PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

WHAT'S INSIDE: **November 2, 2020**

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**

Update: CERiS Review of High Dollar Claims (P49R1-20, published 11/2/20)

The information in this Bulletin updates Provider Bulletin P49-20.

Effective January 1, 2021, the Blue Cross Blue Shield Association (BCBSA) is changing the mandate to review high dollar institutional claims from $200,000 to $100,000.

As previously communicated, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) has engaged CERiS for itemized bill review of high dollar institutional claims. Effective September 1, 2020, CERiS started performing a review and comparative analysis of itemized billing statements against national and Blue Cross payment standards. This includes a review of charge utilization, appropriateness of charges and billing behavior to verify accurate reimbursement of claims.

Out-of-state members

Facility claims dated 9/1/20 through 12/31/20:
Facility claims that are reimbursed under a percent of charge methodology allowing $200,000 or greater will be reviewed on a pre-payment basis with the exception of Medicare Advantage groups. Medicare Advantage groups will be reviewed based on $200,000 charge rather than allowed amount.

Effective January 1, 2021, facility claims that are reimbursed under a percent of charge methodology allowing $100,000 or greater will be reviewed on a pre-payment basis with the exception of Medicare Advantage groups. Medicare Advantage groups will be reviewed based on $100,000 charge rather than allowed amount.

Blue Cross requests that the itemized bill be attached to the claim submission. If the itemized bill is not attached, CERiS will reach out to obtain the itemized bill. Upon receipt of the itemized bill from the provider, a line-item review will be conducted to determine charges that are appropriately billed. All appropriately billed charges will be processed, and in the majority of cases, charges found to be inappropriately billed will be denied as **CO 97 - M80: These charges are not covered. This service is considered part of another service.**

Minnesota members
Facility claims dated 9/1/20 through 12/31/20:
Facility claims that are reimbursed under a percent of charge methodology allowing $200,000 or greater will be reviewed on a post-payment basis.

Effective January 1, 2021, facility claims that are reimbursed under a percent of charge methodology allowing $100,000 or greater will be reviewed on a post-payment basis.

Blue Cross requests that the itemized bill be attached to the claim submission. If the itemized bill is not attached, CERiS will reach out to obtain the itemized bill. Upon receipt of the itemized bill from the provider, a line-item review will be conducted to determine charges that are appropriately billed. All appropriately billed charges will be processed, and in the majority of cases, charges found to be inappropriately billed will be denied as **CO 97 - M86: This service is considered to be an integral part of another service. Therefore, a separate payment cannot be made for this service.**

When the requested itemized bill cannot be obtained by CERiS within 7 to 10 days, the claim will be denied as **CO 252 - N26 In order to process this claim, additional information is required.** The claim should be resubmitted with an itemized bill for each date of service reported. Electronically enabled providers should resubmit electronically.

A findings letter will be sent to the provider upon completion of the review and adjudication of the claim. The standard appeal process should be used to dispute these reviews.

Minnesota Health Care Programs
Facility claims paid under APR-DRG methodology with a calculated outlier payment of $2,500 or greater will be reviewed. The calculated reimbursement for the base APR-DRG allowed will be reimbursed to the provider with one of the following remark codes:

- **(OA 133) Cost outlier calculated outlier charges under payment review.** This remark code will be included if the itemized bill has already been received from the provider. A line-item review will be conducted for the remaining outlier charges to determine that the charges were appropriately billed.
- When the requested itemized bill cannot be obtained by CERiS within 7 to 10 days, the outlier portion of the claim will be denied as **(CO 95*)* Base DRG Pymt made. For outlier review submit itemized bill to CERiS.** A line-item review will be conducted to determine that the charges were appropriately billed once received.
- Once the line-item review of the submitted itemized bill is completed, the outlier allowed will then be processed, excluding any charges determined to be billed in error, and any additional reimbursement will be released. The remark code on the final outlier payment will be **(CO 45) – Paid per CERiS review**.

