PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

WHAT'S INSIDE: May 1, 2018

This summary document can be found in 'Forms and Publications' section of providers.bluecrossmn.com. Individual Bulletins are also available in the 'Forms and Publications' section of providers.bluecrossmn.com.

Questions? If you have questions about any of the updates, unless otherwise specified, please contact provider services at (651) 662-5200 or 1-800-262-0820.

L08R04 (12/13)

ADMINISTRATIVE UPDATES

New Availity Authorization Portal Available to Create, Submit and Inquire on Utilization Management Authorization Requests (P16-18, published 5/1/18)

Effective June 18, 2018, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) providers will have the ability to create and inquire on the status of utilization management authorization requests electronically on our provider portal at **Availity.com**. Beginning June 18, 2018, we encourage our providers to utilize this new efficient self-service tool, in place of faxing and calling. Blue Cross will be requiring use of Availity for Authorization submissions soon.

Out-of-state providers that participate with any Blue Cross and Blue Shield plan can access Availity through the out-of-area member router provided by each state's plan.

The Availity Authorization portal should be used for all required preservice inpatient and outpatient prior authorization requests, except for requests for eligible government program Subscribers for elderly waiver services, home care services authorized by MSHO and MSC+ care coordinators, non-emergent transportation, and personal care assistance (PCA). Please continue to fax or call in your requests for these services using current processes. The Availity Authorization portal should also be used for pre-admission notifications, unless your facility is submitting a 278 or ADT HL7 transaction (see Provider Bulletin P15-18 for more details).

Requests for medical necessity review of services that have already been provided cannot be submitted online and will not be accepted by phone or fax.

Once an authorization request has been successfully submitted on Availity, you will receive an immediate response with a reference number and one of the following statuses:

- Approved
- Pended for Clinical Review
- Cancelled - No Prior Authorization Required

When a request will be pended for review, you will be immediately prompted to attach supporting medical records. The request will not be processed until medical records are attached.

After submission is complete, you will see an Authorization & Referral Dashboard with requests you submitted in Availity and the current status of each request. When a pended request is completed, the Authorization Dashboard will be updated with the final status and the normal determination fax and letter will be generated.

Providers can also:

- Request a concurrent review authorization for additional days on an existing inpatient authorization
- Add discharge details on existing inpatient authorizations
- Attach additional medical records electronically during the clinical review process
- Inquire on the status of any utilization management request completed in the last year

The Blue Cross Authorization portal in Availity is easy to use. Follow the instructions below to enter, search for, or update your Authorizations.

Create an Authorization Request on Availity

1. Sign on to **Availity.com**
2. Select Patient Registration, choose Authorizations & Referrals, then Authorizations
3. Select Payer BCBSMN, your Organization and you'll be redirected to the Authorization application
4. Select Inpatient Authorization or Outpatient Authorization

5. Complete the required fields in steps 1-3, then review and submit your authorization
    - If your Authorization is a specialty authorization, you may be routed to a vendor between steps 1 and 2 to complete the authorization process. As much data as possible will be sent to limit the need for re-entry.
6. Receive and print your confirmation for your records
    - If your submission was pended for clinical review you must attach supporting medical records or your authorization request will not be processed

Inquire on an Authorization Request Entered in the Last Year

1. Sign on to **Availity.com**
2. Select Patient Registration, choose Authorizations & Referrals, then Auth/Referral Inquiry
3. Select Payer BCBSMN, your Organization and you'll be redirected to the Inquiry application
4. Select Inpatient Authorization or Outpatient Authorization
5. Complete the required fields, then submit your Inquiry
6. Select the specific request from the inquiry results
7. Review the details returned in your inquiry. At this point you will have the option to update the request. When you click the "Update" button, you will be taken to a portal to complete the update process. You can:
    - Request a concurrent review authorization for additional days on an existing inpatient authorization
    - Add discharge details on existing inpatient authorizations
    - Attach additional medical records electronically during the clinical review process

View the Status of Authorizations Submitted in Availity Using the Authorization & Referral Dashboard

1. Sign on to **Availity.com**
2. Select Patient Registration, choose Authorizations & Referrals, then Authorization & Referral Dashboard
    - The status is shown for each authorization request in the dashboard
    - Each authorization request will also show the name of the UM entity reviewing the request - BCBSMN or BCBSMN (vendor name)
3. Click on any authorization request line in the dashboard. Additional authorization details will display
4. Additionally, when selecting a line item from the dashboard, you will be able to:
    - View details
    - Print details
    - Request a concurrent review authorization for additional days on an existing inpatient authorization
    - Add discharge details on existing inpatient authorizations
    - Attach additional medical records electronically during the clinical review process
5. From the dashboard, you can navigate to perform the following:
    - Inquiry
    - Create New Authorization or Referral
    - Find Referral – Additional for referrals ONLY
        - BCBSMN will have a proprietary inquiry (FindRef) where the user will be taken to a new screen, and a call out to BCBSMN will occur with user entered information such as NPI and a date range.

