PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

WHAT'S INSIDE: **April 1, 2021**

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**

CONTRACT UPDATES

New Reimbursement Policy: Outpatient Services Prior to an Inpatient Admission

(P5R2-21, published 4/1/21)

Blue Cross and Blue Shield of Minnesota (Blue Cross) previously made the decision to delay the implementation of the 'Outpatient Services Prior to an Inpatient Admission' reimbursement policy. New details, including an updated effective date for this policy, are included in this Provider Bulletin, which replaces P5-21 and P5R1-21.

Effective June 7, 2021, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will implement a new reimbursement policy, Outpatient Services Prior to an Inpatient Admission.

When Blue Cross members receive outpatient diagnostic services that are related to an inpatient admission, it's important that they are billed appropriately as part of the inpatient claim. When these pre-admission testing and diagnostic services are billed as separate outpatient claims, it leads to unnecessarily higher costs for our members, in addition to other inefficiencies and complications. As an advocate for our members' health and health care dollar, Blue Cross is dedicated to ensuring that the care provided to our members is billed appropriately.

The purpose of this reimbursement policy is to ensure related outpatient diagnostic services are billed as part of inpatient claims, when appropriate. This new policy aligns with guidance from CMS and only applies to outpatient facility claims that occur within three days of an inpatient admission.

Starting with June 7, 2021 dates of service, Blue Cross will review outpatient diagnostic claims to determine if any services provided within 72 hours of an inpatient admission were inappropriately billed as a separate outpatient

claim. Outpatient diagnostic services provided at an entity wholly-owned or wholly-operated by the admitting hospital should be submitted on the inpatient claim. Reimbursement for inaccurate claims will be recouped.

Products Impacted

- Fully and Self-Insured commercial lines of business
- Individual and Family plans
- Federal Employee Program (FEP)
- Medicare Advantage plans

Exceptions:

It's important to note that there are a handful of exceptions to this policy, including:

- Non-diagnostic outpatient services that are unrelated to the inpatient admission may be billed separately as an outpatient claim.
- Separate reimbursement may also be permitted for unusual preoperative medical care or for medical treatment attempted to avoid an operation, even though surgery eventually was necessary.
- Psychiatric and Inpatient Rehabilitation facilities are subject to a one-day rule for services provided by an outpatient facility prior to an inpatient admission.
- Admitting Critical Access Hospitals are exempt from this policy.

Also, certain outpatient services are excluded from this policy when performed within three days of an inpatient admission. These services should not be included on the inpatient claim and must be independently billed:

- **Chemotherapy and/or Outpatient Surgery:** These services should not be included on the inpatient claim as long as they are not performed on the same day of the inpatient admission. If they are performed on the same day as the inpatient admission, then they must be included on the inpatient claim.
- **Maternity Services:** Outpatient diagnostic and/or Emergency Department services provided in conjunction with a maternity related diagnosis prior to the inpatient admission should not be included on the inpatient claim.

Reminder Regarding Reimbursement Policies:

This is not a change in medical policy or member benefits, but a change in reimbursement policy. Reimbursement policies are updated on an ongoing basis and used by Blue Cross to define if and how certain claims will be paid for various health care services.

To access the reimbursement policy:
Go to providers.bluecrossmn.com

- Under Tools & Resources, select "Reimbursement Policies"
- Locate "Outpatient Services Prior to an Inpatient Admission"

Summary:

REIMBURSEMENT POLICY EFFECTIVE 6/7/21 (Commercial Fully Insured and Self-Insured, Individual and Family, FEP and Medicare Advantage plan members)
If an admitting hospital system provides outpatient diagnostic services within 72 hours of an inpatient admission, the services are considered inpatient services and must be included in the bundled inpatient bill. Blue Cross will review outpatient diagnostic claims to determine if the services provided were billed correctly and in accordance with this new reimbursement policy. Payment for inaccurate claims will be recouped.

