# PROVIDER BULLETIN
## PROVIDER INFORMATION

BlueCross BlueShield Minnesota

**WHAT'S INSIDE:** **June 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**

## Change to Medical Review Process for Outpatient Therapies Services

(P33-21, published 6/1/21)

As communicated in Provider Bulletin P34-19, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) has been managing outpatient therapies (physical, occupational, and speech therapy) for Medicare Advantage subscribers through retrospective medical necessity review at the point of claim processing.

Effective May 17, 2021, Blue Cross will no longer request records to complete medical necessity reviews for outpatient physical, occupational or speech therapy services at the point of claim processing. Prior authorization is not required for outpatient therapy services, and it is not necessary to submit a request for Organization Determination.

As stated in the *Provider Policy and Procedure Manual*:

- Providers should make sure they understand the applicable Medicare Advantage reimbursement rules (Section 7, Reimbursement for Medicare Advantage PPO, HMO, POS).
- Providers will be held financially liable for Health Services rendered that are determined to be not Medically Necessary during a review or an audit process, even if prior authorization and/or concurrent review is not recommended (Section 4, Provider Contractual Obligations – Important Program Points).

Blue Cross will continue to request records for retrospective medical necessity review for chiropractic claims submitted by providers who are not contracted with SecureCare (as previously communicated in P34-19).

**Products Impacted**

This information only applies to Medicare Advantage.

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

# MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATES

## Update: eviCore Healthcare Specialty Utilization Management Program – Medical Oncology Drug Prior Authorization Updates for Fully Insured Commercial and Medicare Advantage Subscribers (P3R1-21, published 6/1/21)

**The information in this Bulletin updates Provider Bulletin P3-21. On April 23, 2021, the FDA approved loncastuximab tesirine for use in the United States (US) under the brand name Zynlonta. The previous bulletin indicated Lonca 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) |
|---|---|
| Dostarlimab | |
| Loncastuximab tesirine | Zynlonta |
| 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: 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 the 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 **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.

## New Medical, Medical Drug and Behavioral Health Policy Management Updates—Effective August 2, 2021 (P34-21, published 6/1/21)

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 August 2, 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:<br>• Narsoplimab*<br>• Ranibizumab biosimilars*, including but not limited to SB11, FYB201, and Xlucane. | No | New | Commercial |
| II-210 | Fosdenopterin (Nulibry®) | Yes *(Moving from policy II-173)* | Continued | Commercial |
| II-154 | Hematopoietic Stem-Cell Transplantation for Waldenstrom Macroglobulinemia | No | Removed | Commercial/ Medicare Advantage |
| L33394 | Coverage for Drugs & Biologics for Label & Off-Label Uses:<br>• Anifrolumab*<br>• Eteplirsen (Exondys 51™)<br>• Narsoplimab*<br>• Ranibizumab biosimilars*, including but not limited to SB11, FYB201, and Xlucane.<br>• Teplizumab* | No | New | Medicare Advantage |
| II-184 | Alemtuzumab (Lemtrada™) | No *(Moving from LCD L33394)* | Continued | Medicare Advantage |
| II-178 | Edaravone (Radicava®) | No *(Moving from LCD L33394)* | Continued | Medicare Advantage |
| II-240 | Eptinezumab (Vyepti™) | No *(Moving from LCD L33394)* | Continued | Medicare Advantage |
| II-49 | Natalizumab (Tysabri®) | No *(Moving from LCD L33394)* | Continued | Medicare Advantage |
| II-185 | Ocrelizumab (Ocrevus®) | No *(Moving from LCD L33394)* | Continued | Medicare Advantage |
| Medicare, II-08 | Dermabrasion/ Chemical Exfoliation | No | Removed | Medicare Advantage |
| II-190 | Transcatheter Arterial Chemoembolization (TACE) to Treat Primary or Metastatic Liver Malignancies | No | Removed | 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 July 26, 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 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?**
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## eviCore Healthcare Specialty Utilization Management (UM) Program – Medical Oncology Drug Prior Authorization Updates for Fully Insured Commercial and Medicare Advantage Subscribers (P35-21, published 6/1/21)

eviCore has released clinical guideline updates for the Medical Oncology Program. The guideline updates will become **effective August 1, 2021**.

**Guideline with changes:**

- Oncology Medication Policy

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) |
|---|---|
| eflapegrastim | ROLONTIS |
| SH-111 | |

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

(P36-21, published 6/1/21)

Effective August 2, 2021, 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 Upper & Lower Gastrointestinal Endoscopy 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.

***Providers that are exempt from this policy for previously added GI codes will automatically be exempt from the policy as it applies to these two additional codes. The exemption list and additional details about this medical policy can be found HERE.***

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.

Providers should check the subscriber's benefits to confirm the **in-network** site of service.

**List of Impacted Procedures Added to Medical Policy (Commercial and Minnesota Health Care Programs, effective August 2, 2021):**

| **GI** | |
|---|---|
| **Procedure** | **CPT Codes** |
| Upper & Lower Gastrointestinal Endoscopy | G0105, G0121 |

**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 (MHCP) subscribers to Families and Children (formerly Prepaid Medical Assistance Program) and MinnesotaCare (MNCare).

**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 **1-866-518-8448** for MHCP Members.