PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

WHAT'S INSIDE: **DECEMBER 3, 2018**

ADMINISTRATIVE UPDATES

Reminder: Medicare Requirements for Reporting Provider Demographic Changes

(article is published in every monthly Bulletin)

In accordance with Medicare requirements, Blue Cross is required to maintain accurate provider network directories for the benefit of our Subscribers. Blue Cross is hereby reminding all providers to submit a form to us whenever any of the following changes occur:

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

Forms Location

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

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

How do we submit changes?
Send the appropriate form via fax as indicated below:
Fax: 651-662-6684, **Attention: Provider Data Operations**

Update: Change to TPA Business

(P76-18, published 12/3/18)

As previously communicated in Provider Bulletins P35-18 and P41-18, 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 and Blue Shield of Minnesota's (Blue Cross) third-party administrator (TPA).

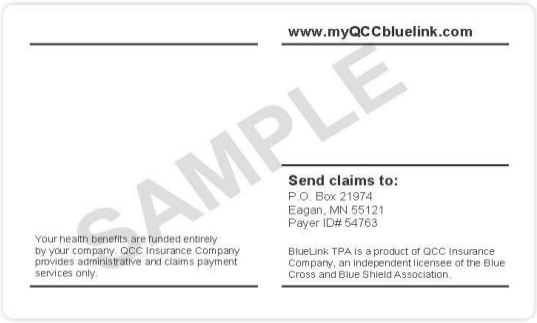
Blue Cross also informed providers that:

- 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;
- The following groups would migrate to the AHA platform on the dates below.

Group Name	Alpha Prefix	Migration Date
OSI Environmental	OSI	10/1/2018
Direct Fulfillment	DFL	
Spectro Alloys	SGI	11/1/2018
Design Electric	DED	12/1/2018
Javens Mechanical Contracting	JVT	

Effective January 1, 2019 the remaining TPA groups listed on the following pages will migrate to the AHA platform. Groups not already using the BlueLink TPA brand and accessing the BlueCard network will begin to do so upon their January 1, 2019 migration and will carry an ID card with the BlueLink TPA name and logo.

FRONT



BACK

TPA groups migrating on January 1, 2019

Group Name	Current Group Number	Alpha Prefix
Activar	5MN03730	AOV
Ag Partners	5MN04910	GPU
Aicota Health Care	5MN05980	HCP
Appleton Hospital	5MN05970	THS
Arrowhead Promotion & Fulfillment	5MN04920	PFB
Arrow Tank and Engineering	5MN06080	RUW
Austin Public Schools	5MN04940	KAP
BendTec Inc	5MN04540	JBT
Bois Forte Reservation Tribal Council	5MN04610	KBF
Capstan Corporation	5MN05530	CUO
Carl Bolander	5MN04300	CZV
Catholic Charities Bureau	5MN04500	CYQ
Community Memorial Hospital	5MN02000	COQ
Confederated Tribes of the Colville Reservation	5BL06100	C2V
Davasee Enterprises	5MN03090	DVE
Diocese of Superior	5MN04490	DIS
Douglas Corporation	5MN01370	XDG
Ely-Bloomenson Community Hospital	5MN05990	EGO
Flandreau Santee Sioux Tribe	5BL05900	FSD
Fond du Lac CHS	5MN03960	DUJ
Fortune Bay Casino Resort	5MN02810	FVC
Grandmas Inc	5MN04750	GDJ
Grand Portage	5MN03610	GPI
Hank's Specialties	5MN06040	HAI
Human Development Center	5MN06010	DGH
Jackpot Junction Casino Hotel	5MN05700	JJL
Jeff Foster Trucking	5MN04820	JFE
Lower Sioux Indian Community	5MN05690	IXS
Marine Credit Union	5MN05440	MWZ
Modernistic	5MN03370	MOQ
National Bank of Commerce	5MN05880	NVQ

Group Name	Current Group Number	Alpha Prefix
North Shore Bank of Commerce	5MN03740	NEB
NRI Electronics	5MN06090	NIR
Nystrom & Associates, Ltd.	5MN05720	NYT
Ponca Tribe	5BL06020	PDT
Prairie Island	5BL05910	PKI
Randy's Sanitation	5MN04370	RAO
Red Wing Publishing	5MN03870	RWC
Republic Bank, Inc.	5MN04640	LRB
Shakopee Mdewakanton Sioux Community	5BL05820	SKJ
Southern Minnesota Regional Legal Services, Inc.	5MN05850	MPG
Sterling State Bank	5MN03820	SKB
St. Paul Stamp Works, Inc.	5MN06050	PFV
The Red Lake Nation	5MN03300	RLI
The Specialty Manufacturing Company	5MN03410	SJV
Torgerson Properties, Inc	5MN03460	TPY
Transit Team	5MN06060	TAN
Treasure Island Resort & Casino	5BL05920	TIC
Tuohy Furniture Corporation	5MN02050	TON
Upper Lakes Foods, Inc	5MN03380	ULI
Upper Sioux Community	5MN05940	UTF
Wells Concrete	5MN04860	WOC
White Earth Band of Chippewa Indians/National Tribal Claims Center	5MN05950	WHR
Woodland Centers	5MN03510	WDV

