187	**Axicabtagene Ciloleucel (Yescarta™)**	C9399, J3490, J3590, Q2041
II-152	**Belimumab (Benlysta®)**	J0490
II-203	**Benralizumab (Fasenra®)**	J0517
II-199	**Bezlotoxumab (Zinplava®)**	J0565
II-16	**Botulinum Toxin (Botox®, Dysport®, Myobloc®, Xeomin®)**	J0585, J0586, J0587, J0588
II-231	**Brexanolone (Zulresso™)**	J1632

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II-245	**Brexucabtagene autoleucel (Tecartus®)**	J3490, J3590, J9999, Q2053
II-212	**Burosumab (Crysvita®)**	J0584
II-228	**Caplacizumab (Cablivi™)**	C9047, J3490
II-176	**Cerliponase alfa (Brineura™)**	J0567
II-179	**Certolizumab Pegol (Cimzia®)**	J0717
II-235	**Crizanlizumab (Adakveo®)**	J0791
II-196	**Eculizumab (Soliris®)**	J1300
II-178	**Edaravone (Radicava™)**	J1301
II-218	**Elosulfase alfa (Vimizim®)**	J1322
II-204	**Emapalumab-Izsg (Gamifant®)**	J9210
II-227	**Enzyme Replacement Therapy for the Treatment of Adenosine Deaminase Severe Combined Immune Deficiency:** • Elapegademase (**Revcovi™**) • Pegademase bovine (**Adagen®**)	C9399, J2504, J3590
II-240	**Eptinezumab (Vyepti™)**	J3032
II-226	**Esketamine Nasal Spray (Spravato™)**	C9399, J3490, S0013
II-173	**Fosdenopterin (Nulibry™)**	C9399, J3490, J3590
II-217	**Galsulfase (Naglazyme®)**	J1458

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II-234	**Givosiran (Givlaari™)**	J0223
II-180	**Golimumab (Simponi Aria®)**	J1602
II-215	**Idursulfase (Elaprase®)**	J1743
II-51	**Immunoglobulin (IV or Sub Q IgG) Replacement Therapy**	J1459, J1554, J1555, J1556, J1557, J1559, J1561, J1562, J1566, J1568, J1569, J1572, J1575, J1558, J1599, 90283, 90284
II-244	**Inebilizumab (Uplizna™)**	J1823
II-97	**Infliximab® (Remicade®)** Note: Infliximab biosimilars [e.g., **Inflectra™** (Q5103), **Renflexis™** (Q5104), **Ixifi™** (Q5109), **Avsola™** (Q5121) **are excluded** from coverage under the medical benefit. See the Medical Drug Exclusion List for guidelines.	J1745
II-29	**Intra-Articular Hyaluronan Injections for Osteoarthritis** No PA required for preferred drugs, Synvisc and Synvisc-One (J7325) PA required for non-preferred drugs (***medical*** exception requests only): **Durolane, Euflexxa, Gel-One, Gelsyn-3, GenVisc 850, Hyalgan, Hymovis, MonoVisc, OrthoVisc, Supartz, Supartz FX, Synojoynt, Triluron, TriVisc, Visco-3** See the Medical Drug Exclusion List for guidelines.	PA required for non-preferred drugs (***medical*** exception requests only): J7318, J7320, J7321, J7322, J7323, J7324, J7326, J7327, J7328, J7329, J7331, J7332
II-214	**Intravenous Enzyme Replacement Therapy for Gaucher Disease (Cerezyme®, Elelyso®, Vpriv®)**	J1786, J3060, J3385

