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Note: A Frequently Asked Questions (FAQ) document has been posted to providers.bluecrossmn.com under the Minnesota Health Care Programs webpage.

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ADMINISTRATIVE UPDATES

Reminder: Medicare Requirements for Reporting Provider Demographic Changes

(article is published in every monthly Bulletin)

In accordance with Medicare requirements, Blue Cross is required to maintain accurate provider network directories for the benefit of our Subscribers. Blue Cross is hereby reminding all providers to submit a form to us whenever any of the following changes occur:

- 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

Forms Location

Based on what change has occurred, submit the appropriate form located on our website at **providers.bluecrossmn.com**. Select “Administrative Updates” in the “What’s Inside” section to obtain instructions on completing the various forms or access the link below:

https://www.bluecrossmn.com/healthy/public/personal/home/providers/admin-updates.

How do we submit changes?
Send the appropriate form via fax as indicated below:
Fax: 651-662-6684, **Attention: Provider Data Operations**

New CMS Regulation for Preclusion List

(P61-18, published 11/1/18)

The purpose of this Provider Bulletin is to inform providers that the Centers for Medicare & Medicaid Services (CMS) have a new Medicare Regulation (CMS-4182-F Final Rule) that applies to the Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries and is effective April 1, 2019. Per CMS regulations, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will deny payment for a health care item or service furnished by an individual or entity on the CMS Preclusion List upon 60 days' notice to Blue Cross of Provider’s addition to CMS Preclusion List.

Revised: 2019 Minnesota Medicare Network Update

(P52R1-18, published 11/1/18)

The information in this Bulletin provides a correction to Provider Bulletin P52-18, which was published on October 1, 2018. The correct name for the Medicare High Value network is Blue Cross Medicare Advantage/Medicare High Value network.

Medicare Advantage Plans to Replace Medicare Cost Plans in Most Minnesota Counties

Effective January 1, 2019, Medicare Cost plans will no longer be available in most Minnesota counties due to a change in federal law. This change affects more than 400,000 Minnesotans. Blue Cross and Blue Shield of Minnesota (Blue Cross) will begin offering Medicare Advantage products across the state to meet the needs of our senior members. It is very important for providers to understand the new Medicare network landscape in Minnesota in order to ensure a seamless transition for Medicare members.

Cost plans (Platinum Blue) *will* continue in these 21 Minnesota counties in 2019:Aitkin, Carlton, Cook, Goodhue, Itasca, Kanabec, Koochiching, Lake, Le Sueur, McLeod, Meeker, Mille Lacs, Pine, Pipestone, Rice, Rock, St. Louis, Sibley, Stevens, Traverse and Yellow Medicine.

For members living in the 21 counties listed above, there will be no changes to their Medicare plan or the network for which it's applicable. For all other counties across the state, the following Blue Cross networks will be supporting Medicare Advantage products in 2019:

- **Group Medicare Advantage** is a state-wide broad network for group retirees that will be offered in the 66 Medicare Advantage counties, including 100% of hospitals and 96% of quality providers.
- **Blue Cross Medicare Advantage/Medicare High Value** is made up of select providers that meet a specific standard of high quality and Total Cost of Care measurements.
- **Medicare Southern MN** is an Accountable Care Organization (ACO) made up of in-network providers in this region.
- **Strive Medicare Advantage Metro Region** is a single-system ACO network included in the Metro region to enable a value-based product with a higher degree of care management.

Please see the maps below detailing which networks apply to which Minnesota residents across the various counties (based on where the member lives, not where the provider is located).

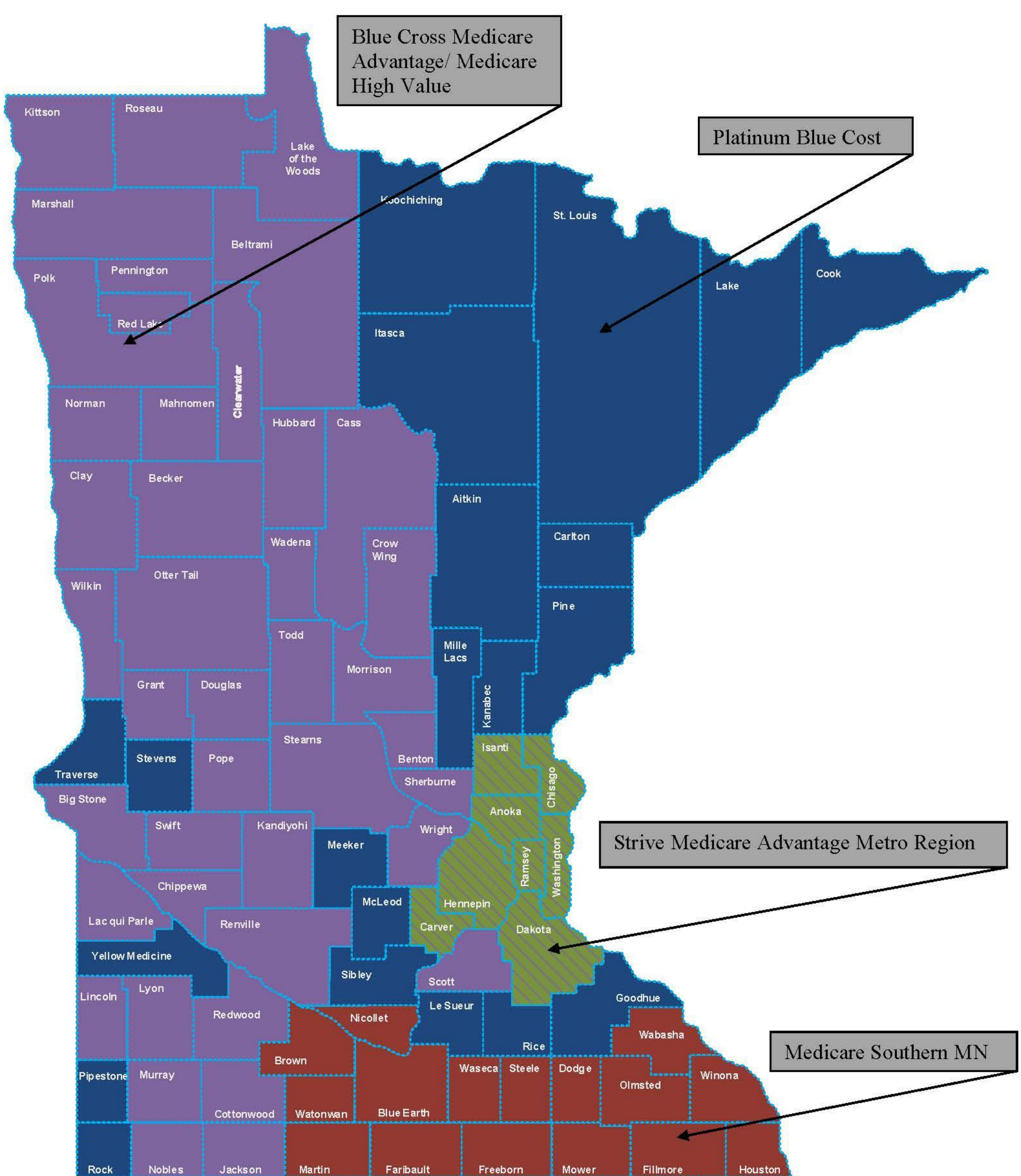
To confirm whether a provider is participating in one or more of these networks, please use the "Find a Doctor" tool on the bluecrossmn.com website. Once you have searched for the provider, validate they are in the network by selecting the appropriate network, 'Group Medicare Advantage', 'Blue Cross Medicare Advantage/Medicare High Value', 'Medicare Southern MN' or 'Strive Medicare Advantage Metro Region' in the search criteria on the left side of the search results screen.