Questions? If you have questions, please contact provider services at **(651) 662-5200** or **1-800-262-0820**.

New Medical, Medical Drug and Behavioral Health Policy Management Updates—Effective May 31, 2021 (P15-21, published 4/1/21)

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be expanding utilization management requirements, including prior authorization (PA) requirements.

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 prior authorization changes will be effective May 31, 2021:

Policy #	Policy Title/ Service	New Policy	Prior Authorization Requirement	Line(s) of Business
II-165	Lyme Disease: Diagnostic Testing and Intravenous Antibiotic Therapy	No	Removed	Commercial and Medicare Advantage
L33394	Coverage for Drugs & Biologics for Label & Off-Label Uses: • Selexipag (Uptravi®) injectable* • Avalglucosidase alfa*	No	New	Medicare Advantage

*PA will be required upon FDA approval.

Products Impacted
The information in this bulletin applies only to subscribers who have coverage through Commercial and Medicare Advantage lines of business.

Submitting a PA Request when Applicable

- **Providers may submit PA requests for any treatment in the above table starting May 24, 2021.**
- Providers must check applicable Blue Cross policy and **attach all required clinical documentation** with the PA request. PA requests will be reviewed when patient-specific, relevant medical documentation has been submitted supporting the medical necessity of the service**.** Failure to submit required information may result in review delays or a denial of the request due to insufficient information to support medical necessity. 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.
- Current and future PA requirements can be found using the *Is Authorization Required* tool in the Availity® portal prior to submitting a PA request. Prior Authorization Lists are also updated to reflect additional PA requirements on the effective date of the management change and includes applicable codes. To access the pdf 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.

Prior Authorization Requests

- Participating providers must submit PA requests online via our free Availity® provider portal
- 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 fax form located under the Forms & Publications section on the Blue Cross website, or their own PA form.

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

Questions?
If you have questions, please contact provider services at (**651**) **662-5200** or **1-800-262-0820**.

eviCore Healthcare Specialty Utilization Management (UM) Program – Medical Oncology Drug Prior Authorization Updates for Fully Insured Commercial and Medicare Advantage Subscribers (P17-21, published 4/1/21)

The eviCore Healthcare Utilization Management Program will be making the following updates to the Medical Oncology Current Procedural Terminology (CPT) Prior Authorization (PA) Code List.

The following drug has been added to the Medical Oncology program and will require prior authorization for oncologic reason **beginning June 1, 2021.**

Drug	Code(s)
PEPAXTO (melphalan-flufenamide)	C9399, J3490, J3590, J9999

The following medications are awaiting regulatory approval. When approved, the medications will automatically be added to the PA list for oncologic reasons effective immediately. CPT codes will be assigned closer to the approval date.

Drug Name	Brand Name (s)
amivantamab	
leuprolide mesylate	CAMCEVI
oportuzumab monatox	VICINIUM
retifanlimab	
tisotumab vendotin	

Prior authorization requests will be reviewed based on eviCore clinical guideline criteria. Providers can view the list of CPT codes that require prior authorizations, eviCore clinical guidelines, and other provider resources on the eviCore Implementation Resources website.

To view CPT Code lists:

- Access the 'Provider Section' of the Blue Cross website at **providers.bluecrossmn.com**
- Select "**Medical Policy**" under *Tools and Resources*, read and accept the Blue Cross Medical Policy Statement
- Under "Medical and Behavioral Health Policies" scroll down and click on the "**eviCore healthcare Specialty Utilization Management Clinical Guidelines**" link
- Select "**Solution Resources**" and then click on the appropriate solution (ex: Laboratory Management)
- Select "**CPT Codes**" to view the current CPT code list that require a prior authorization

To view Clinical Guidelines:

