PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

WHAT'S INSIDE: July 2, 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.

ADMINISTRATIVE UPDATES

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 of their obligation to promptly submit a form to us when any changes occur, including any of the following:

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

Forms Location

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

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

How do we submit changes?

Send the appropriate form via fax as indicated below:
Fax: 651-662-6684, **Attention: Provider Data Operations**

Change to Administration of Interpreter Services for MHCP Subscribers

(P28-18, published 7/2/18)

Effective October 1, 2018, Blue Plus will be switching to a new vendor (Amerigroup) to process interpreter claims. There are some procedural changes that will occur because of this new arrangement. Blue Plus is implementing a change to require all ancillary service providers to perform their own direct billing for interpreter services. All ancillary service providers, including Chiropractic, Acupuncturist, Vision, Occupational Therapy, Physical Therapy, Speech Therapy, Eye Clinics, Pharmacy, Durable Medical Equipment (DME), County Agencies, Care Coordination, ARHMS and ACT, must now perform their own direct billing to Blue Plus. All ancillary providers, other than Dental Clinics and Home Health Agencies, utilizing interpreters are responsible to schedule and bill for interpreter services provided to Blue Plus Minnesota Health Care Program (MHCP) subscribers.

Providers are expected to establish relationships with individual interpreters or interpreter agencies to provide the interpreter services. These relationships must be independent of any agreement with Blue Plus and exist strictly between the provider and the interpreter or interpreter agency. All interpreters must be registered and rostered on the Minnesota Department of Health (MDH) website.

Blue Plus continues to maintain a network of Interpreter Agencies to provide interpreter services to Dental Clinics and Home Health Agencies. Dental Clinics and Home Health Agencies should contact one of the agencies listed below to schedule an interpreter for an appointment.

- Arch Language Network, Inc Metro, Southern MN, Western MN
  (651) 789-7897
- The Bridge World Language Ctr. North Metro, St. Cloud and surrounding Counties
  (320) 259-9239
- The Language Banc Metro, Stearns and surrounding Counties
  (612) 588-9410
- Itasca Interpretation Services Metro
  (651) 457-7400
- Intercultural Mutual Asst. Assoc. Southeast MN
  (507) 289-5960
- Project FINE Winona County Only
  (507) 452-4100

Interpreter services must be billed by the provider in association with a covered service. Services must be billed on an 837P transaction on individual claim lines using procedure code T1013 in 15-minute increments. At least 8-minutes of interpreter services must be provided in order to bill one unit of service. Affiliate the supervising provider to the individual claim line for interpreter services.

Products Impacted

- Prepaid Medical Assistance (PMAP)
- MinnesotaCare
- SecureBlue (HMO SNP)
- Minnesota Senior Care Plus (MSC+)

Minnesota Senior Health Options (MSHO) Model of Care Training Requirements

(P29-18, published 7/2/18)

What is the Special Needs Plan-Model of Care (SNP-MOC)?

SecureBlue[sm] is Blue Plus' Minnesota Senior Health Options (MSHO) plan, a Fully Integrated Dual Eligible Special Needs Plan (SNP) in which Medicare and Medicaid benefits and services are integrated into one benefit package. The SecureBlue Model of Care (SNP-MOC) is the Blue Plus plan for delivering coordinated care to SecureBlue members. The Centers for Medicare & Medicaid Services (CMS) requires all Special Needs Plans to have a MOC. The SNP-MOC documents the staff, systems, procedures, and improvement activities Blue Plus utilizes to simplify access to healthcare and reduce fragmentation of care delivery for SecureBlue members. The SNP-MOC ensures that Blue Plus, in partnership with its contracted providers and care coordination delegates, meets the unique needs of the frail and vulnerable SecureBlue population.

Who is required to complete SNP-MOC training?

CMS requires all providers and appropriate staff to complete Model of Care training upon initial employment and annually thereafter. Providers and appropriate staff required to complete the training include anyone who may participate in a SecureBlue member's Interdisciplinary Care Team, be responsible for implementation of the member's Collaborative Care Plan or manage planned or unplanned transitions of care.

