PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

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ADMINISTRATIVE UPDATES

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

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

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

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

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

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

Hospital Transfer Notification Process for Load Leveling (P2-21, published 1/4/21)

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) is requesting that hospitals submit a notification via e-mail when receiving a transferred Blue Cross member due to load leveling at another hospital. The information provided will be used to ensure the highest level of benefits are provided to members if they are transferred to a hospital outside of their network and to identify ambulance transfers related to load-leveling. Additionally, the information will be used to update pre-certifications and pre-admission notifications to reduce the administrative burden on receiving hospitals. This notification process only applies to members with Blue Cross of Minnesota commercial or Medicare Advantage coverage.

Please send the following information to transfer.notification@bluecrossmn.com on an excel spreadsheet:

- Patient's Blue Cross Identification Number
- Patient First Name
- Patient Last Name
- Patient Date of Birth
- Patient Address
- Sending Facility Name
- Receiving Facility Name
- Receiving Facility Address
- Receiving Facility Phone Number
- Receiving Facility Fax Number
- Procedure Code (if applicable)

- Diagnosis Code
- Patient Transfer Date

You may submit a request to the above e-mail address to request a spreadsheet with the headers pre-populated.

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

CONTRACT UPDATES

Retro Reviews for Post-Acute Care and Home Health Prior Authorizations
(P1-21, published 1/4/21)

In order to best support coordination of care for our members, effective March 1, 2021 retrospective reviews for Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) Medicare Advantage members for Post-Acute Care and Home Health prior authorizations will be limited to 14 calendar days following the initial date of service.

Any authorization requests after 14 days will require the provider to submit a claim. When the claim is administratively denied for no PA, an appeal for medical necessity will not be accepted, but an administrative appeal may be submitted for limited situations. These exceptions are listed below, and must be supported by submitted documentation (Bulletin P35R1-19):

- Blue Cross is the subscriber's secondary coverage and PA is not required (e.g., Medicare is primary).
- Another insurance company is identified as the payer and a claim was submitted to the other payer within the timely filing guidelines with Blue Cross subsequently identified as the patient's primary coverage.
- The patient is identified as the payer and is billed for the service, but later the patient reports Blue Cross coverage for the date of service.
- The subscriber was enrolled in the plan retrospectively, after the service was provided.
- A previously prior-authorized service unexpectedly changed for medically necessary reasons, or it was determined that an unforeseen additional service was necessary.
- Extenuating circumstances beyond the control of the rendering provider or facility that make it impractical to obtain or validate the existence of a precertification of coverage prior to rendering the service (e.g., natural disaster or Availity outage).

Products Impacted
This change only applies to **Medicare Advantage** subscribers.

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

Annual Cultural Competency Training Requirement (P4-21, published 1/4/21)

Minnesota continues to be promoted as one of the healthiest states in the nation, but not all Minnesotans have the same opportunities to achieve good health. An important way to help is to improve our cultural competency awareness — the ability to understand, communicate with and effectively interact with people across different cultures.

To that end, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) requires that all contracted provider organizations complete an annual Cultural Competency Training. This data will be used in compliance with our Minnesota Health Care Program contracts with the Minnesota Department of Health which require that health plans must indicate in their provider directory whether a provider has completed Cultural Competency training.

To assist you in meeting this requirement, Blue Cross offers free of charge cultural competency training available on Availity.com.

1. Log in to the Availity portal at Availity.com

2. Select Payer spaces from the top navigation
3. Select BlueCross BlueShield Minnesota health plan from the Payer spaces menu
4. Select Access BCBSMN Learning and Development from the Resources tab
5. From the Training Opportunities dashboard, search for "Physician's Cultural Competency" course or navigate to it through Filters on the left

Additional Cultural Competency Training can be found on our Cultural competency web page located at: https://www.bluecrossmn.com/providers/education-center/cultural-competency-training-and-resources
Includes links to such things as Cultural Care Connection, My Diverse Patients site and Think Cultural Health site.

Once your organization has completed this training or if your organization already has completed other similar training, please place a checkmark next to the statement below and provide the identification information requested, so that the training can be appropriately reflected in the Blue Cross provider directory. Please return a copy of this Bulletin via fax to 651-662-6684 or send a scan of the Bulletin to Provider.Data@bluecrossmn.com.

Have the staff in your office completed cultural competency training in the past 12 months?
Yes____ No_____ If you answered 'yes', please provide month/year:___________
Legal Clinic Name___________________________________
DBA Name____
NPI____
Tax ID____
Address(s) of the location(s) that have completed the training *(This is especially important if several locations share the same NPI but not all locations have had the training)*

New Reimbursement Policy: Outpatient Services Prior to an Inpatient Admission

(P5-21, published 1/4/21)

Effective March 1, 2021, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will implement a new reimbursement policy, Outpatient Services Prior to an Inpatient Admission.

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

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

Starting with March 1, 2021 dates of service, Blue Cross will review outpatient diagnostic claims to determine if any services provided within 72 hours of an inpatient admission were inappropriately billed as a separate outpatient claim. Outpatient diagnostic services provided at a hospital that shares a Federal Tax ID with the admitting hospital should be submitted on the inpatient claim. Claims for facilities that share the same Federal Tax ID will be reviewed as a singular facility. Reimbursement for inaccurate claims will be recouped.