Blue Cross Blue Shield Association High-Dollar Prepay Review Effective January 1, 2019 (P71-18, published 12/3/18)

Due to the rising cost of health care and its impact on members, the Blue Cross Blue Shield Association (BCBSA) has mandated that all health plans, including Blue Cross and Blue Shield of Minnesota, review all high-dollar claims to ensure that providers are billing in accordance with services performed.

Blue Cross and Blue Shield of Minnesota is required to identify and review high-dollar claims from all providers on behalf of BCBSA.

Effective January 1, 2019, providers will be required to attach an itemized bill of the services rendered when submitting high-dollar claims that meet certain criteria for review, to be eligible for reimbursement.

Claims from participating providers that meet **all** of the following criteria are subject to review:

- Inpatient institutional claim from an acute care facility
- Claims submitted to Blue Cross and Blue Shield of Minnesota for members of another commercial Blue Cross plan
- Claims with an expected allowance that is $250,000 or greater

If a claim meets **all** of the criteria above and an itemized bill is not submitted as an attachment, the claim will be denied advising that an itemized bill is required. The provider should then submit a replacement claim with the itemized bill as an attachment.

CONTRACT UPDATES

Blue Cross to Reimburse CPT Code 97140
(P69-18, published 12/3/18)

Effective January 1, 2019, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will reimburse chiropractors, occupational therapists and physical therapists for CPT code 97140 – Manual Therapy techniques, one or more regions, each 15 minutes.

Products Impacted
This change applies to all lines of business except Medicaid.

Coding requirements reminder
All coding and reimbursements are subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (e.g. **HCPCS, CPT, ICD**), only valid codes for the date of service may be submitted or accepted.

HCPCS stands for Healthcare Common Procedure Coding System
CPT® (Current Procedural Terminology) is a registered trademark of the American Medical Association.

Blue Cross Reimbursement Policy Effective February 1, 2019 – Reimbursement for Maximum Units Per Day (P75-18, published 12/3/18)

As of February 1, 2019, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will allow reimbursement for a procedure or service that is billed for a single member on a single date of service by the same provider and/or provider group up to the maximum number of units allowed per day. When the number of units assigned to a procedure or service exceeds the daily maximum allowed, the units billed in excess of the maximum per day limit will not be eligible for reimbursement.

Maximum Units Per Day edits do not affect National Correct Coding Initiative (NCCI) edits. For more information on NCCI edits, please see our Code and Clinical Editing reimbursement policy.

Product Impacted
This change applies to Minnesota Health Care Programs (MHCP), including Blue Advantage Families and Children (formerly Prepaid Medical Assistance Program), MinnesotaCare (MNCare) and Minnesota Senior Care Plus (MSC+).

For additional information on the Reimbursement for Maximum Units Per Day reimbursement policy 15-003, visit the provider self-service website at
https://www.bluecrossmn.com/healthy/public/personal/home/providers/medicaid-medical-policies/.

Blue Cross Requires use of Anatomical Modifiers

(P80-18, published 12/3/18)

Effective February 1, 2019, Blue Cross and Blue Shield of Minnesota (Blue Cross) will change the Reimbursement Policy titled "General Coding-Modifier Policy". Submission of anatomical modifiers to specify locations will be required when submitting claims.

Anatomical Modifiers

The following modifiers indicate a specific anatomic site. Because these modifiers affect edits and payment, effective February 1, 2019 Blue Cross requires the anatomical modifier(s) be submitted in the first modifier position, if applicable.

E1 Upper left, eyelid
E2 Lower left, eyelid
E3 Upper right, eyelid
E4 Lower right, eyelid
FA Left hand, thumb
F1 Left hand, second digit
F2 Left hand, third digit
F3 Left hand, fourth digit
F4 Left hand, fifth digit
F5 Right hand, thumb
F6 Right hand, second digit
F7 Right hand, third digit
F8 Right hand, fourth digit
F9 Right hand, fifth digit
LC Left circumflex coronary artery
LD Left anterior descending coronary artery
LT Left side (used to identify procedures performed on the left side of the body)
RC Right coronary artery
RT Right side (used to identify procedures performed on the right side of the body)
TA Left foot, great toe
T1 Left foot, second digit
T2 Left foot, third digit
T3 Left foot, fourth digit
T4 Left foot, fifth digit
T5 Right foot, great toe
T6 Right foot, second digit
T7 Right foot, third digit
T8 Right foot, fourth digit
T9 Right foot, fifth digit

Products Impacted

This policy applies to all lines of business.