Starting June 18, 2018, providers can access the Blue Cross Authorization training demo from the Availity portal:

1. Click **Help & Training** | **Get Trained** (Availity Learning Center (ALC) opens a new tab)
2. Go to the very top of the ALC screen, search with the keyword "BCBSMN"
3. Click the course titled **BCBSMN Prior Authorizations - Training Demo**
4. Click Enroll in the top right corner and confirm that you want to enroll
5. Click Start to view the training

Reminder: Blue Cross Will Cease Mailing Certain Provider Bulletins

(P10-18, published 3/1/18)

As of April 2, 2018, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will begin publishing monthly Provider Bulletins and posting them on the first business day of each month on the bluecrossmn.com website. Effective May 1, 2018, Blue Cross will no longer be mailing Provider Bulletins that are published on the first business day of the month. If additional Bulletins are published on a day other than the first business day of the month due to a business need, the Provider Bulletin will be mailed to impacted providers in addition to being posted on the website. These changes support ease of access and administrative efficiency for providers and Blue Cross and will reduce the use of paper to be environmentally friendly. Provider Bulletins will continue to be available on our website as well as on Availity's provider portal.

To view Provider Bulletins on the Blue Cross website

- Access **providers.bluecrossmn.com**
- Select forms and publications
- Select Bulletins

To view Provider Bulletins on Availity's provider portal

- Access **availity.com**
- Select Payer Spaces (Blue Cross)
- Select News and Announcements
- Select "more" to go to the actual Bulletin

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 Second Phase Transition with Magellan
(P14-18, published 5/1/18)

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) would like to provide an update regarding the status of the second phase of its transition with Magellan for behavioral health providers.

Blue Cross has made the decision to continue the delay of the second phase of transition, which includes contracting, credentialing, service and claims through December 31, 2019. Behavioral health providers will continue to work with Blue Cross to maintain their credentialing and contracting status, including participation in the re-credentialing process, should providers be approaching the re-credentialing due date. Blue Cross will update providers via a Provider Bulletin regarding the timing around the second phase of the work and any related next steps.

Magellan will continue to be responsible for authorizing behavioral health services but will not be responsible for paying claims. Subscribers will continue to use the Blue Cross provider network they currently use today.

Update: New Remittance Code OA-45/N801 for Purchased/Referred Care (PRC)-Eligible Subscribers (P19R2-18, published 5/1/18)

The purpose of this Provider Bulletin is to update you regarding how Blue Cross and Blue Shield of Minnesota and its affiliates (Blue Cross) are processing certain PRC facility claims and provide additional information to a previous Provider Bulletin, (P19R1-17) dated October 24, 2017. Federal legislation relating to PRC was effective in July 2007 (42 CFR Part 136) which affects reimbursement rates for certain services provided to subscribers of federally recognized American Indian Tribes.

Description: The RARC code is N801. This is being done to further clarify when a claim is processed with the tribal fee schedule and why the Tribal Fee Schedule is being applied. Impacted claims are processed under Tribal Fee Schedule Self-insured Tribal Group Health Plan, in accordance with Federal Regulation 42 CFR 136.

Explanation: There is a need to provide a more informative reason for the payment reduction and description to the provider on the reduced reimbursement as it relates to a tribe's self-insured program. These are services that are typically provided outside of a tribal clinic.

The federal legislation relating to PRC that became effective in July 2007, Section 506 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (506 Legislation), codified in the federal regulations at 42 CFR Part 136, affects reimbursement rates for certain services provided to subscribers of federally recognized American Indian Tribes under a PRC program, previously known as the Contract Health Services (CHS) program, funded by the Indian Health Service (IHS). Medicare-participating hospitals that furnish inpatient services cannot bill health programs operated by the IHS, Tribes, Tribal organizations and urban Indian organizations (collectively, I/T/U programs) more than a Medicare-like rate as payment in full for services provided to eligible PRC patients for eligible PRC services authorized by the I/T/U program.

How does the PRC program interact with a tribe's self-insured health plan?
Some tribes that have entered into an agreement with the IHS to administer the tribe's PRC program have also contracted with Blue Cross or its affiliates to administer the tribe's health plans. Tribes, like all self-insured groups, have the option of setting a benefit maximum with respect to some benefits under a self-insured plan. Several tribes have designed their health plans to instruct Blue Cross apply a benefit maximum, (e.g., a "Tribal Fee Schedule") that approximates Medicare-like rates, for Medicare participating facilities and eligible services. The Tribal Fee Schedule only applies to PRC eligible subscribers and services.

What is changing in the processing of PRC facility claims?
Current provider remittances reflect group code "PR" (Patient Responsibility) with an ANSI Reduction Reason Code 45 (CHARGES EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/ LEGISLATED FEE ARRANGEMENT). This may result in a provider automatically billing the subscriber the amount not covered by the tribal plan. While PR-45 is a proper code at the time of adjudication, in most cases, once the subscriber and tribe review the patient balance with the provider, they are able to confirm the service was authorized by the tribe's PRC program and no secondary coverage applied. The subscriber and tribe would then be relieved of any patient responsibility pursuant to the 506 Legislation and 42 CFR Part 136.

To ease the billing and final adjudication process, Blue Cross is changing the remittance code from "PR" to "OA" (Other Adjustment) on the processed PRC facility claim. The "OA" indicator will stop the automatic process providers have set up for billing the subscriber. The provider can instead assess the documentation on file, (e.g., ID card and/or PRC referral), or can confirm with the tribe's PRC program directly as indicated on the subscriber's ID card to assess whether to proceed with billing the subscriber. The goal is to reduce unnecessary administrative work for the tribe, subscriber and the provider. By applying the "OA" remittance code, providers also can verify if the subscriber has secondary coverage and bill that payer accordingly.

How will this affect you?
As stated in prior Provider Bulletins, you will be reimbursed at the Tribal Fee Schedule for claims processed pursuant to tribal health plans that adopt a benefit maximum for PRC eligible subscribers and services. These services are not subject to any contractual provider incentives.