At a minimum, the Interdisciplinary Care Team includes the member and/or their authorized caregiver, the Care Coordinator, and the Primary Care Physician. Based on the member's clinical and social needs, the Interdisciplinary Care Team may also include specialists, physician assistants, a psychiatrist or other behavioral health specialists, physical therapists, community health workers, nurses, local or social service case managers, and Blue Plus Health Coaches. CMS does not provide a definition for "routine basis." You should ensure that all providers and staff who are delivering care that is part of the patient's treatment plan are completing this training. The Collaborative Care Plan addresses the member's medical, functional, cognitive, psychosocial, and mental health needs identified in the Minnesota Long Term Care Consultation health risk assessment tool.

How to Complete SNP-MOC Training

Blue Plus has made this training available in a brief and easy to understand presentation in order to help providers meet this requirement in the most efficient manner possible. The SecureBlue SNP-MOC training is available online as a PowerPoint presentation at: https://carecoordination.bluecrossmn.com/training/.

As described in the Blue Plus Manual, providers must document and maintain MOC training completion records and provide such records to Blue Plus upon request to validate that the training has been completed. At a minimum, your training completion record must include the provider's or staff person's name, their department or title, and the date the training was completed.

Compliance with SNP-MOC Training Requirements

Blue Plus is committed to maintaining strong, collaborative partnerships with our providers to ensure they have easy access to the information and tools necessary to provide the highest quality, evidence-based care. We therefore work with our provider partners to validate that mandated and regulated activities such as Model of Care Training occur and assist providers in identifying and overcoming any barriers to training completion. Your Blue Plus Provider Service Agreement reflects these commitments. Because compliance is critical, if a provider fails to complete the CMS required training and remains noncompliant, they may be required to develop a Corrective Action Plan or be subject to other remediation activities.

Questions?

We are here to assist you in overcoming any barriers to training completion. If you have questions or require assistance, please send an email to medicare.compliance.training@bluecrossmn.com.

New Fully Insured Commercial Medication Therapy Management Program

(P30-18, published 7/2/18)

The purpose of this Bulletin is to inform providers that effective August 15, 2018, a Medication Therapy Management (MTM) benefit will be included for fully insured commercial subscribers who are taking four or more medications for 2 or more chronic conditions. The MTM service is an interactive person-to-person, telephonic or telehealth medication review and consultation conducted in real-time between the patient and /or other authorized representative, such as prescriber or caregiver, and a pharmacist. Participating subscribers will receive a consultation with a pharmacist in which the pharmacist will employ a systematic process of collecting patient-specific information, assessing medication therapies to identify medication related problems, developing a prioritized list of medication related problems, and creating a plan to resolve them with the patient, caregiver to the patient, and/or the patient's prescriber. Subscribers must opt in to the MTM service.

A MTM service includes the following components:

- Performing assessments of the subscriber's health status;
- Formulating a medication review plan;
- Evaluating the subscriber's response to therapy for appropriateness, effectiveness, safety and adherence;
- Identifying, resolving, and preventing medication-related problems;
- Documenting the care delivered and communicating essential information to the Subscriber's other primary care providers to support coordination of care;
- Providing education designed to enhance the subscriber's understanding and appropriate use of medications;
- Providing information, support services and resources designed to enhance the subscriber's adherence to therapeutic regimens.

Subscribers may receive up to 3 visits in a calendar year.

CONTRACT UPDATES

New Site of Care Drug Management Program for Infused and Injectable Drugs Administered by a Health Care Provider (P27-18, published 7/2/18)

Effective September 3, 2018, select specialty medications that are already subject to prior authorization (PA) requirements for Commercial subscribers will be included in the Site of Care Drug Management Program. Within the program, infused and injectable specialty medications administered by a health care provider are required to be administered in a clinic, infusion center, or by a home infusion agency. Site of Care criteria will be added to existing drug policies and PA requirements and reviews can be submitted beginning August 20, 2018.