The new Medicare networks were developed by Blue Cross based on:

- Stars Scores of Providers
- Risk Scores of Providers
- Quality Measured (HEDIS Data)
- CMS Network Adequacy Guidelines
- Medicare Total Cost of Care
- 3rd Party Evidence Based Medicine Protocols
  - Choosing Wisely (trusted vendor)

In preparation for 2019, it is important to reiterate that not all providers participate in all Blue Cross networks. Members should be directed to confirm the participation status of providers within their specific plan network by calling the number on the back of their member ID card. We are available to assist members to identify in-network providers in their specific Plan to ensure the most appropriate care at the greatest benefit of their plan. Directories of participating providers are available at bluecrossmn.com or upon request by contacting provider services at **1-800-262-0820** or **(651) 662-5200**.

Network Availability Based on Member's Place of Residence				
GROUP MEDICARE ADVANTAGE	**BLUE CROSS MEDICARE ADVANTAGE/ MEDICARE HIGH VALUE**	**MEDICARE SOUTHERN MN**	**STRIVE MEDICARE ADVANTAGE METRO REGION**	**PLATINUM BLUE COST**
This is a state-wide broad network used in the 66 Medicare Advantage counties, including 100% of hospitals and 96% of quality providers.	This network is made up of select providers that meet a specific standard of high quality and Total Cost of Care measurements.	This ACO will be the in-network provider for members in this region.	This single-system ACO network will be included for the Metro region to enable a value-based product with a higher degree of care management.	This network will not change as cost plans are set to continue for these 21 counties.


Blue Cross Medicare Advantage/ Medicare High Value
Platinum Blue Cost
Strive Medicare Advantage Metro Region
Medicare Southern MN
Kittson
Roseau
Lake of the Woods
Marshall
Koochiching
St. Louis
Beltrami
Polk
Pennington
Red Lake
Lake
Cook
Itasca
Clearwater
Norman
Mahnomen
Hubbard
Cass
Clay
Becker
Aitkin
Wadena
Crow Wing
Carlton
Wilkin
Otter Tail
Pine
Todd
Mille Lacs
Morrison
Grant
Douglas
Kanabec
Stearns
Isanti
Traverse
Stevens
Pope
Benton
Sherburne
Chisago
Big Stone
Anoka
Swift
Kandiyohi
Wright
Meeker
Ramsey
Washington
Chippewa
McLeod
Hennepin
Lac qui Parle
Renville
Carver
Dakota
Yellow Medicine
Sibley
Scott
Lincoln
Lyon
Goodhue
Redwood
Nicollet
Le Sueur
Wabasha
Brown
Rice
Pipestone
Murray
Waseca
Steele
Dodge
Winona
Olmsted
Cottonwood
Watonwan
Blue Earth
Rock
Nobles
Jackson
Martin
Faribault
Freeborn
Mower
Fillmore
Houston

New Accountable Care Organization (ACO) Products for 2019

(P54-18, published 11/1/18)

Effective January 1, 2019, Blue Cross and Blue Shield Minnesota and Blue Plus will introduce the following **new** ACO products. These products will be available in addition to our existing ACO products. Network names will appear on subscriber ID cards.

Individual Markets

Product Name	Network Name	Featured Care System(s)	Marketing/Service Area
Blue Plus Strive – Metro Region	Blue Plus Strive – Metro Region Network	Fairview, North Memorial Health and Entira	Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott and Washington Counties

As noted above, we will continue to offer: Blue Plus Metro MN, Blue Plus Western MN, Blue Plus Southeast MN and Blue Plus Northeast MN in our Individual markets.

Group Markets

Product Name	Network Name	Featured Care System(s)	Marketing/Service Area
Strive – Metro Region	Strive – Metro Region Network	Fairview, North Memorial Health and Entira	Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott and Washington Counties
Southeast MN	Southeast MN Network	Mayo Clinic Health System, Northfield Hospital & Clinics, St. Elizabeth's Medical Center, Winneshiek Medical Center, Winona Health and United Hospital District	Blue Earth, Dodge, Faribault, Fillmore, Freeborn, Goodhue, Houston, Le Sueur, Martin, Mower, Nicollet, Olmsted, Rice, Steele, Wabasha, Waseca, Watonwan and Winona

As noted above, we will continue to offer Metro MN, Western MN and Northeast MN in our large group markets.

Medicare Advantage (The list below represents ACO products only, and is not a comprehensive list of all new Medicare Advantage plans)

Product Name	Network Name	Featured Care System(s)	Marketing/Service Area
Blue Cross Strive Medicare Advantage Complete	Strive Medicare Advantage Metro Region Network	Fairview, North Memorial Health and Entira	Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, and Washington Counties
Blue Cross Strive Medicare Advantage Choice	Strive Medicare Advantage Metro Region Network	Fairview, North Memorial Health and Entira	Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, and Washington Counties
Blue Cross Medicare Advantage Complete	Medicare Southern MN Network	Mayo Clinic Health System, Mankato Clinic, Northfield Hospital & Clinics, Olmsted Medical Center, St. Elizabeth's Medical Center, Winneshiek Medical Center, Winona Health and United Hospital District	Blue Earth, Brown, Dodge, Faribault, Fillmore, Freeborn, Houston, Martin, Mower, Nicollet, Olmsted, Steele, Wabasha, Waseca, Watonwan, and Winona

Product Name	Network Name	Featured Care System(s)	Marketing/Service Area
Blue Cross Medicare Advantage Choice	Medicare Southern MN Network	Mayo Clinic Health System, Mankato Clinic, Northfield Hospital & Clinics, Olmsted Medical Center, St. Elizabeth's Medical Center, Winneshiek Medical Center, Winona Health and United Hospital District	Blue Earth, Brown, Dodge, Faribault, Fillmore, Freeborn, Houston, Martin, Mower, Nicollet, Olmsted, Steele, Wabasha, Waseca, Watonwan, and Winona
Blue Cross Medicare Advantage Core	Medicare Southern MN Network	Mayo Clinic Health System, Mankato Clinic, Northfield Hospital & Clinics, Olmsted Medical Center, St. Elizabeth's Medical Center, Winneshiek Medical Center, Winona Health and United Hospital District	Blue Earth, Brown, Dodge, Faribault, Fillmore, Freeborn, Houston, Martin, Mower, Nicollet, Olmsted, Steele, Wabasha, Waseca, Watonwan, and Winona

Update to Administration of Interpreter Services for MHCP Subscribers

(P28R1-18, published 11/1/18)

The information in this Bulletin contains an update to Provider Bulletin P28-18, which was published on July 2, 2018.The information in italic is the updated information:

Effective immediately, all contracted County Social Services and Public Health providers, Blue Plus Coordination Delegates and Blue Plus Interpreter Network Agencies are exempt from the change to billing procedures outlined in Provider bulletin P28-18. These providers will continue to utilize the Blue Plus interpreter network and they should contact one of the agencies listed below to schedule an interpreter for an appointment when face-to-face interpretation is needed.