Your remittance advice will include the language "**Tribal Fee Schedule"** for any service reimbursed pursuant to the Tribal Fee Schedule. If you receive a remittance electronically, the verbiage "Tribal Fee Schedule" is populated in loop 2100, class of contract reference segment of the 835. Because you were not reimbursed at your provider negotiated rate, the claim will process with "Other Adjustment."

When may providers balance bill the subscriber?
Except for emergency services, PRC eligibility requirements must be met by the tribe and subscriber prior to the subscriber receiving care. Therefore, a provider may confirm a subscriber's PRC eligibility at the time of service. If the provider does not have the information needed to confirm the PRC eligibility of the subscriber or service (e.g., ID card and/or PRC referral or by contacting the tribe directly), the provider may balance bill the subscriber.

How will you know whose care may be reimbursed pursuant to the Tribal Fee Schedule?
Subscriber ID Card Designation:
Tribal health plan subscribers who are eligible for PRC and whose care will be reimbursed pursuant to the Tribal Fee Schedule have subscriber ID cards that includes language reflecting the subscriber's PRC eligibility, such as the following:

A tribal fee schedule has been applied for PRC eligible services for this member. Members must call their PRC office for required referrals prior to care. Please call XXX-XXX-XXXX.

People who are covered by a tribe's health plan but are not eligible for PRC do not have this designation on their subscriber ID cards. In addition, providers may receive a PRC referral directly from the Tribe's PRC program office.

What do you need to do differently for claim processing?
Nothing. Please continue to submit claims as indicated on the back of the subscriber ID card. The claim will then be adjudicated based on the eligibility of the subscriber and the services rendered.

Questions?
If you have questions about the eligibility of a PRC subscriber or service, please contact the tribe's PRC office at the telephone number located on the subscriber ID card. If you have questions about payments related to the claims, please contact provider service at (**651) 662-4593** or **1-866-477-1587**.

Pre-Admission Notification Requirement for Commercial Admissions

(P15-18, published 5/1/18)

To best support the coordination of care for our subscribers, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will begin enforcing the existing requirement of a pre-admission notification (PAN) submission **late this summer**, for **commercial** subscribers for both planned and urgent admissions. **This change will also apply to subscribers belonging to an out of state Blue Plan**. **Blue Cross is providing early notification in order to provide time for hospitals to prepare for this administrative requirement. A separate Provider Bulletin will be published with the effective date of the enforcement.** Blue Cross will require that PANs be submitted within 24 hours or on the next business day following a weekend or holiday. **If a PAN is not submitted timely, the inpatient facility claim will be administratively denied upon its submission for lack of notification**. For inpatient facility claims submitted with observation hours, the PAN submission timeframe requirement will be extended by the number observation hours submitted. If a prior authorization is submitted for a procedure, a PAN is also required to be submitted for the inpatient admission.

Please note: If an admission requires pre-certification, a PAN is not required, and thus is not impacted by this change in requirement. A list of inpatient services that require pre-certification can be found in the Medical Policy section of the Blue Cross provider website under Utilization Management for each line of business.

Enforcement of the PAN requirement will exclude the following:

- Coordination of Benefits (COB) when Blue Cross is not the primary payor
- Normal Labor and Delivery
- Newborns (children less than 30 days old)

The denial of the inpatient claim will be an administrative denial and cannot be appealed for medical necessity.

Submitting a PAN for a Blue Cross of Minnesota subscriber:

There are currently five options:

- Submit a 278 file (see information on following page to get started).
- Submit Admission, Discharge, Transfer (ADT) dates via an HL7 file (see the following page to get started).
- Submit via the fillable form within the Blue Cross portal at **Availity.com**
- Fax the "Inpatient Admission Notification & Pre-Certification Request Form" to **651-662-7006**. To access the form:
    1. Go to **providers.bluecrossmn.com**
    2. Under What's Inside, select "Forms & publications"
    3. Choose "forms – precertification/preauthorization/notification" from the drop-down
    4. Select the "Inpatient Admission Notification & Pre-Certification Form"
- Contact Blue Cross via phone at **1-800-528-0934**

Providers should also use **Availity.com** to inquire about, make updates, or add a discharge date to a previously submitted PAN. If you receive a pre-admission notification number, please include the number on the claim to expedite processing. If a PAN number isn't provided at the time of submission, providers can obtain the PAN number via an inquiry on Availity the day following the submission.

Submitting a PAN for an out-of-state Blue Plan subscriber:

There are currently three options:

- Contact the patient's home plan using the Provider Service phone number on the back of the subscriber's ID card.
- Use the Medical Policy and Pre-Certification/Authorization Router to identify the home plan and to find the instructions for submitting a PAN to a specific home plan. The router is available on the **providers.bluecrossmn.com** webpage or on **Availity.com** in Payer Spaces.

- Call **1-800-676-BLUE** for assistance in routing your call regarding a PAN submission to the appropriate Blue Plan.

Additional information regarding PAN requirements can be found on the Blue Cross provider website:

1. Go to **providers.bluecrossmn.com**
2. Under Tools & Resources, select "Medical Policy," and read/accept the Medical Policy and UM Statement
3. Click on the '+' next to 'Utilization Management' and under the 'Precertification Lists' select the MN Government Programs or Commercial Pre-Certification/Pre-Authorization/Notification List'

Electronic Solutions for Pre-Admission Submission

To assist providers with the requirement of PANs, Blue Cross has implemented electronic solutions to accept PANs via 278 real-time transactions or via the submission of Admission, Discharge, and Transfer data (ADT) via an HL7 file through a connection with our clearinghouse, Availity.