Products Impacted

- Fully and Self-Insured commercial lines of business
- Individual and Family plans
- Medicare Advantage plans

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

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

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

• **Chemotherapy and/or Outpatient Surgery:** These services should not be included on the inpatient claim as long as they are not performed on the same day of the inpatient admission. If they are performed on the same day as the inpatient admission, then they must be included on the inpatient claim.

• **Maternity Services:** Outpatient diagnostic and/or Emergency Department services provided in conjunction with a maternity related diagnosis prior to the inpatient admission should not be included on the inpatient claim.

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

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

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

Summary:

REIMBURSEMENT POLICY EFFECTIVE 3/1/21 (Commercial Fully Insured, Individual and Family, and Medicare Advantage plan members)
If an admitting hospital system provides outpatient diagnostic services within 72 hours of an inpatient admission, the services are considered inpatient services and must be included in the bundled inpatient bill. Blue Cross will review outpatient diagnostic claims to determine if the services provided were billed correctly and in accordance with this new reimbursement policy. Payment for inaccurate claims will be recouped.

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

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATES

eviCore Healthcare Specialty Utilization Management (UM) Program – Medical Oncology Drug Prior Authorization Updates for Fully Insured Commercial and Medicare Advantage Subscribers (P3-21, published 1/4/21)

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

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

Drug	Code(s)
Danyelza (naxitamab-gqgk)	C9399, J3490, J3590, J9999

The following oncologic drugs already require PA through eviCore's Medical Oncology program but will have the following code changes **effective February 20, 2021.**

Drug	Deleted/Discontinued Code(s)	Newly added Code(s)
Blenrep (belantamb mafodotin-blmf)		C9069
Darazalex Faspro (daratumumab and hyaluronidase-fihj)		J9144
Jelmyto (mitomycin)		J9281
Monjuvi (tafasitamab-cxix)		C9070
Nyvepria (pegfilgrastim-apgf)		Q5122
Phesgo (pertuzumab/trastuzumab/hyaluronidase-zzxf)		J9316
Trodelvy (sacituzumab govitecan-hziy)		J9317
Zepzelca (lurbinectedin)		J9223

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)
Dostarlimab	
Loncastuximab tesirine	Lonca
Margetuximab	
MSB11455	Stimufend
MYL-14020 (Avastin biosimilar)	
Rituximab-arrx	Riabni
Trilaiclib	

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

To view CPT Code lists:

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

To view Clinical Guidelines:

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

Products Impacted

This change only applies to:

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

Prior Authorization Look Up Tool

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

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

To access the Prior Authorization Look Up Tool:

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

To submit a Prior Authorization (PA) Request to eviCore

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

Instructions on how to utilize this portal are found on the Availity website. Providers should reference the eviCore clinical guideline criteria, submit prior authorization requests via Availity, and submit all applicable clinical documentation with the PA request. Failure to submit required information may result in review delays or denial of the request due to insufficient information.

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

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

Questions?

If you have questions and would like to speak to an eviCore representative call **844-224-0494**, 7:00 a.m. to 7:00 p.m. CST, Monday - Friday.

Update: eviCore Healthcare Specialty Utilization Management (UM) Program - Cardiology and Radiology Clinical Guideline Updates for Fully Insured Commercial and Medicare Advantage Subscribers (P81R1-20, published 1/4/21)

The information in this bulletin updates Provider Bulletin P81-20. The effective date for clinical guideline updates for the Cardiology and Radiology program is changing from January 1, 2021 to February 1, 2021.

eviCore has released clinical guideline updates for the Cardiology & Radiology program. Guideline updates that were communicated as becoming effective January 1, 2021 will not become effective until **February 1, 2021**:

Please review all guidelines when submitting a prior authorization request.

Guidelines with substantive changes:

- Abdomen Imaging Guidelines
- Breast Cancer Imaging Guidelines
- Cardiac Imaging Guidelines
- Chest Imaging Guidelines
- Cardiac Rhythm Implantable Device (CRID) Policy
- Musculoskeletal Imaging Guidelines
- Neck Imaging Guidelines
- Oncology Imaging Guidelines
- Pelvis Imaging Guidelines
- Peripheral Nerve Disorders (PND) Imaging Guidelines
- Peripheral Vascular Disease (PVD) Imaging Guidelines
- Spine Imaging Guidelines
- Pediatric Abdomen Imaging Guidelines
- Pediatric Cardiac Imaging Guidelines
- Pediatric Chest Imaging Guidelines
- Pediatric Musculoskeletal Guidelines
- Pediatric Neck Imaging Guidelines
- Pediatric Oncology Imaging Guidelines
- Pediatric Pelvis Imaging Guidelines
- Pediatric Peripheral Nerve Disorders (PND) Imaging Guidelines
- Pediatric Peripheral Vascular Disease (PVD) Imaging Guidelines
- Pediatric Spine Imaging Guidelines

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- 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: Cardiology)
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- Select the appropriate solution: i.e. Cardiology & Radiology
- 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

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