PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

WHAT'S INSIDE: SEPTEMBER 4, 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: 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**

Provider Price Disclosure Requirement

(P43-18, published 9/4/18)

Effective January 1, 2019, in accordance with Minnesota Statute 62.J.81, Providers must provide patients with information regarding other types of fees or charges that the patient may be required to pay in conjunction with a visit to the Provider, including but not limited to any applicable facility fees, within ten business days from the day of a completed request. In addition, Providers must maintain a list of the services over $25.00 that correspond with the Provider's 25 most frequently billed current procedural terminology (CPT) codes. This list shall be updated annually and must be posted in the Provider's reception area of the clinic or office and made available on the Provider's Web site if the Provider maintains a website. No contract between a Provider and Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) prohibits any of these price disclosures. Price disclosure is not a guarantee of final costs for Health Services received nor a final determination of eligibility of coverage.

Blue Cross to Post Provider Quick Points Twice per Month on Standard Schedule
(P40-18, published 9/4/18)

As of November 1, 2018, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will begin posting Quick Points on the second and fourth Wednesday of each month on the **bluecrossmn.com** website. This change will provide expected dates of publication to support ease of access to new information and administrative efficiency for providers and Blue Cross. Quick Points will continue to be available on our website as well as on Availity's provider portal.

To view Provider Quick Points on the Blue Cross website

- Access **providers.bluecrossmn.com**
- Select forms and publications
- Select Quick Points

To view Provider Quick Points on Availity's provider portal

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

CONTRACT UPDATES

No-Load Miles (Deadhead) Reimbursement Rate for Minnesota Health Care Programs Subscribers (P42-18, published 9/4/18)

Effective November 1, 2018, approved deadhead mileage billed on eligible transportation claims for Minnesota Health Care Programs (MHCP) subscribers will be reimbursed by Blue Plus at $.54 per mile.

Products Impacted

This notice applies to the following MHCP products:

- Blue Advantage Prepaid Medical Assistance Program (PMAP)
- Minnesota Senior Care Plus (MSC+)
- MinnesotaCare
- SecureBlue (MSHO)

Deadhead Mileage Approval

Medical transportation miles driven without the MHCP Subscriber in the vehicle is considered deadhead mileage. Deadhead mileage may be covered on a case by case basis and must be pre-approved by BlueRide staff. Authorization must be requested prior to the non-emergency medical ride being provided. BlueRide reserves the right to work with the most cost-effective form of transportation.

Billing Deadhead Mileage

Deadhead mileage must be billed on a separate line from the actual loaded miles using the mileage code with TP modifier. The miles will equal the units of service (1 approved deadhead mile = 1 unit of service).

Update: Change to TPA Business

(P41-18, published 9/4/18)

Blue Cross and Blue Shield of Minnesota (Blue Cross) notified you on August 1, 2018 (Bulletin P35-18) that Independence Health Group (Independence) subsidiary AmeriHealth Administrators, Inc. (AHA) completed an asset purchase May 1, 2018 that included self-insured customer contracts from Blue Cross' third-party administrator (TPA).

Blue Cross also informed you that:

- AHA's platform will manage eligibility, benefits, claims processing and health management services for the purchased customer accounts.
- After transition to the AHA platform, members will carry an ID card with the BlueLink TPA name and logo and access the BlueCard provider network.

On **October 1, 2018**, *only* two groups (OSI Environmental and Direct Fulfillment) which were part of the purchase will migrate to the AHA technology platform.

Group Name	Alpha Prefix
OSI Environmental	OSI
Direct Fulfillment	DFL

On **November 1**, **2018**, the following additional group will migrate to the AHA platform, begin using the BlueLink TPA brand, and accessing the BlueCard network:

Group Name	Alpha Prefix
Spectro Alloys	SGI

On **December 1**, **2018**, the following groups will migrate to the AHA platform, begin using the BlueLink TPA brand, and accessing the BlueCard network:

Group Name	Alpha Prefix
Design Electric	DED
Javens Mechanical Contracting Co.	JVT

New Payment Policy Auditing System

(P45-18, published 9/4/18)

Effective October 19, 2018, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be enhancing the claims editing system to ensure claims are coded to the highest level of specificity to allow for proper payment. The edits used will be consistent with the expectations outlined in the Blue Cross Provider Policy and Procedure Manual and utilizes the Centers for Medicare & Medicaid (CMS), the American Medical Association (AMA) and other specialty academy policies and procedures; as well as proprietary Blue Cross plan specific requirements.

