PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

WHAT'S INSIDE: **August 3, 2020**

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

Documentation Requirements for Replacement Claims (P54-20, published 8/3/20)

Effective October 1, 2020, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be updating the Modifier Reimbursement Policy to require the submission of medical records with the replacement claim to support the addition of modifier(s) -24, -25, -59, -XE, -XP, -XS, or -XU.

Medical records will be reviewed to determine if the change is supported. If documentation supports the change, the replacement claim will be processed per normal procedures. If documentation does not support the addition of the modifier, the claim line will remain as originally processed.

Replacement claims submitted without supporting documentation will not be processed.

Another replacement claim may be submitted; however, documentation must be submitted in order to be considered.

Products Impacted

This policy only applies to subscribers who have commercial and Medicare lines of business.

Coding Requirements Reminder
All coding and reimbursements are subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (e.g. HCPCS, CPT, ICD, Revenue), only valid codes for the date of service may be submitted or accepted.

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

HCPCS stands for Healthcare Common Procedure Coding System
CPT® (Current Procedural Terminology) is a registered trademark of the American Medical Association

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATES

New Medical, Medical Drug and Behavioral Health Policy Management Updates—Effective October 5, 2020 (P56-20, published 8/3/20)

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 October 5, 2020:

Policy #	Policy Title/ Service	New Policy	Prior Authorization Requirement	Line(s) of Business
II-243	Intravenous Iron Replacement Therapy • Ferumoxytol (Feraheme®) • Ferric carboxymaltose (Injectafer®) • Ferric derisomaltose (Monoferric®)	Yes	New	Commercial
IV-80	Implanted Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea	Yes	New	Commercial
L38387 (A57092)	Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea	No	New	Medicare Advantage

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 September 28, 2020.
- 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**.

New Prior Authorization Timeframes Required by Legislation (P55-20, published 8/3/20)

The Minnesota legislature recently passed legislation (SF3204 3rd Engrossment) that will require prior authorization review timeframes to change effective January 1, 2021 for subscribers with commercial **fully insured coverage**. Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) is evaluating current prior authorization processes to meet these requirements in a way that ensures a standardized, simplified process for providers and commercial subscribers.

New prior authorization requirements beginning January 1, 2021 include:

- Electronically submitted prior authorizations must have a decision communicated no later than 5 business days after receipt
- Prior authorizations submitted by phone, fax or mail must have a decision communicated no later than 6 business days after receipt
- Urgent prior authorizations must have a decision communicated within 48 hours of receipt or the end of the first business day after receipt of the initial request, whichever is later
- Denials of prior authorizations for medical and behavioral health services must be determined by a like-specialty reviewer
- Pre-service appeals of denied prior authorizations must have a decision communicated no later than 15 calendar days after receipt

Partnering for success now and in the future
In order to ensure a smooth transition to these new timeframes as soon as possible, Blue Cross asks that providers strive to submit all of the necessary clinical information at the time of submission, and work to return any additional requested information in an expedited manner.

- All prior authorization requests should be submitted with clinical records supporting the requirements found in the applicable Blue Cross medical policy or eviCore clinical guideline.
- Blue Cross medical policies include a "Documentation Submissions" section which outlines additional documents that must be submitted, when applicable.
- For inpatient hospital admission authorization requests, please be sure to include any information supporting the need for acute inpatient level of care, including the patient's History & Physical and physician notes and any other relevant clinical information, such as emergency department, nursing and therapy notes, diagnostic test results, lab results, patient monitoring plan, medications and treatment plan.

Products Impacted
This change applies only to commercial subscribers.

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

Site of Service Program Updates for Selected Specialty Medical Drugs for Commercial Subscribers: Medical Policy XI-06 (P57-20, published 8/3/20)

Effective October 5, 2020, important updates will be made to the Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) Site of Service program for specialty medical drugs. A new stand-alone medical policy has been developed for this program, XI-06: Site of Service for Selected Specialty Medical Drugs. Drug-specific policies will continue to address site of service; however, users will be referred to policy XI-06 for the complete site of service criteria.

Medical policy XI-06 determines the medical necessity of hospital outpatient facility level of care for selected specialty medical drugs. The policy addresses patient and/or procedural factors that may increase a patient's risk of requiring urgent access to a higher level of care available in a hospital outpatient facility. Drugs administered in a hospital outpatient facility that do not meet medical policy criteria will not be eligible for reimbursement. As part of the prior authorization process for these drugs, reviews will be conducted to ensure documentation of medical necessity to receive the drug at an outpatient hospital setting.