The previous Provider Bulletin (P28-18) was directed at all ancillary service providers performing services to Blue Plus Minnesota Health Care Program (MHCP) subscribers. The Bulletin specifically stated that effective October 1, 2018, all ancillary service providers would be directly responsible for scheduling and billing for interpreter services provided to Blue Plus subscribers.

Ancillary service providers were defined as: Chiropractic, Acupuncturist, Vision retail, Occupational Therapy, Physical Therapy, Speech Therapy, Eye Clinics, Pharmacy, Durable Medical Equipment (DME), ARHMS and ACT.

All contracted County Social Services and Public Health providers, Blue Plus Care Coordination Delegates, and Blue Plus Interpreter Network Agencies will be exempt from this change to billing procedures. These providers will continue to utilize the Blue Plus interpreter network. In addition, as previously stated in Provider Bulletin P28-18, Dental Clinics and Home Health Agencies should also contact one of the agencies listed below to schedule an interpreter for an appointment when face-to-face interpretation is needed.

- Arch Language Network, Inc — Metro, Southern MN, Western MN
  (651) 789-7897
- The Bridge World Language Ctr. — North Metro, St. Cloud and surrounding Counties
  (320) 259-9239
- The Language Banc — Metro, Stearns and surrounding Counties
  (612) 588-9410
- Itasca Interpretation Services — Metro
  (651) 457-7400

- Intercultural Mutual Asst. Assoc. Southeast MN
  (507) 289-5960
- Project FINE Winona County Only
  (507) 452-4100

The Blue Plus Interpreter Network will continue to provide direct billing services to Blue Plus for interpreter services.

Products Impacted

- Prepaid Medical Assistance (PMAP)
- MinnesotaCare
- SecureBlue (HMO SNP)
- Minnesota Senior Care Plus (MSC+)

CONTRACT UPDATES

2019 Renewal Changes Summary for Institutional Providers

(P50-18, published 11/1/18)

The purpose of this Blue Cross and Blue Shield of Minnesota, Blue Plus, and Affiliates (Blue Cross) Bulletin is to communicate substantive changes to the 2019 Institutional Provider Service Agreement. The complete Provider Service Agreement (Agreement) is modified periodically to reflect the most current regulatory changes and other clarifications necessary to properly administer the Agreement. The minor changes and clarifications to the Agreement effective January 1, 2019 are detailed below. The summary items are listed in order of appearance in the Agreement.

Provider Service Agreement Changes

Article II. K. The definition of "Minnesota Health Care Programs" has been updated to include the most current term for prepaid public programs - Families and Children. Therefore, the definition is hereby superseded by the following:

"Minnesota Health Care Programs" means prepaid public programs including Medical Assistance, MinnesotaCare, Families and Children or other prepaid public programs in which Blue Cross provides coverage under a contract with any Minnesota County or with the Minnesota Department of Human Services (DHS). This Agreement applies to Health Services provided to Minnesota Health Care Program Subscribers where applicable. In the event of a government shutdown or lack of state funding which results in DHS ceasing to make payments to Blue Cross for Health Services provided to Minnesota Health Care Programs Subscribers, Blue Cross may, in its sole discretion, immediately terminate those portions of this Agreement which apply to Minnesota Health Care Programs Subscribers.

Article II. P. The definition of "Protected Health Information" (PHI) has been further clarified to include the most current CFR Section reference. Therefore, the definition is hereby superseded by the following:

“Protected Health Information" (PHI) means individually identifiable information transmitted or maintained in any format as further defined in 45 Code of Federal Regulations ("C.F.R.") Section 160.103.

Article III. M. Notices has been expanded to ensure Provider prompt notification of administrative changes or information of any kind to Blue Cross in order to provide Subscribers with the most accurate information possible Therefore, the provision is hereby superseded by the following:

Notices. Provider shall promptly notify Blue Cross of any changes to any administrative, demographic, or other provider information of any kind to ensure that Blue Cross has the most current and accurate Provider information. Notices, reports and records sent to Blue Cross, unless otherwise requested by Blue Cross, shall be addressed to:

Blue Cross and Blue Shield of Minnesota, Attn: Provider Relations, R317, P. O. Box 64560, St. Paul, Minnesota 55164-0560.

Article IV. G. Overpayments provision has been clarified to ensure correct administration of the Agreement to best support the commitment of both Parties to accurate payment.

Article IV J. Subscriber Liability provision is further clarified to align with the requirements of Minnesota Statute Section 62Q.751 and detailed in the Provider Policy and Procedure Manual which includes Provider requirement to return overpayments to Subscriber within 30 days of the date in which the claim adjudication is received by Provider.

Article XIV. N. Provider Merger or Acquisition provision has been updated to include notification of any material business transactions such as a merger or acquisition must be provided to Blue Cross no later than 60 days prior to the finalization of the transaction.

Schedule of Payment Plan Changes

Provisions of the Schedule of Payment for Institutional Providers and all provisions of the Medicare Schedule of Payment Plan for Critical Access Hospitals have been moved into the Institutional Provider Service Agreement, therefore eliminating these separate documents.

No changes have been made to the Medicare Amendment.

Disclosure of Ownership

A Disclosure of Ownership form **must be completed and submitted annually** to Blue Cross per Minnesota Department of Human Services requirements whether or not you have any information to report. Information about the requirement and an electronic version of the form are available at bluecrossmn.com.

Questions?

Providers that have questions about the changes made in 2019 can contact Provider Services at **(651) 662-5200** or **1-800- 262-0820**. Providers that would like a copy of the new Agreement should send a request to the following email box: Request.Contract.Renewal@bluecrossmn.com

2019 Renewal Changes Summary for Blue Plus Primary Care Clinic Providers

(P58-18, published 11/1/18)

Blue Cross and Blue Shield of Minnesota, Blue Plus, and Affiliates (Blue Plus) is simplifying the annual renewal process by communicating substantive changes to the 2019 Blue Plus Primary Care Clinic Provider Service Agreement via this Provider Bulletin. The complete Provider Service Agreement (Agreement) is modified periodically to reflect the most current regulatory changes and other clarifications necessary to properly administer the Agreement. The minor changes and clarifications to the Agreement effective January 1, 2019 are detailed below. The summary items are listed in order of appearance in the Agreement.

Provider Service Agreement Changes

1) Article II.J. The definition of Minnesota Health Care Programs has been expanded to include Families and Children as a prepaid public program.

2) Article II.O. The definition of Protected Health Information has been further clarified to include the most current citation of the federal regulations. Therefore, the definition is hereby superseded by the following:

   "Protected Health Information" (PHI) means individually identifiable information transmitted or maintained in any format as further defined in 45 Code of Federal Regulations ("C.F.R.") Section 160.103.

3) Article III.N. Notices; Updates; Changes has been revised to clarify that PCC shall promptly notify Blue Plus of any changes to any administrative, demographic, or other provider information of any kind to ensure that Blue Plus has the most current and accurate PCC information to support accurate provider directories for Subscribers.

4) Article IV.E. CPIU Payment Increase of the previous Agreement has been removed and is no longer in effect.

5) Article IV.H. Subscriber Liability provision is further clarified to align with the requirements of Minnesota Statute Section 62Q.751 and detailed in the Provider Policy and Procedure Manual, which includes PCC requirement to return overpayments to Subscriber within 30 days of the date in which the claim adjudication is received by PCC.