Interim claims (discharge status 30) with billed charges of $25,000 or more will be reviewed. If an itemized bill has already been received, the remark code will be **(OA 133) Cost outlier calculated outlier charges under payment review**; otherwise, the provider will receive the remark code **(CO 252) Please submit with itemized bill for CERiS review.**

General information
Providers submitting claims that qualify for review are encouraged to submit the itemized bill as an attachment to the claim to expedite processing. A findings letter will be sent to the provider upon completion of the review and adjudication of the claim. The standard appeal process should be used to dispute these reviews.

2021 Medicare Product Acupuncture Benefit Changes (P77-20, published 11/2/20)

Beginning January 1, 2021, two separate benefits, with separate accumulations, will apply to acupuncture services provided to subscribers enrolled with a Medicare Advantage or Platinum Blue (Medicare Cost) plan.

Medicare Eligible Benefit
The Centers for Medicare & Medicaid (CMS) announced that acupuncture for low back pain is a covered benefit beginning in January 2020. Twenty acupuncture (20) visits are covered within a rolling 12-month period. Acupuncture services will only be allowed if billed for diagnosis codes listed in NCD 30.3.3. Providers must accurately point the correct diagnosis to each claim line for dates of service in 2021 to apply the appropriate benefit. Acupuncture services pointed to pain diagnoses other than those in NCD 30.3.3 will process under the Supplemental Benefit described below.

Supplemental Benefit
Blue Cross and Blue Shield of Minnesota (Blue Cross) will offer a supplemental benefit for acupuncture services for physical pain diagnoses other than low back pain. Acupuncture services for diagnoses unrelated to physical pain will not be covered. Providers must accurately point the correct diagnosis to each claim line for dates of service in 2021 to apply the appropriate benefit. This benefit is limited to 20 visits per calendar year.

Reimbursement Allowance
The reimbursement for *Medicare eligible* acupuncture for *Medicare Advantage* plans will be as follows:

- Professional claim: the contracted Medicare fee schedule allowance
- Facility claim: contracted Medicare allowance

The reimbursement for *non-Medicare eligible* acupuncture for *Medicare Advantage* plans will be as follows:

- Professional claim: the contracted Medicare fee schedule allowance
- Facility claim: 35% of billed charges based on the provider billing the usual and customary charge

The reimbursement for *Medicare eligible* acupuncture for *Platinum Blue (Medicare Cost)* plans will be as follows:

- Professional claim: the contracted Medicare fee schedule allowance
- Facility claim: Medicare is primary, Blue Cross will coordinate based on Medicare processing

The reimbursement for *non-Medicare eligible* acupuncture for *Platinum Blue (Medicare Cost)* plans will be as follows:

- Professional claim: the contracted commercial fee schedule allowance
- Facility claim: 100% of billed charges based on the provider billing the usual and customary charge

Eligible providers
Must be under supervision of a licensed Physician; Independent Acupuncturists are not covered. Physicians *as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements.*

Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:

- a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and,
- a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia.

- Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.

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

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATES

Reminder: New Prior Authorization Timeframes Required by Legislation (P78-20, published 11/2/20)

As previously announced, the Minnesota legislature passed legislation (see amendments to Minnesota Statutes, Chapter 62M (2020 Minnesota Laws, Chapter 114) that requires prior authorization review timeframes to change effective January 1, 2021 for subscribers with **commercial fully insured and state-regulated self-funded commercial coverage**. Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) continues to evaluate current prior authorization processes to meet these requirements in a way that ensures a standardized, simplified process for providers and commercial subscribers.

New prior authorization requirements beginning January 1, 2021 include:

- Electronically submitted prior authorizations must have a decision communicated no later than 5 business days after receipt
- Prior authorizations submitted by phone, fax or mail must have a decision communicated no later than 6 business days after receipt
- Urgent prior authorizations must have a decision communicated within 48 hours of receipt or the end of the first business day after receipt of the initial request, whichever is later
- Denials of prior authorizations for medical health services must be determined by a like-specialty reviewer
- Pre-service appeals of denied prior authorizations must have a decision communicated no later than 15 calendar days after receipt

Prior Authorization and Pre-Service Appeals Best Practices to Meet New Timeframes
In order to meet these new timeframes, Blue Cross asks that providers strive to submit all of the necessary clinical information at the time of submission and return any additional requested information in an expedited manner.