278 is an HIPAA standard format for EDI transmission for Pre-Admission Notification.

ADT is the Admission, Discharge, and Transfer messages within a hospital's system. These notifications are communicated as HL7 messages, a set of international standards for transfer of clinical and administrative data between systems needed for Pre-Admission Notification, Discharge, and Transfer.

With the implementation of either of these solutions, there is no longer the need to fax PANs, make status calls, or manually enter PAN data into our portal application.

**Please note, services requiring medical necessity review-precertification and prior authorization are excluded from this automated process but watch for additional information regarding the rollout of the Prior Authorization Portal capabilities for these services on Availity.*

Getting Stated with 278 File Submissions

If you are interested in the opportunity, you will need to take the next steps listed below:

Step 1 - You will need to verify with your Electronic Medical Records (EMR) vendor that they can send the 278-real-time transaction from your system.

Step 2 - Review the Blue Cross 278 real-time transaction companion guide details found at the following link: https://www.bluecrossmn.com/healthy/public/portalcomponents/PublicContentServlet?contentId=P11GA_16268309

Step 3 - After completing above steps, please contact your Blue Cross Contract/Account Manager or Network Management Consultant and provide them with your technical contact information.

Step 4 - The Blue Cross Contract/Account Manager or Network Management Consultant will engage the Blue Cross EDI/Availity Operations team to coordinate next steps with your technical contact(s).

Step 5 - The Blue Cross EDI/Availity Operations team will work with the technical representative at your organization and Availity to assist with set up and through the testing process.

Getting Started with ADT

If you are interested in the opportunity, you will need to take the next steps listed below:

Step 1 - Confirm if you have an existing Portal Account with Availity,

If Yes - Contact your internal Availity Administrator and have them add users to the account that will be utilizing the ADT/HL7 solution in production

If No - Go to www.availity.com and complete the registration steps for a portal account

Step 2 - After completing the above steps, please contact your Blue Cross Contract/Account Manager or Network Management Consultant and provide them with your technical contact information.

Step 3 - The Blue Cross Contract/Account Manager or Network Management Consultant will engage the Blue Cross EDI/Availity Operations team to coordinate next steps with your technical contact(s).

Step 4 - The Blue Cross EDI/Availity Operations team will work with the technical representative at your organization and Availity to assist with set up and through the testing process.

2018 Renewal Changes Summary for Aware Professional Providers

(P18-18, published 5/1/18)

Blue Cross and Blue Shield of Minnesota and Affiliates (Blue Cross) is simplifying the annual renewal process by communicating substantive changes to the 2018 Aware Provider Service Agreement via this Provider Bulletin. The complete Aware Provider Service Agreement (Agreement) is modified periodically to reflect the most current regulatory changes and other clarifications necessary to properly administer the Agreement. The minor changes and clarifications to the Agreement effective July 1, 2018 are detailed below. The summary items are listed in order of appearance in the Agreement.

Provider Service Agreement Changes

1) Article II. B. The definition of "Agreement" has been clarified to include the Reimbursement Policies as item 6. Therefore, the definition is restated as follows:

   "Agreement" means this Aware Provider Service Agreement, including (1) the originally executed signature page, which shall be binding upon all of Provider's Health Care Professionals, (2) the applicable fee schedule(s), (3) the Amendment to the Agreement – Medicare Programs, as applicable, (4) the Provider Policy & Procedure Manual as it may be amended from time to time (available at bluecrossmn.com), (5) any and all existing and effective Provider Bulletins (available at bluecrossmn.com) as well as any Provider Bulletins issued by Blue Cross during the term of this Agreement, (6) the Reimbursement Policies as may be amended by Blue Cross from time to time (available at bluecrossmn.com), (7) any and all existing and effective Exhibits, (8) the provisions of the Credentialing and Recredentialing Policy Manual as it may be amended by Blue Cross from time to time (available at bluecrossmn.com), and (9) any other Addenda or Amendments whose terms and provisions are incorporated into and made a part of this Agreement.

2) Article III.N Notices; Updates; Changes. This provision has been clarified by the addition of the following initial sentence, in an effort to illustrate the critical importance of providers promptly advising Blue Cross of any changes to provider information:

   "Provider shall promptly notify Blue Cross of any changes to any administrative, demographic, or other provider information of any kind to ensure that Blue Cross has the most current and accurate Provider information."

3) Article IV.D Minnesota Health Care Programs. This provision has been clarified and restated as shown below:

   Minnesota Health Care Programs. For those Health Services provided to Minnesota Health Care Programs Subscribers, Blue Cross will pay Provider for Health Services at 100% of the Blue Cross medical assistance fee schedule as determined by Blue Cross.

4) Article IV.F Overpayments. This provision has been clarified as shown below by the addition of the process for conducting a charge audit:

   Blue Cross may conduct an audit to determine if Provider's aggregate reimbursement adjustment exceeded the Negotiated Reimbursement Adjustment that was expected and agreed upon in writing between the Provider and Blue Cross during their good faith negotiations. In the event that Provider's actual Charge Description Master Adjustment causes an aggregate change to reimbursement in excess of the Negotiated Reimbursement Adjustment, Blue Cross shall have the right to adjust Reimbursement Rates to the Provider in order to achieve

the Negotiated Reimbursement Adjustment that should have been implemented to yield the expected and agreed upon aggregate reimbursement. The adjusted Reimbursement Rates shall also be applicable to the calculations used by Blue Cross for any future Negotiated Reimbursement Adjustments.