- Access the 'Provider Section' of the Blue Cross website at **providers.bluecrossmn.com**
- Select "**Medical Policy**" under *Tools and Resources*, read and accept the Blue Cross Medical Policy Statement
- Under "Medical and Behavioral Health Policies" scroll down and click on the "**eviCore healthcare Specialty Utilization Management Clinical Guidelines**" link
- Click on the "**Resources**" dropdown in the upper right corner
- Click "**Clinical Guidelines**"
- Select the appropriate solution: i.e. Laboratory Management
- Type "**BCBS MN**" (space is important) in 'Search by Health Plan'
- Click on the "**Current**", "**Future**", or "**Archived**" tab to view guidelines most appropriate to your inquiry

Products Impacted

This change only applies to:

- Individual subscribers
- Fully insured commercial subscribers
- Medicare Advantage subscribers

Prior Authorization Look Up Tool

Providers should use the Prior Authorization Look Up Tool on the Availity Provider Portal to quickly determine if an authorization is required. By entering Member Group Number, Date of Service and Procedure Code, the tool will indicate whether an Authorization is required. If an Authorization is not required, the tool will allow the user to print the results for their records. If an Authorization is required, the user will move directly into the next field in Authorization application to complete the request.

This feature is accessible for lines of business managed by Blue Cross and will advise providers if Blue Cross or eviCore will review the request.

To access the Prior Authorization Look Up Tool:

1. Log in at **Availity.com**
2. Select **Patient Registration**, choose **Authorization & Referrals**, then **Authorizations**
3. Select Payer **BCBSMN**, your Organization, Transaction Type **Outpatient** and you will be redirected to the Authorization Look Up Tool application

To submit a Prior Authorization (PA) Request to eviCore

Providers submit eviCore PA requests via our free **Availity** provider portal. There is no cost to the provider for using the portal.

Instructions on how to utilize this portal are found on the Availity website. Providers should reference the eviCore clinical guideline criteria, submit prior authorization requests 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.

If a provider does not obtain a required prior authorization before rendering services, Blue Cross will deny claims as provider liability for lack of prior authorization.

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.

MINNESOTA HEALTH CARE PROGRAMS (MHCP) UPDATES

Updated Minnesota Health Care Programs and Minnesota Senior Health Options Prior Authorization and Medical Policy Requirements (P19-21, published 4/1/21)

Effective June 1, 2021, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be updating its government programs medical policy and pre-authorization/pre-certification/notification lists. The lists clarify medical policy, prior authorization, and notification requirements for the Minnesota Health Care Programs (Families and Children, MinnesotaCare and Minnesota Senior Care Plus) and MSHO products.

As stewards of healthcare expenditures for our subscribers, we are charged with ensuring they receive appropriate, quality care while also maintaining overall costs. The prior authorization process ensures that the health service or drug being proposed is medically necessary, and reflective of evidence-based medicine and industry standards, prior to treatment. This process helps us manage the cost and quality of care appropriately for our members.

The following policies have transitioned to new policy numbers, with changes in clinical criteria, and **will be applicable** to subscriber claims on or after **June 1, 2021**.

New Policy #	Prior Policy #	Policy Name	Prior Authorization Required	
			Medicaid	MSHO
Blue Cross VII-05	MHCP	Continuous Glucose Monitoring Systems	No	No

The following policies and/or prior authorization requirements will be archived and **will not be applicable** under the medical benefit plan to subscriber claims on or after **June 1, 2021**.

Policy #	Policy Name	Prior Authorization Required	
		Medicaid	MSHO
Blue Cross VI-09	Genetic Testing for Inherited Non-Cancer Conditions	Yes	Yes

Medical Prior Authorization (PA) Claims Denial Update

Blue Cross recently identified that the code for the Cologuard test, which should not have required a PA, has denied for no PA. The code listed below has been **removed** from requiring PA effective **September 1, 2020**.

An update to the system is in progress, and any claims that denied incorrectly for no PA will be reprocessed.

CPT® Code	Code Description
81528	Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result

Where do I find the current government programs Pre-Certification/Pre-Authorization/Notification list?