- Submit prior authorizations for medical services/drugs using the Availity application.
- All medical prior authorization requests must be submitted with clinical records supporting the requirements found in the applicable Blue Cross medical policy or eviCore clinical guideline. Blue Cross medical policies include a "Documentation Submissions" section which outlines additional documents that must be submitted, when applicable.
- For inpatient hospital admission authorization requests, please be sure to include any information supporting the need for acute inpatient level of care, including the patient's History & Physical and physician notes and any other relevant clinical information, such as emergency department, nursing and therapy notes, diagnostic test results, lab results, patient monitoring plan, medications and treatment plan.
- For Blue Cross subscribers who have pharmacy benefits through Blue Cross, pharmacy benefit drug prior authorization requests can be submitted through CoverMyMeds's (CMM) free web portal or by sending an electronic NCPDP file to Prime through an integrated Electronic Medical Record (EMR) system during the e-prescribing process.
- When submitting an appeal for a denied prior authorization, clearly identify on the fax cover sheet that the submitted document is a "Pre-Service Appeal".

Products Impacted
This change applies only to subscribers with commercial fully insured and commercial self-insured state-regulated coverage. This change does not apply to Federal Employee Program (FEP), Medicare subscribers, or Minnesota Health Care Programs subscribers.

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

Change in Medical Necessity Criteria to InterQual® for Substance Use Disorder Admissions (P79-20, published 11/2/20)

Effective January 4, 2021, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will use InterQual® criteria to determine the medical necessity of prior authorization requests for substance use disorder admissions. Blue Cross will no longer use American Society of Addiction Medicine (ASAM) Criteria for medical necessity determinations. There are no changes to the substance use disorder admissions that require prior authorizations.

To access the Prior Authorization Lists, follow the steps below.

1. Access the 'Provider Section' of the Blue Cross website at **providers.bluecrossmn.com**
2. Under 'Tools and Resources' select 'Medical policy' then acknowledge the Acceptance Statement.
3. Click on the '+' next to 'Utilization Management' and select the appropriate "Pre-Certification/Pre-Authorization/Notification List"

InterQual® criteria are available upon request.

Products Impacted
This information applies to all commercial and Medicare Advantage lines of business.

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 January 4, 2021 (P80-20, published 11/2/20)

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 January 4, 2021:

Policy #	Policy Title/ Service	New Policy	Prior Authorization Requirement	Line(s) of Business
IV-169 (*replacing II-73*)	Left Atrial Appendage Occluder Devices	No	New	Commercial
NCD 20.34	Percutaneous Left Atrial Appendage Closure (LAAC)	No	New	Medicare Advantage

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 December 28, 2020.**
- 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**.

eviCore Healthcare Specialty Utilization Management (UM) Program - Cardiology and Radiology Clinical Guideline Updates for Fully Insured Commercial and Medicare Advantage Subscribers (P81-20, published 11/2/20)

eviCore has released clinical guideline updates for the Cardiology & Radiology program. Guideline updates will become **effective January 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

Prior authorization requests will be reviewed based on eviCore clinical guideline criteria. Providers can view the list of Current Procedural Terminology (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: Cardiology)
- 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 upper right corner
- Click “**Clinical Guidelines**”
- 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

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 **Authorizations & 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 the 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.

As a reminder, 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 is Changing Prior Authorization Guidelines used to Review Durable Medical Equipment and Post-Acute Care Services (Home Health Care, Inpatient Rehabilitation Facility, Long Term Acute Care Facility and Skilled Nursing Facility) for Medicare Advantage Subscribers (P50R2-20, published 11/2/20)

To help ensure our members receive the highest quality of evidence-based care, eviCore will transition to using Milliman Care Guidelines for Durable Medical Equipment (DME) and Post-Acute Care (PAC) services (Home Health Care, Inpatient Rehabilitation Facility, Long Term Acute Care Facility and Skilled Nursing Facility Services).