This audit will use one consistent Data Set and apply the Reported Charge Description Master Adjustment and agreed upon Reimbursement Rates to determine the modeled aggregate increase that should have occurred for the Contract Period. The Data Set will then be used to apply the actual Charge Description Master Adjustments and the agreed upon Reimbursement Rates to determine whether any variance in expected reimbursement exists.

Recovery of Identified Overpayments. If an audit determines that an overpayment exists, Blue Cross shall have the right to take the following actions:

1. Recover amounts paid in excess of the Negotiated Reimbursement Adjustment. This may be accomplished via a lump sum cash settlement, adjustment of claims, or an offset of future claims payments. Adjustment of claims generally shall be limited to Health Services incurred during the current calendar year. For Health Services rendered prior to the current calendar year, generally a lump sum cash settlement or other similar retrospective reconciliation shall occur. Provider must make payment to Blue Cross within 180 days of notification by Blue Cross of an overpayment due. Any amounts that remain owed to Blue Cross following 180 days will be recovered by Blue Cross through deductions from future payments owed to Provider;

2. Blue Cross may adjust the Reimbursement Rates applicable to future claim payments in order to neutralize the impact of the Provider 's charge adjustments which exceeded the agreed upon reimbursement. Blue Cross shall provide 45 days advance written notice of Provider's new Reimbursement Rates, and payment shall continue at such Reimbursement Rates until a new agreement is reached between the Parties according to the terms of the Agreement.

5) Article IV.L Subscriber Liability. This provision has been further clarified by the addition of the following sentence to support the requirements of Minnesota Statute 62Q.751:

   "Provider shall not withhold or delay service to a Subscriber based on the Subscriber's failure to pay the deductible or coinsurance at or prior to service."

6) Article VIII.B Termination. The opening paragraph of this provision has been clarified and restated as shown below to bring clarity to the need to send termination requests in writing:

   Termination. This Agreement may be terminated by either Party according to any one or more of the following provisions. Termination determinations are not subject to appeal. Written notice of termination must be mailed to Blue Cross and Blue Shield of Minnesota, Attn: Provider Relations, R317, P. O. Box 64560 St. Paul, Minnesota 55164-0560.

7) Article VIII.B Termination. An additional bulleted item has been added to this provision as follows:

   In the event that Blue Cross does not receive any claims submitted by Provider for a 12 month period, Blue Cross will terminate the agreement upon the expiration of that 12 month period.

No changes have been made to the Amendment to the Agreement – Medicare Programs.

Disclosure of Ownership

A Disclosure of Ownership form must be completed and submitted to Blue Cross per Minnesota Department of Human Services requirements. Information about the requirement and an electronic version of the form are available at bluecrossmn.com.

Reimbursement
Participating Providers may request a list of applicable rate allowances by submitting an e-mail request to Fee.Schedule.Allowance.Request@bluecrossmn.com up to twice annually. Your request must include the participating provider's NPI(s) and Blue Cross Internal Reference Number(s).

Questions
If you have any questions about the changes made in 2018, please call our provider service center at (**651) 662-5200** or **1-800-262-0820**. If you would like to have a comprehensive copy of a new Agreement that reflects these changes, please send a request to the following email box: Request.Contract.Renewal@bluecrossmn.com and a complete copy of your Agreement will be sent to you for your convenience.

2018 Renewal Changes Summary for Blue Plus Referral Health Professional Providers (P20-18, published 5/1/18)

Blue Cross and Blue Shield of Minnesota, Blue Plus and Affiliates (Blue Plus) is simplifying the annual renewal process by communicating substantive changes to the 2018 Blue Plus Referral Health Professional Provider Service Agreement via this Provider Bulletin. The complete Blue Plus Referral Health Professional Provider Service Agreement (Agreement) is modified periodically to reflect the most current regulatory changes and other clarifications necessary to properly administer the Agreement. The minor changes and clarifications to the Agreement effective July 1, 2018 are detailed below. The summary items are listed in order of appearance in the Agreement.

Provider Service Agreement Changes

1) Article II. B. The definition of "Agreement" has been clarified to include the Reimbursement Policies as item 6. Therefore, the definition is restated as follows:

   "Agreement" means this Referral Health Professional Provider Service Agreement, including (1) the originally executed signature page, which shall be binding upon all of Provider's Health Care Professionals, (2) the applicable fee schedule(s), (3) the Amendment to the Agreement – Medicare Programs, as applicable, (4) the Provider Policy & Procedure Manual as it may be amended from time to time (available at bluecrossmn.com), (5) the Blue Plus Manual as it may be amended from time to time (available at bluecrossmn.com), (6) any and all existing and effective Provider Bulletins (available at bluecrossmn.com) as well as any Provider Bulletins issued by Blue Plus during the term of this Agreement, (7) the Reimbursement Policies as may be amended by Blue Plus from time to time (available at bluecrossmn.com), (8) any and all existing and effective Exhibits, (9) the provisions of the Credentialing and Recredentialing Policy Manual as it may be amended by Blue Plus from time to time (available at bluecrossmn.com), and (10) any other Addenda or Amendments whose terms and provisions are incorporated into and made a part of this Agreement.

