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. Prior authorization should be obtained before a service is rendered and, if applicable, before additional services are rendered beyond what has been previously 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. 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

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- 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.

MCG Care Guidelines
Blue Cross licenses and utilizes MCG Care Guidelines to guide utilization management decisions and has the right to customize MCG Care Guidelines, as applicable. MCG Care Guidelines criteria are available upon request.

Accessing the Medical Policies:

- Blue Cross Prior Authorization
  - Medical Policies
    - Enter a specific medical policy name or part of a policy, word, or phrase into the search bar to search.
  - Clinical Criteria Pharmacy Policies

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.

Prior Authorization and Notification List
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 following 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.

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BlueCross BlueShield Minnesota

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

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) – 10 or more hours/week (MN and participating border county providers)	97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158
MCG	Eating Disorder Residential Services (MN providers)	No specific coding
MCG	Mental Health Residential Services	No specific coding
X-45	Psychological & Neuropsychological Testing	96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146
MCG	Substance Use Disorder Residential Services	No specific coding
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

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BlueCross BlueShield Minnesota

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 Preferred Medical Drug Program – Commercial plans (PDF)*** *for drug guidelines that apply.* ****For additional detail, see Preferred Medical Drug Program.***		
II-161	Abatacept (Orencia®)	J0129
II-107	Advanced Pharmacologic Therapies for Pulmonary Arterial Hypertension: • Epoprestenol (Flolan® or Veletri ®) • Selexipag injection (Uptravi®) • Sildenafil (Revatio®) • Treprostinil (Remodulin®)	C9399, J1325, J3285, J3490, J3590
II-238	Afamelanotide (Scenesse®)	J7352
II-26	Agalsidase beta (Fabrazyme®)	J0180
II-290	Avacincaptad pegol (Izervay™)	C9162, C9399, J3490, J3590
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-255	Anifrolumab (Saphnelo™)	J0491
II-256	Avalglucosidase Alfa (Nexviazyme®)	J0219
II-187	Axicabtagene Ciloleucel (Yescarta™)	Q2041
II-152	Belimumab (Benlysta®)	J0490
II-203	Benralizumab (Fasenra®)	J0517
II-267	Betibeglogene autotemcel (Zynteglo®)	C9399, J3490, J3590
II-199	Bezlotoxumab (Zinplava®)	J0565
II-16	Botulinum Toxin (Botox®, Dysport®, Myobloc®, Xeomin®)	J0585, J0586, J0587, J0588
II-231	Brexanolone (Zulresso™)	J1632
II-245	Brexucabtagene autoleucel (Tecartus®)	Q2053
II-212	Burosumab (Crysvita®)	J0584
II-176	Cerliponase alfa (Brineura™)	J0567
II-179	Certolizumab Pegol (Cimzia®)	J0717

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II-262	Ciltacabtagene autoleucel (Carvykti™)	Q2056
II-173	Cipaglucosidase alfa (Pombiliti)	C9399, J3490, J3590
II-235	Crizanlizumab (Adakveo®)	J0791
II-173	DaxibotulinumtoxinA-lamn (Daxxify)	C9160, J3490, J3590
II-196	Eculizumab (Soliris®)	J1300
II-178	Edaravone (Radicava™)	J1301
II-260	Efgartigimod alfa (Vyvgart™, Vyvgart ® Hytrulo)	J9332, J9334
II-268	Elivaldogene autotemcel (Skysona®)	C9399, J3490, J3590
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-283	Epcoritamab (Epkinly®)	J9321
II-240	Eptinezumab (Vyepti™)	J3032
II-226	Esketamine Nasal Spray (Spravato™)	C9399, G2082, G2083, J3490, S0013
II-172	Eteplirsen (Exondys 51)	J1428
II-273	Etranacogene dezaparvovec (Hemgenix®)	J1411
II-250	Evinacumab (Evkeeza™)	J1305
II-210	Fosdenopterin (Nulibry™)	C9399, J3490, J3590
II-217	Galsulfase (Naglazyme®)	J1458
II-234	Givosiran (Givlaari™)	J0223
II-180	Golimumab (Simponi Aria®)	J1602
II-252	Idecabtagene Vicleucel (Abecma®)	Q2055
II-215	Idursulfase (Elaprase®)	J1743
II-51	Immunoglobulin (IV or Sub Q IgG) Replacement Therapy	J1459, J1551, J1554, J1555, J1556, J1557, J1559, J1561, J1562, J1566, J1568, J1569, J1572, J1575, J1576, J1558, J1599, 90283, 90284