Coding Requirements Reminder

All coding and reimbursements are subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (e.g. **HCPCS, CPT, ICD**), only valid codes for the date of service may be submitted or accepted.

HCPCS stands for Healthcare Common Procedure Coding System.
CPT® (Current Procedural Terminology) is a registered trademark of the American Medical Association.

Reimbursement Policy Change to immunizations with Evaluation and Management Services (P79-18, published 12/3/18)

Effective February 1, 2019 Blue Cross and Blue Shield of Minnesota (Blue Cross) will be making changes to the General Coding Immunizations/Vaccines Reimbursement Policy on administration charges billed with vaccine/toxoid.

Immunizations with Evaluation and Management (E/M) services
If only a vaccine immunization is administered, bill only the code for the vaccine/toxoid administered and the applicable administration code.

Reimbursement for vaccines/toxoids and immunization administration that is billed with the following services, Preventive medicine services (99381-99387, 99391-99397, 99401-99404), newborn care services (99460-99463), and illness-related E/M's (99201-99205, 99212-99215) will be allowed **with supporting documentation** and the **correct modifier(s) 25/59**.

Products Impacted
This policy applies to all lines of business.

Coding requirements reminder
All coding and reimbursements are subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (e.g. **HCPCS, CPT, ICD**), only valid codes for the date of service may be submitted or accepted.

HCPCS stands for Healthcare Common Procedure Coding System
CPT® (Current Procedural Terminology) is a registered trademark of the American Medical Association.

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATES

Lab Management CPT Code Updates for Fully Insured Commercial and Medicare Advantage Members – eviCore Healthcare Specialty Utilization Management (UM) Program (P68-18, published 12/3/18)

The following CPT® Codes have been deleted by the American Medical Association (AMA) **effective December 31, 2018:**

Code	Description
81211	BRCA1, BRCA2 (breast cancer 1 and 2) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and common duplication/deletion variants in BRCA1 (ie, exon 13 del 3.835kb, exon 13 dup 6kb, exon 14-20 del 26kb, exon 22 del 510bp, exon 8-9 del 7.1kb)
81213	BRCA1, BRCA2 (breast cancer 1 and 2) (eg, hereditary breast and ovarian cancer) gene analysis; uncommon duplication/deletion variants
81214	BRCA1 (breast cancer 1) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and common duplication/deletion variants (ie, exon 13 del 3.835kb, exon 13 dup 6kb, exon 14-20 del 26kb, exon 22 del 510bp, exon 8-9 del 7.1kb)

The following new Proprietary Laboratory Analyses CPT® Codes have been added by the AMA and will **require prior authorization (PA) beginning February 1, 2019:**

Code	Description
81163	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis
81164	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)
81165	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis
81166	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion anlaysis (ie, detection of large gene rearrangements)
81167	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)
81173	AR (androgen receptor) (eg,spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; full gene sequence
81174	AR (androgen receptor) (eg,spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; known familial variant
81185	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; full gene sequence
81186	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; known familial variant
81189	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; full gene sequence
81190	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; known familial variant (s)
81286	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; full gene sequence
81289	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; known familial variant (s)
81306	NUDT15 (nudix hydrolase 15) (eg, drug metabolism) gene analysis, common variant(s) (eg, *2, *3, *4, *5, *6)
81336	SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; full gene sequence
81337	SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; known familial sequence variant(s)
81443	Genetic testing for severe inherited conditions (eg, cystic fibrosis, Ashkenazi Jewish-associated disorders [eg, Bloom syndrome, Canavan disease, Fanconi anemia type C, mucolipidosis type VI, Gaucher disease, Tay-Sachs disease], beta hemoglobinopathies, phenylketonuria, galactosemia), genomic sequence analysis panel, must include sequencing of at least 15 genes (eg, ACADM, ARSA, ASPA, ATP7B, BCKDHA, BCKDHB, BLM, CFTR, DHCR7, FANCC, G6PC, GAA, GALT, GBA, GBE1, HBB, HEXA, IKBKAP, MCOLN1, PAH)
81518	Oncology (breast), mRNA, gene expression profiling by real-time RT-PCR of 11 genes (7 content and 4 housekeeping), utilizing formalin-fixed paraffin- embedded tissue, algorithms reported as percentage risk for metastatic recurrence and likelihood of benefit from extended endocrine therapy [Breast Cancer Index, Biotheranostics, Inc]
81596	Infectious disease, chronic hepatitis C virus (HCV) infection, six biochemical assays (ALT, A2-macroglobulin, apolipoprotein A-1, total bilirubin, GGT, and haptoglobin) utilizing serum, prognostic algorithm reported as scores for fibrosis and necroinflammatory activity in liver [HCV FibroSURE, FibroTest, BioPredictive S.A.S.]

