Blue Cross and Blue Shield of Minnesota Platinum Blue℠ Prior Authorization / Notification Requirements

Overview

Platinum Blue℠ is a Medicare approved Cost plan from Blue Cross and Blue Shield of Minnesota. A Medicare Cost plan (also called a Section 1876 plan) is a type of Medicare Advantage plan. Blue Cross is the administrator for most services eligible under Medicare Part B. Medicare is primary for any service eligible under Part A.

Prior Authorization is required for various services, procedures, prescription drugs, and medical devices. This document contains the full list of services, procedures, prescription drugs under Part B, and medical devices[1] that require prior authorization/notification for Blue Cross and Blue Shield of Minnesota Platinum Blue℠ products. Prior authorization should be obtained before a service is rendered and, if applicable, before additional services are rendered beyond what has previously been approved.

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. Prior authorization is based on a medical necessity review and is not a guarantee of payment. Payment requires that the contract is in force on the day services are provided and is subject to all provisions and limitations in the subscriber's health plan benefit contract, including general exclusions.

Blue Cross and Blue Shield of Minnesota also requires notification[2] for certain service(s). This document further outlines the notification process and the service(s) that require notification below.

Submitting Prior Authorization/Org-Determination/Notifications

Providers may submit prior authorization, org-determination and/or 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, org-determination, 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

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

[2] A notification is a notice of service that does not require medical necessity criteria review to be completed at the time of admission or onset of outpatient service.

- 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 ensure timely processing, please submit your request on Availity.com.

The below list includes the standard prior authorization (PA)/notification requirements for Platinum Blue℠ 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.

The CPT/HCPCS 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.

Prior authorization is required for Platinum Blue℠ members in the following circumstances:

- Prior to admission to a religious non-medical health care institution.
- Requests for in-network benefits from a non-network provider for non-urgent, non-emergent care.
- Durable Medical Equipment Prior authorization is required for following items:

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Blue Cross and Blue Shield of Minnesota Platinum Blue ℠ Prior Authorization Requirements		
Criteria	**Service Category**	**CPT/HCPCS Codes**
Equipment/Products/Prosthetic/Supplies		
Medicare	**Bone Growth Stimulators**	E0747, E0748, E0760
Medicare	**Communication Devices**	E2351, E2500, E2502, E2504, E2506, E2508, E2510, E2511, E2512, E2599
Medicare	**Hospital Beds – all types (rental and purchase)**	E0250, E0251, E0255, E0256, E0260, E0261, E0290, E0291, E0292, E0293, E0294, E0295, E0301, E0302, E0303, E0304, E0328, E0329
Medicare	**Knee Microprocessor**	L5856, L5857, L5858
Medicare	**Manual Wheelchair**	E1037, E1038, E1039, E1161, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0004, K0005, K0006, K0007, K0008, K0009

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Medicare	**Power Wheelchairs** **(also known as power mobility devices)**	K0013, K0015, K0813, K0814, K0815, K0816, K0820, K0821, K0822, K0823, K0824, K0825, K0826, K0827, K0828, K0829, K0830, K0831, 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
Medicare	**Scooters**	K0800, K0801, K0802, K0806, K0807, K0808, K0812

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For all other services, prior authorization or notification is not required.
If the provider is unsure if the service is covered, they may submit an org-determination of coverage request. Org-determination of coverage requests must be for Part B services only. These requests will be reviewed for medical necessity.

Blue Cross and Blue Shield of Minnesota follows CMS coverage policy guidelines for services performed. If no Medicare guideline exists, Blue Cross and Blue Shield of Minnesota medical policy guidelines apply. Providers are familiar with CMS coverage policy guidelines and may assist members to determine if the services are covered.

Services performed as part of a Part A stay are eligible for payment if the Part A stay is covered by Medicare.
Part B services associated with Part A stays do not require review.
Claims for Part B services may be subject to retrospective medical necessity review utilizing CMS coverage policy guidelines when applicable.

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