Provider Press

Provider information

December 2019 / Vol. 24, No. 4

BlueCross BlueShield Minnesota

UPCOMING SURVEYS

We Need Your Feedback. Your Opinion Matters to us!

As a participating provider in the Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) networks, we rely on you to provide quality care and service to our members—your patients. We also need to hear from you, our partners, on your experience with different aspects of the health care system.

Your Provider Service Agreement requires your support and collaboration to maintain the best quality of care for the patients we both serve. The National Committee for Quality Assurance (NCQA) standards are one of the many ways that our partnership helps support this delivery of quality care and patient satisfaction. Blue Cross is asking its provider partners to assist in the important requirements of NCQA by cooperating with surveys, if you are randomly selected.

Below is a summary of surveys that are conducted annually. These surveys can come in a variety of formats, so please keep an eye out for a mailed, telephone, or email survey. A strong response rate provides us with a clearer picture of our network's experience and expectations, so we can more confidently identify opportunities to improve your satisfaction with Blue Cross.

Additionally, we ask that you notify your front-line staff about these surveys and support their cooperation. We have built these surveys for efficiency and the best use of your staff's time as to create only minimal interruption to your operations.

SURVEY PURPOSE	SURVEY MODE	EXPECTED IN FIELD
Access to Care - This survey studies your ability to provide timely appointment access based on provider specialty and member need (urgent, routine, new patient, or existing patient).	Telephone	2nd Quarter
After Hours Access - This survey studies your ability to either care for or direct members to appropriate care outside of normal business hours.	Telephone	1st Quarter
Utilization Management - This survey studies practitioners' satisfaction with utilization management policies and procedures, including the appeals process.	Email	4th Quarter
Accuracy of Provider Directory - This survey measures the accuracy of practitioner and hospital information available to members on our online or printed provider directories.	Mailed	2nd Quarter
Coordination of Medical and/or Behavioral Care - This survey studies the frequency and effectiveness of continuity and coordination of care across different avenues of care.	Telephone	3rd Quarter

Questions?

If you have questions, please contact Provider Service at **(651) 662-5200** or **1-800-262-0820**.

NEED HELP UNDERSTANDING OUR NETWORKS?

Blue Cross has published two guides to help providers identify and understand our products. The Commercial Network Guide provides details regarding commercial products, including our narrow networks, and the Medicare Product Guide provides details about our Medicare products. Both guides are located on our website at **providers.bluecrossmn.com** under the "Education Center" section. The Medicare product guide is available under "Medicare Education" and the Commercial Network Guide has its own section in the Education Center.

Inside preview

FYI

PROVIDER MANUAL UPDATES

The following is a list of Blue Cross provider manuals that have been updated from September 2019 to November 2019. As a reminder, provider manuals are available online at **providers.bluecrossmn.com**. To view the manuals, select "Forms & publications," then "manuals." Updates to the manuals are documented in the "Summary of changes" section of the online manuals.

MANUAL NAME: CHAPTER NUMBER AND TITLE	CHANGE
Provider Policy and Procedure Manual: Chapter 4, Care Management	Content Changes to the following sections: • Care Management • Medical Policy and Behavioral Health Policies • Pre-Certification /Authorization Notification • Utilization Management Services Requiring Pre-Certification/Authorization/Notification • Where to Send Requests • Referrals to Case, Maternity and Condition/Disease Management • Documentation in the Medical Records
Provider Policy and Procedure Manual: Chapter 2, Provider Agreements	Content Changes to Government and Compliance Required Provisions
Provider Policy and Procedure Manual: Chapter 9, Reimbursement/ Reconciliation	Content Changes to Payment Methodology and MNCare Tax
Provider Policy and Procedure Manual: Chapter 10, Appeals	Content changes to Provider Appeals
Provider Policy and Procedure Manual: Chapter 11, Coding Policies and Guidelines	Content changes to Minnesota Health Care Programs Section

WHOM TO CONTACT?

HELPFUL PHONE NUMBERS	
BLUELINE (voice response unit)	**(651) 662-5200 or 1-800-262-0820**
BlueCard® member benefits or eligibility	**1-800-676-BLUE (2583)**
FEP® (voice response unit)	**(651) 662-5044 or 1-800-859-2128**
Availity	**1-800-282-4548**
Provider services	**(651) 662-5200 or 1-800-262-0820 and 1-888-420-2227** **Notes:** eviCore provider service: **1-844-224-0494** Minnesota Health Care Programs (MHCP) provider service: **1-866-518-8448**
Please verify these numbers are correctly programmed into your office phones.	
For phone numbers, fax numbers and addresses for Care Management programs and services please refer to the Provider Policy and Procedure Manual, Chapter 1 "How to Contact Us" section.	

FYI

Provider Press

Provider Press is a quarterly newsletter available online. Issues are published in March, June, September and December. Below is the URL (select "provider press" from the "Select a Category" drop down option): https://www.bluecrossmn.com/Page/mn/en_US/forms-and-publications.

HOLIDAY SCHEDULE

Provider services will be closed on the following days in 2019:

Thursday, November 28

Friday, November 29

Tuesday, December 24

Wednesday, December 25

Except for the dates stated above, representatives answering the provider services numbers are available to assist providers 7 a.m. to 6 p.m. Monday through Friday.

FYI

PUBLICATIONS AVAILABLE ONLINE

The following is a list of Quick Points and Bulletins published from September 2019 to November 15, 2019 that are available online at **providers.bluecrossmn.com**. As a reminder, Bulletins are published on the first business day of each month and Quick Points are published on the second and fourth Wednesday of every month.