Please note criteria and drug list changes below, which are also effective October 5, 2020.

Medical Necessity Criteria Changes

- Geographic criteria addressing distance from the patient's home to the nearest non-hospital outpatient facility with supervised infusion or injection capabilities was changed from >30 miles to >25 miles to better align with the provider finder tool.
- Clarification regarding maintenance therapy has been added regarding reinitiating therapy after not being on therapy for ≥6 months (Note: this does not include maintenance therapy).

Complete List of Specialty Medical Drugs Included in Medical Policy XI-06

All drugs included in policy XI-06, Site of Service for Selected Specialty Medical Drugs, are listed below, including new drugs to the site of service program effective October 5, 2020.

Category	Policy #	Policy Title	Site of Service
Autoimmune	II-51	Immunoglobulin Therapy (Hizentra®, Gamunex®-C, Gammaked™, Gammagard Liquid®, Cuvitru™, and HyQvia)	Continuation
Autoimmune	II-161	Abatacept (Orencia®)	Continuation
Autoimmune	II-179	Certolizumab Pegol (Cimzia®)	Continuation
Autoimmune	II-180	Golimumab (Simponi Aria®)	Continuation
Autoimmune	II-97	Infliximab (Remicade®, Inflectra®, Renflexis®, Ixifi®)	Continuation
Autoimmune	II-181	Tocilizumab (Actemra®)	Continuation
Autoimmune	II-168	Ustekinumab (Stelara®)	Continuation
Autoimmune	II-182	Vedolizumab (Entyvio®)	Continuation
Autoimmune	II-47	Rituximab (Rituxan®, Rituxan Hycela™)	Continuation
Autoimmune	II-222	Tidrakizumab (Ilumya™)	Continuation
ALS	II-178	Edaravone (Radicava™)	Continuation
Multiple Sclerosis	II-49	Natalizumab (Tysabri®)	Continuation
Multiple Sclerosis	II-185	Ocrelizumab (Ocrevus®)	Continuation
Enzyme Therapy	II-26	Agalsidase Beta (Fabrazyme®)	Continuation
Enzyme Therapy	II-186	Alglucosidase Alfa (Lumizyme®)	Continuation
Enzyme Therapy	II-214	Intravenous Enzyme Replacement Therapy for Gaucher Disease (Cerezyme®, Elelvso®, Vpriv®)	Continuation
Enzyme Therapy	II-200	Sebelipase Alfa (Kanuma®)	Continuation
Asthma	II-203	Benralizumab (Fasenra®)	New
Asthma	II-201	Mepolizumaab (Nucala®)	New
Asthma	II-34	Omalizumab (Xolair®)	New
Asthma	II-202	Reslizumab (Cinqair®)	New
Autoimmune	II-196	Eculizumab (Soliris®)	New
Autoimmune	II-152	Belimumab (Benlysta®)	New
Enzyme Therapy	II-147	Pegloticase (Krystexxa®)	New
Enzyme Therapy	II-215	Idursulafse (Elaprase®)	New
Enzyme Therapy	II-216	Laronidase (Aldurazyme®	New

Enzyme Therapy	II-217	Galsulfase (Naglazyme®)	New
Enzyme Therapy	II-218	Elosulfase alfa (Vimizim®)	New
Enzyme Therapy	II-219	Vestronidase alfa (Mepsevii™)	New
Blood Disorders	II-211	Romiplostim (Nplate®)	New
Misc.	II-102	Pharmacologic Therapies for Hereditary Angioedema (Berinert®, Cinryze®, Firazyr®, Haegarda®, Kalbitor®, Ruconest®, Takhzyro™)	New
Misc.	II-206	Alpha-1 Proteinase Inhibitors (Aralast NP™, Glassia®, Prolastin-C®, Zemaira®)	New
Misc.	II-212	Burosumab (Crysvita®)	New
Misc.	II-220	Patisiran (Onpattro™)	New

Products Impacted

This program only applies to fully-insured and self-insured commercial lines of business. As a reminder for an Accountable Care Organization (ACO) subscriber, please have the subscriber call Blue Cross at **(651) 662-5200** or **1-800-262-0820.**

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 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

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

Update: Medical Oncology Drug Prior Authorization Updates for Fully Insured Commercial and Medicare Advantage Subscribers – eviCore Healthcare Specialty Utilization Management (UM) Program (P28R1-20, published 8/3/20)

The information in this Bulletin updates Provider Bulletin P28-20. On June 15, 2020, the FDA approved Lurbinectedin for use in the US under the brand name Zepzelca. The previous bulletin indicated Zepsyre as the brand name.