The following existing codes will now **require PA** through the eviCore Lab Management Program **effective February 1, 2019:**

Code	Description
0002M	Liver disease, ten biochemical assays (ALT, A2-macroglobulin, apolipoprotein A-1, total bilirubin, GGT, haptoglobin, AST, glucose, total cholesterol and triglycerides) utilizing serum, prognostic algorithm reported as quantitative scores for fibrosis, steatosis and alcoholic steatohepatitis (ASH)
0003M	Liver disease, ten biochemical assays (ALT, A2-macroglobulin, apolipoprotein A-1, total bilirubin, GGT, haptoglobin, AST, glucose, total cholesterol and triglycerides) utilizing serum, prognostic algorithm reported as quantitative scores for fibrosis, steatosis and nonalcoholic steatohepatitis (NASH)

eviCore's Lab Management 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 "**eviCore healthcare Specialty Utilization Management Clinical Guidelines**" link
- Scroll down to the **Lab Management** section.
- Click on the "**BCBSMN Lab Resources Page**"

Products Impacted

- This change only applies to the **fully insured commercial** and **Medicare Advantage** members.
- The changes do not impact commercial self-insured health plans, Government Programs lines of business (Families and Children (F&C), 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), Platinum Blue as those lines of business have separate PA requirements.

To submit a PA Request to eviCore

Providers 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 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.

New Medical, Medical Drug and Behavioral Health Policy Management Updates for Commercial & Medicare Advantage Lines of Business – Effective February 4, 2019

(P70-18, published 12/3/18)

Effective February 4, 2019, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be expanding utilization management requirements for commercial and Medicare Advantage 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 medical policies will require prior authorization effective February 4, 2019 for commercial and Medicare Advantage lines of business:

Policy #	Policy Name	Existing Policy	New Policy	Prior Authorization Required	
				Medicare Advantage	Commercial
X-46	Electroconvulsive Therapy (ECT)		X	Yes	No
II-220	Patisiran (Onpattro®)		X	Yes	Yes
II-222	Tidrakizumb (Ilumya®)		X	Yes	Yes
II-102	Pharmacologic Therapies for Hereditary Angioedema - Adding Lanadelumab (Takhzyro®)*	X		Yes	Yes

*****This drug currently requires prior authorization for commercial members under medical policy II-173.

Products Impacted

The information in this Bulletin applies **only** to subscribers who have coverage through commercial and Medicare Advantage lines of business.

Submitting a PA Request when Applicable

- 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 starting January 28, 2019.**

Providers can Submit an Electronic Prior Authorization (ePA) Request

- Online via our free Availity provider portal – for Blue Cross to review.
- For Medical Drugs, PA's can also be submitted using a NCPDP standard XML file feed to Blue Cross through CenterX, via an integrated Electronic Medical Record (EMR) system. To learn how to do this, providers should contact their EMR vendor for assistance.
- Out of state, non-contracted providers can submit a PA request to Blue Cross by either using the electronic processes above, the 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

Cardiology Program Prior Authorization Updates for Fully Insured Commercial Subscribers – eviCore Healthcare Utilization Management (UM) Program

(P72-18, published 12/3/18)

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

Effective December 3, 2018, the following codes no longer require prior authorization:

Code	Description
93320	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete
93321	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; follow-up or limited study
93325	Doppler echocardiography color flow velocity mapping
93352	Use of echocardiographic contrast agent during stress echocardiography

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
- Scroll down and click on the "**eviCore healthcare Specialty Utilization Management Clinical Guidelines**" link.
- Scroll down and click on "**Clinical Guidelines**"
- Select "**Cardiology & Radiology**" solution

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 (Families and Children (F&C), MinnesotaCare (MNCare), SecureBlue (MSHO), and Minnesota Senior Care Plus (MSC+) health plans), Federal Employee Program (FEP), Medicare Advantage, Medicare Supplement (Senior Gold, Basic Medicare Blue and Extended Basic Blue), 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**, 7 a.m. to 7 p.m., Monday-Friday.

Update: Radiation Therapy Program CPT® Code Update for Fully Insured Commercial Subscribers – eviCore Healthcare Specialty Utilization Management (UM) Program

(P60R1-18, published 12/3/18)

Blue Cross and Blue Shield of Minnesota published Provider Bulletin P60-18 that incorrectly stated the below list of Radiation Therapy CPT Codes would no longer require Prior Authorization through eviCore effective November 1, 2018. Please note that this was an oversight, and the codes listed below do require Prior Authorization through the eviCore Radiation Therapy Program. To allow for a 60-calendar day notification, the change will be effective February 1, 2019.

