PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

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

ADMINISTRATIVE UPDATES

Reminder: Medicare Requirements for Reporting Provider Demographic Changes
(article is published in every monthly Bulletin)

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

- Accepting new patients
- Demographic address and phone changes
- Office hours or other changes that affect availability
- Tax ID changes
- Practitioner additions or terminations
- Branch additions

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

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

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

CONTRACT UPDATES

Change in Liability for Members of Other Blue Plans (P7-21, published 2/1/21)

Services and items provided to members covered by a Blue Plan outside of Minnesota which require a prior authorization (PA) but for which a PA was not obtained will be denied as provider liability for claims processed April 19, 2021 and after. Prior to this date, these services would have denied as subscriber liability. If a claim denial is received for no PA for a member covered by another Blue Plan, providers may either submit a retro-authorization to the member's home plan or an appeal may be submitted to Blue Cross and Blue Shield of Minnesota following the standard appeals process.

This change applies to Commercial, Medicare, and Medicaid members of Blue Plans outside of Minnesota.

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

New Reimbursement Policy – Mohs-Micrographic Surgery (P8-21, published 2/1/21)

Effective April 1, 2021, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will implement a new Reimbursement Policy titled Mohs-Micrographic Surgery. The policy will be available in the provider section of the Blue Cross website located at **providers.bluecrossmn.com.** Go to the section titled, "Tools and Resources" and select "Reimbursement Policies".

This policy addresses the requirements for submitting Mohs Micrographic Surgery codes and the certification requirements for the performing physician.

Reminder Regarding Reimbursement Policies
Reimbursement policies are updated on an ongoing basis and used by Blue Cross to define if and how certain claims will be paid for various health services.

Products Impacted
- Fully and Self-Insured commercial lines of business
- Medicare Advantage plans

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

New Claim Edits for Professional Lab Claims Missing Required Data
(P9-21, published 2/1/21)

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be enforcing front-end edits for professional lab claims beginning April 1, 2021. These edits may result in rejected claims when specific, required provider information is missing. Updates to the Blue Cross reimbursement policy, "Laboratory Services-General Guides", provide additional clarity and will be published on February 1, 2021.

Background
- Blue Cross published Provider Bulletin P20-19 on February 1, 2019 providing the claim requirements for purchased labs.
- A Provider Quick Points (QP52-20) was published on June 10, 2020 to provide a reminder and additional education on lab claim submission requirements.
- Throughout 2019 and 2020, Blue Cross worked directly with providers that were billing incorrectly to correct their billing procedures.

Required Lab Claims Data beginning with claims received on or after April 1, 2021:

Referring (ordering) physician
All lab claims must contain referring (ordering) provider information to ensure that laboratory tests are ordered by a physician or other qualified healthcare practitioner. The following loop information is required on all laboratory services:
- Loop 2310A (Claim Level) or 2420F (Line Level), the provider name and the NPI (NM109) are required to be submitted.
  - If not present, reject code AP0058 will be assigned and the transaction will be sent back.

Claims containing modifier 90
Blue Cross allows for purchased lab services to be billed with a modifier 90. If a lab service is billed with a modifier 90, the following fields are required to be submitted on the claim:

- Service Facility Location Name - Loop 2310C (Claim Level) or 2420C (Line Level), the provider name and the NPI (NM109) are required to be submitted. If not present, reject code AP0059 will be assigned and the transaction will be sent back.
- Purchase Service Provider Name - Loop 2420B (Line Level only), the NM109 – NPI is required to be submitted.
    - If not present, reject code AP0060 will be assigned and the transaction will be sent back.

Phased Implementation of Edits:
The above edits will be rolled out in phases for claim submissions beginning on April 1, 2021.

Phase 1 (April 1, 2021) – High volume Genetic lab services

Phase 2 (April 15, 2021) – Remaining Genetic/Molecular services

Phase 3 (May 1, 2021) – All general lab services

Lines of business impacted:
Commercial (including FEP) and Medicare.

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

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATES

New Medical Policy IV-168: Hysterectomy Surgery for Non-Malignant Conditions

(P6-21, published 2/1/21)

Effective April 5, 2021, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will implement a new medical policy, IV-168: Hysterectomy for Non-Malignant Conditions.