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 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)
nivolumab / ipilimumab	Opdivo / Yervoy
lurbinectedin, PM1183	Zepzelca
pertuzumab / trastuzmab	Perjeta / Herceptin SQ FDC

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: Medical Oncology)
- 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 upper right corner
- Click "**Clinical Guidelines**"
- Select the appropriate solution: i.e. Medical Oncology
- 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 **Authorizations & 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 the **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.
- Some of the Medical Oncology Drugs listed above may be approved by the Food and Drug Administration (FDA) for use treating non-oncology indications. To identify if a prior authorization for a drug for non-oncology use, please refer to the Prior Authorization Lists posted on the Blue Cross website. To access the Pre-Authorization Lists:
  - Go to providers.bluecrossmn.com

- Select “Medical Policy” under Tools and Resources, read and accept the Blue Cross Medical Policy Statement
- Review the lists under the “Utilization Management” section

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.

Hereditary Angioedema (HAE) Drug Prior Authorization Management Changes for generic Icatibant, Firazyr, Haegarda, and Takhzyro — Effective October 5, 2020

(P58-20, published 8/3/20)

Effective October 5, 2020, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will change management of the self-administered hereditary angioedema (HAE) drugs identified in the table below that are covered under the pharmacy benefit. For subscribers who have Prime Therapeutics as their Pharmacy Benefit Manager (PBM), prior authorization (PA) reviews for the self-administered HAE drugs will be completed by Prime Therapeutics applying Prime’s Hereditary Angioedema PA with Quantity Limit Criteria. These drugs will be removed from Blue Cross medical policy II-102 and medical benefit PA requirements, as self-administered drugs are excluded from coverage under the medical benefit. PA requirements for these drugs will continue under the pharmacy benefit.

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.

Effective October 5, 2020 – the following self-administered injectable HAE drugs will be subject to Pharmacy Utilization Management (UM) Criteria with PA.

Drug (Brand Name)	Blue Cross Medical Policy Change	Prime Pharmacy UM Criteria Change
• Human C1 esterase inhibitor (***Haegarda***) • Lanadelumab (***Takhzyro***) • Icatibant (***Firazyr, generic Icatibant***)	• Removing self-administered drugs Haegarda, Takhzyro, Firazyr, and generic Icatibant criteria from medical policy II-102*: Pharmacologic Therapies for Hereditary Angioedema* • Removing medical benefit PA requirements and excluding Haegarda, Takhzyro, Firazyr, and generic Icatibant from coverage under the medical benefit, as the drugs are intended for self-administration and are processed under the pharmacy benefit.	• Activating *Hereditary Angioedema Prior Authorization with Quantity Limit Criteria* for Haegarda, Takhzyro, Firazyr, and generic Icatibant • For Blue Cross members who have Prime Therapeutics as their pharmacy benefit manager, prior authorization reviews for Haegarda, Takhzyro, Firazyr, and generic Icatibant can be submitted to Prime Therapeutics starting October 1, 2020.

To access Pharmacy UM Criteria, follow the steps below.
- Go to providers.bluecrossmn.com
- Under Tools and Resources, select Medical Policy, then acknowledge the Acceptance statement
- Under Utilization Management, select Pharmacy Utilization Management
- Scroll through the Pharmacy UM Program Criteria to locate specific criteria

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

CoverMyMeds prior authorization request service
Prescribers can submit ePA drug requests for Blue Cross subscribers who have pharmacy benefits through Blue Cross by either submitting a request through CoverMyMeds's (CMM) free web portal or by sending an electronic NCPDP file to Prime through an integrated Electronic Medical Record (EMR) system during the e-prescribing process.

- To access CMM, go to www.covermymeds.com
- The first time you use the portal to submit a PA, you will need to create a CMM account.
- For help using the CMM site select Support (top of the web page) to view FAQs, CMM physician training webinar offerings, and support options to help you get started.

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

Lab Management CPT Codes added by the American Medical Association (AMA) and eviCore Healthcare Specialty Utilization Management (UM) Program Updates (P60-20, published 8/3/20)

The following new Proprietary Lab Management CPT Codes have been added by the American Medical Association (AMA). Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will require prior authorization (PA) **beginning October 1, 2020** for fully insured commercial and Medicare Advantage Subscribers under the eviCore Healthcare Specialty Utilization Management (UM) program.