6) Article X.B. Termination has been revised to clarify that termination determinations are not subject to appeal. Written notice of termination must be mailed to Blue Plus, Attn: Provider Relations, R317, P. O. Box 64560 St. Paul, Minnesota 55164-0560. In addition, the final two bullet points under Article X.B. Termination are hereby superseded by the following:

   - Blue Plus shall have the right to terminate PCC's participation in benefit plans (including but not limited to the Minnesota Advantage Health Plan, political subdivisions, and Workers' Compensation) if PCC is determined by DHS to be out of compliance with Minnesota Statutes, Section 256B.0644 (requiring providers to accept medical assistance patients) or any other applicable laws. PCC shall notify Blue Plus immediately in event of such non-compliance. The termination shall be effective as of the first date of such non-compliance.
   - In the event that Blue Plus does not receive any claims submitted by PCC for a 12 month period, Blue Plus will terminate the agreement upon the expiration of that 12 month period.

7) Article XII.N. Provider Merger or Acquisition. The following sentence is hereby added to Article XII.N: Notification of any material business transactions such as a merger or acquisition must be provided to Blue Plus no later than 60 days prior to the finalization of the transaction.

No changes have been made to the Medicare Amendment.

Disclosure of Ownership
A Disclosure of Ownership form must be completed and submitted to Blue Plus per Minnesota Department of Human Services requirements. Information about the requirement and an electronic version of the form are available at bluecrossmn.com.

Questions?
Providers that have questions about the changes made in 2019 can contact Provider Services at **(651) 662-5200** or **1-800- 262-0820**. Providers that would like a copy of the new Agreement should send a request to the following email box: Request.Contract.Renewal@bluecrossmn.com

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATES

New Acupuncture Update for Commercial Lines of Business-Effective January 1, 2019

(P59-18, published 11/1/18)

Effective January 1, 2019, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will change the prior authorization (PA) requirement for Commercial lines of business related to acupuncture services related to medical policy (III-01-006) updated in October 2018.

Medically necessary acupuncture services will be limited to 20 visits per person per calendar year for all networks combined. No PA is required for the first 20 visits. After 20 visits, the benefit maximum will be reached, and additional claims will process as subscriber liability. This policy change applies to Fully Insured and select Self

Insured (SI) groups with 2019 renewal dates. SI groups may have different benefit limits, and if a contract allows greater than 20 acupuncture visits per calendar year, PA after 20 visits will still apply.

Acupuncture services that are provided in a Chiropractic office will accumulate within both applicable Chiropractic and Acupuncture Service limitations for group plans that also include a limit on chiropractic services.

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.

Products Impacted

- The information in this Bulletin applies to Commercial lines of business.
- The changes do not impact Government Programs lines of business (Prepaid Medical Assistance Program (PMAP), MinnesotaCare (MNCare), SecureBlue (MSHO), and Minnesota Senior Care Plus (MSC+) health plans), Federal Employee Program (FEP), Medicare Supplement (Senior Gold, Basic Medicare Blue and Extended Basic Blue), Medicare Advantage or Platinum Blue as those lines of business have separate PA requirements.

Submitting a PA Request when Applicable

Before submitting a PA request, Providers are asked to check applicable Blue Cross benefits and medical policy and **attach all required clinical documentation** with the request. PA requests will be reviewed when patient-specific, relevant medical documentation has been provided supporting the medical necessity of the service**.**

Lab Management Clinical Guideline Updates for Fully Insured Commercial and Medicare Advantage Subscribers – eviCore Healthcare Specialty Utilization Management (UM) Program (P65-18, published 11/1/18)

eviCore has released clinical guideline updates for their Lab Management program becoming **effective on January 2, 2019:**

Guidelines Retired:

- Prenatal Chromosome Analysis
- Gene Expression Profiling Tests for Prostate Cancer

New guidelines requiring prior authorization (PA):

- Breast Cancer Index for Breast Cancer Prognosis
- Genetic Presymptomatic and Predictive Testing for Adult-Onset Conditions in Minors
- Genetic Testing for Known Familial Mutations
- Genetic Testing for Variants of Uncertain Clinical Significance
- Genetic Testing for Arrhythmogenic Right Ventricular Cardiomyopathy
- Chromosome Analysis for Reproductive Disorders, Prenatal Testing, and Developmental Disorders
- Genetic Testing for Dilated Cardiomyopathy
- Decipher Prostate Cancer Classifier
- DermTech Pigmented Lesion Assay
- Genetic Testing for Facioscapulohumeral Muscular Dystrophy
- Genetic Testing for Autism
- Genetic Testing for Hereditary Pancreatitis
- Genetic Testing for Limb Girdle Muscular Dystrophy

- Macula Risk
- Mammaprint-70-Gene Breast Cancer Recurrence Assay
- Multiple Endocrine Neoplasia Type 1 (MEN1)
- Oncotype DX for Prostate Cancer
- OVA1
- Prolaris
- ProMark Proteomic Prognostic Test
- RosettaGX Reveal

eviCore's Lab Management clinical guidelines are available on the Blue Cross website at **providers.bluecrossmn.com**

- To access the link, select "**Medical Policy**" under **Tools and Resources**, read and accept the Blue Cross Medical Policy Statement
- Click on the "+" (plus) sign next to "**Medical and Behavioral Health Policies**" and locate the "**Medical Policy Supporting Documents**" section
- Click on "**eviCore healthcare Specialty Utilization Management Clinical Guidelines**" link
- Scroll down to the **Lab Management** section.
- Click on the "**BCBSMN Lab Resources Page**"
- Click on clinical guidelines **effective January 2, 2019**

Products Impacted

- This change only applies to **fully insured commercial** and **Medicare Advantage** subscribers.
- Subscribers who **do not require PA** through eviCore are:
  - Blue Cross Commercial Self-Insured Subscribers
  - Blue Cross Federal Employee Program Subscribers
  - Blue Cross Platinum Blue and Senior Gold Subscribers
  - Blue Plus Minnesota Health Care Programs (PMAP, MNCare, MSC+), SecureBlue (MSHO) Subscribers

To submit a PA Request to eviCore

Providers submit eviCore PA requests via our free **https://www.availity.com** provider portal. Instructions on how to utilize this portal are found on the Availity website.

Providers need to reference the eviCore clinical guideline criteria, submit prior authorization request 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.

Questions?

If you need to submit a PA by phone or need to speak to an eviCore representative call **844-224-0494**, 7:00 a.m. to 7:00 p.m. CST, Monday - Friday.

New Medical, Medical Drug and Behavioral Health Policy Management Updates for Commercial Lines of Business (P56-18, published 11/1/18)

Effective January 7, 2019, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be expanding utilization management requirements for commercial lines of business. This includes both prior authorization (PA) requirements and the Medical Drug Prior Authorization Program.

