PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

WHAT'S INSIDE:

March 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

Delay of New Reimbursement Policy: Outpatient Services Prior to an Inpatient Admission (P5R1-21, published 3/1/21)

Blue Cross and Blue Shield of Minnesota (Blue Cross) has made the decision to delay the implementation of the 'Outpatient Services Prior to an Inpatient Admission' reimbursement policy. A new Provider Bulletin will be published when Blue Cross has additional details, including an updated effective date for this policy.

Below is the information that was previously published in Provider Bulletin P5-21:

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

New Medical, Medical Drug and Behavioral Health Policy Management Updates—Effective May 3, 2021 (P14-21, published 3/1/21)

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 May 3, 2021:

Policy #	Policy Title/ Service	New Policy	Prior Authorization Requirement	Line(s) of Business
II-248	Lumasiran (Oxlumo®)	Yes *(Replacing policy II-173)*	Continued	Commercial
II-173	Accepted Indications for Medical Drugs Which are not Addressed by a Specific Medical Policy • Fosdenopterin*	No	New	Commercial
L33394 (A52452)	Coverage for Drugs & Biologics for Label & Off-Label Uses: • Rituximab-arrx (Riabni™)	No	New *(Adding PA for non-oncologic conditions)*	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 April 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 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

Updated Minnesota Health Care Programs and Minnesota Senior Health Options Prior Authorization and Medical Policy Requirements (P13-21, published 3/1/21)

Effective May 3, 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, MinnesotaCare and Minnesota Senior Care Plus) and Minnesota Senior Health Options (MSHO) products.

As stewards of healthcare expenditures for our members, 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 member claims on or after **May 3, 2021**.

Policy #	Policy Name	New Policy	Prior Authorization Required	
			Medicaid	MSHO
CG-LAB-15	Red Blood Cell Folic Acid Testing	Yes	No	No
CG-LAB-16	Serum Amylase Testing	Yes	No	No
GENE.00055	Gene Expression Profiling for Risk Stratification of Inflammatory Bowel Disease (IBD) Severity	Yes	No	No
LAB.00037	Serologic Testing for Biomarkers of Irritable Bowel Syndrome (IBS)	Yes	No	No
SURG.00158	Implantable Peripheral Nerve Stimulation Devices as a Treatment for Pain	Yes	No	No
ING-CC-0181	Veklury (remdesivir)	Yes	No	No
ING-CC-0185	Oxlumo (lumasiran)	Yes	Yes	Yes
ING-CC-0184	Danyelza (naxitamab-gqgk)	Yes	Yes	Yes
ING-CC-0177	Zilretta (triamcinolone acetonide extended-release)	Yes	Yes	Yes

The following policies have changes in clinical criteria and **will be applicable** to member claims on or after **May 3, 2021**.

Policy #	Policy Name	Prior Authorization Required	
		Medicaid	MSHO
ADMIN.00001	Medical Policy Formation	No	No
ANC.00009	Cosmetic and Reconstructive Services of the Trunk and Groin	Yes	Yes
CG-GENE-18	Genetic Testing for TP53 Mutations	Yes	Yes
CG-GENE-20	Epidermal Growth Factor Receptor (EGFR) Testing	No	No
CG-LAB-14	Respiratory Viral Panel Testing in the Outpatient Setting	No	No
CG-MED-38	Inpatient Admission for Radiation Therapy for Cervical or Thyroid Cancer	No	No
CG-MED-53	Cervical Cancer Screening Using Cytology and Human Papillomavirus Testing	No	No
CG-MED-59	Upper Gastrointestinal Endoscopy in Adults	Yes	Yes
CG-MED-87	Single Photon Emission Computed Tomography Scans for Noncardiovascular Indications	Yes	Yes
CG-SURG-94	Keratoprosthesis	Yes	Yes
DME.00011	Electrical Stimulation as a Treatment for Pain and Other Conditions: Surface and Percutaneous Devices	No	No