QUICK POINTS	TITLE
QP40R1-19	Medical Drug Update for Drug Golodirsen
QP75-19	Addition of Drugs to Existing Prior Authorization (PA) with Quantity Limit (QL) or PA Programs
QP76-19	Update: Attachments for Minnesota Health Care Programs (MHCP) Claims
QP77-19	Preadmission Notification Language
QP78-19	Availity Prior Authorization Submission and Inquiry Tips
QP79-19	Blue Cross Introduces a New and Easier Way to Find Medical Policies
QP80-19	Pharmacy Benefit Exclusion for ProAir®Digihaler™
QP81-19	Pharmacy Benefit Exclusion for Pazeo®, Bepreve®, and Rasuvo®
QP82R1-19	Pharmacy Benefit Update – $0 Insulin Member Cost-Share Benefit for Commercial Lines of Business
QP83-19	Pharmacy Benefit Update – New Drug-Related Prior Authorization (PA) with Quantity Limit (QL) Criteria: Egrifta® (tesamorelin)
QP84-19	Skilled Nursing Facility (SNF) Billing
QP85-19	Pharmacy Benefit Update – New Drug-Related Prior Authorization (PA) with Quantity Limit (QL) Criteria: Sunosi
QP86-19	Pharmacy Benefit Exclusion for Invermectin Cream 1%
QP87-19	Medical Drug Exclusion List Expands to Include Triluron
QP88-19	Pharmacy Benefit Exclusion for Healthcare Professional Administered Drugs
QP89-19	CMS Provider Data Accuracy Audit
QP90-19	Pharmacy Benefit Update – New Drug-Related Prior Authorization with Quantity Limit Criteria: tadalfil
QP91-19	Availity Provider Portal Authorization Tool Enhancements
QP92-19	Multiple Claim Appeals for Minnesota Health Care Programs (MHCP)

BULLETINS	TITLE
P23R1-19	Alignment of Start Date for Prior Authorization Requests
P23R2-19	Updated Bulletin: Alignment of Start Date for Prior Authorization Requests
P54R2-19	Update: Precertification for Commercial Inpatient Admissions
P67-19	New Medical, Medical Drug and Behavioral Health Policy Management Updates- Effective November 4, 2019
P68-19	Radiation Oncology Program Updates for Fully Insured Commercial and Medicare Advantage Subscribers – eviCore Healthcare Specialty utilization Management (UM) Program
P69-19	Claim Recoupment Processing for Legacy Platform Runout Claims

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FYI

MEMBER RIGHTS AND RESPONSIBILITIES

Blue Cross is committed to treating its members in a way that respects their rights, while maintaining an expectation of their individual responsibilities. All Blue Cross members have certain rights concerning their care and treatment, and responsibilities as a member, such as following agreed upon instructions for care, or supplying information needed to provide care. A complete listing of Member Rights and Responsibilities can be found online at **bluecrossmn.com** by entering "member rights" in the search field. Questions or requests for a paper copy may be directed to Lisa K. at **(651) 662-2775**.

FYI

FYI

PUBLICATIONS AVAILABLE ONLINE (continued)

BULLETINS	TITLE
P70-19	Updated Minnesota Health Care Programs and Minnesota Senior Health Options (MSHO) Prior Authorization and Medical Policy Requirements
P71-19	Attachments for Minnesota Health Care Programs (MHCP) Claims
P71R1-19	Update: Attachments for Minnesota Health Care Programs (MHCP) Claims
P72-19	New Medical, Medical Drug and Behavioral Health Policy Management Updates- Effective December 2, 2019
P73-19	Blue Cross Contracts with TruHearing to Manage Certain Medicare Audiology and Hearing Aid Benefits Effective January 1, 2020
P74-19	Updated Minnesota Health Care Programs and Minnesota Senior Health Options (MSHO) Prior Authorization and Medical Policy Requirements
P75-19	Identified Global Claims Issues Grids
P76-19	CMS Changing Payment Classification System for Home Health Effective January 1, 2020
P77-19	New Medical, Medical Drug and Behavioral Health Policy Management Updates – Effective January 6, 2020
P78-19	Payment Changes for all Medicare Supplement Products
P79-19	New Medicare Benefit for Opioid Treatment Programs – Effective January 1, 2020
P80-19	2020 Renewal Changes Summary for Primary Care Clinic Providers
P81-19	2020 Renewal Changes Summary for Institutional Providers
P82-19	Reimbursement Policy Clarification to Unlisted Codes for Commercial and Medicare Products
P83-19	Blue Cross Discontinues Vendor Relationship with Magellan
P84-19	Updated Minnesota Health Care Programs and MSHO Prior Authorization and Medical Policy Requirements
P85-19	New Colonoscopy Reimbursement Policy for Commercial Lines of Business

UTILIZATION MANAGEMENT (UM) STATEMENT

UM decision making is based only on appropriateness of care and service and on existing coverage provisions. Blue Cross does not compensate providers, practitioners or other individuals making UM decisions for denial of coverage or services. We do not offer incentives to decision makers to encourage denial of coverage or services that would result in less than appropriate care or underutilization of appropriate care and services.

FYI

DISCLOSURE OF OWNERSHIP FORM

Blue Cross makes every effort to assist providers in the ease of complying with the annual Disclosure of Ownership and Business Transactions document. This document is required in accordance with Minnesota Department of Human Services (DHS) rules. It is imperative that every provider complete and submit this form annually, and failure to do so may result in material noncompliance with the requirements of participation. To support ease of administration and completion of the form for Providers, Blue Cross utilizes a uniform document for all providers participating with any Minnesota health plan. Blue Cross has posted the form on our website, so providers have easy access electronically. In addition, providers can simply email their completed form to Blue Cross at the following email address DisclosureStatement@bluecrossmn.com.