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 **medical policies** will be managed as follows effective January 7, 2019 for commercial lines of business:

Policy #	Policy Name	Existing Policy	New Policy	Enforcement
II-218	Elosulfase Alfa (Vimizim)		X	Prior Authorization
II-217	Galsulfase (Naglazyme)		X	Prior Authorization
II-215	Idursulfase (Elaprase)		X	Prior Authorization
II-216	Laronidase (Aldurazyme)		X	Prior Authorization
II-219	Vestronidase Alfa (Mepsevii)		X	Prior Authorization
II-160	Air Ambulance	X		Prior Authorization **Non Emergent Only**; Emergent does **NOT** require Prior Authorization

Products Impacted

- The information in this Bulletin applies to subscribers that have coverage through commercial lines of business.
- The changes do not impact Government Programs lines of business (Prepaid Medical Assistance Program (PMAP), MinnesotaCare (MNCare), SecureBlue (MSHO), and Minnesota Senior Care Plus (MSC+) health plans), Federal Employee Program (FEP), Medicare Supplement (Senior Gold, Basic Medicare Blue and Extended Basic Blue), Medicare Advantage or Platinum Blue as those lines of business have separate PA requirements.

Submitting a PA Request when Applicable

- Before submitting a PA request, Providers are asked to check applicable Blue Cross policy and **attach all required clinical documentation** with the request. PA requests will be reviewed when patient-specific, relevant medical documentation has been provided supporting the medical necessity of the service. Failure to submit required information may result in review delays (if outreach is needed to obtain missing clinical information) or a denial of the request due to insufficient information. 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 providers.bluecrossmn.com
  - Under Tools & Resources, select “Medical Policy”, and read/accept the Blue Cross Medical Policy Statement
  - Select the “+” (plus) sign next to Medical and Behavioral Health Policies, then select “Blue Cross Blue Shield of Minnesota Medical Policies” to access policy criteria.
- Prior Authorization Lists are updated to reflect additional PA requirements on the effective date of the management change and includes applicable codes. To access Prior Authorization Lists for all lines of business:
  - Go to providers.bluecrossmn.com
  - Under Tools & Resources, select “Medical Policy”, and read/accept the Blue Cross Medical Policy Statement
  - Select the “+” (plus) sign next to “Utilization Management” to access the Prior Authorization Lists.
- 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. The requirement applies to subscribers starting therapy and to those already being treated with a therapy noted above.
- Providers may submit PA requests for any treatment in the above table starting December 31, 2018.

Providers can Submit an Electronic Prior Authorization (ePA) Request

- Online via our free Availity provider portal – for Blue Cross to review.
- For Medical Drugs, PA's can also be submitted using a NCPDP standard XML file feed to Blue Cross through CenterX, via an integrated Electronic Medical Record (EMR) system. To learn how to do this, providers should contact their EMR vendor for assistance.
- Out of state, non-contracted providers can submit a PA request to Blue Cross by either using the electronic processes above, the Minnesota Uniform Form for PA Request and Formulary Exceptions fax form located under the Forms section on the Blue Cross website, or their own PA form (secure fax: 651.662.2810).

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 providers.bluecrossmn.com
- Under Tools & Resources, select "Medical Policy", and read/accept the Blue Cross Medical Policy Statement
- Select the "+" (plus) sign next to "Medical and Behavioral Health Policies" to see the Upcoming Medical Policy Notifications section

Blue Cross Contracts with eviCore to Expand Utilization Management for Home Health Services (P57-18, published 11/1/18)

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) has contracted with eviCore healthcare (eviCore), an independent specialty medical benefits management company, to manage Prior Authorization (PA) requests for Home Health Care (HHC) services for Medicare Advantage subscribers effective January 1, 2019.

eviCore healthcare will begin accepting PA requests for HHC services for dates of service beginning January 1, 2019 for the following HHC services:

- Skilled Nursing
- PT/OT/ST
- Social Worker
- Home Health Aides (for subscribers receiving **skilled** HHC services)

Key eviCore program points effective January 1, 2019:

- HHC agencies are responsible to submit the initial PA request for HHC services for subscribers discharging from the hospital, or for members with a new community referral from a physician or treating practitioner.
- The initial HHC request for patients discharging from a Post-Acute Care (PAC) facility, which includes Skilled Nursing, Inpatient Rehab and Long Term Acute Care Facilities, may be submitted by either the admitting HHC Agency, Hospital or discharging PAC facility.
- The discharging PAC Facility or the admitting HHC Agency may submit Home Health PA requests to eviCore.
- In addition, HHC agencies should submit all concurrent review requests to eviCore.

eviCore will accept benefit PA requests from providers in any of the following ways:

- www.availity.com will be the most efficient way to create PAs and check existing case status
- Fax - Home Health Prior Authorizations: 866-506-3087
- Telephone – Clinical information can be called in to eviCore at 844-224-0494, choose options 1, 8, 1, 1 for Home Health. Follow appropriate prompts based on inquiry.

Training Opportunities & Provider resources:
eviCore will be conducting a series of online orientation webinar sessions to educate providers on the new PA process. PA forms, training schedules and provider resources will be posted at www.evicore.com/healthplan/bluecrossmn. Provider questions can be emailed to client.services@evicore.com.

Radiation Therapy Program CPT® Code Update for Fully Insured Commercial Subscribers – eviCore Healthcare Specialty Utilization Management Program

(P60-18, published 11/1/18)

The following Radiation Therapy CPT® Codes will no longer require prior authorization (PA) **effective November 1, 2018**:

Code	Description
19294	Preparation of tumor cavity, with placement of radiation therapy applicator for intraoperative radiation therapy (IORT), concurrent with partial mastectomy
19296	Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy
19297	Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; concurrent with partial mastectomy (List separately in addition to code for primary procedure)
19298	Placement of radiotherapy after loading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance
31643	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of catheter(s) for intracavitary radioelement application
32553	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple
41019	Placement of needles, catheters, or other device(s) into the head and/or neck region (percutaneous, transoral, or transnasal) for subsequent interstitial radioelement application
49411	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple
49412	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure)
55875	Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy
55876	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple
55920	Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application
57155	Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy
57156	Insertion of a vaginal radiation after loading apparatus for clinical brachytherapy
58346	Insertion of Heyman capsules for clinical brachytherapy

Code	Description
76873	Ultrasound, transrectal; prostate volume study for brachytherapy treatment planning (separate procedure)
76965	Ultrasonic guidance for interstitial radioelement application
77261	Therapeutic radiology treatment planning; simple
77262	Therapeutic radiology treatment planning; intermediate
77263	Therapeutic radiology treatment planning; complex
77280	Therapeutic radiology simulation-aided field setting; simple
77285	Therapeutic radiology simulation-aided field setting; intermediate
77290	Therapeutic radiology simulation-aided field setting; complex
77293	Respiratory motion management simulation (List separately in addition to code for primary procedure)
77295	3-dimensional radiotherapy plan, including dose-volume histograms
77299	Unlisted procedure, therapeutic radiology clinical treatment planning
77300	Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, onl
77301	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications
77306	Teletherapy isodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s)
77307	Teletherapy isodose plan; complex (multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s)
77316	Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s)
77317	Brachytherapy isodose plan; intermediate (calculation[s] made from 5 to 10 sources, or remote afterloading brachytherapy, 2-12 channels), includes basic dosimetry calculation(s)
77318	Brachytherapy isodose plan; complex (calculation[s] made from over 10 sources, or remote afterloading brachytherapy, over 12 channels), includes basic dosimetry calculation(s)
77321	Special teletherapy port plan, particles, hemibody, total body
77331	Special dosimetry (eg, TLD, microdosimetry) (specify), only when prescribed by the treating physician
77332	Treatment devices, design and construction; simple (simple block, simple bolus)
77333	Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)
77334	Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)
77336	Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy
77338	Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan
77370	Special medical radiation physics consultation