The following Radiation Therapy CPT Codes will require Prior Authorization (PA) effective February 1, 2019:

Code	Description
19294	Preparation of tumor cavity, with placement of radiation therapy applicator for intraoperative radiation therapy (IORT), concurrent with partial mastectomy
19296	Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy
19297	Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; concurrent with partial mastectomy (List separately in addition to code for primary procedure)
19298	Placement of radiotherapy after loading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance
31643	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of catheter(s) for intracavitary radioelement application
32553	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple

Code	Description
41019	Placement of needles, catheters, or other device(s) into the head and/or neck region (percutaneous, transoral, or transnasal) for subsequent interstitial radioelement application
49411	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple
49412	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure)
55875	Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy
55876	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple
55920	Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application
57155	Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy
57156	Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy
58346	Insertion of Heyman capsules for clinical brachytherapy
76873	Ultrasound, transrectal; prostate volume study for brachytherapy treatment planning (separate procedure)
76965	Ultrasonic guidance for interstitial radioelement application
77261	Therapeutic radiology treatment planning; simple
77262	Therapeutic radiology treatment planning; intermediate
77263	Therapeutic radiology treatment planning; complex
77280	Therapeutic radiology simulation-aided field setting; simple
77285	Therapeutic radiology simulation-aided field setting; intermediate
77290	Therapeutic radiology simulation-aided field setting; complex
77293	Respiratory motion management simulation (List separately in addition to code for primary procedure)
77295	3-dimensional radiotherapy plan, including dose-volume histograms
77299	Unlisted procedure, therapeutic radiology clinical treatment planning
77300	Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, onl
77301	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications
77306	Teletherapy isodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s)
77307	Teletherapy isodose plan; complex (multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s)
77316	Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s)
77317	Brachytherapy isodose plan; intermediate (calculation[s] made from 5 to 10 sources, or remote afterloading brachytherapy, 2-12 channels), includes basic dosimetry calculation(s)

Code	Description
77318	Brachytherapy isodose plan; complex (calculation[s] made from over 10 sources, or remote afterloading brachytherapy, over 12 channels), includes basic dosimetry calculation(s)
77321	Special teletherapy port plan, particles, hemibody, total body
77331	Special dosimetry (eg, TLD, microdosimetry) (specify), only when prescribed by the treating physician
77332	Treatment devices, design and construction; simple (simple block, simple bolus)
77333	Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)
77334	Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)
77336	Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy
77338	Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan
77370	Special medical radiation physics consultation
77399	Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services
77417	Therapeutic radiology port image(s)
77427	Radiation treatment management, 5 treatments
77431	Radiation therapy management with complete course of therapy consisting of 1 or 2 fractions only
77432	Stereotactic radiation treatment management of cranial lesion(s) (complete course of treatment consisting of 1 session)
77435	Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions
77469	Intraoperative radiation treatment management
77470	Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral or endocavitary irradiation)
77499	Unlisted procedure, therapeutic radiology treatment management
77789	Surface application of low dose rate radionuclide source
77790	Supervision, handling, loading of radiation source
77799	Unlisted procedure, clinical brachytherapy
G0458	Low dose rate (LDR) prostate brachytherapy services, composite rate
G6017	Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (eg, 3d positional tracking, gating, 3d surface tracking), each fraction of treatment
S2095	Transcatheter occlusion or embolization for tumor destruction, percutaneous, any method, using yttrium-90 microspheres
S8030	Scleral application of tantalum ring(s) for localization of lesions for proton beam therapy
C2616	Brachytherapy source, nonstranded, yttrium-90, per source

eviCore's Radiation Therapy clinical guidelines and PA code list 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 fully insured commercial subscribers.
- 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, and Platinum Blue as those lines of business have separate PA requirements.

To submit a PA Request to eviCore

Providers submit eviCore PA requests via our free **https://www.availity.com** 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 and would like to speak to an eviCore representative call **844-224-0494**, 7:00 a.m. to 7:00 p.m. CST, Monday through Friday.

New Medical Policy for Upper and Lower Gastrointestinal Endoscopy Services Including Colonoscopies (P55-18, published 12/3/18)

Beginning March 4, 2019, upper and lower gastrointestinal endoscopy services (listed below), including colonoscopies, will be subject to a new Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) medical policy (XI-03-001). The policy states that these services must be redirected and performed in an in-network Ambulatory Surgical Center (ASC) when medical or geographic criteria for use of a hospital outpatient facility are not met, in order to ensure coverage. Many specialists in the Blue Cross network have already started redirecting patients to the ASC setting when clinically appropriate. Groups performing these procedures outside the hospital have shown evidence of safe, high quality outcomes at a lower cost, while maintaining an excellent patient experience.