Areas of Focus

Blue Cross requires the correct use of all modifiers covered under CPT, CMS, and National Correct Coding Initiative (NCCI) guidelines, including but not limited to:

- Modifier GN, GO, GP
- Modifier 91
- Anatomic Modifiers

- Correct use of a modifier in combination with Medicare column 1 column 2
- Alignment of modifier to professional service

As a reminder the primary diagnosis must be present on all claims in accordance with ICD 10 coding guidelines.

Examples of Automated Claim Edits:
Please note, the scope of the edits implemented is not limited to the following examples; the examples are to illustrate the types of correct coding expectations that are in place in the enhanced system.

Modifier GN, GO, GP
Rehabilitative therapies that are submitted for Medicare Advantage plan subscribers without the appropriate modifier will be denied with the claim adjustment reason code of 4, "The procedure code is inconsistent with the modifier used or a required modifier is missing."

The use of one of the three therapy modifiers (GN, GO, or GP) is required on a certain set of Healthcare Common Procedure Coding System (HCPCS) codes to identify when each OPT service is furnished under an SLP, OT, or PT plan of care.

Modifier 91
Repeat lab services require modifier 91 (not 59) unless the narrative supports submission of multiple units.

Modifier 91 should not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required.

Anatomic Modifiers
Certain procedures require an anatomical modifier (fingers, toes, eyelids, coronary arteries, right, left and bilateral). When an anatomic modifier is not appended, the procedure will be denied. Anatomic modifiers must match the anatomic diagnosis. A CPT code for a fracture of the right ankle (modifier RT) must align to the diagnosis code, reflecting the same anatomic appendage/extremity.

NCCI
Immunization administration (90471) when billed in combination with 99213 (office or another outpatient visit for E&M of an established patient) would require a modifier 25 on the E&M, otherwise would deny.

Immunization administration (90471) includes: percutaneous, intradermal, subcutaneous, or intramuscular injections; 1 vaccine (single or combination vaccine/toxoid).

Reference material for NCCI can be found at the following location:
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How-To-Use-NCCI-Tools.pdf

ICD Coding Guidelines
ICD manual guidelines state that chemotherapy, immunotherapy, and radiation administration must be billed using the primary or principal diagnosis, in these instances the Z code should be the principle diagnosis followed by the malignancy diagnosis.

Global, Technical, Professional Policy
According to CMS, codes with a PC/TC Indicator of "9" cannot be split into professional components (modifier 26) and technical components (modifier TC) as the concept of PC/TC does not apply. Therefore, when these services are billed with modifiers 26 or TC, they will be denied.

Impacted Lines of Business
Commercial fully insured, self-insured and individual plans, as well as Medicare Advantage products are included. ITS, Federal Employee Program (FEP), and Medicaid are not in scope at this time.

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATES

Blue Cross Contracts with eviCore to Expand Utilization Management for Post-Acute Care (P39-18, published 9/4/18)

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) has contracted with eviCore Healthcare (eviCore), an independent specialty medical benefits management company, to manage benefit preauthorization requests for Post-Acute Care (PAC) services for subscribers enrolled in the following programs:

- Individual
- Commercial Fully Insured Small & Large Groups
- Medicare Advantage

eviCore's PAC program is designed to align the member's discharge planning decisions with the facility's clinical team which ensures our member safety and reduces avoidable readmissions.