Code	Description
77399	Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services
77417	Therapeutic radiology port image(s)
77427	Radiation treatment management, 5 treatments
77431	Radiation therapy management with complete course of therapy consisting of 1 or 2 fractions only
77432	Stereotactic radiation treatment management of cranial lesion(s) (complete course of treatment consisting of 1 session)
77435	Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions
77469	Intraoperative radiation treatment management
77470	Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral or endocavitary irradiation)
77499	Unlisted procedure, therapeutic radiology treatment management
77789	Surface application of low dose rate radionuclide source
77790	Supervision, handling, loading of radiation source
77799	Unlisted procedure, clinical brachytherapy
G0458	Low dose rate (LDR) prostate brachytherapy services, composite rate
G6017	Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (eg, 3d positional tracking, gating, 3d surface tracking), each fraction of treatment
S2095	Transcatheter occlusion or embolization for tumor destruction, percutaneous, any method, using yttrium-90 microspheres
S8030	Scleral application of tantalum ring(s) for localization of lesions for proton beam therapy
C2616	Brachytherapy source, nonstranded, yttrium-90, per source
0190T	Placement of intraocular radiation source applicator (List separately in addition to primary procedure)

eviCore's Radiation Therapy clinical guidelines and PA code list are available on the Blue Cross website at **providers.bluecrossmn.com**

- To access the link, select "**Medical Policy**" under **Tools and Resources**, read and accept the Blue Cross Medical Policy Statement
- Click on the "+" (plus) sign next to "**Medical and Behavioral Health Policies**" and locate the "**Medical Policy Supporting Documents**" section
- Click on the "**eviCore healthcare Specialty Utilization Management Clinical Guidelines**" link

Products Impacted

- This change only applies to fully insured commercial subscribers.
- The changes do not impact commercial self-insured health plans, Government Programs lines of business (Prepaid Medical Assistance Program (PMAP), MinnesotaCare (MNCare), SecureBlue (MSHO), and Minnesota Senior Care Plus (MSC+) health plans), Federal Employee Program (FEP), Medicare Supplement (Senior Gold, Basic Medicare Blue and Extended Basic Blue), Medicare Advantage, and Platinum Blue as those lines of business have separate PA requirements.

To submit a PA Request to eviCore

Providers submit eviCore PA requests via our free https://www.availity.com provider portal. Instructions on how to utilize this portal are found on the Availity website.

Providers need to reference the eviCore clinical guideline criteria, submit prior authorization request 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 member's benefit plan. Member benefit plans vary in coverage and some plans may not provide coverage for certain services discussed in the medical policies.

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.

Update: eviCore Healthcare Specialty Utilization Management (UM) – Durable Medical Equipment (P62-18, published 11/1/18)

The prior authorization (PA) requirements for Medicare Advantage will go into effect January 1, 2019. A new timeline for implementation across other lines of business (Commercial Fully Insured and Individual) will be announced at a later date.

Blue Cross and Blue Shield of Minnesota (Blue Cross) has contracted with eviCore Healthcare (eviCore) to review and process PAs for Durable Medical Equipment (DME) for subscribers enrolled in the Medicare Advantage program.

Note: Only DME items dispensed and billed by providers or vendors that hold a DME or Orthotic and Prosthetic contract with Blue Cross are subject to the PA requirements.

Providers should submit PA requests via our free **Availity** provider portal. Instructions on how to utilize this portal are found on the Availity website. The Availity portal is available 24/7 and is the **quickest** way to create PAs and check existing case status.

Providers can view the eviCore DME list and the provider orientation materials by visiting the Blue Cross website. The Healthcare Procedure Codes (HCPC) **list of DME that require PA is posted** on the eviCore implementation site.

1. Access the 'Provider Section' of the Blue Cross website at **providers.bluecrossmn.com**
2. Under 'Tools and Resources' select 'Medical policy' then acknowledge the Acceptance Statement.
3. Click on the '+' next to 'Utilization Management' and under the 'Precertification Lists' select 'eviCore Healthcare Specialty Utilization Management Clinical Guidelines' to view the eviCore medical policies, the CPT (Current Procedural Terminology) code list that require PA, or the provider orientation materials please visit https://www.evicore.com/healthplan/bluecrossmn

Products Impacted

PA is required through eviCore for Blue Cross subscribers enrolled in the **Medicare Advantage** programs.

Subscribers who **do not require PA** through eviCore are:

- Blue Cross Commercial Fully-Insured and Self-Insured Subscribers
- Blue Cross Federal Employee Program Subscribers
- Blue Cross Platinum Blue and Senior Gold Subscribers
- Blue Plus Minnesota Health Care Programs (PMAP, MNCare, MSC+), SecureBlue (MSHO)

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.

Questions?

If you need to submit a PA by phone or need to speak to an eviCore representative call **844-224-0494**, 7:00 a.m. to 7:00 p.m. CST, Monday - Friday.

eviCore Healthcare Specialty Utilization Management (UM) for Medicare Advantage Subscribers (P66-18, published 11/1/18)

Effective January 1, 2019, Blue Cross and Blue Shield of Minnesota (Blue Cross) will expand work with eviCore Healthcare to review and process prior authorizations (PAs) for Medicare Advantage subscribers, in addition to fully insured commercial subscribers, for the following specialty utilization management (UM) services:

Lab Management (Molecular and genetic testing)

- Medical Oncology
- Radiation Therapy
- Radiology
- Cardiology (Advanced imaging and diagnostic services; implantable device services)
- Musculoskeletal (spine, large joint and interventional pain)
- Sleep Management (sleep apnea testing; treatment with sleep related DME)

As stewards of healthcare expenditures for our subscribers, we are committed to ensuring they receive high quality, evidence-based care. One method for doing so is through the PA process. The primary purpose of the PA process is to ensure that evidence-based care is provided to our subscribers to promote quality, safety, and affordability.

eviCore's clinical guidelines and prior authorization code lists are available on the Blue Cross website at **providers.bluecrossmn.com**

- To access the link, select "**Medical Policy**" under **Tools and Resources**, read and accept the Blue Cross Medical Policy Statement
- Click on the "+" (plus) sign next to "**Medical and Behavioral Health Policies**" and locate the "**Medical Policy Supporting Documents**" section
- Click on the "**eviCore healthcare Specialty Utilization Management Clinical Guidelines**" link

Products Impacted

- Medicare Advantage subscribers
- Fully insured commercial subscribers have been effective in this program since August 1, 2018

PA is not required through eviCore for Blue Cross subscribers enrolled in the following programs:

- Blue Cross Commercial Self-Insured Subscribers
- Blue Cross Federal Employee Program Subscribers
- Blue Cross Platinum Blue and Senior Gold Subscribers
- Blue Plus Minnesota Health Care Programs (PMAP, MNCare, MSC+), SecureBlue (MSHO) Subscribers

To submit a PA Request to eviCore

Providers submit eviCore PA requests via our free **https://www.availity.com** provider portal. Instructions on how to utilize this portal are found on the Availity website.

Providers need to reference the eviCore clinical guideline criteria, submit prior authorization request 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.

Questions?

If you need to submit a PA by phone or need to speak to an eviCore representative call **844-224-0494**, 7:00 a.m. to 7:00 p.m. CST, Monday - Friday.