Beginning March 4, 2019, upper and lower endoscopy procedures administered in a hospital outpatient setting that do not meet medical policy criteria will not be eligible for reimbursement. Post-service audits will be conducted for services taking place at an outpatient hospital setting using the following information to ensure policy criteria are met:

- Documentation of medical necessity to receive the procedure at an outpatient hospital setting rather than an ASC.

Geographic exclusions for post-service audits include:

- Services for patients living greater than 25 miles from an in-network ASC performing these procedures are excluded from this program.
- Hospital outpatient facilities that do not have an in-network ASC performing these procedures within 25 miles of the outpatient hospital setting are excluded from this program.

Please check the subscriber's benefits and confirm the **in-network** site of care.

List of Impacted Procedures and Associated CPT Codes:

- Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure) (43235)
- Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple (43239)
- Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter) (43249)
- Colonoscopy, flexible; diagnostic, including collection of specime(s) by brushing or washing, when performed (separate procedure) (45378)
- Colonoscopy, flexible; with biopsy, single or multiple (45380)
- Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps (45384)
- Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique (45385)

Products Impacted

This program only applies to fully insured and self-insured commercial lines of business. As a reminder for an Accountable Care Organization (ACO) subscriber, please have the subscriber call Blue Cross at **(651) 662-5200** or **1-800-262-0820**

Predetermination Process for Providers:

If certain unforeseen clinical circumstances **not** outlined in the medical policy arise that dictate the member should receive care in an outpatient hospital setting, providers may submit a predetermination form to verify if a service listed above will be deemed appropriate prior to treatment. Predeterminations are **not** required and do not guarantee payment.

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

Radiology and Cardiology (Cardiac Rhythm Implantable Device) Program Updates for Fully Insured Commercial and Medicare Advantage Members – eviCore Healthcare Specialty Utilization Management (UM) Program (P73-18, published 12/3/18)

eviCore has released clinical guideline updates for their Radiology and Cardiology (Cardiac Rhythm Implantable Device) programs. Updates include, but are not limited to: New information added, criteria updated, indications updated, clarification added, etc.

Updates to these programs will become **effective beginning February 15, 2019:**

Radiology, and Cardiology (Cardiac Rhythm Implantable Device) programs:

- Preface to the Imaging Guidelines
- Abdomen Imaging Policy
- Breast Imaging Policy
- Cardiac Imaging Policy
- Cardiac Rhythm Implantable Device (CRID) Policy
- Chest Imaging Policy
- Head Imaging Policy
- Musculoskeletal Imaging Policy
- Neck Imaging Policy
- Oncology Imaging Policy
- Pelvis Imaging Policy
- PND Imaging Policy
- PVD Imaging Policy
- Spine Imaging Policy
- Pediatric Abdomen Imaging Policy
- Pediatric Cardiac Imaging Policy
- Pediatric Chest Imaging Policy
- Pediatric Head Imaging Policy
- Pediatric Musculoskeletal Imaging Policy
- Pediatric Neck Imaging Policy
- Pediatric Oncology Imaging Policy
- Pediatric Pelvis Imaging Policy
- Pediatric PND Imaging Policy
- Pediatric PVD Imaging Policy
- Pediatric Spine Imaging Policy

eviCore's Radiology and Cardiology 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**"
  - Scroll down to locate the "**Medical Policy Supporting Documents**" section
- Click on "**eviCore healthcare Specialty Utilization Management Clinical Guidelines**" link
  - Click on the "**Clinical Guidelines**" link
  - Select desired solution in dropdown.

Products Impacted
This change only applies to **fully insured commercial** and **Medicare Advantage** subscribers.

The changes do not impact:

- Government Programs lines of business (Prepaid Medical Assistance Program (PMAP), Families and Children (F&C), MinnesotaCare (MNCare), SecureBlue (MSHO), and Minnesota Senior Care Plus (MSC+) health plans)
- Federal Employee Program (FEP as those lines of business have separate PA requirements

To submit a PA Request to eviCore
Providers submit eviCore PA requests via our free **https://www.availity.com** 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 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.

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.

Migration of Minnesota Health Care Programs Subscribers to Amerigroup Delayed to January 1, 2019 (P77-18, published 12/3/18)

To ensure a successful member and provider experience, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) has made the decision to delay the migration of the Minnesota Health Care Programs (MHCP), including Blue Advantage Families and Children (formerly Prepaid Medical Assistance Program), MinnesotaCare (MNCare), SecureBlue (MSHO) and Minnesota Senior Care Plus (MSC+) to Amerigroup until January 1, 2019. **Effective January 1, 2019, Providers are required to follow the policies and procedures that were previously published in the October and November Provider Bulletins and as indicated below for MHCP Subscribers.**

Subscriber ID
Members newly enrolled to Blue Cross in December will be mailed an ID card under the current Blue Cross process for dates of service December 1, 2018 through December 31, 2018. **Eligible** subscribers will be mailed new ID cards to be used for dates of service beginning January 1, 2019.