Please take a moment to complete and submit the Disclosure of Ownership form annually via email. This form is accessible on our website under Forms & Publications then forms-Clinical Operations for your convenience. If you have any questions, please email us at DisclosureStatement@bluecrossmn.com.
Thank you for your attention to this important compliance effort.

TRANSITION OF CARE FROM PEDIATRIC TO ADULT

Changing doctors is never easy especially for a teenager new to advocating for their own health care. If there is a chronic illness like diabetes or cystic fibrosis, it can be even more challenging to make the transition. Ideally, children should transition from pediatric to adult-oriented health care between the ages of 18 and 21 years.

For adolescents seeing a pediatrician, the transition will involve choosing a new physician, transferring medical records, communicating treatment histories and insurance information. Although adolescents seeing a family physician may stay in the same practice, they may still need to transfer some aspects of their care. It is important you have these conversations with your patients.

Blue Cross Customer Service can help find adult primary care practitioners who can best serve their medical needs. Customer Service can also assist pregnant adolescents in their transition from pediatrics to an adult primary care practitioner, OB/GYN, family practitioner or internist.

For assistance in medical care transitions, please direct your patients to contact Blue Cross Customer Service at the phone number listed on the back of their member ID card. The online "Find a Doctor" tool can also help them easily find a provider. If using the "Find a Doctor" tool, please direct your patients to visit bluecrossmnonline.com, sign in and select "Find a Doctor."

UTILIZATION MANAGEMENT CLINICAL CRITERIA

Upon request, any Blue Cross practitioner may review the clinical criteria used to evaluate an individual case. Medical and behavioral health policies are available for your use and review on our website at **providers.bluecrossmn.com**.

FYI

MEDICARE ANNUAL WELLNESS VISITS

The annual wellness visit (AWV) is a yearly preventive visit emphasizing health screenings and wellness planning. AWVs include a wide range of preventive services and assessments, like Health Risk Assessments, physical measurements, depression screening, and advance care planning.

AWVs benefit Medicare beneficiaries and their providers by increasing access to and utilization of preventive services and reducing healthcare costs. However, since AWVs were first offered in 2011, uptake has been slow, with nationwide utilization hovering around 16%.

Blue Cross has undertaken member and provider education efforts to increase the percentage of AWV's completed for our Medicare members.

Member Outreach

To inform Medicare members about the AWV and encourage participation, Blue Cross conducts various member outreach efforts.

- Written articles about AWV in the Blue Cross Medicare member magazine – ***thrive*** (print and digital versions).
- Including an educational postcard about AWV in the member welcome packet as well as provide similar information during new member outbound welcome calls.
- Offering in-home AWVs to members identified as not having scheduled an AWV.
- Providing Blue Cross Retail Centers with AWV resources to share with Medicare members seeking plan information.
- Including the URL in member communications that leads to an updated landing page on the Blue Cross website that explains the difference between AWV and AWE.

Provider Resources

Blue Cross works with our network providers to encourage the availability and scheduling of AWV's. Resources related to Medicare covered wellness visits and advance care planning are available through Blue Cross and the Centers for Medicare & Medicaid services.

- Blue Cross provides Medicare resources through the Blue Cross Availity Learning Center at bcbsmn.availitylearningcenter.com. Resources include summaries of Annual Wellness Visit, Welcome to Medicare Initial Preventive Physical Examination (IPPE), Care of Older Adults, and Provider Reference Sheet – Medicare Star Measures.
- Additional resources are available through the CMS Medicare Learning Network cms.gov/Medicare/Medicare.html. This site includes a downloadable fact sheet on Annual Wellness Visit as well as a fact sheet on Advance Care Planning. Use the search function to find downloads for each.

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FYI

MEDICARE ANNUAL WELLNESS VISITS (continued)

Providers bill Medicare covered wellness visits using HCPS codes.

HCPS CODES	BILLING CODE DESCRIPTION	FREQUENCY
G0438	Annual wellness visit; includes a personalized prevention plan of service, initial visit	Once per lifetime and after member has had Medicare Part B for 12 months
G0439	Annual wellness visit; includes a personalized prevention plan of service, subsequent visit	Once every 12 months
G0468	Federally qualified health center (FQHC) visit, IPPE or AWV	Refer to your FQHC for additional information
G0402	Welcome to Medicare Exam	Initial preventative physical examination limited to a new patient during the first 12 months of Medicare enrollment

REMINDER: MEDICARE REQUIREMENTS FOR REPORTING PROVIDER DEMOGRAPHIC CHANGES

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) has continually collaborated with providers in an effort to ensure accurate information is provided in all provider directories. Accuracy requires both Providers and Blue Cross to make every effort to support current information.

In accordance with Medicare requirements, Blue Cross is required to maintain accurate provider network directories for the benefit of Subscribers. Please promptly submit a form to us when changes occur, including any of the following:

- 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 this link: 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**

Questions?

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

QUALITY IMPROVEMENTS

ACCESS & AVAILABILITY SURVEY

Blue Cross conducted an Access & Availability survey between March and April of 2019. The survey was sent to a random selection of medical specialties and behavioral health care practitioners. These specialties were broken into three groups: High Volume, High Impact, and Behavioral Health. High volume specialty care is defined as types of practitioners most likely to provide services to the largest segment of the membership and included OB/GYN and Dermatology. High impact specialty care was defined as practitioner types that treat conditions that have high mortality and morbidity rates and included Cardiology and Oncology. Behavioral Health was broken out into categories; prescribers which included psychiatrists and psychiatric nurse practitioners and non-prescribers, which included psychologists.