Code	Description
0203U	Autoimmune (inflammatory bowel disease), mRNA, gene expression profiling by quantitative RT - PCR, 17 genes (15 target and 2 reference genes), whole blood, reported as a continuous risk score and classification of inflammatory bowel disease aggressiveness
0204U	Oncology (thyroid), mRNA, gene expression analysis of 593 genes (including BRAF, RAS, RET, PAX8, and NTRK) for sequence variants and rearrangements, utilizing fine needle aspirate, reported as detected or not detected
0205U	Ophthalmology (age-related macular degeneration), analysis of 3 gene variants (2 CFH gene, 1 ARMS2 gene), using PCR and MALDI-TOF, buccal swab, reported as positive or negative for neovascular age related macular-degeneration risk associated with zinc supplements
0208U	Oncology (medullary thyroid carcinoma), mRNA, gene expression analysis of 108 genes, utilizing fine needle aspirate, algorithm reported as positive or negative for medullary thyroid carcinoma
0209U	Cytogenomic constitutional (genome-wide) analysis, interrogation of genomic regions for copy number, structural changes and areas of homozygosity for chromosomal abnormalities
0211U	Oncology (pan-tumor), DNA and RNA by next-generation sequencing, utilizing formalin-fixed paraffin-embedded tissue, interpretative report for single nucleotide variants, copy number alterations, tumor mutational burden, and microsatellite instability, with therapy association
0212U	Rare disease (constitutional/heritable disorders), whole genome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, proband
0213U	Rare disease (constitutional/heritable disorders), whole genome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, each comparator genome (e.g., parent, sibling)
0214U	Rare disease (constitutional/heritable disorders), whole exome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, proband

0215U	Rare disease (constitutional/heritable disorders), whole exome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, each comparator exome (e.g., parent, sibling)
0216U	Neurology (inherited ataxias), genomic DNA sequence analysis of 12 common genes including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification, and categorization of genetic variants
0217U	Neurology (inherited ataxias), genomic DNA sequence analysis of 51 genes including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants
0218U	Neurology (muscular dystrophy), DMD gene sequence analysis, including small sequence changes, deletions, duplications, and variants in non-uniquely mappable regions, blood or saliva, identification and characterization of genetic variants
0220U	Oncology (breast cancer), image analysis with artificial intelligence assessment of 12 histologic and immunohistochemical features, reported as a recurrence score

Prior authorization requests will be reviewed based on eviCore clinical guideline criteria. Providers can view the list of Current Procedural Terminology (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:

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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 **Authorizations & 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.

Medical Oncology Drug Prior Authorization Updates for Fully Insured Commercial and Medicare Advantage Subscribers – eviCore Healthcare Specialty Utilization Management (UM) Program (P59-20, published 8/3/20)

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 drugs have been added to the Medical Oncology program and will require prior authorization **for oncologic reasons beginning October 1, 2020:**

Drug	Code(s)
Enfortumb vedotin-ejfv (Padcev)	C9399, J9999, J9177
Fam-trastuzumab deruxtecan-nxki (Enhertu)	C9399, J9999, J9358
Pegfilgrastim-apgf (Nyvepria)	J3490, J3590
Pertuzmab, trastuzumab, and hyaluronidase (PHESGO)	J3490, J3590

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: Medical Oncology)
- 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 upper right corner
- Click "**Clinical Guidelines**"
- Select the appropriate solution: i.e. Medical Oncology
- 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 **Authorizations & 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.
- Some of the Medical Oncology Drugs listed above may be approved by the Food and Drug Administration (FDA) for use treating non-oncology indications. To identify if a prior authorization for a drug for non-oncology use, please refer to the Prior Authorization Lists posted on the Blue Cross website. To access the Pre-Authorization Lists:
  - Go to providers.bluecrossmn.com
  - Select "Medical Policy" under Tools and Resources, read and accept the Blue Cross Medical Policy Statement
  - Review the lists under the "Utilization Management" section

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.

Site of Service for Selected Outpatient Procedures: XI-03 Medical Policy Update

(P61-20, published 8/3/20)

Effective October 5, 2020, an update will be made to the Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) medical policy, XI-03: Site of Service for Selected Outpatient Procedures.

Selected outpatient Hernia, Gynecology and Orthopedic Arthroscopy & Foot procedures (listed below) will be added to this medical policy and must be performed in a non-hospital outpatient setting – such as an Ambulatory Surgical Center (ASC). Claims will not be eligible for reimbursement in a hospital facility unless certain medical, geographic or contractual criteria are met.