Hysterectomies are one of the most frequently performed surgical procedures in the United States. National guidelines support the need for non-malignant hysterectomy in circumstances in which there has been a lack of response to conservative treatments. As an advocate for our members' health and health care dollars, Blue Cross is dedicated to ensuring that members receive medically necessary care at the right time and place. To that end, Blue Cross is committed to ensuring that non-malignant hysterectomies are supported by medical necessity guidelines. Non-malignant hysterectomies will be reviewed according to standards for medical necessity as published in the new medical policy.

On February 1, 2021, Blue Cross will begin reviewing historical medical records to inform providers which procedures would not meet medical necessity according to the upcoming medical policy criteria. Blue Cross will inform providers of procedures that will not meet medical necessity as of April 5, 2021. This information will be provided for educational purposes only, based on claims for dates of service between December 1, 2020 and March 31, 2021.

Beginning with April 5, 2021 dates of service, reimbursement will be recouped for hysterectomy surgeries for non-malignant conditions that do not meet the medical necessity criteria outlined in the new medical policy.

List of Impacted Procedures (Subject to change prior to 2/1/21)	
Procedure	**CPT Codes**
Hysterectomy Surgery for Non-Malignant Conditions	58150 58152 58180 58260 58262-58263 58267 58270 58275 58280 58290-58294 58541-58544 58550 58552-58554 58570-58573 59525

Products Impacted

All procedures included in the IV-168 medical policy will apply to the following Blue Cross products:

- Fully and Self-Insured commercial lines of business

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

Summary:

MEDICAL POLICY EFFECTIVE 4/5/21 (Commercial Fully Insured and Self-Insured)
• Non-malignant hysterectomies must meet medical necessity criteria defined in an upcoming medical policy to qualify for reimbursement. • Blue Cross will review outpatient non-malignant hysterectomy claims to determine if the services provided were in accordance with this new medical policy. • Payment for procedures that do not meet medical necessity will be recouped beginning with dates of service on or after April 5, 2021.

Questions?

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

New Medical, Medical Drug and Behavioral Health Policy Management Updates—Effective April 5, 2021 (P10-21, published 2/1/21)

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

As stewards of healthcare expenditures for our subscribers, we are charged with ensuring they receive the highest quality, evidence-based care. This is accomplished through expanded development of medical policies and through management of these policies to include the PA process. The primary purpose of the PA process is to ensure that evidence-based care is provided to our subscribers, driving quality, safety, and affordability.

The following prior authorization changes will be effective April 5, 2021:

Policy #	Policy Title/ Service	New Policy	Prior Authorization Requirement	Line(s) of Business
II-173	Accepted Indications for Medical Drugs Which Are Not Addressed by a Specific Medical Policy • Plasminogen (Ryplazim™)*	No	New	Commercial
L33394	Coverage for Drugs & Biologics for Label & Off-Label Uses: • Plasminogen (Ryplazim™)*	No	New	Medicare Advantage

* PA will be required upon FDA approval.

Products Impacted

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

Submitting a PA Request when Applicable

- **Providers may submit PA requests for any treatment in the above table starting March 29, 2021.**
- Providers must check applicable Blue Cross policy and **attach all required clinical documentation** with the PA request. PA requests will be reviewed when patient-specific, relevant medical documentation has been submitted supporting the medical necessity of the service**.** Failure to submit required information may result in review delays or a denial of the request due to insufficient information to support medical necessity. If a provider does not obtain the required PA before rendering services, Blue Cross will deny claims as provider liability for lack of prior authorization.
- PA approval will be based on the Blue Cross policy criteria. To review Blue Cross criteria:
  - Go to providers.bluecrossmn.com
  - Under Tools & Resources, select "Medical Policy", and read/accept the Blue Cross Medical Policy Statement
  - Select the "+" (plus) sign next to Medical and Behavioral Health Policies, then select "Blue Cross Blue Shield of Minnesota Medical Policies" to access policy criteria.
- Current and future PA requirements can be found using the *Is Authorization Required* tool in the Availity® portal prior to submitting a PA request. Prior Authorization Lists are also updated to reflect additional PA requirements on the effective date of the management change and includes applicable codes. To access the pdf Prior Authorization Lists for all lines of business:
  - Go to providers.bluecrossmn.com
  - Under Tools & Resources, select "Medical Policy", and read/accept the Blue Cross Medical Policy Statement
  - Select the "+" (plus) sign next to "Utilization Management" to access the Prior Authorization Lists.