Prior Authorization Requirements for Blue Cross Medicare Advantage – Effective January 1, 2019 (Effective 1/1/19, published 11/1/18)

Blue Cross and Blue Shield of Minnesota (Blue Cross) will publish an updated list of Prior Authorization (PA)/notification requirements that will be effective January 1, 2019 for Medicare Advantage (MA) members. **The 2019 list with procedure codes will be available online by November 16, 2018.** To access Blue Cross prior authorization lists:

- Go to providers.bluecrossmn.com
- Under Tools & Resources, select "Medical Policy", and read/accept the Blue Cross Medical Policy Statement
- Select the "+" (plus) sign next to "Utilization Management" to access the Prior Authorization Lists. Or Select the "+" (plus) sign next to "Medical and Behavioral Health Policies" to see the Upcoming Medical Policy Notifications section.

PA Requirements

Only the services on the PA/Notification and eviCore CPT Code Lists require prior authorization.

However, if a Medicare member wants to know if a service is covered, the member, their appointed representative, or any provider that furnishes, or intends to furnish services to a Medicare member may also ask the plan if the service is covered. (See Provider Bulletin P19-14, *Discontinuation of the Advance Beneficiary Notices of Non-Coverage (ABN)* dated July 14, 2014).

When PA is required for a service, procedure or item, the provider must submit the clinical information in advance. The prior authorization must be completed before the service is rendered.

PA requirements listed below will be added to the existing MA PA list effective January 1, 2019. As noted above, the full PA list with procedure codes will be published on the Blue Cross website by November 16, 2018.

CHANGES

- Prior authorization required for **all** planned and unplanned medical and behavioral inpatient admissions
- Non-emergent ground and air ambulance
- Ancillary Services (chiropractic and outpatient therapies) **-** PA required from the first visit (after initial evaluation)

NEW

Policy #	Policy Name / Description
II-04 Medicare	Hyperbaric oxygen treatment
II-147, II-161, II-178, II-179, II-196, II-202, II-206, II-26, II-34, II-49, II-51, II-71, Medicare	Part B drugs and injectables
II-154 Medicare	Bone marrow transplants
II-190	Transcatheter arterial chemoembolization
II-192	Plasma exchange
II-194	Extracorporeal photopheresis (Transplant services)
II-205	Photodynamic therapy
III-03	Cognitive Rehabilitation

Policy #	Policy Name / Description
IV-01	Balloon Ostial Dilation for Treatment of Chronic Rhinosinusitis
IV-123	Gender dysphoria
IV-143, IV-144, IV-149, IV-152 Medicare	Vagus Nerve Stimulation
IV-150	Endothelial Keratoplasty
IV-17 Medicare	Blepharoplasty and Brow Ptosis Repair
IV-74	Spinal Cord Stimulation
IV-84	Implantable Cardioverter-Defibrillator

Important: PA approvals for Platinum Blue members do not automatically carry over for members moving from Platinum Blue to Medicare Advantage. Providers will need to reference the Medicare Advantage PA list to determine what services require a PA in 2019.

eviCore Healthcare Specialty UM

As notified through separate Bulletins, Blue Cross has contracted with eviCore Healthcare (eviCore), an independent specialty medical benefits management company, to manage benefit preauthorization requests for:

- Post-Acute Care (PAC) services. See Provider Bulletin P39R1-18, published on October 1, 2018.
- Durable Medical Equipment (DME). See Provider Bulletin P62-18, published on November 1, 2018.
- Core Specialty UM programs. See Provider Bulletin P66-18, published on November 1, 2018.

Providers should Submit an Electronic Prior Authorization (ePA) Request

- Online via our free Availity provider portal – for Blue Cross and eviCore to review.
- For medical drugs, prior authorizations can also be submitted using a NCPDP standard XML file feed to Blue Cross through CenterX, via an integrated Electronic Medical Record (EMR) system. To learn how to do this, providers should contact their EMR vendor for assistance.
- Out of state, non-contracted providers can submit a PA request to Blue Cross by either using the electronic processes above, the Minnesota Uniform Form for PA Request and Formulary Exceptions fax form located under the Forms section on the Blue Cross website, or their own PA form (secure fax: 651.662.2810).

An approved PA does not guarantee coverage under a member's benefit plan. Members' 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:

- Changes to Blue Cross Medical Policy 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 providers.bluecrossmn.com
  - ✓ Under Tools & Resources, select "Medical Policy", and read/accept the Blue Cross Medical Policy Statement
  - ✓ Select the "+" (plus) sign next to "Medical and Behavioral Health Policies" to see the Upcoming Medical Policy Notifications section

- Changes to eviCore clinical guidelines and prior authorization code lists are available on Blue Cross website at providers.bluecrossmn.com
  - ✓ Under Tools & Resources, select "**Medical Policy**" and read/accept the Blue Cross Medical Policy Statement

- ✓ Select the "+" (plus) sign next to "**Medical and Behavioral Health Policies**" and locate the "**Medical Policy Supporting Documents**" section
- ✓ Click on the "**eviCore healthcare Specialty Utilization Management Clinical Guidelines**" link

- Changes to CMS medical polices for LCD and NCD can be found on CMS.gov

Questions?
If you have questions regarding a request you have submitted to:

- Blue Cross, call Provider Services (**651**) **662-5200** or **1-800-262-0820**, 8:00a.m. to 5:00p.m. CST, Monday – Friday.
- eviCore, call **844-224-0494**, 7:00 a.m. to 7:00 p.m. CST, Monday - Friday.

MINNESOTA HEALTH CARE PROGRAMS MIGRATION UPDATES

Updated Minnesota Health Care Programs and Minnesota Senior Health Options (MSHO) Medical Policies (P67-18, published 11/1/18)

As previously communicated in Provider Bulletin P53-18, effective December 1, 2018, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) is expanding utilization management requirements for the Minnesota Health Care Programs (Families and Children, MNCare and MSC+) and Minnesota Senior Health Options (MSHO). This includes both prior authorization (PA) requirements and the Medical Drug Prior Authorization Program.

As stewards of health care expenditures for members, 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 members, driving quality, safety and affordability.

Effective November 5, 2018, providers will be able to utilize the Precertification Lookup Tool (PLUTO) outside of the Availity portal. This will allow providers to review upcoming prior authorization requirements for outpatient services at a code level and determine potential changes needed within current operations/processes.

The tool will be available via the Amerigroup website at https://providers.amerigroup.com/Pages/PLUTO.aspx
Select **Minnesota** for the market drop-down option as of November 5, 2018.

PLUTO will be directly accessible through the new Payer space within Availity as of December 1, 2018 and will continue to be the source Providers should utilize when reviewing prior authorization requirements.

The following updates have been made to the **Medical Policies** published via Provider Bulletin P53-18 which was published on October 1, 2018.

The following policies have been archived and are no longer applicable to subscriber claims as of December 1, 2018.

Policy #	Policy name
CG-BEH-14	Intensive In-Home Behavioral Health Services
CG-BEH-15	Activity Therapy for Autism Spectrum Disorders and Rett Syndrome
RAD.00046	Cerebral Perfusion Studies using Diffusion and Perfusion Magnetic Resonance Imaging

The following policies had PA requirements updated. See PLUTO for additional information as of November 5, 2018.