2019 was our fourth year conducting this survey. The results showed that many of the specialties met Blue Cross' goals and/or showed improvement from 2018 to 2019. However, it also showed that some specialties are still not meeting accessibility requirements and will require additional assessment and follow up. If you would like a copy of the summary of results, please contact Blue Cross at the Quality.Improvement@bluecrossmn.com mailbox.

What does this mean for you? Blue Cross will use these results to identify improvement opportunities to enhance our network capabilities, such as continuing to provide and educate members about Network options such as utilizing the Find a Doctor tool to locate practitioners or specialties and online appointment options, as well as continue to improve and optimize internal processes. Blue Cross also sent out letters to those providers who did not meet requirements to work on fixing any identified issues. As a contracted provider you are bound by the appointment accessibility requirements listed in the Provider Policy and Procedure Manual posted on our website at **providers.bluecrossmn.com**.

AFTER-HOURS SURVEY

Blue Cross conducted an After-Hours survey between March and April of 2019. The survey was sent to a random selection of our primary care physicians (PCP) utilized by Blue Cross members. 2019 was our fourth year conducting this survey. The results showed that 91.4% of the PCP's surveyed met Blue Cross' goals in the 2019 survey, this is a slight reduction from the previous year and highlights that some PCP locations are still not meeting After-Hours requirements and will require additional assessment and follow up.

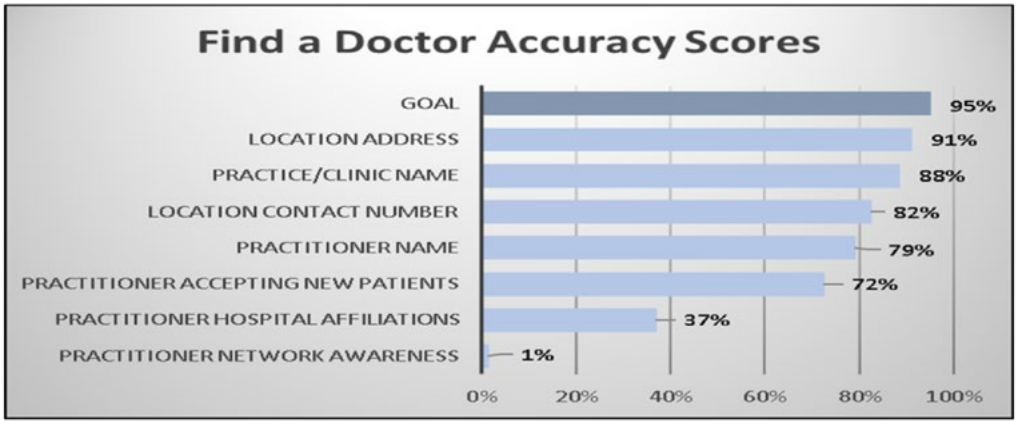
What does this mean for you? Blue Cross sent out letters to those providers who did not meet requirements to work on fixing any identified issues. As a contracted provider you are bound by the After-Hours requirements listed in the Provider Policy and Procedure Manual posted on our website at **providers.bluecrossmn.com**.

QUALITY IMPROVEMENTS

PROVIDER DATA ACCURACY SURVEY

Provider directories are an important tool used by members and prospective members to select and contact their physicians and other contracted providers who deliver their medical care. Members and their caregivers rely on our online provider directory, the Find a Doctor (FAD) tool, to make informed decisions regarding their health care choices. Inaccurate data in the directory can create a barrier to care as well as negatively impact member experience.

The 2019 survey was a huge success with an 18.3% response rate from you, the providers. Blue Cross very much appreciates your efforts in helping us provide the best possible FAD tool for our members and your patients. We are currently working on making the various updates indicated from your responses. Depicted below are the accuracy percentages as a result of this year's survey. As you can see, the Blue Cross FAD did not achieve the established business goal of 95%.



Based on the survey component and responses, the category with the biggest concern is the Practitioner Network Awareness. Blue Cross is required to assess a provider's/practitioner's office staff's ability to identify every product line and organizational network in which the provider/practitioner participates.

We understand that this is not an easy requirement as not only do you have Blue Cross members but other health plans you are trying to provide medical services for. We try to make this easier by posting this information in the FAD tool for both your convenience and for our members.

As providers/practitioners you may review this data by going to the Blue Cross website, clicking on "Find a Doctor" and then click on "Go to Doctor Search." At this point you can search as a guest and look up your information by name in our FAD tool. Once you find your name choose "View accepted Networks."

Blue Cross understands that there are a lot of Networks listed and you may not be aware of many of them. You have been added to these networks based on internal business rules. We are currently working on a way to make this process easier for both you and our members.

Blue Cross appreciates your participation in this survey and all our annual surveys needed to serve our members.

QUALITY IMPROVEMENTS

IMPROVING CONTINUITY AND COORDINATION OF CARE

Serious problems can occur for patients undergoing transitions across sites of care. Problems with communication between providers, patient's understanding of complex treatment regimens and follow-up plans, and overall sharing of information can affect the quality and effectiveness of care received and ultimately health outcomes for patients.

Particularly challenging to continuity and coordination of care are concepts such as:

- Access to care (availability of after-hours care, access to medical insurance, transportation to locations of care, ability to understand and navigate the health care system).
- Continuity of care (a continuous relationship with a single provider over time, ongoing familiarity and trust, smooth and coordinated transitions between care providers), and
- Shared decision making (engaging patients in discussions of treatment options).

