# Blue Cross and Blue Shield of Minnesota and Blue Plus
# Prime MRx Medical Drug Program
# Frequently Asked Questions

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) is committed to providing members with access to high-quality healthcare consistent with evidence-based, nationally recognized clinical criteria and guidelines. To ensure value to our members, we are implementing a change in the way we manage certain specialty medications that fall under the medical benefit. This new program will be administered by Magellan Rx Management, a Prime Therapeutics Company (Prime/MRx).

### Products Impacted

- Fully Insured Commercial
- Self Insured Commercial
- Medicare Advantage
- Minnesota Health Care Programs (MHCP) including:
    - Families and Children
    - MinnesotaCare (MNCare)
    - Minnesota Senior Care (MSC+)
    - Minnesota Senior Health Options (MSHO)

### What is the effective date of the program?

For dates of service beginning August 1, 2024.

### Where can I find the list of medications that will require a prior authorization review by Prime/MRx, and their associated medical policies criteria and guidelines?

- Access the 'Provider Section' of the Blue Cross website at bluecrossmn.com/providers
- Select "Medical and behavioral health policies" under "Medical Management"
- Scroll down and click on the "Prime/MRx Medical Drug clinical guidelines" link, located under other evidence-based criteria and guidelines we use and how to access them
- Medical Drugs are listed in alphabet order. To search for a specific drug, Ctrl + F and type in the drug name.

### How will I know that the medication list has been updated?

A provider bulletin will be posted 60 days prior to the effective date of any changes made to the medication lists. Bulletins can be found at https://www.bluecrossmn.com/providers/forms-and-publications. From the category drop down choose bulletins-providers.

### At which places of service (POS) is the prior authorization required?

Prior authorizations are required for medications administered at the following places of service:

- Physician Office (POS 11)
- In Home (POS 12)
- Outpatient Facility (POS 19, 22)
- Inpatient CAR-T (POS 21)

### How do providers contact Prime/MRx to request a prior authorization?

Providers directly contracted with Blue Cross may request **non-urgent** authorizations on the Availity Essentials provider portal. Providers may also call Prime/MRx for authorization requests at 800-424-1706. **Providers are required to submit URGENT authorization requests via phone call.** Hours of operation are Monday through Friday from 8am to 6pm local time for routine requests, and 24 hours per day/7 days per week for urgent requests.

To expedite review of prior authorization requests, the provider should have the following information:

- Member name, date of birth and ID number
- Health plan name
- Member height and weight
- Ordering provider name, tax ID number, NPI, practice address, and office telephone and fax numbers
- Rendering provider name, tax ID number, NPI, practice address, and office telephone and numbers (if different from ordering provider)
- Requested medication name or HCPCS code
- Anticipated start date of treatment
- Dosing information and frequency
- Diagnosis (ICD-10 code)
- Any additional clinical information pertinent to the request

If requested by Prime/MRx, the provider should be prepared to upload the following documents to the provider portal, or to fax the following documents to Prime/MRx's HIPAA-compliant fax:

- Clinical notes
- Pathology reports
- Relevant lab test results

**Please note:** It is the responsibility of the ordering provider to obtain prior authorization before services are rendered. If the ordering provider and the rendering provider are different, the rendering provider is responsible for ensuring that the appropriate approval is on file prior to rendering services.

## Prior Authorization Requests

### Will the provider be able to speak directly to the clinician making a determination on a prior authorization request?

Yes. In most cases, approvals may be made based on the initial information provided to Prime/MRx by the requestor. If there is a question or concern regarding the information provided, the case will be sent to a pharmacist who will reach out to the requesting provider. If the pharmacist cannot reach an agreement regarding the appropriate course of treatment with respect to the requested medication, the case will be escalated to a Prime/MRx physician. A Prime/MRx physician will discuss the case with the provider. They will make a mutual decision, in accordance with plan guidelines, on an appropriate course of action.

### Who receives copies of the determination notices?

The ordering provider, rendering provider (if different from ordering) and member receive copies of the final determination notices.

### Does a prior authorization for one provider apply to all providers in a group practice?

Approvals are valid for all network providers who share the same TIN listed on the authorization.

### If a specialist orders the treatment and receives an approved prior authorization, but the medication is to be administered in and billed for by the outpatient facility, how should the clinic verify the prior authorization is on file with Prime/MRx?

The outpatient facility will receive a copy of the approval letter and may view the authorization on the provider portal.

### Once prior authorization approval is received, can a request be made to change the dose or frequency before the approval duration has expired?