- If a provider does not obtain the required PA before rendering services, Blue Cross will deny claims as provider liability for lack of prior authorization. The requirement applies to subscribers starting therapy and to those already being treated with a therapy noted above.

Prior Authorization Requests

- Participating providers must submit PA requests online via our free Availity® provider portal.
- For medical drugs, PA's can also be submitted using a NCPDP standard XML file feed to Blue Cross through CenterX, via an integrated Electronic Medical Record (EMR) system. To learn how to do this, providers should contact their EMR vendor for assistance.
- Out of state, non-contracted providers can submit a PA request to Blue Cross by either using the electronic processes above, the fax form located under the Forms & Publications section on the Blue Cross website, or their own PA form.

Note: An approved PA does not guarantee coverage under a subscriber's benefit plan. Subscriber benefit plans vary in coverage and some plans may not provide coverage for certain services discussed in the medical policies.

Reminder Regarding Medical Policy Updates & Changes:

Medical Policy changes are communicated in the Upcoming Medical Policy Notifications section of the Blue Cross Medical and Behavioral Health Policy website. The Upcoming Policies section lists new, revised, or inactivated policies approved by the Blue Cross Medical and Behavioral Health Policy Committee and are effective at minimum 45 days from the date they were posted. To access the website:

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

Questions?

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

MINNESOTA HEALTH CARE PROGRAMS (MHCP) UPDATES

Update: Updated Minnesota Health Care Programs and Minnesota Senior Health Options (MSHO) Prior Authorization and Medical Policy Requirements

(P93R1-20, published 2/1/21)

The information in this bulletin replaces Provider Bulletin P93-20 published December 1, 2020. A clarification has been made that prior authorization requirements for Berinert (C1 esterase inhibitor), Cinryze (C1 esterase inhibitor), and Ruconest (C1 esterase inhibitor) will be removed under the medical benefit, and these drugs should be referred to the pharmacy benefit plan. Kalbitor (ecallantide) will continue to require prior authorization under the medical benefit.

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

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

The following **new** policies and/or prior authorization requirements **will be applicable** to subscriber claims on or after **February 1, 2021**.

Policy #	Policy Name	New Policy	Prior Authorization Required	
			Medicaid	MSHO
MED.00134	Non-invasive Heart Failure and Arrhythmia Management and Monitoring System	Yes	No	No
SURG.00156	Implanted Artificial Iris Devices	Yes	No	No
SURG.00157	Minimally Invasive Treatment of the Posterior Nasal Nerve to Treat Rhinitis	Yes	No	No
ING-CC-0170	Uplizna (inebilizumab)	Yes	Yes	Yes
ING-CC-0172	Viltepso (viltolarsen)	Yes	Yes	Yes
ING-CC-0168	Tecartus (brexucabtagene autoleucel)	Yes	Yes	Yes
ING-CC-0171	Zepzelca (lurbinectedin)	Yes	Yes	Yes
ING-CC-0169	Phesgo (pertuzumab/trastuzumab/hyaluronidase-zzxf)	Yes	Yes	Yes
ING-CC-0179	Blenrep (belantamab mafodotin-blmf)	Yes	Yes	Yes
ING-CC-0180	Monjuvi (tafasitamab-cxix)	Yes	Yes	Yes

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

New Policy #	Prior Policy #	Policy Name	Prior Authorization Required	
			Medicaid	MSHO
ING-CC-0178	MHCP	Synribo (omacetaxine mepesuccinate)	Yes	Yes
ING-CC-0176	MHCP	Beleodaq (belinostat)	Yes	Yes
ING-CC-0175	MHCP	Proleukin (aldesleukin)	Yes	Yes
MHCP	ING-CC-0161	Sarclisa (isatuximab-irfc)	Yes	Yes
MHCP	ING-CC-0162	Tepezza (teprotumumab-trbw)	Yes	Yes
MHCP	ING-CC-0163	Durysta (bimatoprost implant)	Yes	Yes
MHCP	ING-CC-0165	Trodelvy (sacituzumab govitecan)	Yes	Yes
MHCP	ING-CC-0041	Ultomiris (ravulizumab-cwvz)	Yes	Yes

The following policies have changes in clinical criteria and **will be applicable** to subscriber claims on or after **February 1, 2021.**