2) Article III.N Notices; Updates; Changes. This provision has been clarified by the addition of the following initial sentence, in an effort to illustrate the critical importance of providers promptly advising Blue Plus of any changes to provider information:

   "Provider shall promptly notify Blue Plus of any changes to any administrative, demographic, or other provider information of any kind to ensure that Blue Plus has the most current and accurate Provider information."

3) Article IV.D Minnesota Health Care Programs. This provision has been clarified and restated as shown below:

   Minnesota Health Care Programs. For those Health Services provided to Minnesota Health Care Programs Subscribers, Blue Plus will pay Provider for Health Services at 100% of the Blue Plus medical assistance fee schedule as determined by Blue Plus.

4) Article IV.F Overpayments. This provision has been clarified as shown below by the addition of the process for conducting a charge audit:

Blue Plus may conduct an audit to determine if Provider's aggregate reimbursement adjustment exceeded the Negotiated Reimbursement Adjustment that was expected and agreed upon in writing between the Provider and Blue Plus during their good faith negotiations. In the event that Provider's actual Charge Description Master Adjustment causes an aggregate change to reimbursement in excess of the Negotiated Reimbursement Adjustment, Blue Plus shall have the right to adjust Reimbursement Rates to the Provider in order to achieve the Negotiated Reimbursement Adjustment that should have been implemented to yield the expected and agreed upon aggregate reimbursement. The adjusted Reimbursement Rates shall also be applicable to the calculations used by Blue Plus for any future Negotiated Reimbursement Adjustments.

This audit will use one consistent Data Set and apply the Reported Charge Description Master Adjustment and agreed upon Reimbursement Rates to determine the modeled aggregate increase that should have occurred for the Contract Period. The Data Set will then be used to apply the actual Charge Description Master Adjustments and the agreed upon Reimbursement Rates to determine whether any variance in expected reimbursement exists.

Recovery of Identified Overpayments. If an audit determines that an overpayment exists, Blue Plus shall have the right to take the following actions:

1. Recover amounts paid in excess of the Negotiated Reimbursement Adjustment.This may be accomplished via a lump sum cash settlement, adjustment of claims, or an offset of future claims payments. Adjustment of claims generally shall be limited to Health Services incurred during the current calendar year. For Health Services rendered prior to the current calendar year, generally a lump sum cash settlement or other similar retrospective reconciliation shall occur. Provider must make payment to Blue Plus within 180 days of notification by Blue Plus of an overpayment due. Any amounts that remain owed to Blue Plus following 180 days will be recovered by Blue Plus through deductions from future payments owed to Provider;

2. Blue Plus may adjust the Reimbursement Rates applicable to future claim payments in order to neutralize the impact of the Provider 's charge adjustments which exceeded the agreed upon reimbursement. Blue Plus shall provide 45 days advance written notice of Provider's new Reimbursement Rates, and payment shall continue at such Reimbursement Rates until a new agreement is reached between the Parties according to the terms of the Agreement.

5) Article IV.I Subscriber Liability. This provision has been further clarified by the addition of the following sentence to support the requirements of Minnesota Statute 62Q.751:

"Provider shall not withhold or delay service to a Subscriber based on the Subscriber’s failure to pay the deductible or coinsurance at or prior to service."

6) Article X.B Termination. The opening paragraph of this provision has been clarified and restated as shown below to bring clarity to the need to send termination requests in writing:

Termination. This Agreement may be terminated by either Party according to any one or more of the following provisions. Termination determinations are not subject to appeal. Written notice of termination must be mailed to Blue Plus, Attn: Provider Relations, R317, P. O. Box 64560 St. Paul, Minnesota 55164-0560.

7) Article X.B Termination. An additional bulleted item has been added to this provision as follows:

In the event that Blue Plus does not receive any claims submitted by Provider for a 12 month period, Blue Plus will terminate the agreement upon the expiration of that 12 month period.

No changes have been made to the Amendment to the Agreement – Medicare Programs.

Disclosure of Ownership
A Disclosure of Ownership form must be completed and submitted to Blue Plus per Minnesota Department of Human Services requirements. Information about the requirement and an electronic version of the form are available at bluecrossmn.com.

Reimbursement
Participating Providers may request a list of applicable rate allowances by submitting an e-mail request to Fee.Schedule.Allowance.Request@bluecrossmn.com up to twice annually. Your request must include the participating provider's NPI(s) and Blue Plus Internal Reference Number(s).

Questions
If you have any questions about the changes made in 2018, please call our provider service center at **(651) 662-5200** or **1-800-262-0820**. If you would like to have a comprehensive copy of a new Agreement that reflects these changes, please send a request to the following email box: Request.Contract.Renewal@bluecrossmn.com and a complete copy of your Agreement will be sent to you for your convenience.

2018 Renewal Changes Summary for Suppliers of DME (P22-18, published 5/1/18)

Blue Cross and Blue Shield of Minnesota and Affiliates (Blue Cross) is simplifying the annual renewal process by communicating substantive changes to the 2018 Provider Service Agreement with Suppliers of Durable Medical Equipment via this Provider Bulletin. The complete Provider Service Agreement with Suppliers of Durable Medical Equipment (Agreement) is modified periodically to reflect the most current regulatory changes and other clarifications necessary to properly administer the Agreement. The minor changes and clarifications to the Agreement effective July 1, 2018 are detailed below. The summary items are listed in order of appearance in the Agreement.