Eligibility and Benefits and Claim Status
When checking eligibility and benefits or claim status on Availity.com for a service date prior to January 1, 2019, providers are instructed to use the current process and Payer ID code 00720. When checking eligibility and benefits or claim status on Availity.com for a service date on or after January 1, 2019, u**se the new Payer ID code 00562** or select 'BCBSMN Blue Plus Medicaid' from the Payer listing. **If an eligibility and benefits EDI transaction or a claim status EDI transaction is not submitted with the new Payer ID code, a non-covered claim not found response will be received. Providers will need to correct the payer ID and resubmit the transaction.** Please note that eligibility files will not be loaded until December 2018.

Claims Submission
Continue to submit claims for dates of service through December 31, 2018 with current Payer Code 00720. Claims for dates of service beginning January 1, 2019 must be submitted with the new payer ID Code 00562.

Claims currently processed via Bridgeview (i.e. Elderly Waiver claims) will continue to be processed via Bridgeview through December 31, 2018 dates of service. Effective January 1, 2019, Availity will change the Bridgeview Company payer name to **BCBSMN Blue Plus Medicaid Waiver** with the same payer ID of FS802.

Claims Submission for Non-Emergent Transportation (NEMT) Providers
Claims for dates of service through December 31, 2018 should be submitted with current Payer Code 00720. Claims for dates of service that occur on or after January 1, 2019 will be processed by LogistiCare. **Claims for dates of service beginning January 1, 2019 must be submitted with the new payer ID Code A5143. Claims submitted under the wrong Payer ID Code will reject and the claims will need to be resubmitted under the correct payer ID code.**

Provider Services
The phone number for contacting Blue Cross Provider Services for all questions will remain unchanged for claims with dates of service through December 31, 2018.

For dates of service on or after January 1, 2019, please contact Provider Services at **1-866-518-8448** for questions regarding eligibility and benefits, utilization management, or claims.

Utilization Management: Prior Authorizations (PA) for Outpatient Services and Pre Admission Notification or Pre-Certification for Inpatient Services
Changes to utilization management processes that were previously announced with an effective date of December 1, 2018 will be implemented on January 1, 2019. Continue to follow current Blue Cross processes until January 1, 2019, regardless of the date of service. Any PA's obtained through the current process through Blue Cross will be forwarded to Amerigroup for use in claims adjudication where applicable.

Changes to medical policies and UM authorization requirements that were previously published with a December 1, 2018 effective date will be delayed until January 1, 2019. Blue Cross will be allowing providers the ability to become accustomed to the policy criteria and documentation required with a PA request. Blue Cross' expectation is that the providers take this opportunity to familiarize themselves with the new policies and authorization requirements during this initial implementation phase. **Enforcement of prior authorizations and pre-certifications will begin for March 1, 2019 dates of service**. Claims for dates of service beginning March 1, 2019 will deny provider liability without an approved prior authorization.

Effective Dates of Service: January 1, 2019 – February 28, 2019

- Provider will submit all relevant clinical information for review
- Clinical information will be reviewed to determine if the requests meets the clinical guidelines
- Requests that do not meet criteria per the evidence-based guidelines will receive a denial with educational language in the rationale to help providers understand why a PA request did not meet the clinical guidelines

Updated Minnesota Health Care Programs Information (P78-18, published 12/3/18)

The information in this Provider Bulletin provides updates to Provider Bulletin P48-18, that was published on October 1, 2018.

Products Impacted

This information applies to the following products:

- Minnesota Health Care Programs (MHCP), including Blue Advantage Families and Children (formerly Prepaid Medical Assistance Program), Minnesota Senior Care Plus (MSC+) and MinnesotaCare (MNCare)
- SecureBlue (MSHO)

Appeals Submission Update

When submitting claims appeals, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) recommends using the online appeal process through Availity. Additional documentation may be attached along with the appeal request.

Providers may still fax the *AUC Appeal Form* to **1-833-224-6929**.

Adjustments have been made to the mailing information previously published to avoid confusion for providers.