For dates of service effective November 1, 2018, eviCore will be accepting initial and extended stay (concurrent) prior-approval requests for the following provider types:

- Skilled Nursing Facilities (SNF)
- Long-Term Acute Care Facilities (LTAC)
- Home Health Care (HHC)
- Inpatient Rehabilitation Facilities (IRF)

Key eviCore program points effective beginning November 1, 2018:

- For members in a facility, the Hospitals will be responsible for submitting the initial inpatient PAC prior-approval requests for SNF, IRF and LTAC (PAC Facilities).
- PAC Facilities will submit concurrent review requests for all PAC admissions and prior approval requests for community referrals.
- HHC agencies will submit prior-approval requests for direct hospital discharges and community referrals.
- Discharging PAC Facilities or the admitting HHC Agency may submit Home Health prior-approval requests.

eviCore will accept benefit preauthorization requests from providers in any of the following ways:

- **http://www.availity.com**will be the quickest way to create prior authorizations and check existing case status
- Fax – PAC authorizations 888-738-3916, Home Health authorizations: 877-791-4097; DME authorizations 866-663-7740.
- Telephone – Clinical information can be called in to eviCore at **1-844-224-0494** option 5 for PAC, HH or Transitional Care, option 4 for DME, follow appropriate prompts based on inquiry.

Training opportunities and provider resources
Blue Cross will provide training on the PAC program beginning in October to ensure understanding of the new prior authorization process. Preauthorization forms, training schedules and provider resources will be posted at www.evicore.com/healthplan/bluecrossmn.

eviCore Healthcare Specialty Utilization Management – Durable Medical Equipment
(P44-18, published 9/4/18)

Effective November 1, 2018, Blue Cross and Blue Shield of Minnesota (Blue Cross) has contracted with eviCore healthcare (eviCore), an independent specialty medical benefits management company, to manage benefit preauthorization (PA) requests for Durable Medical Equipment (DME) for subscribers enrolled in the following programs:

- Individual
- Commercial Fully Insured Small & Large Groups
- Medicare Advantage

Providers should submit PA requests via our free **Availity** provider portal. Instructions on how to utilize this portal are found on the Availity website. The Availity portal is available 24/7 and is the **quickest** way to create prior authorizations and check existing case status.

On September 15, 2018, providers can view the eviCore DME medical policies and the provider orientation materials by visiting the Blue Cross website. The Healthcare Procedure Codes (HCPC) **list of DME that require PA is already posted** on eviCore implementation site.

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 under the 'Precertification Lists' select eviCore Healthcare Specialty Utilization Management Clinical Guidelines To view the eviCore medical policies, the CPT (Current Procedural Terminology) code list that require PA, or the provider orientation materials please visit https://www.evicore.com/healthplan/bluecrossmn

Products Impacted
Prior Authorization is required through eviCore for Blue Cross subscribers enrolled in the following programs:

- Individual
- Commercial Fully Insured Small & Large Groups
- Medicare Advantage

Subscribers who **do not require prior authorization** through eviCore are:

- **Blue Cross Commercial Self-Insured Subscribers**
- **Blue Cross Federal Employee Subscribers**
- **Blue Cross Medicare/Medicaid Subscribers**

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.

Questions?
If you need to submit a PA by phone or need to speak to an eviCore representative call **844-224-0494**, 7:00 a.m. to 7:00 p.m. CST, Monday - Friday.

Medical Oncology Drug Prior Authorization Updates for Fully Insured Commercial Members – eviCore Healthcare Utilization Management

(P37-18, published 9/4/18)

The eviCore Healthcare Utilization Management Program will be making the following updates to the Medical Oncology CPT List.

Effective August 1, 2018, the following drugs no longer require prior authorization for oncologic reasons, under the medical benefit:

Description	Codes
Alemtuzumab (Campath®)	J0202
Amifostine (Ethyol®)	J0207
Anakinra (Kineret®)	J3590
Epoetin beta (Mircera®)	J0888
Ganciclovir sodium (Cytovene®)	J1570
Histrelin Implant (Supprelin LA®)	J9226
Interferon, alfa-n3 (Alferon N®)	J9215
Mesna (Mesnex®)	J9209
Plerixafor (Mozobil®)	J2562
Rasburicase (Elitek®)	J2783

Starting November 1, 2018, the following drugs will require prior authorization for oncologic reasons:

Description	Codes
Copanlisib (Aliqopa®)	C9030
Trastuzumab-dkst (Ogiviri®)	J3490, J3590, J9999
Aprepitant (Cinvanti®)	J3490, C9463
Epoetin alfa-epbx (Retacrit®)	Q5106
Fosnetupitant/Palonosetron (Akynzeo®)	C9399, J3490
Gemtuzumab Ozogamicin (Mylotarg®)	J9203
Leuprolide Acetate (Eligard®, Lupron Depot®, Lupron®) 3.75mg dose	J1950
Rituximab and Hyaluronidase Human (Rituxan Hycela)	C9467
Pegfilgrastim-jmdb (Fulphila®)	C9399, J3590, Q5108
Rolapitant (Varubi®)	J8670, C9464, J3490

Prior authorization requests will be reviewed based on eviCore clinical guideline criteria available for review on the Blue Cross website at **providers.bluecrossmn.com:**

- 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" and locate the "Medical Policy Supporting Documents section
- Click on the 'eviCore healthcare Specialty Utilization Management Clinical Guidelines' link

Products Impacted

- This change only applies to **fully insured commercial members.**
- The changes do not impact commercial self-insured health plans, 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.

To submit a Medical Oncology Drug Prior Authorization (PA) Request to eviCore

Providers began submitting 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 clinical guideline criteria, submit prior authorization request 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 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.
- Some of the Medical Oncology Drugs listed above may be approved by the Food and Drug Administration (FDA) for use treating non-oncology indications. To identify if a prior authorization for a drug for non-oncology use, please refer to the Prior Authorization Lists posted on the Blue Cross website. To access the Pre-Authorization Lists:
  - Go to **providers.bluecrossmn.com**
  - Select "Medical Policy" under Tools and Resources, read and accept the Blue Cross Medical Policy Statement
  - Click on the "+" (plus) sign next to "Utilization Management"

Questions?
If you have questions, please contact eviCore provider service at **844-224-0494**.

Radiology/Cardiology Program Prior Authorization Updates for Fully Insured Commercial Members – eviCore Healthcare Utilization Management Program

(P36-18, published 9/4/18)

The eviCore Healthcare Utilization Management Program will be making the following updates to the Radiology/Cardiology CPT List.

Effective August 1, 2018, the following tests no longer require prior authorization:

Code	Description
78499	Unlisted Cardiovascular Procedure
78699	Unlisted Nuclear Medicine Procedure

Starting November 1, 2018, the following procedure will require prior authorization:

Code	Description
78456	Unlisted Cardiovascular Procedure

Prior authorization requests will be reviewed based on eviCore clinical guideline criteria available for review on the Blue Cross website at **providers.bluecrossmn.com:**

- 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" and locate the "Medical Policy Supporting Documents section
- Click on the 'eviCore healthcare Specialty Utilization Management Clinical Guidelines' link

Products Impacted

- This change only applies to **fully insured commercial members.**
- The changes do not impact commercial self-insured health plans, 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.

To submit a Prior Authorization (PA) Request to eviCore

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 clinical guideline criteria, submit prior authorization request 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 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.

Questions?
If you have questions, please contact eviCore provider service at **844-224-0494**.

Musculoskeletal Clinical Guidelines for Fully Insured Commercial Members – eviCore Healthcare Specialty Utilization Management Program

(P38-18, published 9/4/18)

eviCore has released updates to the following Musculoskeletal Clinical Guidelines:

- Large Joint Services
- Spine Surgery
- Interventional Pain Management

The clinical guideline updates become effective on October 22, 2018.

eviCore clinical guidelines are available 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" and locate the "Medical Policy Supporting Documents section
- Click on the 'eviCore healthcare Specialty Utilization Management Clinical Guidelines' link

Products Impacted

- This change only applies to the fully insured commercial members.
- The changes do not impact commercial self-insured health plans, 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.

To submit a Prior Authorization (PA) Request to eviCore

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 clinical guideline criteria, submit prior authorization request 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 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.

Questions?
If you have questions, please contact eviCore provider service at **844-224-0494**.