Infusions or injections administered in a hospital outpatient setting for medications subject to PA requirements are not eligible for reimbursement unless the medical necessity criteria have been met. No partial approvals will be granted.

Prior Authorizations requests must include the following additional information:

- Site of care location:
  - Infusion agency in the Home
  - Clinic/Office
  - Infusion Center
  - Hospital outpatient, if selected requires an exception reason to be provided based on medical policy criteria

Please check the subscriber's benefits and confirm the **in-network** site of care. All new requests and upon renewal, drug PAs will be subject to site of care management unless otherwise stated in the medical policy criteria.

List of Medications and the medical policy number:

- Abatacept, II-161
- Agalsidase Beta, II-26
- Alemtuzumab, II-184 (non-oncologic indications only)
- Alglucosidase Alfa, II-186
- Certolizumab Pegol, II-179
- Edaravone, II-178
- Golimumab (Simponi Aria), II-180
- Immunoglobulin Therapy, II-51
- Infliximab, II-97
- Natalizumab, II-49
- Ocrelizumab, II-185
- Rituximab, II-47 (non-oncologic indications only)
- Sebelipase Alfa, II-200
- Tocilizumab, II-181 (non-oncologic indications only)
- Ustekinumab, II-168
- Vedolizumab, II-182

For more information, please visit:
Procedures/Services/Drugs under the medical benefit:

- Go to: providers.bluecrossmn.com
- Under Tools and Resources, select "Medical Policy" and acknowledge the Acceptance statement
- Select the "+" plus sign next to the Medical and Behavioral Health Policies
- Under the "Medical Policy Supporting Documents", Click on the Site of Care link, available after August 1, 2018

Products Impacted

- This program only applies to commercial lines of business. As a reminder for a value network subscriber, please have the subscriber call Blue Cross at **(651) 662-5200** or **1-800-262-0820**.
- The changes do not impact subscribers who have coverage through Prepaid Medical Assistance Program (PMAP), MinnesotaCare, SecureBlue (MSHO), Minnesota Senior Care Plus (MSC+), Federal Employee Program (FEP), Medicare Advantage or Platinum Blue as those lines of business have separate PA requirements.

Submitting a Medical Drug PA Request

Providers must submit a PA request for approval for the medical specialty drugs listed above. If a provider does not obtain required PA before rendering services, Blue Cross will deny claims as provider liability for lack of prior authorization. The requirement applies to subscribers starting drug therapy and to those already being treated with one of the medications above.

Before submitting a PA request, providers are asked to check the Medical Policy criteria and attach **all required clinical documentation** with the request including documentation of previous therapies tried and evidence of symptom improvement using the drug. PA requests will be reviewed when patient-specific, relevant medical documentation has been provided supporting the medical necessity of the drug**.** 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 insufficient information.

Providers can submit an electronic medical drug (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 use the process above, the Minnesota Uniform Form for PA Request and Formulary Exceptions fax form located under the Forms section on the Blue Cross website, or submit the PA request to Blue Cross using their own form (secure fax: 651.662.2810).

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATES

New Medical, Medical Drug and Behavioral Health Policy Management Updates for Commercial Lines of Business (Effective 9/3/18, P31-18)

Effective September 3, 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 September 3, 2018 for commercial lines of business:

Policy #	Policy Name	Enforcement
IV-154	Artificial Retinal Devices	Retrospective Review
VII-63	Powered Exoskeleton for Ambulation in Patients with Lower-Limb Disabilities	Deny as Investigative
IV-27	Prophylactic Mastectomy	Prior Authorization

Products Impacted

- The information in this Bulletin applies to subscribers that have coverage through 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 policy 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.
- 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.

- 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.

- 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.

- Providers may submit PA requests for any treatment in the above table started July 23, 2018.

Providers can Submit an Electronic Prior Authorization (ePA) Request

- Online via our free Availity provider portal – for Blue Cross to review.
- Out of state, non-contracted providers can submit a PA request to Blue Cross by either using the electronic processes above, 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