In addition, Provider Bulletin P50R1-20 is being updated by changing the effective date from November 1, 2020 to January 1, 2021 for implementation of Milliman Care Guidelines for Durable Medical Equipment, Home Health Care (HHC), Inpatient Rehabilitation Facility (IRF), Long Term Acute Care Facility (LTAC) and Skilled Nursing Facility (SNF) services.

eviCore will begin applying Milliman Care Guidelines to the following services effective January 1, 2021:

- Durable Medical Equipment
- Home Health Care
- Inpatient Rehabilitation Facility
- Long Term Acute Care Facility
- Skilled Nursing Facility

Prior authorization requests will be reviewed based on eviCore clinical guideline criteria. Providers can view the list of Current Procedural Terminology (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: Cardiology)
- 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 upper right corner
- Click "**Clinical Guidelines**"
- 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

Products Impacted
This change only applies to 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 **Authorizations & Referrals**, then **Authorizations**
3. Select Payer **BCBSMN**, your Organization, Transaction Type **Outpatient** and you will be redirected to the Authorization Look Up Tool application

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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.

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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 (P82-20, published 11/2/20)

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 drugs have been added to the Medical Oncology program and will require prior authorization **for oncologic reasons beginning February 1, 2021**:

Generic Name	Brand Name	Code(s)
mitomycin	JELMYTO	C9064, C9399, J9999
romidepsin non-lypohilized		C9065
pemetrexed	PEMFEXY	J9304

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 the 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?

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eviCore Healthcare Specialty Utilization Management (UM) Program - Laboratory Management Clinical Guideline Updates for Fully Insured Commercial and Medicare Advantage Subscribers (P83-20, published 11/2/20)

eviCore has released clinical guideline updates for the Lab Management program. Guideline updates will become **effective January 1, 2021**:

Please review all guidelines when submitting a prior authorization request.

New guidelines:

- Chromosomal Microarray for Solid Tumors
- In-vitro Testing for HIV
- In-vitro Testing for SARS-CoV-2 (COVID-19)
- Lyme Disease Testing
- Medically Necessary Laboratory Testing
- Microsatellite Instability and Immunohistochemistry Testing in Cancer

Guidelines with substantive changes:

- BRCA Analysis
- BRCA Ashkenazi Jewish Founder Mutation Testing
- Decipher Prostate Cancer Classifier
- Exome Sequencing
- Genetic Testing for Autism
- Genetic Testing to Diagnose Non-Cancer Conditions
- Genitourinary Conditions Molecular Testing
- Hereditary Cancer Syndrome Multigene Panels
- HLA Typing for Celiac Disease
- Investigational and Experimental Molecular/Genomic
- Laboratory Claim Reimbursement
- Li-Fraumeni Syndrome Testing
- Liquid Biopsy Testing – Solid Tumors
- Long QT Syndrome Testing
- Mammaprint 70. Gene Breast Cancer Recurrence Assay
- Multiple Endocrine Neoplasia Type 2 (MEN2)
- myChoice CDx
- Pharmacogenomic Testing for Drug Toxicity and Response
- Somatic Mutation Testing – Hematological Malignancies
- Somatic Mutation Testing – Sold Tumors
- Tay-Sachs Disease Testing

Prior authorization requests will be reviewed based on eviCore clinical guideline criteria. Providers can view the list of Current Procedural Terminology (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 the 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.

Predetermination Request Form for Commercial Lines of Business (P84-20, published 11/2/20)

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) makes every effort to help our subscribers access safe, timely, and affordable care that is medically necessary and appropriate using evidence-based criteria. Services that require prior authorization (PA) can be found on **bluecrossmn.com/providers** and on the "Is Authorization Required" tool in the Availity® portal prior to submitting a PA request.

Effective January 1, 2021, Blue Cross will no longer be accepting predetermination requests for services that do not require PA, unless the service warrants a clinical review for medical necessity based on extenuating circumstances.

Requests that are received through either Availity or fax will be sent back if a PA is not required. If there is an existing medical policy for a service, but PA is not required, providers will be directed back to Blue Cross medical policies to review criteria. If benefit coverage information is needed, providers will be guided to provider service for assistance with review of the subscriber's benefits.