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II-258	Inclisiran (Leqvio®)	J1306
II-244	Inebilizumab (Uplizna™)	J1823
II-97	*Infliximab® (Remicade®, Inflectra™, Renflexis™, Ixifi™, Avsola™, Unbranded Infliximab)	J1745, Q5103, Q5104, Q5109, Q5121
II-29	*Intra-Articular Hyaluronan Injections for Osteoarthritis No PA required for preferred drugs, Synvisc, Synvisc-One and Euflexxa (J7325, J7323) PA required for non-preferred drugs (*medical* exception requests only): Durolane, Gel-One, Gelsyn-3, GenVisc 850, Hyalgan, Hymovis, MonoVisc, OrthoVisc, Supartz, Supartz FX, Synojoynt, Triluron, TriVisc, Visco-3	PA required for non-preferred drugs (***medical*** exception requests only): J7318, J7320, J7321, J7322, J7324, J7326, J7327, J7328, J7329, J7331, J7332
II-214	*Intravenous Enzyme Replacement Therapy for Gaucher Disease (Cerezyme®, Elelyso®, Vpriv®)	J1786, J3060, J3385
II-243	Intravenous Iron Replacement Therapy *(No PA required for dialysis patients)* • Ferumoxytol (Feraheme®) • Ferric Carboxymaltose (Injectafer®) • Ferric Derisomaltose (Monoferric®)	J1437, J1439, Q0138
II-265	Intravenous Risankizumab (Skyrizi®)	J2327
II-71	*Intravitreal Angiogenesis Inhibitors for Treatment of Retinal and Choroidal Vascular Conditions (Beovu™, Byooviz™, Cimerli™, Eylea®, Faricimab (Vabysmo®), Lucentis®, Macugen®, Susvimo™, Eylea® HD)	C9161, C9399, J0178, J0179, J2503, J2777, J2778, J2779, J3490, J3590, Q5124, Q5128
II-216	Laronidase (Aldurazyme®)	J1931
II-249	Lisocabtagene Maraleucel (Breyanzi®)	Q2054
II-248	Lumasiran (Oxlumo™)	J0224
II-237	Luspatercept (Reblozyl®)	J0896

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II-201	Mepolizumab (Nucala®)	J2182
II-173	Mirikizumab (Omvoh)	C9399, J3490, J3590
II-192	Motixafortide (Aphexda™)	C9399, J3490, J3590
II-274	Nadofaragene Firadenovec (Adstiladrin®)	J9029
II-49	Natalizumab (Tysabri®)	J2323
II-171	Nusinersen (Spinraza™) – Medical drug PA will be required every 6 months	J2326
II-185	Ocrelizumab (Ocrevus®)	J2350
II-270	Olipudase Alfa (Xenpozyme®)	J0218
II-34	Omalizumab (Xolair®)	J2357
II-173	Omidubicel-onlv (Omisirge®)	J3490, J3590, C9399
II-230	Onasemnogene abeparvovec (Zolgensma®)	J3399
II-62	Palivizumab (Synagis®) – Respiratory Syncytial Virus (RSV) Prophylaxis	90378
II-220	Patisiran (Onpattro ™)	J0222
II-277	Pegcetacoplan (Syfovre™)	J2781
II-147	Pegloticase (Krystexxa®)	J2507
II-281	Pegunigalsidase alfa (Elfabrio®)	J2508
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®)	J2796