Policy #	Policy name	Medicaid		MSHO		Changed item
		Clinicatl edi	PA required	Clinical edit	PA required	
GENE.00006	Epidermal Growth Factor Receptor Testing					MSHO: PA not required
GENE.00039	Genetic Testing for Frontotemporal Dementia					MSHO: PA not required
GENE.00040	Genetic Testing for CHARGE Syndrome					MSHO: PA not required
LAB.00003	In-Vitro Chemosensitivity Assays and In-Vitro Chemoresistance Assays	X				Medicaid: PA not required
MED.00099	Electromagnetic Navigational Bronchoscopy	X				Medicaid: PA not required
SURG.00052	Intradiscal Annuloplasty Procedures (Percutaneous Intradiscal Electrothermal Therapy, Percutaneous Intradiscal Radiofrequency Thermocoagulation and Intradiscal Biacuplasty)			X		Medicaid: PA not required
BEH.00002	Transcranial Magnetic Stimulation	X				Medicaid and MSHO: PA not required
GENE.00005	BCR-ABL Mutation Analysis					Medicaid and MSHO: PA not required
GENE.00046	Prothrombin G20210A (Factor II) Mutation Testing	X				Medicaid and MSHO: PA not required
GENE.00047	Methylenetetrahydrofolate Reductase Mutation Testing					Medicaid and MSHO: PA not required
TRANS.00025	Laboratory Testing as an Aid in the Diagnosis of Heart Transplant Rejection	X				Medicaid and MSHO: PA not required

The following Medical Policies have transitioned to new policy numbers. The new policies will be in effect as of December 1, 2018, with no changes in clinical criteria from the original policy. Highlighted policies have an applicable Minnesota Department of Human Services (MN DHS) policy for one or more codes within the service category. MN DHS policies are noted within PLUTO where applicable.

New policy #	Policy name	Prior policy #
CG-DME-45	Ultrasound Bone Growth Stimulation	DME.00027
CG-DRUG-103	Botulinum Toxin	DRUG.00006
CG-DRUG-104	Omalizumab (Xolair®)	DRUG.00024
CG-DRUG-105	Abatacept (Orencia®)	DRUG.00040
CG-DRUG-106	Brentuximab Vedotin (Adcetris®)	DRUG.00047
CG-DRUG-111	Sebelipase alfa (KANUMA™)	DRUG.00093

New policy #	Policy name	Prior policy #
CG-DRUG-112	Abaloparatide (Tymlos™) Injection	DRUG.00103
CG-MED-73	Hyperbaric Oxygen Therapy (Systemic/Topical)	MED.00005
CG-MED-74	Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry	MED.00051
CG-REHAB-11	Cognitive Rehabilitation	MED.00081
CG-MED-75	Medical and Other Nonbehavioral Health Related Treatments for Autism Spectrum Disorders and Rett Syndrome	MED.00107
CG-MED-76	Magnetic Source Imaging and Magnetoencephalography	RAD.00019
CG-SURG-81	Cochlear Implants and Auditory Brainstem Implants	SURG.00014
CG-SURG-82	Bone Anchored and Bone Conduction Hearing Aids	SURG.00020
CG-SURG-83	Bariatric Surgery and Other Treatments for Clinically Severe Obesity (transition from SURG.00024 effective October 31, 2018)	SURG.00024
CG-SURG-84	Mandibular/Maxillary (Orthognathic) Surgery	SURG.00049
CG-SURG-86	Endovascular/Endoluminal Repair of Aortic Aneurysms, Aortoiliac Disease, Aortic Dissection and Aortic Transection	SURG.00054
CG-SURG-87	Nasal Surgery for the Treatment of Obstructive Sleep Apnea and Snoring	SURG.000074
CG-SURG-88	Mastectomy for Gynecomastia	SURG.00085
CG-SURG-89	Radiofrequency Neurolysis and Pulsed Radiofrequency Therapy for Trigeminal Neuralgia	SURG.00090
CG-TRANS-03	Donor Lymphocyte Infusion for Hematologic Malignancies after Allogeneic Hematopoietic Progenitor Cell Transplantation	TRANS.00018
CG-DRUG-107	Pharmacotherapy for Hereditary Angioedema	DRUG.00058
CG-DRUG-108	Enteral Carbidopa and Levodopa Intestinal Gel Suspension	DRUG.00064
CG-DRUG-109	Asfotase Alfa (Strensiq™)	DRUG.00087
CG-DRUG-110	Naltrexone Implantable Pellets	DRUG.00091
CG-MED-77	SPECT/CT Fusion Imaging	RAD.00042
CG-SURG-85	Hip Resurfacing	SURG.00051

Minnesota Health Care Programs and SecureBlue Authorization Requirement Updates Effective December 1, 2018 (P63-18, published 11/1/18)

As previously communicated, Blue Cross and Blue Shield of Minnesota (Blue Cross) has contracted with Amerigroup to administer claims for Minnesota Health Care Program Subscribers effective December 1, 2018. Because there may be a delay in obtaining access to all necessary tools via Availity for administering the authorization process, Amerigroup will not deny payment for services where no authorization was obtained for newly required prior authorization/precertification beginning December 1, 2018. The provider must make a good faith effort to complete a required authorization prior to January 1, 2019. Amerigroup and Blue Cross are aware of the timing restrictions in accessing the new Medicaid Availity Portal and Authorization Tool (Interactive Care Reviewer-ICR) which is being made available for the initial dates of service.

Effective November 5, 2018, providers will be able to utilize the Precertification Lookup Tool (PLUTO) outside of the Availity portal. This will allow providers to review upcoming prior authorization requirements for outpatient services at a code level and determine potential changes needed within current operations/processes.

The tool will be available via the Amerigroup website at https://providers.amerigroup.com/Pages/PLUTO.aspx Select **Minnesota** for the market drop-down option as of November 5, 2018.

PLUTO will be directly accessible through the new Payer space within Availity as of December 1, 2018 and will continue to be the source Providers should utilize when reviewing prior authorization requirements.

Effective December 1, 2018 Inpatient Admissions

As previously communicated in Provider Bulletin P48-18, published on October 1, 2018, all elective and emergent medical inpatient admissions, for subscribers enrolled in Blue Advantage Families and Children (F&C), Blue Advantage Minnesota Senior Care Plus (MSC+) and Blue Plus MinnesotaCare will require initial precertification and concurrent authorization beginning December 1, 2018.

The following admissions require notification only:

- Inpatient Admissions for SecureBlue℠ Subscribers
- Behavioral Health Inpatient Admissions

Inpatient notifications should be submitted in one of the following ways:

- Phone: **1-866-518-8448**
- Fax: F&C, MSC+ and MinnesotaCare **1-844-480-6839** Fax: SecureBlue: **1-866-959-1537**
- Web: To access Interactive Care Reviewer (ICR) on Availity for the first time, contact your Availity Administrator and request to be assigned the *Authorization and Referral Request* role to create and submit a PA. Once you have the role assignment you can immediately access ICR by taking the following steps:
  - From the Availity home page (www.availity.com), select **Patient Registration** from the top navigation.
  - Select **Authorizations & Referrals**, then select **Authorizations**.
  - Select the **Payer** (BCBSMN Blue Plus Medicaid) and **Organization** and submit.

The ICR application will open. Use ICR to submit and manage your medical PAs.

Reminder: As Amerigroup begins to adjudicate Medicaid and SecureBlue subscriber claims, providers may begin to see differences between the coding edits in the current operating system and the Amerigroup operating system. During the implementation of the new alliance, Blue Cross is taking the opportunity to better align our coding edits with current Blue Cross coding policies, state and federal coding standards, national industry practices and instructions in the medical code sets.