This policy continues to include the ENT and Upper & Lower Gastrointestinal Endoscopy procedures (also listed below), which were added in 2019.

A clarification has been added to the policy stating that the use of an inpatient hospital facility solely for one of the procedures included in the Site of Service medical policy is considered not medically necessary.

Many specialists in the Blue Cross network have started redirecting patients to an ASC for these services when clinically appropriate. Performance of these procedures outside the hospital has shown evidence of safe, high quality outcomes at a lower cost, while maintaining an excellent patient experience.

Procedures administered in a hospital outpatient facility must meet medical policy criteria to be eligible for reimbursement. Post-service audits will be conducted for services taking place in a hospital setting using the following information to ensure policy criteria are met:

- Documentation of medical necessity to receive the procedure at an outpatient hospital setting.

Geographic exclusions for post-service audits include:

- Services for patients living greater than 25 miles from an in-network ASC or office performing these procedures are excluded from this program.
- Hospital outpatient facilities that do not have an in-network ASC or office performing these procedures within 25 miles of the hospital are excluded from this program.

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

List of Impacted Procedures Added to Medical Policy (Commercial and Minnesota Health Care Programs, effective October 5, 2020):

HERNIA	
Procedure	**CPT Codes**
Hernia Repair	49505, 49585, 49650, 49651, 49652, 49654

GYNECOLOGY	
Procedures	**CPT Codes**
Cervical Conization	57522
Endometrial Ablation	58353
Hysteroscopy	58558, 58563, 58565

ORTHOPEDIC ARTHROSCOPY & FOOT	
Procedures	**CPT Codes**
Arthroscopy Ankle	29891-29899
Arthroscopy Elbow	29830, 29834-29838
Arthroscopy Hip	29860-29863, 29914-29916
Arthroscopy Knee	29870, 29873-29875, 29876, 29877, 29879-29889
Arthroscopy Shoulder	29805-29807, 29819-29828
Arthroscopy Wrist	29840, 29844-29848
Foot & Toe Surgery	28289, 28291, 28292, 28296-28299, 28285

The site of service medical policy for the following procedures previously only applied to Commercial lines of business. As of October 5, 2020, the policy will also apply to Minnesota Health Care Programs:

GI	
Procedure	**CPT Codes**
Upper & Lower Gastrointestinal Endoscopy	43235, 43239, 43249, 45378, 45380, 45384, 45385

ENT	
Procedures	**CPT Codes**
Ear, Nose & Throat	21320, 30140, 30520, 69436, 69631

Products Impacted
All procedures included in the X1-03 medical policy will apply to the following Blue Cross products:

- Fully and Self-Insured commercial lines of business
- Minnesota Health Care Program subscribers to Families and Children (formerly Prepaid Medical Assistance) and MinnesotaCare (MNCare).

Predetermination Process for Providers:
Providers may submit a predetermination form via fax prior to treatment if the subscriber is experiencing unique clinical circumstances not outlined in the medical policy that may dictate surgery taking place in an outpatient hospital setting. Predeterminations are **not** required and do not guarantee payment.

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** for Commercial Members or **(866) 518-8448** for MHCP Members.

CMS Decision on Acupuncture for Chronic Low Back Pain (P56-20, published 8/3/20)

On January 21, 2020, the Centers for Medicare & Medicaid Services (CMS) issued a decision memo (CAG-00452N) communicating future coverage of acupuncture for chronic low back pain, including a draft national coverage determination (NCD) outlining the criteria for coverage. Prior to the decision memo, CMS considered acupuncture to be not reasonable and necessary for the treatment of any condition. CMS has since published NCD 30.3.3 and acupuncture is covered for chronic low back pain when criteria are met, effective for dates of service on and after January 21, 2020.

Products Impacted
This information only applies to Medicare Advantage and Platinum Blue subscribers.

Eligible codes
Acupuncture codes (97810, 97811, 97813, 97814, 20560 and 20561) that were previously considered non-covered are now eligible for chronic low back pain when criteria are met. No more than 20 acupuncture treatments for chronic low back pain may be administered annually in accordance with NCD 30.3.3. Providers are required to follow the criteria in NCD 30.3.3. No prior authorization is required.

Claims filing
Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) continues to work on updating systems to process claims in accordance with NCD 30.3.3. Once updates are complete, impacted claims will be processed for Platinum Blue and Medicare Advantage retroactive to January 21, 2020. Claims for Medicare Advantage and Platinum Blue members should be filed to Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross).