In the article Healthcare Coordination: Connecting Clinicians to Patients originally published on the Jive Software site on May 3, 2017, several factors were identified that contribute to care coordination failure:

- Current healthcare systems are often disjointed, and processes vary among and between primary care practices (PCPs) and specialty sites.
- There is often no central point of responsibility for the entire cycle of care.
- Many organizations don't have sufficient people or systems dedicated to care coordination.
- Much of the time and labor that goes into care coordination is not reimbursed.

The article goes on to mention that electronic health records (EHRs) are helping to eliminate disconnects and discrepancies in patient records, but they don't provide the dynamic collaboration and communication capabilities needed to make collective decisions, fully orchestrate care and make sure all participants are informed and on the same page. In addition, while individual physicians do an admirable job attending to their areas of responsibility, there are gaps related to cross-functional connections and teamwork that the system cannot compensate for.

Consider reviewing the EHR used by your system for opportunities to maximize its use for improving communication during hand-offs and transitions between care providers and settings. Also, are there other opportunities to improve understanding for patients by improving health literacy and utilizing patient decision tools in your practice. Watch for more articles related to best practices and Blue Cross' efforts to help improve continuity and coordination of care for our members.

PHARMACY UPDATES

PHARMACY DRUG FORMULARY UPDATE FOR QUARTER 4, 2019

New $0 Insulin Member Cost-Share Benefit for Commercial Lines of Business

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) is committed to providing access to safe, quality, cost-effective health care. In response to the rising cost of insulin and as part of its broader efforts to reign in health care costs, Blue Cross is collaborating with our pharmacy benefit manager (PBM) Prime Therapeutics (Prime), to implement a new **$0 Insulin Member Cost-Share benefit** to help ensure our commercial members using insulin have continued access to affordable insulin therapy options.

Starting January 1, 2020, commercial members who have pharmacy coverage through Blue Cross will have Tier 1 and Tier 2 insulin brand options available with a $0 out-of-pocket benefit when the insulin is filled at an in-network pharmacy. Applicable network charges will apply when prescriptions are filled at an out-of-network pharmacy. The $0 Insulin Member Cost-Share benefit only applies to the cost of insulin, not diabetes supplies, such as: syringes, diabetic test strips, lancets, blood glucose monitors, continuous glucose monitors, continuous glucose monitoring systems for insulin pumps and associated supplies.

To review the list of insulin brands included in the $0 Insulin Member Cost-Share benefit, members are encouraged to contact Blue Cross Customer Service or search online. Starting December 1, 2019, members can log in to their Blue Cross online account to check their pharmacy benefit plan.

Products Impacted

The $0 Insulin Member Cost-Share benefit applies to Blue Cross members of eligible group plans that include:

- Individual and Family Plans (both on and off MNsure)
- Fully insured commercial small group and large group employer plans
- Minnesota HealthCare Consortium, also known as the Minnesota Service Cooperatives
- Self-insured groups – Only those groups that have decided to participate in the initiative

The Initiative does not impact Government Programs lines of business (Families and Children, MinnesotaCare (MNCare), and Minnesota Senior Care Plus (MSC+), and Minnesota Senior Health Options (MSHO) products), 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 pharmacy benefit formularies.

Other Formulary Updates & Link to Formulary Updates

As part of our continued efforts to evaluate and update our formularies, Blue Cross evaluates drugs on a regular basis. This evaluation includes a thorough review of clinical information, including safety information and utilization.

(continued on next page)

PHARMACY UPDATES

PHARMACY DRUG FORMULARY UPDATES (continued)

Blue Cross has developed several formularies based on each of our products and population requirements. A complete list of all formularies and updates can be found at the following web address:

Formularies:
https://www.bluecrossmn.com/providers

Under "TOOLS AND RESOURCES" select "Learn more" under "Formularies and drug programs." Next, select "Search a drug list." You will be prompted to select "yes" or "no" to the question on whether the member is a Medicare Part D member. Select "yes" if you wish to view formularies for Platinum Blue, SecureBlue or Medicare Advantage members. Select "no" for all other plans. Once you have selected the applicable pharmacy plan, under "helpful documents" select the documents titled "Drug list" or "Formulary updates" to review the applicable formulary.

PHARMACY UTILIZATION MANAGEMENT (UM) UPDATES

Blue Cross employs a variety of utilization management programs such as Prior Authorization, Step Therapy, and Quantity Limits. Blue Cross has implemented additional Prior Authorizations and Quantity Limits depending on the member's prescription drug benefit. Updates include new and changes to existing Prior Authorization (PA), Step Therapy (ST), and Quantity Limit (QL) programs. Quantity Limits apply to brand and generic agents.

New Prior Authorization with Quantity Limit Program Effective 10/1/19

BRAND NAME (generic name - if available)	**UM Program**		
ADYNOVATE® [**Antihemophilic Factor (Recombinant), PEGylated**] INJ	PA	QL	
AFSTYLA® [**Antihemophilic Factor (Recombinant), Single Chain**] KIT	PA	QL	
ALPROLIX™ [**Coagulation Factor IX (Recombinant), FC Fusion Protein**] INJ	PA	QL	
ELOCTATE® [**Antihemophilic Factor (Recombinant), Fc Fusion Protein**] INJ	PA	QL	
IDELVION® [**Coagulation Factor IX (Recombinant), Albumin Fusion Protein**] SOLUTION	PA	QL	
JIVI® [**Antihemophilic Factor (recombinant), PEGylated-aucl**] INJ	PA	QL	
REBINYN® [**Coagulation Factor IX (Recombinant), GlycoPEGylated**] SOLUTION	PA	QL	
TIGLUTIK™ (**riluzole**) SUS 50/10ML	PA	QL	
VASCEPA® (**icosapent ethyl**) CAP 0.5 gm, 1 gm	PA	QL	