Policy #	Policy Name	Prior Authorization Required	
		Medicaid	MSHO
ADMIN.00006	Review of Services for Benefit Determinations in the Absence of a Company Applicable Medical Policy or Clinical Utilization Management (UM) Guideline	No	No
CG-DME-44	Electric Tumor Treatment Field (TTF)	Yes	Yes
CG-MED-51	Three-Dimensional (3-D) Rendering of Imaging Studies	Yes	Yes
CG-MED-63	Treatment of Hyperhidrosis	Yes	Yes
CG-MED-69	Inhaled Nitric Oxide	No	No
CG-SURG-01	Colonoscopy	No	No
CG-SURG-15	Endometrial Ablation	No	No
CG-SURG-59	Vena Cava Filters	No	No
CG-SURG-83	Bariatric Surgery and Other Treatments for Clinically Severe Obesity	Yes	Yes
GENE.00052	Whole Genome Sequencing, Whole Exome Sequencing, Gene Panels, and Molecular Profiling	Yes	Yes
LAB.00011	Analysis of Proteomic Patterns	No	No
SURG.00077	Uterine Fibroid Ablation: Laparoscopic, Percutaneous, or Transcervical Image Guided Techniques	No	No
SURG.00112	Implantation of Occipital, Supraorbital, or Trigeminal Nerve Stimulation Devices (and Related Procedures)	No	No
SURG.00128	Implantable Left Atrial Hemodynamic Monitor	No	No
ING-CC-0132	Mylotarg (gemtuzumab ozogamicin)	Yes	Yes
ING-CC-0104	Levoleucovorin Agents	Yes	Yes
ING-CC-0094	Alimta (pemetrexed disodium)	Yes	Yes
ING-CC-0061	GnRH Analogs for the Treatment of Non-Oncologic Indications	Yes	Yes
ING-CC-0141	Off-Label Drug and Approved Orphan Drug Use	No	No
ING-CC-0021	Fabrazyme (agalsidase beta)	Yes	Yes
ING-CC-0017	Xiaflex (collagenase clostridium histolyticum)	Yes	Yes

Policy #	Policy Name	Prior Authorization Required	
		Medicaid	MSHO
ING-CC-0023	Naglazyme (galsulfase)	Yes	Yes
ING-CC-0024	Elaprase (idursulfase)	Yes	Yes
ING-CC-0025	Aldurazyme (laronidase)	Yes	Yes

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

Policy #	Policy Name	Prior Authorization Required	
		Medicaid	MSHO
MHCP	Hereditary Angioedema Agents (Berinert, Cinryze, Ruconest [C1 esterase inhibitor] only)	Yes	Yes
ING-CC-0035	Duopa (carbidopa and levodopa enteral suspension)	Yes	Yes
CG-SURG-74	Total Ankle Replacement	Yes	Yes
RAD.00062	Intravascular Optical Coherence Tomography (OCT)	No	No

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

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

OR

Go to **providers.bluecrossmn.com**

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

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

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

- Click on "Medical Policies and UM Guidelines"

OR

Go to **providers.bluecrossmn.com**

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

Where can I access medical policies?

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

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

- **Blue Cross Policies:**

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

- **Amerigroup Policies:**

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

  AND

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

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

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

Updated Preadmission Services for Inpatient Stays Reimbursement Policy for Minnesota Health Care Programs Members (P11-21, published 2/1/21)

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be publishing an updated Reimbursement Policy for Preadmission Services for Inpatient Stays effective April 1, 2021.

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

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

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

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

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

Early Intensive Developmental and Behavioral Intervention (EIDBI) Service Authorization for Minnesota Health Care Programs (P12-21, published 2/1/21)

As previously announced in Provider Bulletin P69-20, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will require the completed Individual Treatment Plan (ITP) form to be submitted as part of the initial, 6-month, and annual authorization requests for dates of service beginning November 1, 2020.

Effective April 1, 2021, Blue Cross will align with the MN Department of Human services Prior Authorization guidelines and use a 180-day time span for EIDBI service authorization requests. Requests that exceed 180 days will be reduced to meet the requirement.

Products Impacted
This information applies to the following Minnesota Health Care Programs:

- Families and Children (formerly Prepaid Medical Assistance Program)
- MinnesotaCare

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