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II-236	Romosozumab (Evenity®)	J3111
II-287	Rozanolixizumab (Rystiggo)	J9333
II-200	Sebelipase alfa (Kanuma®)	J2840
II-269	Spesolimab (Spevigo®)	J1747
II-263	Sutimlimab (Enjaymo™)	J1302
II-282	Teclistamab (Tecvayli™)	J9380
II-272	Teplizumab (Tzield®)	J9381
II-239	Teprotumumab (Tepezza™)	J3241
II-259	Tezepelumab (Tezspire™)	J2356
II-222	Tildrakizumab (Ilumya ™)	J3245
II-183	Tisagenlecleucel (Kymriah™)	Q2042
II-181	Tocilizumab (Actemra® & Tofidence™): Non-oncologic indications only	J3262, J3490, J3590, C9399
II-257	Triamcinolone Acetonide Suprachoroidal Injection (Xipere™)	J3299
II-275	Ublituximab (Briumvi™)	J2329
II-168	Ustekinumab (Stelara®)	J3357, J3358
II-286	Valoctocogene roxaparvovec (Roctavian™)	J1412
II-182	Vedolizumab (Entyvio®)	J3380
II-278	Velmanase alfa (Lamzede®)	J0217
II-219	Vestronidase alfa (Mepsevii™)	J3397
II-188	Voretigene Neparvovec (Luxturna™)	J3398
II-264	Vutrisiran (Amvuttra™)	J0225
Equipment/Products/Prosthetic/Supplies		
VII-11	Functional Neuromuscular Electrical Stimulation (Upper Extremity)	E0764, E0770

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VII-60	Myoelectric Prosthesis for the Upper Limb	L6026, L6715, L6880, L6925, L6935, L6945, L6955, L6965, L6975, L7007, L7008, L7009, L7045, L7190, L7191
II-91	Wearable Cardioverter-Defibrillators	K0606, K0607, K0608, K0609
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: • Prior authorizations required after 20 visits. This applies to member contracts with benefit maximums beyond 20 visits.	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
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.		
MCG	Inpatient Rehabilitation	No specific coding

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Medical Policy Number or Criteria	Service Category	CPT/HCPCS/Revenue Codes
MCG	Long Term Acute Care (LTAC)	No specific coding
MCG	Skilled Nursing Facility Services (SNF)	No specific coding
MCG	Out of Country: All inpatient admissions	No specific coding
Medical/Procedures/Surgical (Inpatient or Outpatient)		
IV-162	Balloon Dilation of the Eustachian Tube	69705, 69706
IV-01	Balloon Ostial Dilation	31295, 31296, 31297, 31298
IV-19	Bariatric Surgery	43644, 43645, 43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845, 43846, 43847, 43848, 43860, 43865, 43886, 43887, 43888
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	C1817, 93580
II-207	Corneal Collagen Cross-Linking	0402T, J2787
IV-123	Gender Affirming Procedures	55970, 55980, 56805, 57291, 57292, 57335
VI-56	Genetic Cancer Susceptibility Panels	81432, 81433
IV-71	Gynecomastia Surgery	19300
IV-80	Implanted Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea	64582, 64583
IV-169	Percutaneous Left Atrial Appendage Occluder Devices	33340

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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-164	Perirectal Spacer for Use During Radiotherapy for Prostate Cancer	55874
IV-32	Reduction Mammoplasty (**No PA required for breast reduction due to breast cancer*)	19318
IV-73	Rhinoplasty, Septorhinoplasty, and Septoplasty	30400, 30410, 30420, 30430, 30435, 30450
IV-126	Sacroiliac Joint Fusion	27278, 27279, 27280
IV-87	Spinal Fusion (Lumbar)	22533, 22558, 22612, 22630, 22632, 22633, 22634, 22800, 22802, 22804, 22808, 22810, 22812
II-07	Temporomandibular Disorder (TMD): Diagnosis and Selected Treatments	D7880
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
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 Cell Transplantation and Cellular Therapy	0584T, 0585T, 0586T, 48160, C9399, G0341, G0342, G0343, J3490, J3590, S2102

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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-121, II-122, II-123, II-129, II-130, II-131, II-133, II-135, II-136, II-138	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	
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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