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II-243	**Intravenous Iron Replacement Therapy** • Ferumoxytol **(Feraheme®)** • Ferric Carboxymaltose **(Injectafer®)** • Ferric Derisomaltose **(Monoferric®)**	J1437, J1439, Q0138
II-71	**Intravitreal Angiogenesis Inhibitors for Treatment of Retinal and Choroidal Vascular Conditions (Beovu™, Eylea®, Lucentis®, Macugen®)**	J0178, J0179, J2503, J2778
II-216	**Laronidase (Aldurazyme®)**	J1931
II-173	**Lisocabtagene Maraleucel (Breyanzi®)**	C9399, J3490, J3590, J9999
II-248	**Lumasiran (Oxlumo™)**	C9074, J3490, J3590
II-237	**Luspatercept (Reblozyl®)**	J0896
II-201	**Mepolizumab (Nucala®)**	J2182
II-49	**Natalizumab (Tysabri®)**	J2323
II-171	**Nusinersen (Spinraza™)** – a medical drug PA will be required every 6 months	J2326
II-185	**Ocrelizumab (Ocrevus®)**	J2350
II-34	**Omalizumab (Xolair®)**	J2357
II-230	**Onasemnogene abeparvovec (Zolgensma®)**	J3399
II-62	**Palivizumab (Synagis®) – Respiratory Syncytial Virus (RSV) Prophylaxis**	90378
II-220	**Patisiran (Onpattro ™)**	J0222
II-241	**Peanut allergen powder (Palforzia®) &** **Peanut allergy patch (*Viaskin® Peanut -** PA required upon FDA Approval**)**	J3490

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II-147	**Pegloticase (Krystexxa®)**	J2507
II-102	**Pharmacologic Therapies for Hereditary Angioedema [Berinert®, Cinryze®, ecallantide (Kalbitor®), Ruconest®]**	J0596, J0597, J0598, J1290
II-229	**Ravulizumab (Ultomiris™)**	J1303
II-202	**Reslizumab (Cinqair®)**	J2786
II-47	**Rituximab (Rituxan®),** non-oncologic indications only	J9312
II-211	**Romiplostim (Nplate®),** non-oncologic indications only	J2796
II-236	**Romosozumab (Evenity®)**	J3111
II-200	**Sebelipase alfa (Kanuma®)**	J2840
II-239	**Teprotumumab (Tepezza™)**	J3241
II-222	**Tildrakizumab (Ilumya ™)**	J3245
II-183	**Tisagenlecleucel (Kymriah™)**	C9399, J3490, J3590, Q2042
II-181	**Tocilizumab (Actemra®),** non-oncologic indications only	J3262
II-168	**Ustekinumab (Stelara®)**	J3357, J3358
II-182	**Vedolizumab (Entyvio®)**	J3380
II-219	**Vestronidase alfa (Mepsevii™)**	J3397
II-188	**Voretigene Neparvovec (Luxturna™)**	J3398
Equipment/Products/Prosthetic/Supplies		
VII-11	**Functional Neuromuscular Electrical Stimulation (Upper Extremity)**	E0764, E0770

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VII-16	**Microprocessor Controlled Prostheses for the Lower Limb**	K1014, L2006, L5856, L5857, L5858, L5859, L5973
VII-60	**Myoelectric Prosthesis for the Upper Limb**	L6026, L6715, L6880, L6925, L6935, L6945, L6955, L6965, L6975, L7007, L7008, L7009, L7045, L7190, L7191, L8701, L8702
VII-35	**Oscillatory Devices for the Treatment of Cystic Fibrosis and Other Respiratory Disorders in the Home (Vest Percussor)**	E0481, E0483
VII-52	**Speech Generating Devices (SGD)**	E1902, E2351, E2500, E2502, E2504, E2506, E2508, E2510, E2511, E2512, E2599
Contract Benefits	**Unlisted DME over $500**	No specific coding
II-91	**Wearable Cardioverter-Defibrillators**	K0606, K0607, K0608, K0609