PHARMACY UPDATES

PHARMACY UTILIZATION MANAGEMENT (UM) UPDATES (continued)

New Prior Authorization Program Effective 10/1/19

BRAND NAME (generic name - if available)	UM Program		
CRESEMBA® (**isavuconazonium sulfate**) INJ 372 mg	PA		
CRESEMBA® (**isavuconazonoim sulfate**) TAB 186 mg	PA		
NOXAFIL® (**posaconazole**) TAB 100 mg	PA		
NOXAFIL® (**posaconazole**) INJ 300/16.7	PA		
NOXAFIL® (**posaconazole**) SUSP 40 mg/ml	PA		
VFEND® (**voriconazole**) TAB 50 mg, 200 mg	PA		
VFEND® (**voriconazole**) IV INJ 200 mg	PA		
VFEND® (**voriconazole**) SUS 40 mg/ml	PA		

New Quantity Limit Program Effective 10/1/19

BRAND NAME (generic name - if available)	UM Program		
ALINIA® (**nitazoxanide**) TAB 500 mg		QL	
ALINIA® (**nitazoxanide**) SUS 100 mg/5 ml		QL	

Changes to Existing Utilization Management Programs, Effective 10/1/19

BRAND NAME (generic name - if available)	UM Program		
ADHANSIA™ XR (**methylphenidate**) CAP		QL	
CORLANOR® (**ivabradine**) SOLUTION 5 mg/ml	PA	QL	
EVEKO ODT™ (**amphetamine sulfate**) TAB		QL	
EZALLOR™ (**rosuvastatin**) SPRINKLE CAP		QL	ST
MAVENCLAD® (**cladribine**) PAK 10 mg		QL	ST
NUBEQA® (**darolutamide**) TAB 300 mg	PA	QL	
PIQRAY® (**alpelisib**) TAB 200 mg, 250 mg, 300 mg	PA	QL	
QTERN® (**dapagliflozin/saxagliptin**) TAB 5 mg		QL	
RUZURGI® (**amifampridine**) TAB 10 mg	PA	QL	
SYMDEKO® (**tezacaftor/ivacaftor**) TAB 50-75 mg	PA	QL	
TURALIO™ (**pexidartinib**) CAP 200 mg	PA	QL	
VYLEESI™ (**bremelanotide**) INJ 1.75/0.3	PA	QL	
XPOVIO™ (**selinexor**) PAK 60 mg, 80 mg, 100 mg	PA	QL	
ZELNORM™ (**tegaserod**) TAB 6 mg	PA		

Key for all the above tables:
PA=Prior Authorization; QL=Quantity Limit; ST=Step Therapy

Effective September 1, 2019

- Hepatitis C First Generation Agents Prior Authorization Program and Hepatitis C Second Generation Antivirals Prior Authorization Program will be combined into one program named Hepatitis C Antivirals Prior Authorization Program.

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PHARMACY UPDATES

PHARMACY UTILIZATION MANAGEMENT (UM) UPDATE (continued)

Effective October 1, 2019
- Topical Estrogens Quantity Limit Program will be discontinued for Commercial.
- Neprilysin (Entresto®) Prior Authorization Program will be discontinued for Commercial.
- Procysbi® Prior Authorization Program will be implemented for Commercial.

Effective October 15, 2019
- Egrifta® Prior Authorization with Quantity Limit Program will be implemented for Medicaid.

Effective November 1, 2019
- Egrifta® Prior Authorization with Quantity Limit Program will be implemented for Commercial.
- Tafamadis Prior Authorization with Quantity Limit Program will be implemented for Commercial and Medicaid.

Effective January 1, 2020
- Tadalafil Prior Authorization Program will be implemented for Commercial. Quantity limits will continue to apply.

A detailed list of all drugs included in these programs can be found at the following web address:

Utilization Management information: https://www.bluecrossmn.com/providers

Under "TOOLS AND RESOURCES" select "Learn more" under "Formularies and drug programs." Next, select "Search a drug list." You will be prompted to select "yes" or "no" to the question on whether the member is a Medicare Part D member. Select "yes" if you wish to view formularies for Platinum Blue, SecureBlue or Medicare Advantage members. Select "no" for all other plans. Once you have selected the applicable pharmacy plan, under "helpful documents" you will see documents titled "Utilization management." These will list all applicable drugs currently included in one of the above programs.

PHARMACY BENEFIT EXCLUSIONS

Blue Cross will no longer cover the following medications under the Commercial pharmacy benefit. Subscribers must use a medication alternative that is covered under the pharmacy benefit plan or pay full price for continued use of their current medication.

(continued on next page)

PHARMACY UPDATES

PHARMACY UTILIZATION MANAGEMENT (UM) UPDATES (continued)

Drug Name	Pharmacy Benefit Exclusion Effective Date for Commercial
BEPREVE® (**bepotastine besilate**) OPTH SOLUTION	10/1/2019
PAZEO® (**olopatadine hydrochloride**) OPTH SOLUTION	10/1/2019
PROAIR®DIGIHALER™ (**albuterol sulfate**)	10/1/2019
RASUVO® (**methotrexate**) AUTO-INJECTOR	10/1/2019

Due to their route of administration and/or clinician required administration, the following drugs will no longer be covered under the pharmacy drug benefit but may be covered and processed under the medical drug benefit. For drugs that require a prior authorization under the medical benefit, failure to obtain authorization prior to service will result in a denied claim and payment.