After an approval is generated, a change in dose and/or frequency may be requested via phone by contacting Prime/MRx at 800-424-1706.

### Can the length of the prior authorization be negotiated or is it predetermined?

The approval duration or validity period of a prior authorization is dependent on the medication and is not negotiable.

### Can one prior authorization include multiple medications, or will the provider have to obtain a prior authorization for each medication?

There is one prior authorization number per medication. However, Prime/MRx can process multiple requests via a single portal session or telephone call.

### What is the turnaround time for standard and expedited requests?

| Line of Business | Standard Request | Expedited Request |
|---|---|---|
| Commercial | ≤ 5 business days from receipt of all information not to exceed 10 business days from receipt of request | ≤ 48 calendar hours from the receipt of request (must include 1 business day) |
| MHCP | ≤ 24 calendar hours from receipt of all information not to exceed 10 business days from receipt of request | ≤ 24 calendar hours from receipt of all information not to exceed 72 calendar hours from receipt of request |
| Medicare | ≤ 72 calendar hours from receipt of request | ≤ 24 calendar hours from receipt of request |

### Does Prime/MRx manage appeals/reconsiderations?

Prime/MRx will manage 1st Level Pre-Service appeals for all lines of business (Commercial, MHCP and Medicare). Information on how to request 1st Level Pre-Service appeals will be included in the determination notification sent to the provider. Reconsiderations are out of scope for Prime/MRx for all lines of business.

### Does Prime/MRx allow Retrospective Requests?

Retrospective requests will not be accepted or reviewed for Medicare members. Prime/MRx manages retrospective requests for Commercial and MHCP lines of business only. Requests can be submitted within 14

calendar days from the date of service if a claim has not been submitted. Providers can call Prime/MRx at 800-424-1706 to initiate a retrospective request.

### Why does the authorization status on the Prime/MRx provider portal differ from the status on the Availity dashboard?

The status for authorization determinations reflected on the Prime/MRx provider portal are in real time. This status information may be different on Availity due to the status transmission time from Prime/MRx to the Availity dashboard.

**Please note, authorizations can only be viewed on the Prime/MRx provider portal for all lines of business**.

# Transition of Care

### Will existing authorizations still be valid?

Authorizations issued by Blue Cross for dates of service beginning prior to 8/1/24, for the medications included in this program, will be effective until the authorization end date. To continue treatment after the original authorization end date, providers must obtain a new authorization from Prime/MRx prior to the expiration date of the original authorization. Claims for dates of services after the authorized end date will be denied if a provider has not obtained a successive authorization from Prime/MRx.

# Claims

### How will this new program affect claims processing?

Prime/MRx will be performing utilization management only. Claims should continue to be submitted to Blue Cross for adjudication.

### Will a claim submitted by the rendering provider be denied if the ordering provider fails to obtain the appropriate prior authorization?

Yes. Rendering providers need to confirm an approved prior authorization is on file with Prime/MRx before administering the medications to members. These denials cannot be appealed unless exceptions are met as outlined in Chapter 10 of the Provider Policy and Procedure Manual. Blue Cross will be responsible for reviewing post service claims appeals that meet criteria for an exception.
https://www.bluecrossmn.com/sites/default/files/DAM/2023-05/bcbsmn-provider-policy-and-procedure-manual.pdf.

### Is this prior authorization process required when Blue Cross is secondary?

No. Prior authorization review with Prime/MRx is not required when Blue Cross is designated as secondary to other insurance coverage.

# General Information

### Who can a provider contact for more information?

For more information about prior authorizations, providers can call Prime/MRx at 800-424-1706.

### Who can a provider contact for system outage issues pertaining to the provider portal?

- For issues pertaining to Availity, please contact 800-282-4548.
- For issues pertaining to the Prime/MRx provider portal please contact ProviderInquiry@PrimeTherapeutics.com.

### If a user already has access to the Prime/MRx provider portal (MRxGateway.com), do they need to obtain new access for BCBSMN members?

No. Users may use their existing login credentials to request prior authorizations for BCBSMN members on MRxGateway.com. If a user encounters difficulty finding BCBSMN in the Health Plan dropdown menu, please contact Provider Relations at ProviderInquiry@PrimeTherapuetics.com.

### If a member already has an approved authorization, when can a provider request a new authorization for the same drug?

A provider can request a new authorization within 30 days before the expiration date of the existing authorization. The new authorization validity date will begin 1 day after the expiration date of the existing authorization. This policy also applies to Transition of Care (TOC) authorizations from BCBSMN.