Eligible providers
Must be under supervision of a licensed Physician; Independent Acupuncturists are not covered. Physicians *as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements.*

Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:

- a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and,
- a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia.
- Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.

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

Prior Authorization Updates for Skilled Nursing Facility Admissions (P63-20, published 8/3/20)

Effective October 1, 2020, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) and eviCore will resume its prior authorization (PA) requirement for skilled nursing facility (SNF) admissions from the acute care setting for Medicare Advantage, commercial and Federal Employee Program (FEP) members.

This requirement was temporarily modified due to the COVID-19 pandemic to help free up hospital beds. Currently, providers are required to notify the plan of any SNF admission. Admissions from acute care facilities to skilled nursing facilities (SNF) for patients with and without COVID-19 diagnosis are automatically approved for the first 7 days. Current data shows adequate hospital capacity. We will continue to monitor hospital capacity and communicate future changes if/when it is warranted.

Products Impacted
This change applies only to Medicare Advantage, commercial and Federal Employee Program (FEP) members.

Submitting a PA Request for a Skilled Nursing Facility Admission
Starting October 1, 2020, SNF admissions from the acute care setting will once again require prior authorization. The prior authorization process ensures that the health service 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.

- PA requests must be submitted online via our free Availity® provider portal
- SNF admissions for Medicare Advantage members are managed by eviCore healthcare
  - For members in an acute care facility, the hospital is responsible for submitting the initial request for SNF admissions
  - SNF facilities are required to submit concurrent review requests
  - SNF facilities are responsible to submit initial admission requests when a patient admits directly from the community
- SNF admissions for Blue Cross and Blue Shield of Minnesota commercial and FEP members, request can be submitted by either the discharging hospital or the admitting skilled nursing facility

- PA requests submitted retrospectively must be submitted by the admitting facility as soon as possible after the admission, no later than the 14th day

Note: Home Health: Initial home health requests will continue to be approved for 60 days. Home health extension requests will be approved for 30 days at a time until the pandemic has passed.

Coronavirus (COVID-19) Information for Providers
Blue Cross created a Coronavirus website where providers can access all updates related to COVID-19. The website can be accessed by going to bluecrossmn.com/providers and clicking 'see latest information' within the 'Coronavirus Info' box in the upper right-hand portion of the provider landing page.

The webpage includes a regularly updated Frequently Asked Questions (FAQ) document, along with all other provider communications related to COVID-19, including Provider Bulletins and Quick Points. Blue Cross encourages providers to access this website regularly for updates as additional information is published as it becomes available.

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

CMS Issued Prior Authorization Requirements for Certain Hospital Outpatient Department (OPD) Services - Effective July 1, 2020 (P48-20, published 7/1/20)

Retraction: CMS mandate does not apply to Medicare Advantage or Platinum Blue lines of business. Please disregard this bulletin, previously published on 7/1/20.

The Centers for Medicare & Medicaid Services (CMS) is implementing a prior authorization program for certain hospital outpatient department (OPD) services for dates of service on or after July 1, 2020. CMS believes prior authorization for certain hospital OPD services will ensure that Medicare beneficiaries continue to receive medically necessary care while protecting the Medicare Trust Fund from improper payments and keeping the medical necessity documentation requirements unchanged for providers.

The following prior authorization changes will be effective July 1, 2020:

Policy #	Policy Title/ Service	New Policy	Prior Authorization Requirement	Line(s) of Business
Medicare (A52837)	Blepharoplasty	No	New	Medicare Platinum Blue
Medicare (L33646 & A52837)	Botulinum Toxin Injections	No	New	Medicare Platinum Blue
BCBSMN IV-24	Panniculectomy/Excision of Redundant Skin or Tissue	No	New	Medicare Platinum Blue
BCBSMN IV-82	Liposuction	No	New	Medicare Advantage & Medicare Platinum Blue
Medicare (Benefit Policy Manual 100.2) & IV-73	Rhinoplasty and related services	No	New	Medicare Advantage & Medicare Platinum Blue
Medicare (L33575 & A52870)	Vein Ablation	No	New	Medicare Platinum Blue

For more information on these changes, see CMS Prior Authorization for Certain Hospital Outpatient Department (OPD) Services.

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

Submitting a PA Request when Applicable

- Providers may submit PA requests for any treatment in the above table starting June 26, 2020**.**
- 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 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.

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