Provider Service Agreement Changes

1) Article II. C. The definition of "Agreement" has been clarified to include the Reimbursement Policies as item 6. Therefore, the definition is restated as follows:

   "Agreement" means this Provider Service Agreement with Suppliers of Durable Medical Equipment, including (1) the originally executed signature page, which shall be binding upon all of Provider's Health Care Professionals, (2) the applicable fee schedule(s), (3) the Amendment to the Agreement – Medicare Programs, as applicable, (4) the Provider Policy & Procedure Manual as it may be amended from time to time (available at bluecrossmn.com), (5) any and all existing and effective Provider Bulletins (available at bluecrossmn.com) as well as any Provider Bulletins issued by Blue Cross during the term of this Agreement, (6) the Reimbursement Policies as may be amended by Blue Cross from time to time (available at bluecrossmn.com), (7) any and all existing and effective Exhibits, (8) the provisions of the Credentialing and Recredentialing Policy Manual as it may be amended by Blue Cross from time to time (available at bluecrossmn.com), and (9) any other Addenda or Amendments whose terms and provisions are incorporated into and made a part of this Agreement.

2) Article II. H. The definition of "Health Care Professional" has been clarified as follows:

   "Health Care Professional" means (1) an individual employed by Provider or an independent contractor of Provider who maintains the necessary and appropriate state health care license, registration or certification, and (2) an individual or entity that is duly licensed or legally authorized to provide durable medical equipment and supplies and has entered into a participating agreement with Blue Cross.

3) Article III.P. Notices; Updates; Changes. This provision has been clarified by the addition of the following initial sentence, in an effort to illustrate the critical importance of providers promptly advising Blue Cross of any changes to provider information:

"Provider shall promptly notify Blue Cross of any changes to any administrative, demographic, or other provider information of any kind to ensure that Blue Cross has the most current and accurate Provider information."

4) Article IV.I Overpayments. This provision has been clarified as shown below by the addition of the process for conducting a charge audit:

Blue Cross may conduct an audit to determine if Provider's aggregate reimbursement adjustment exceeded the Negotiated Reimbursement Adjustment that was expected and agreed upon in writing between the Provider and Blue Cross during their good faith negotiations. In the event that Provider's actual Charge Description Master Adjustment causes an aggregate change to reimbursement in excess of the Negotiated Reimbursement Adjustment, Blue Cross shall have the right to adjust Reimbursement Rates to the Provider in order to achieve the Negotiated Reimbursement Adjustment that should have been implemented to yield the expected and agreed upon aggregate reimbursement. The adjusted Reimbursement Rates shall also be applicable to the calculations used by Blue Cross for any future Negotiated Reimbursement Adjustments.

This audit will use one consistent Data Set and apply the Reported Charge Description Master Adjustment and agreed upon Reimbursement Rates to determine the modeled aggregate increase that should have occurred for the Contract Period. The Data Set will then be used to apply the actual Charge Description Master Adjustments and the agreed upon Reimbursement Rates to determine whether any variance in expected reimbursement exists.

Recovery of Identified Overpayments. If an audit determines that an overpayment exists, Blue Cross shall have the right to take the following actions:

1. Recover amounts paid in excess of the Negotiated Reimbursement Adjustment. This may be accomplished via a lump sum cash settlement, adjustment of claims, or an offset of future claims payments. Adjustment of claims generally shall be limited to Health Services incurred during the current calendar year. For Health Services rendered prior to the current calendar year, generally a lump sum cash settlement or other similar retrospective reconciliation shall occur. Provider must make payment to Blue Cross within 180 days of notification by Blue Cross of an overpayment due. Any amounts that remain owed to Blue Cross following 180 days will be recovered by Blue Cross through deductions from future payments owed to Provider;

2. Blue Cross may adjust the Reimbursement Rates applicable to future claim payments in order to neutralize the impact of the Provider 's charge adjustments which exceeded the agreed upon reimbursement. Blue Cross shall provide 45 days advance written notice of Provider's new Reimbursement Rates, and payment shall continue at such Reimbursement Rates until a new agreement is reached between the Parties according to the terms of the Agreement.

5) Article IV.L Subscriber Liability. This provision has been further clarified by the addition of the following sentence to support the requirements of Minnesota Statute 62Q.751:

"Provider shall not withhold or delay service to a Subscriber based on the Subscriber’s failure to pay the deductible or coinsurance at or prior to service."

6) Article IX.B Termination. The opening paragraph of this provision has been clarified and restated as shown below to bring clarity to the need to send termination requests in writing:

Termination. This Agreement may be terminated by either Party according to any one or more of the following provisions. Termination determinations are not subject to appeal. Written notice of termination must be mailed to Blue Cross and Blue Shield of Minnesota, Attn: Provider Relations, R317, P. O. Box 64560 St. Paul, Minnesota 55164-0560.

7) Article IX.B Termination. An additional bulleted item has been added to this provision as follows:

   In the event that Blue Cross does not receive any claims submitted by Provider for a 12 month period, Blue Cross will terminate the agreement upon the expiration of that 12 month period.

No changes have been made to the Amendment to the Agreement – Medicare Programs.

Disclosure of Ownership
A Disclosure of Ownership form must be completed and submitted to Blue Cross per Minnesota Department of Human Services requirements. Information about the requirement and an electronic version of the form are available at bluecrossmn.com.

Reimbursement
Participating Providers may request a list of applicable rate allowances by submitting an e-mail request to Fee.Schedule.Allowance.Request@bluecrossmn.com up to twice annually. Your request must include the participating provider's NPI(s) and Blue Cross Internal Reference Number(s).