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VII-04	**Wheelchairs – Mobility Assistive Equipment (Manual & Power) & Scooters– Wheelchair Purchase only**	Manual (Non-Motorized) Wheelchair: E1050, E1060, E1070, E1083, E1084, E1085, E1086, E1087, E1088, E1089, E1090, E1092, E1093, E1100, E1110, E1130, E1140, E1150, E1160, E1170, E1171, E1172, E1180, E1190, E1195, E1161, E1200, E1220, E1221, E1222, E1223, E1224, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, E1240, E1250, E1260, E1270, E1280, E1285, E1290, E1295, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0008, K0009 Power Operated Vehicles (POV): E1230, K0800, K0801, K0802, K0806, K0807, K0808, K0812 Motorized/Power Wheelchair (PWC): E1239, K0010, K0011, K0012, K0013, K0014, K0813, K0814, K0815, K0816, K0820, K0821, K0822, K0823, K0824, K0825, K0826, K0827, K0828, K0829, K0835, K0836, K0837, K0838, K0839, K0840, K0841, K0842, K0843, K0848, K0849, K0850, K0851, K0852, K0853, K0854, K0855, K0856, K0857, K0858, K0859, K0860, K0861, K0862, K0863, K0864, K0868, K0869, K0870, K0871, K0877, K0878, K0879, K0880, K0884, K0885, K0886, K0890, K0891, K0898, K0899 Specialized Seating/Options/Accessories: E1002, E1003, E1004, E1005, E1006, E1007, E1008, E1009, E1010, E1037, E1038, E1039, E1225, E1226, E2230, E2300, E2301, K0669, K0830, K0831
Ancillary (formerly Home Health Care/Outpatient Therapies/Acupuncture)		
III-01	**Acupuncture:** • Fully-Insured and Self-Insured – Prior authorizations will be required after 20 visits. This applies to member contracts with benefit maximums beyond 20 visits. Contracts with a benefit maximum of 20 visits per calendar year – no PA required.	97810, 97811, 97813, 97814
II-160	**Air Ambulance (nonemergent only)**	A0430, A0431, A0435, A0436, S9960, S9961
IX-01	**Extended Hours Skilled Nursing in the Home for Patients with Medically Complex Conditions**	T1002, T1003 Revenue Codes: 0550, 0551, 0552 or 0559

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InterQual	**Home Health Skilled Nursing Visits** • Fully Insured – After 20 visits per calendar year • Self-Insured – After 20 visits per calendar year or per Contract Requirement	G0162, G0299, G0300, G0493, G0494, G0495, G0496, S9097, S9098, S9123, S9124, T1001, T1022, T1030, T1031, 99500, 99505, 99506, 99507, 99509, 99511, 99600 Revenue codes: 0550, 0551, 0552, 0559
InterQual	**Home Health Aide**	G0156, S9122, T1004, T1021 Revenue Codes: 0570, 0571, 0572, 0579
No authorization needed for the following Home Care Services ONLY: Occupational Therapy, Physical Therapy, Respiratory Therapy, Speech, Language Therapy, Social Worker or Dietitian.		
Benefit Contract / InterQual	**Inpatient Hospice/Palliative Care**	No specific coding
Inpatient Facility - The following require Prior Authorization as soon as the admission is ordered/scheduled, but no later than two working days after the admission occurs.		
InterQual	**Inpatient Rehabilitation Admissions**	No specific coding
InterQual	**Long Term Acute Care (LTAC)**	No specific coding
InterQual	**Skilled Nursing Facility (SNF)**	No specific coding
InterQual	**Out of Country: All inpatient admissions**	No specific coding

Medical Policy Number or Criteria	Service Category	CPT/HCPCS/Revenue Codes
Medical/Procedures/Surgical (Inpatient or Outpatient)		
IV-01	**Balloon Ostial Dilation**	31295, 31296, 31297, 31298, 31299
IV-19	**Bariatric Surgery**	43644, 43645, 43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43886, 43887, 43888

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IV-17	**Blepharoplasty and Brow Ptosis Repair**	15820, 15821, 15822, 15823, 67900, 67901, 67902, 67903, 67904, 67906, 67908
IV-14	**Breast Implant, Removal or Replacement** (*No PA required for breast reconstruction due to breast cancer or high risk of breast cancer due to known genetic mutation*)	C1789, L8600, 11970, 19325, 19328, 19330, 19340, 19342, 19396
IV-143	**Closure Devices for Patent Foramen Ovale and Atrial Septal**	93580
II-207	**Corneal Collagen Cross-Linking**	0402T, J2787
IV-123	**Gender Affirming Procedures for Gender Dysphoria**	55970, 55980, 56805, 57291, 57292, 57335
IV-71	**Gynecomastia Surgery**	19300
IV-80	**Implanted Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea**	0466T, 0467T
IV-169	**Percutaneous Left Atrial Appendage Occluder Devices**	33340
IV-16	**Orthognathic Surgery**	D7941, D7943, D7944, D7945, D7946, D7947, D7948, D7949, 21120, 21121, 21122, 21123, 21125, 21127, 21141, 21142, 21143, 21145, 21146, 21147, 21150, 21151, 21154, 21155, 21159, 21160, 21188, 21193, 21194, 21195, 21196, 21198, 21199, 21206, 21208, 21209
IV-24	**Panniculectomy / Excision of Redundant Skin or Tissue**	15819, 15825, 15828, 15829, 15830, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, 15847, 56620, 56625
IV-95	**Percutaneous Facet Joint Denervation**	64633, 64634, 64635, 64636
IV-32	**Reduction Mammoplasty**	19318
IV-126	**Sacroiliac Joint Fusion**	27279, 27280
IV-87	**Spinal Fusion (Lumbar)**	22533, 22558, 22612, 22630, 22633, 22634, 22800, 22802, 22804, 22808, 22810, 22812
IV-149	**Transcatheter Aortic Valve Implantation/Replacement (TAVI/TAVR) for Aortic Stenosis**	33361, 33362, 33363, 33364, 33365, 33366, 33367, 33368, 33369
IV-152	**Transcatheter Mitral Valve Repair (TMVR)**	0345T, 33418, 33419