Please note, claims for services that are not on the Blue Cross PA lists will process through the claims system according to the subscriber's benefits with or without a predetermination.

PA Lists are updated on the effective date of a PA management change and include applicable codes. To access the pdf PA Lists for all lines of business:

- Go to **bluecrossmn.com/providers**
- Under Tools & Resources, select "Medical Policy," and read/accept the Blue Cross Medical Policy and UM Statement
- Expand the Utilization Management section
- Click on Commercial Pre-Certification/Pre-Authorization/Notification List (PDF)

Where do I find medical policies and policy criteria?

- Go to **bluecrossmn.com/providers**
- Under Tools & Resources, select "Medical Policy," and read/accept the Blue Cross Medical Policy and UM Statement
- Expand the Medical and Behavioral Health Policies section
- Click on "Blue Cross and Blue Shield of Minnesota Medical Policies"
- Search for the applicable policy by keyword, policy number, procedure code or 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 (MSHO) Prior Authorization and Medical Policy Requirements (P85-20, published 11/2/20)

Effective January 2, 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 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 policies have transitioned to new policy numbers, with changes in clinical criteria, and **will be applicable** to subscriber claims on or after **January 2, 2021**.

New Policy #	Prior Policy #	Policy Name	Prior Authorization Required	
			Medicaid	MSHO
ANC.00007	MHCP ANC.00007	Cosmetic and Reconstructive Services: Skin Related	Yes	Yes
ANC.00008	MHCP ANC.00008	Cosmetic and Reconstructive Services of the Head and Neck	Yes	Yes
ANC.00009	MHCP ANC.00009	Cosmetic and Reconstructive Services of the Trunk and Groin	Yes	Yes
SURG.00129	MHCP SURG.00129	Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea or Snoring	Yes	Yes
ING-CC-0001	MHCP ING-CC-0001	Erythropoiesis Stimulating Agents	Yes	Yes
ING-CC-0096	MHCP	Asparaginase, not otherwise specified	Yes	Yes

The following prior authorization requirements will be archived and **will not be applicable** under the medical benefit plan to subscriber claims on or after **January 2, 2021**. However, the policies will remain in effect.

Policy #	Policy Name	Prior Authorization Required	
		Medicaid	MSHO
MHCP	Vyxeos (liposomal daunorubicin and cytarabine)	Yes	Yes
MHCP	Leucovorin calcium	Yes	Yes
MHCP	Dacogen (decitabine)	Yes	Yes

Policy #	Policy Name	Prior Authorization Required	
		Medicaid	MSHO
MHCP	Doxorubicin HCl	Yes	Yes
MHCP	Trisenox (arsenic trioxide)	Yes	Yes
MHCP	Clolar (clofarabine)	Yes	Yes
MHCP	BCG (intravesical)	Yes	Yes
MHCP	Bleomycin sulfate	Yes	Yes
MHCP	Carboplatin	Yes	Yes
MHCP	Carmustine	Yes	Yes
MHCP	Cisplatin, powder or solution	Yes	Yes
MHCP	Cladribine	Yes	Yes
MHCP	Cyclophosphamide	Yes	Yes
MHCP	Cytarabine liposome	Yes	Yes
MHCP	Cytarabine	Yes	Yes
MHCP	Dactinomycin	Yes	Yes
MHCP	Dacarbazine	Yes	Yes
MHCP	Daunorubicin	Yes	Yes
MHCP	Epirubicin HCl	Yes	Yes
MHCP	Etoposide	Yes	Yes
MHCP	Fludarabine phosphate	Yes	Yes
MHCP	Fluorouracil	Yes	Yes
MHCP	Floxuridine	Yes	Yes
MHCP	Infugem (gemcitabine HCl)	Yes	Yes
MHCP	Irinotecan liposome	Yes	Yes
MHCP	Irinotecan	Yes	Yes
MHCP	Ifosfamide	Yes	Yes
MHCP	Idarubicin HCl	Yes	Yes
MHCP	Mechlorethamine HCl (nitrogen mustard)	Yes	Yes
MHCP	Melphalan HCl	Yes	Yes
MHCP	Methotrexate sodium	Yes	Yes
MHCP	Nelarabine	Yes	Yes