Go to **https://provider.publicprograms.bluecrossmn.com/minnesota-provider/resources/prior-authorization**

OR

Go to **providers.bluecrossmn.com**

- Under Tools & Resources, select "Minnesota Health Care Programs site"
- Under Resources, select "Prior Authorization Requirements" and scroll down to "Related Information" to select "Prior Authorization Grid"

Where do I find the current government programs Medical Policy Grid?

Go to **https://provider.publicprograms.bluecrossmn.com/minnesota-provider/resources/provider-manuals-and-guides**

- Click on "Medical Policies and UM Guidelines"

OR

Go to **providers.bluecrossmn.com**

- Under Tools & Resources, select "Minnesota Health Care Programs site"
- Under Resources, select "Manuals and Guides"
- Click on "Medical Policies and UM Guidelines"

Where can I access medical policies?

- **MN DHS (MHCP) Policies:**

  http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_157386

- **Blue Cross Policies:**

  https://www.bluecrossmn.com/providers/medical-policy-and-utilization-management

- **Amerigroup Policies:**

  https://provider.publicprograms.bluecrossmn.com/minnesota-provider/medical-policies-and-clinical-guidelines

  AND

  https://www.anthem.com/pharmacyinformation/clinicalcriteria

Please note that the Precertification Look-Up Tool (PLUTO) is not available for prior authorization look up.

Questions?

If you have questions, please contact provider services at **1-866-518-8448**.

Genetic/Molecular Lab Test Coding Reimbursement Policy for MHCP (P16-21, published 4/1/21)

Advancements in the science of genetics and genomics have led to remarkable new options for medical professionals to diagnose, treat, and prevent disease. As increases in genetic and molecular testing continue, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) is committed to improving the sustainability of care by ensuring high-quality, appropriate care is delivered at a fair price.

Beginning June 1, 2021, Blue Cross will expand the requirements for billing of genetic and molecular testing. In accordance with the new Blue Cross Reimbursement Policy for Genetic and Molecular Test Coding, all providers billing for genetic and molecular testing services will be required to adhere to the coding recommendations from Concert Genetics, our industry-leading genetic testing technology partner. Billing integrity requirements in the reimbursement policy will be administered on a post-payment review basis by Concert Genetics.

The provider portal can be accessed here: join.concertgenetics.com/bcbsmn

List of Impacted Tests Included in Reimbursement Policy (sections in CPT/HCPCS manual):

- Molecular Pathology
- Genomic Sequencing Procedures and Other Molecular Multianalyte Assays
- Multianalyte Assays with Algorithmic Analyses

Next Steps for Providers:

- Register with Concert Genetics and implement self-reporting quality metrics
- **Providers do not need to register again if they have already registered through another product or market**
- Verify accuracy of test catalog and review coding recommendations and fee schedule
- Utilize Concert Genetics' recommended codes when billing for genetic and molecular tests

Registration:
Please visit the Concert Genetics website (see link above) and submit a registration request. Labs will receive a welcome packet via email from Concert Genetics with an invitation to the Concert Genetics platform, where labs can review and validate the accuracy of their test catalog data and complete the quality questionnaire.

During onboarding, Concert Genetics will work with labs to gather the necessary information to calculate coding recommendations and self-reporting quality metrics. Labs will use the "Report as Inaccurate" feature to report specific test corrections. To assist providers:

- Concert Genetics will provide training materials and other documentation to assist labs with registration
- Concert Genetics will provide online, email, and phone support during and after registration
- For general inquiries, labs are encouraged to connect with a Concert Genetics representative
    - help@concertgenetics.com
    - (855) 435-7643

Post-Payment Reviews

Beginning with 6/1/2021 dates of service, claims will be reviewed by Concert Genetics on a post-payment basis. Claims that are identified as being billed incorrectly will be denied and recouped by Blue Cross. Providers will be asked to resubmit appropriate claims. Providers may appeal any/all determinations through the standard Blue Cross appeals process.