Policy #	Policy Name	Prior Authorization Required	
		Medicaid	MSHO
GENE.00052	Whole Genome Sequencing, Whole Exome Sequencing, Gene Panels, and Molecular Profiling	Yes	Yes
MED.00116	Near-Infrared Spectroscopy Brain Screening for Hematoma Detection	No	No
SURG.00011	Allogeneic, Xenographic, Synthetic and Composite Products for Wound Healing and Soft Tissue Grafting	Yes	Yes
SURG.00062	Vein Embolization as a Treatment for Pelvic Congestion Syndrome and Varicocele	No	No
SURG.00145	Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts)	Yes	Yes
ING-CC-0059	Selected Injectable NK-1 Antiemetic Agents	Yes	Yes
ING-CC-0056	Selected Injectable 5HT3 Antiemetic Agents	Yes	Yes
ING-CC-0148	Agents for Hemophilia B	Yes	Yes
ING-CC-0149	Select Clotting Agents for Bleeding Disorders	Yes	Yes
ING-CC-0065	Agents for Hemophilia A and von Willebrand Disease	Yes	Yes
ING-CC-0150	Kymriah (tisagenlecleucel)	Yes	Yes
ING-CC-0151	Yescarta (axicabtagene ciloleucel)	Yes	Yes
ING-CC-0001	Erythropoiesis Stimulating Agents	Yes	Yes
ING-CC-0121	Gazyva (obinutuzumab)	Yes	Yes
ING-CC-0002	Colony Stimulating Factor Agents	Yes	Yes
ING-CC-0003	Immunoglobulins	Yes	Yes
ING-CC-0039	GamaSTAN immune globulin (human)	Yes	Yes
ING-CC-0073	Alpha-1 Proteinase Inhibitor Therapy	Yes	Yes
ING-CC-0075	Rituximab Agents for Non-Oncologic Indications	Yes	Yes
ING-CC-0019	Zoledronic Acid Agents (Reclast, Zometa)	Yes	Yes
ING-CC-0058	Ocreotide Agents	Yes	Yes

MCG Care Guidelines 24th Edition

Effective **May 3, 2021**, the following MCG Care Guideline 24th edition customizations will be implemented:

- Gastrointestinal Bleeding, Upper Gastrointestinal Bleeding (W0170) – Revised the criteria for Clinical Indications for Admission to Inpatient Care and added reference and footnote.
- Gastrointestinal Bleeding, Upper: Observation Care (W0171) – Revised Observation Care Admission Criteria

To view the summary of the MCG Care Guidelines 24th Edition customizations, select this **link.**
Customizations to MCG Care Guidelines 24th Edition (publish date May 3, 2021).

For questions, please contact the Provider Services number on the back of the member's ID card.

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 Blue Cross Provider Services at **1-866-518-8448**.

Update: Change in Requirements for Newborn Precertification Process for Minnesota Health Care Programs (P15R2-20, published 3/1/21)

This bulletin communicates the requirement for a precertification request for newborns and updates Provider Bulletin P15R1-20, published on October 1, 2020.

As previously communicated, effective April 1, 2020, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) requests that providers submit the Newborn Notification of Delivery Form when submitting the mother's inpatient precertification request. Blue Cross uses this information to offer the member additional resources as quickly as possible after delivery.

The Newborn Notification of Delivery Form information is included in the online (Interactive Care Reviewer) submission of the mother's precertification request. Providers that submit the precertification via ICR are not required to submit a separate Newborn Notification of Delivery form.

Providers have an option to submit the request for the mother's inpatient admission by faxing the request to **1-844-480-6839**. If the information for the Newborn Notification of Delivery form is not initially available, providers may include it when submitting discharge documentation.

Forms are available on the website at **https://provider.publicprograms.bluecrossmn.com/minnesota-provider/home** in the 'Forms' section.

Healthy newborn services will continue to be allowed under the mother's inpatient precertification.

What is changing?
Effective May 1, 2021, facilities are required to submit a separate precertification request for any newborn that remains hospitalized greater than 96 hours regardless of the Nursery Level for the newborn's stay (All Nursery Levels as represented by revenue codes 0170-0174 and 0179).

Effective May 1, 2021 a separate precertification request will be required for any newborn in a Level II, Level III, or Level IV Nursery regardless of length of stay as represented by revenue codes 0172-0174. Any newborn that will require care beyond a Level I newborn, must have a separate, individual precertification submitted as soon as the provider is aware of the newborn's condition, including upon birth. The request must be submitted via fax or by phone and providers should note that the Minnesota Personal Master Index number (PMI or Medicaid number) is not yet available from the Minnesota Department of Human Services (DHS). Completed newborn precertification forms should be faxed to **1-800-964-3627**.

Newborn claims should not be submitted until DHS has enrolled the newborn and will not be processed until Blue Plus receives the newborn's enrollment information from DHS and the baby is active in our system.

Newborns of mothers enrolled in Blue Advantage Families and Children (F&C) or Blue Plus MinnesotaCare are automatically enrolled in Blue Plus for the calendar month of the birth only. It is important that the mother notify her local agency of the birth of her child as soon as possible following the birth for the enrollment process to begin (if enrolled in F&C or MinnesotaCare).

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

- Families and Children (F&C)
- MinnesotaCare (MNCare)

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