Drug Name	Pharmacy Benefit Exclusion Effective Date for Commercial
TESTOPEL® (testosterone) IMPLANT	8/23/2019

EXCEPTION REQUESTS

Prescribing providers may request coverage of a non-preferred drug for a Subscriber by completing the Minnesota Uniform Form for Prescription Drug Prior Authorization (PA) Requests and Formulary Exceptions. Subscriber liability for non-preferred drugs is subject to the Subscriber specific benefit design. You may find this form at the web address below:

Exception request: https://www.bluecrossmn.com/providers

Under "TOOLS AND RESOURCES" select "Learn more" under "Formularies and drug programs." Next, select "Search a drug list." You will be prompted to select "yes" or "no" to the question on if the member is a Medicare Part D member. Select "yes" if you wish to view formularies for Platinum Blue, SecureBlue or Medicare Advantage members. Select "no" for all other plans. Once you have selected the applicable pharmacy plan on the top bar of the web page, select "Forms" and then "Coverage Exception Form" or you may call Provider Services to obtain the documentation.

ADDITIONAL RESOURCES

For tools and resources regarding Pharmacy please visit our website at bluecrossmn.com and select "Shop Plans" and "Prescription Drugs." Tools include information on preventive drugs (if covered by plan), specialty drugs and other pharmacy programs. You will also be able to search for frequently asked questions and answers. Formulary updates are completed quarterly and posted online for review.

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PHARMACY UPDATES

PHARMACY UTILIZATION MANAGEMENT (UM) UPDATES (continued)

Additional information regarding Pharmacy is also located in the Provider Policy and Procedure Manual. To access the manual, go online to https://www.bluecrossmn.com/providers and select "Forms and Publications" then "Manuals." Topics in the manual include, but are not limited to, claims submission and processing, formulary exceptions, quantity limits and step therapy.

Similar Pharmacy Management for the Federal Employee Program (FEP) subscribers can be found online at https://www.fepblue.org. FEP subscribers have a different PBM (Caremark) and will have a different formulary list and procedures for prior authorizations and quantity limits than listed above. This information can be found by scrolling down to "Pharmacy Benefits" and selecting "Finding out more."

QUALITY IMPROVEMENTS

QUALITY OF CARE COMPLAINT REPORT

Your participating provider agreement with Blue Plus outlines the complaint procedure for primary care clinics. MN Rules 4685.1110 and 4685.1700-1900 outline the requirements of complaint collection and analysis of quality of care complaints for the Health Plan. Blue Plus requires providers to report these complaints quarterly. Reporting is required, even if there were no complaints during the reporting period.

Complaints should be submitted via secure email in a report format (e.g. Excel, csv).

Required data elements for the report are as follows:

- Member ID Number
- Patient Name
- Patient Date of Birth
- Date of Service / Incident
- Date Complaint Received by Provider
- Practitioner Named in Complaint
- Practitioner NPI
- Location of Service / Incident
- Summary of Complaint
- Categorizations Used to Classify Complaint
- Summary of Outcome / Resolution, including date

Submit report via secure email to: Quality.of.Care.Mailbox@bluecrossmn.com

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

MEDICAL AND BEHAVIORAL HEALTH POLICY ACTIVITY

Policies Effective: November 4, 2019 Notification Posted: September 3, 2019

Policies developed

- Bone Growth Stimulators for Non-Spinal Indications, II-110
- Brexanolone, II-231

Policies revised

- Microprocessor-Controlled Prostheses for the Lower Limb, VII-16
- Myoelectric Prosthetic and Orthotic Components for the Upper Limb, VII-60
- Bariatric Surgery, IV-19
- Tisagenlecleucel, II-183
- Cardiovascular Disease Risk Assessment and Management: Laboratory Evaluation of Non-Traditional Lipid and Nonlipid Biomarkers, VI-24

Policies inactivated

- None

Policies delegated to eviCore

- Proton Beam Radiation Therapy, V-20

Policies Effective: December 2, 2019 Notification Posted: October 1, 2019

Policies developed

- Humanitarian Use Devices, IV-11

Policies revised

- Tumor Treating Fields Therapy, II-164
- Immunoglobulin Therapy, II-51
- Plasma Exchange, II-192
- Certolizumab Pegol, II-179
- Infliximab, II-97
- Ustekinumab, II-168
- Golimumab, II-180
- Abatacept, II-161
- Tildrakizumab, II-222
- Tocilizumab, II-181
- Vedolizumab, II-182
- Wheelchairs and Options/Accessories, VII-04
- Romiplostim, II-211

(continued on next page)

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

MEDICAL AND BEHAVIORAL HEALTH POLICY ACTIVITY (continued)

Policies inactivated

- None

Policies delegated to eviCore

- None

Policies Effective: January 6, 2020 Notification Posted: November 1, 2019

Policies developed

- None

Policies revised

- Speech Generating Devices,(SGD), VII-52
- Eculizumab, II-196
- Botulinum Toxin, II-16
- Lyme Disease: Diagnostic Testing and Intravenous Antibiotic Therapy, II-165
- Ablation of Peripheral Nerves to Treat Pain, IV-130
- Intermittent Intravenous Insulin Therapy, II-189

Policies inactivated

- None

Policies delegated to eviCore

- Interspinous Process Spacers, IV-51

Policies reviewed with no changes in August, September, October 2019:

- Acupuncture, III-01
- Air Ambulance, II-160
- Artificial Retinal Devices, IV-154
- Autologous Hematopoietic Stem-Cell Transplantation for Malignant Astrocytomas and Gliomas, II-120
- Axial (Percutaneous) Lumbar Interbody Fusion, IV-91
- Axicabtagene Ciloleucel, II-187
- Bioengineered Skin and Soft Tissue Substitutes, IV-137
- Biofeedback, X-25
- Bronchial Thermoplasty, IV-117
- Burosumab, II-212
- Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting, II-43
- Computed Tomography Angiography (CTA) for Evaluation of Coronary Arteries, V-14
- Coverage of Routine Care Related to Clinical Trials, II-19

(continued on next page)

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

Policies reviewed with no changes in August, September, October 2019: (continued)

- Cranial Electrotherapy Stimulation, X-32
- Diagnosis and Treatment of Chronic Cerebrospinal Venous Insufficiency (CCSVI) in Multiple Sclerosis, II-155
- Edaravone, II-178
- Elosulfase Alfa, II-218
- Expanded Cardiovascular Risk Panels, VI-51
- Expanded Molecular Panel Testing of Solid Tumors, VI-49
- Facet Arthroplasty, IV-110
- Galsulfase, II-217
- Genetic Cancer Susceptibility Panels, VI-56
- Hematopoietic Stem-Cell Transplantation for Acute Lymphoblastic Leukemia, II-118
- Hematopoietic Stem-Cell Transplantation for Multiple Myeloma and POEMS Syndrome, II-138
- Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood, II-131
- Hematopoietic Stem-Cell Transplantation in the Treatment of Germ-Cell Tumors, II-114
- Hyperbaric Oxygen Therapy, II-04
- Hypnotherapy, III-02
- Idursulfase, II-215
- Implantable Middle Ear Hearing Aids (Semi-Implantable and Fully Implantable) for Moderate to Severe Sensorineural Hearing Loss, IV-37
- Intravenous Enzyme Replacement Therapy for Gaucher Disease, II-214
- Investigative Indications for Medical Technologies Which Are Not Addressed by a Specific Medical Policy, XI-01
- Laronidase, II-216
- Laser and Photodynamic Therapy for Onychomycosis, II-153
- Left Atrial Appendage Occluder Devices, II-73
- Mastopexy, IV-33
- Medical Necessity Criteria for Medical Technologies Which Are Not Addressed by a Specific Medical Policy, XI-02
- Nerve Fiber Density Measurement, II-177
- Ovarian and Internal Iliac Vein Embolization as a Treatment for Pelvic Congestion Syndrome, V-26
- Panniculectomy/Excision of Redundant Skin or Tissue, IV-24
- Percutaneous Ultrasonic Ablation of Soft Tissue, IV-160
- Pneumatic Compression Devices in the Outpatient or Home Setting, II-60
- Positron Emission Tomography (PET), V-27
- Prophylactic Mastectomy, IV-27
- Reduction Mammoplasty, IV-32
- Rituximab, II-47
- Sacroiliac Joint Fusion, IV-126
- Selected Treatments for Hyperhidrosis, II-55
- Single Photon Emission Computed Tomography (SPECT) for Mental Health Disorders, X-16
- Sublingual Immunotherapy Drops for Allergy Treatment, II-169
- Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease (GERD), II-31
- Vagus Nerve Blocking Therapy, IV-132
- Vagus Nerve Stimulation, IV-131
- Vestronidase Alfa, II-219
- Wound Healing: Electrostimulation and Electromagnetic Therapy, II-85

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

To access medical and behavioral health policies:
Medical and behavioral health policies are available for your use and review on the Blue Cross and Blue Shield of Minnesota website at https://www.bluecrossmn.com/healthy/public/personal/home/providers/medical-affairs/. From this site, there are two ways to access medical policy information depending on the patient's Blue Plan membership.

For out-of-area Blue Plan patients:
Under "Medical Policy and Pre-Certification/Authorization Router," click Go. You will be taken to the page where you select either medical policy or pre-certification/prior authorization and enter the patient's three-digit prefix as found on their member identification card and click Go. Once you accept the requirements, you will be routed to the patient's home plan where you can access medical policy or pre-certification/pre-authorization information.

For local Blue Cross and Blue Shield of Minnesota Plan patients:
Select "Medical policy" (under Tools & Resources), and then read and accept the Blue Cross Medical Policy Statement. You have now navigated to the Blue Cross and Blue Shield of Minnesota Medical Policy web page.

Click on the "+" (plus) sign next to "Medical and Behavioral Health Policies."
- The "Upcoming Medical Policy Notifications" section lists new or revised policies approved by the Blue Cross Medical and Behavioral Health Policy Committee. Policies are effective a minimum of 45 days from the date they were posted.
- The "Medical and Behavioral Health Policies" section lists all policies effective at the time of your inquiry.

Click on the "+" (plus) sign next to "Utilization Management."
- The Pre-Certification/Pre-Authorization/Notification lists identify various services, procedures, prescription drugs, and medical devices that require pre-certification/pre-authorization/notification. These lists are not exclusive to medical policy services only; they encompass other services that are subject to pre-certification/pre-authorization/notification requirements.

If you have additional questions regarding medical or behavioral health policy issues, call provider services at **(651) 662-5200** or **1-800-262-0820** for assistance.

Provider Press is posted on our website quarterly for business office staff of multi-specialty clinics, physicians, public health agencies, DME providers, chiropractors, podiatrists, physical therapists, occupational therapists, optometrists and behavioral health professionals/providers. Direct inquiries to:

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Editor: Holly Batchelder
P.O. Box 64560
St. Paul, MN 55164-0560
(651) 662-2014
toll free: 1-800-382-2000, ext. 22014

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Network Management R317
P.O. Box 64560
St. Paul, MN 55164-0560