Questions
If you have any questions about the changes made in 2018, please call our provider service center at **(651) 662-5200** or **1-800-262-0820**. If you would like to have a comprehensive copy of a new Agreement that reflects these changes, please send a request to the following email box: Request.Contract.Renewal@bluecrossmn.com and a complete copy of your Agreement will be sent to you for your convenience.

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATES

New Medical, Medical Drug and Behavioral Health Policy Updates for Commercial Lines of Business (Effective 7/2/18, P17-18)

Effective July 2, 2018, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be expanding both the overall medical policy library set and utilization management requirements for commercial lines of business. This includes both prior authorization (PA) requirements and the Medical Drug Prior Authorization Program.

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 **new medical policies** will be managed as follows effective July 2, 2018 for commercial lines of business:

Policy #	Policy Name	Enforcement
II-26	Agalsidase beta (Fabrazyme®)	Prior Authorization
II-186	Alglucosidase alfa (Lumizyme®)	Prior Authorization
II-203	Benralizumab (Fasenra®)	Prior Authorization
II-199	Bezlotoxumab (Zinplava®)	Prior Authorization
IV-17	Blepharoplasty and Brow Ptosis Repair	Prior Authorization
IV-108	Breast Ductal Lavage and Fiberoptic Ductoscopy	Deny as Investigative
VII-64	Esophageal pH Monitoring	Post Service Audit
II-198	Fecal Microbiota Transplantation	Covered for indications noted in policy
IV-71	Gynecomastia Surgery	Prior Authorization
II-145	Injectable Clostridial Collagenase for Fibroproliferative Disorders (Xiaflex®)	Covered for indications noted in policy
VII-66	Interferential Current Stimulation	Deny as Investigative
II-201	Mepolizumab (Nucala®)	Prior Authorization
II-147	Pegloticase (Krystexxa®)	Prior Authorization
II-202	Reslizumab (Cinqair®)	Prior Authorization
IV-83	Sacral Nerve Neuromodulation/Stimulation for Selected Conditions	Retrospective Review/ Post Service Audit
II-200	Sebelipase Alfa (Kanuma®)	Prior Authorization
IV-152	Transcatheter Mitral Valve Repair (TMVR)	Prior Authorization
IV-155	Transcatheter Pulmonary Valve Implantation	Post Service Audit

Products Impacted

- The information in this Bulletin applies to subscribers that have coverage through all commercial lines of business.
- The changes do not impact government programs lines of business (Prepaid Medical Assistance Program (PMAP), MinnesotaCare (MNCare), SecureBlue (MSHO), and Minnesota Senior Care Plus (MSC+) health plans), Federal Employee Program (FEP), Medicare Supplement (Senior Gold, Basic Medicare Blue and Extended Basic Blue), Medicare Advantage or Platinum Blue as those lines of business have separate PA requirements.

Submitting a PA Request when Applicable

- Before submitting a PA request, Providers are asked to check applicable Blue Cross criteria and **attach all required clinical documentation** with the request. PA requests will be reviewed when patient-specific, relevant medical documentation has been provided supporting the medical necessity of the service**.** Failure to submit required information may result in review delays (if outreach is needed to obtain missing clinical information) or a denial of the request due to insufficient information. 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.
- Prior Authorization Lists are updated to reflect additional PA requirements on the effective date of the management change and includes applicable codes. To access 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
  - Complete the PA required PA form and fax to the appropriate number, including the required clinical documentation

Providers can Submit an Electronic Medical Drug Prior Authorization (ePA) Request

- Online via our free Availity provider portal – for Blue Cross to review.
- 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 Minnesota Uniform Form for PA Request and Formulary Exceptions fax form located under the Forms section on the Blue Cross website, or their own PA form (secure fax: 651.662.2810).

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

eviCore Healthcare Specialty Utilization Management (UM) For Fully Insured Commercial Members (Effective 8/1/18, P21-18)

Effective August 1, 2018, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will work with eviCore Healthcare to review and process prior authorizations (PAs) for the following specialty utilization management (UM) services:

- Lab Management (Molecular and genetic testing)
- Medical Oncology
- Radiation Therapy
- Radiology
- Cardiology (Advanced imaging and diagnostic services; implantable device services)
- Musculoskeletal (spine, large joint and interventional pain)
- Sleep Management (sleep apnea testing; treatment with sleep related DME)

As stewards of healthcare expenditures for our members, we are committed to ensuring they receive high quality, evidence-based care. One method for doing so is through the PA process. The primary purpose of the PA process is to ensure that evidence-based care is provided to our members to promote quality, safety, and affordability.

eviCore medical policies will be available for your use and review on approximately June 1, 2018, on the Blue Cross website at **providers.bluecrossmn.com**

- To access the link, select "Medical Policy" under Tools and Resources, read and accept the Blue Cross Medical Policy Statement
- Click on the "+" (plus) sign next to "Medical and Behavioral Health Policies"

Products Impacted
This change only applies to the fully insured commercial members.

eviCore Prior Authorization (PA) Requests
Beginning July 23, 2018, providers should submit eviCore PA requests via our free **Availity** provider portal. Instructions on how to utilize this portal are found on the Availity website.

Providers need to reference the eviCore medical policy criteria (instructions above) and submit all clinical documentations 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 member's benefit plan. Member benefit plans vary in coverage and some plans may not provide coverage for certain services discussed in the medical policies.