Policy #	Policy Name	Prior Authorization Required	
		Medicaid	MSHO
MHCP	Oxaliplatin	Yes	Yes
MHCP	Paclitaxel	Yes	Yes
MHCP	Pentostatin	Yes	Yes
MHCP	Mitomycin	Yes	Yes
MHCP	Mitoxantrone HCl	Yes	Yes
MHCP	Pralatrexate	Yes	Yes
MHCP	Streptozocin	Yes	Yes
MHCP	Temozolomide	Yes	Yes
MHCP	Thiotepa	Yes	Yes
MHCP	Topotecan	Yes	Yes
MHCP	Valrubicin, intravesical	Yes	Yes
MHCP	Vinblastine sulfate	Yes	Yes
MHCP	Vincristine sulfate	Yes	Yes
MHCP	Vincristine sulfate liposome	Yes	Yes
MHCP	Vinorelbine tartrate	Yes	Yes
MHCP	Porfimer sodium	Yes	Yes

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**.

Appeals Policy for no Prior Authorization for Minnesota Health Care Programs

(P86-20, published 11/2/20)

In an effort to provide more consistency across lines of business, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will implement a new appeals policy related to the existing requirement of a prior authorization (PA) submission. **The policy will go into effect with dates of service beginning January 1, 2021 for Minnesota Health Care Programs (MHCP) subscribers and is applicable to services that currently require PA.**

When a PA is required for a service, procedure or item, the provider must submit the clinical information in advance to Blue Cross via the Interactive Care Reviewer (ICR) portal or by faxing the applicable form to the appropriate area. An authorization must be obtained prior to the provider performing the service. Same-day requests will be reviewed and the provider will be subject to the medical necessity determination.

Certain circumstances may make obtaining an approval prior to rendering the service difficult. Retrospective clinical review will be considered by Blue Cross for up to 14 days after the date of service and prior to the claim being submitted in consideration of scenarios (such as after-hours urgent situations). Pre-claim retrospective review exceptions to post-service requests are limited to radiology, cardiology and musculoskeletal due to the propensity of additional procedures potentially identified during a procedure.

Retrospective PA requests should be submitted via the applicable forms and fax numbers located here: https://provider.publicprograms.bluecrossmn.com/minnesota-provider/resources/prior-authorization

If a request is received post-service, only approved exceptions will receive a review; all others will be returned to the provider indicating that late requests are not allowed and will not be reviewed. The Utilization Management (UM) team reviews the clinical information and determines if the request meets medical necessity criteria based on the current medical policy and accepted standards of care. If incomplete documentation is submitted, UM may request additional information to complete the review. Providers must submit the requested documentation in a timely manner or may receive a medical necessity denial. If a denial is received, the provider has 60 days to submit an appeal to the medical necessity denial with additional documentation. Medically emergent services do not require a PA.

If a PA is not submitted prior to the service, the claim will be denied for lack of authorization, and the provider will be held liable. The claim denial will be administrative and cannot be appealed for medical necessity.

Appeal exceptions/exemptions
If a claim is administratively denied for no authorization, 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:

- Blue Cross is the member's secondary coverage and authorization 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. Appeals for this exception must include notes about accounts receivable actions. For example, include notes documenting calls with the Blue Cross Service Center or notes that the member was sent to collections within 120 days of the date of service.
- The member was enrolled in the plan retrospectively, after the service was provided.
- A previously 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 made it impractical to obtain or validate the existence of an authorization prior to rendering the service (e.g., natural disaster or Availity outage).

Other exemptions from this policy:

- Emergency and urgent care services that are performed in the emergency room do not require authorization and will be considered at the in-network benefit level.
- Inpatient admissions, including those that require pre-certification or notification, are exempt from this administrative Appeals Policy.

PA requirements
PA lists are updated to reflect current PA requirements on the effective date of the management change, including applicable codes. To access PA lists for MHCP subscribers go to:
https://provider.publicprograms.bluecrossmn.com/minnesota-provider/resources/prior-authorization

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**.