Pass-Through Billing

Providers are only allowed to bill for lab services that are completed on-site for Minnesota Health Care Programs (MHCP) subscribers.

Reimbursement Policies

This is not a change in medical policy or member benefits, but a change in reimbursement policy. Reimbursement policies are updated on an ongoing basis and used by Blue Cross to define if and how certain claims will be paid for various health care services.

Blue Cross requires that all providers billing for genetic and molecular testing services bill according to the coding recommendation in the Concert Genetics portal. Non-compliance with this policy may result in a written notification from Blue Cross. Continued non-compliance may result in a denied payment or termination of the provider's contract per the terms of the Provider Services Agreement.

Genetic Testing procedure codes that have been identified by the Minnesota Department of Human Services as not covered for MHCP subscribers will be rejected indicating the service is not covered under the benefit.

To access the reimbursement policy:
Go to https://provider.publicprograms.bluecrossmn.com/minnesota-provider/claims/reimbursement-policies

Products Impacted

- Families and Children [formerly known as Prepaid Medical Assistance Program (PMAP)]
- MinnesotaCare (MNCare)
- Minnesota Senior Care Plus (MSC+)
- SecureBlue (MSHO)

Please check the subscriber's benefits and confirm the **in-network** site of service.

Questions? If you have questions, please contact provider services at **1-866-518-8448**.

New Reimbursement Policy for Minnesota Health Care Programs Modifier 90: Reference (Outside) Laboratory and Pass-Through Billing (P18-21, published 4/1/21)

On April 1, 2021, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will publish Reimbursement Policy **Modifier 90: Reference (Outside) Laboratory and Pass-Through Billing.** This policy will be effective immediately as it memorializes the current process as documented in the Blue Plus Provider Manual.

The reimbursement policy does not allow pass-through billing for lab services. Claims appended with Modifier 90 and an office place of service will be denied unless provider, state, federal or the Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements indicate otherwise.

Reimbursement will be made directly to the laboratory that performed the clinical diagnostic laboratory test based on 100% of the applicable fee schedule or contracted/negotiated rate.

Modifier 90 is defined as when laboratory procedures are performed by a party other than the treating or reporting physician or other qualified healthcare professional. The procedure may be identified by adding Modifier 90 to the usual procedure number.

Products impacted:

- Families and Children (F&C)
- Minnesota Senior Care Plus (MSC+)
- Minnesota Senior Health Options (MSHO)
- MinnesotaCare (MNCare)

Questions? If you have questions, please contact provider services at **1-866-518-8448**.

UPDATE: Updated Preadmission Services for Inpatient Stays Reimbursement Policy for Minnesota Health Care Programs Members (P11R1-21, published 4/1/21)

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) has made the decision to delay the implementation of the 'Preadmission Services for Inpatient Stays' reimbursement policy. This policy will now be effective on June 1, 2021. This bulletin updates Provider Bulletin P11-21, published on 2/1/21.

Blue Cross will be publishing an updated Reimbursement Policy for Preadmission Services for Inpatient Stays effective June 1, 2021.

The Reimbursement Policy will be updated to reflect a three-day preadmission period rather than the current one-day period. All other information contained in the policy will remain the same.

When Blue Cross members receive outpatient diagnostic services that are related to an inpatient admission, it is important that the services are billed appropriately as part of the inpatient claim.

The purpose of this reimbursement policy is to ensure related outpatient diagnostic services are billed as part of inpatient claims, when appropriate. This new policy aligns with guidance from CMS and only applies to outpatient facility claims that occur within three days of an inpatient admission.

Products impacted:

- Families and Children (F&C)
- Minnesota Senior Care Plus (MSC+)
- Minnesota Senior Health Options (MSHO)
- MinnesotaCare (MNCare)

Questions?

If you have questions, please contact provider services at **1-866-518-8448**.