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II-164	**Tumor Treating Fields Therapy**	A4555, E0766
IV-07	**Uvulopalatopharyngoplasty** (UPPP – Surgical Treatment of Obstructive Sleep Apnea)	42145
IV-144	**Viscocanalostomy and Canaloplasty for the Treatment of Glaucoma**	66174, 66175
Transplants *Consult, Evaluation, Workup & Human Leukocyte Antigen (HLA) typing and testing also called Tissue Typing, do not require prior authorization/notification.*		
IV-09	**Islet Transplantation**	0584T, 0585T, 0586T, 48160, G0341, G0342, G0343, S2102
IV-128	**Organ Transplantation** (No PA required for Kidney and Cornea)	S2053, S2054, S2055, S2060, S2061, S2065, S2152, 0494T, 0495T, 0496T, 32850, 32851, 32852, 32853, 32854, 32855, 32856, 33930, 33933, 33935, 33940, 33944, 33945, 44132, 44133, 44135, 44136, 44137, 44715, 44720, 44721, 47133, 47135, 47140, 47141, 47142, 47143, 47144, 47145, 47146, 47147, 48550, 48551, 48552, 48554, 48556
II-114, II-115, II-117, II-118, II-119, II-120, II-121, II-122, II-123, II-129, II-130, II-131, II-133, II-135, II-136, II-138, II-154	**Stem Cell Transplantation**	S2140, S2142, S2150, 38204, 38205, 38208, 38209, 38210, 38211, 38212, 38213, 38214, 38215, 38230, 38232, 38240, 38241, 38242, 38243
Specialty Utilization Management *Pre-Authorization medical necessity reviews are completed by eviCore and for Fully Insured members only. Please submit your request on Availity.com for timely processing.*		
eviCore (Cardiology)	**Cardiac Advanced Imaging** (including Echo Stress Testing, Nuclear Stress Tests / MPI, Cardiac MRI, Cardiac PET, and CCTAs)	(**FULLY INSURED MEMBERS ONLY**) For a current list of code(s) please visit: eviCore Healthcare Specialty Utilization Management Clinical Guidelines
eviCore (Cardiology)	**Cardiac Catheterization, Cardiac Resynchronization Implantable Devices**	
eviCore (Musculoskeletal)	**Interventional Pain Management** (Spine/Joint Injections, Stimulators, Blocks, RF Ablation, etc.)	
eviCore (Musculoskeletal)	**Knee/Hip/Shoulder Surgery**	

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eviCore (Medical Oncology)	**Medical Oncology** (Primary and Supportive Cancer Treatment Drugs)
eviCore (Lab Management)	**Molecular and Genomic Testing**
eviCore (Radiology)	**Radiology Advance Imaging** (MRI, MRA, PET, CT, and Nuclear Studies)
eviCore (Radiation Therapy)	**Radiation Therapy**
eviCore (Sleep Management)	**Sleep Management**
eviCore (Musculoskeletal)	**Spine Surgery**

If a question arises regarding a specific service or to verify if prior authorization or notification is required or questions pertaining to member benefits, please use Availity® provider portal or contact Provider Services at 1-800-262-0820 or (651) 662-5200.

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