When submitting by mail, send the *AUC Appeal Form* with documentation via mail to:
Blue Cross and Blue Shield of Minnesota and Blue Plus
ATTN: Consumer Service Center
P.O. Box 64033
St. Paul, MN 55164-4033

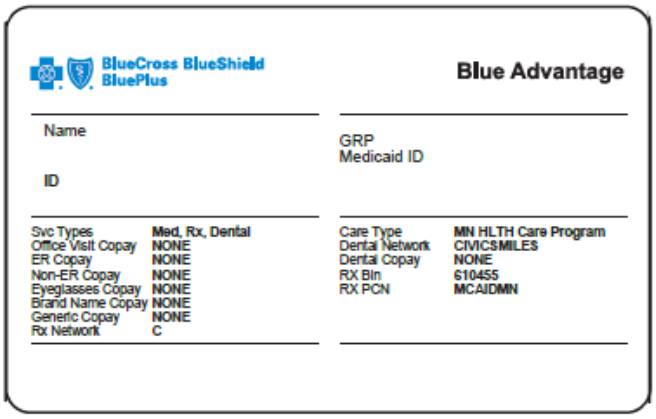
Obstetrics and Delivery Medical Necessity Review Update

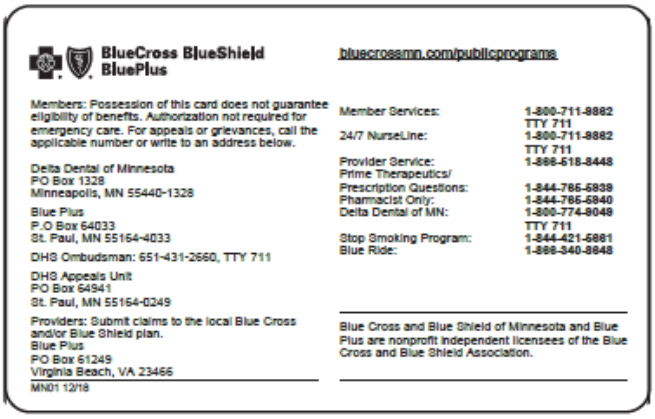
As of January 1, 2019, Amerigroup will follow the CMS ruling and will only require medical necessity review for cesarean deliveries over a 96-hour stay. The previous notification requirement of a 72-hour stay will be updated to allow for MN DHS use of the CMS guideline.

Subscriber ID Cards and PCC Selection

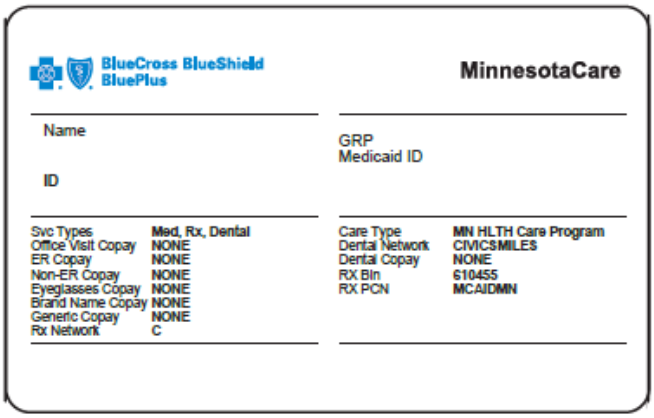
For dates of service beginning January 1, 2019, subscribers will be receiving updated ID cards. The subscriber's Primary Care Clinic (PCC) will **not** be listed on the subscriber ID cards.

PMAP/MSC+:





MNCare:


BlueCross BlueShield BluePlus

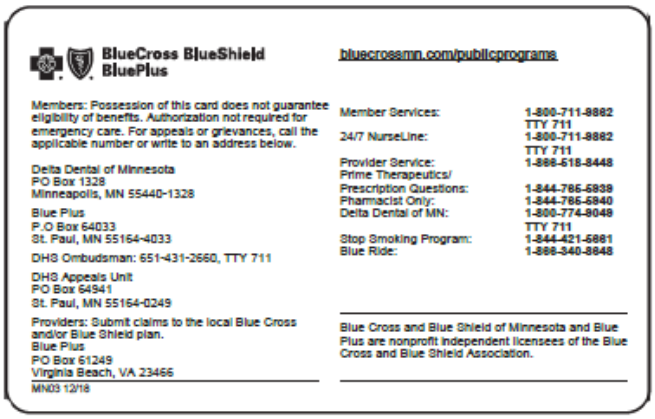
MinnesotaCare

Name

ID

GRP
Medicaid ID

Svc Types	Med, Rx, Dental	Care Type	MN HLTH Care Program
Office Visit Copay	NONE	Dental Network	CIVICSMILES
ER Copay	NONE	Dental Copay	NONE
Non-ER Copay	NONE	RX Bin	610455
Eyeglasses Copay	NONE	RX PCN	MCAIDMN
Brand Name Copay	NONE		
Generic Copay	NONE		
Rx Network	C		


BlueCross BlueShield BluePlus

bluecrossmn.com/publicprograms

Members: Possession of this card does not guarantee eligibility of benefits. Authorization not required for emergency care. For appeals or grievances, call the applicable number or write to an address below.

Delta Dental of Minnesota
PO Box 1328
Minneapolis, MN 55440-1328

Blue Plus
P.O Box 64033
St. Paul, MN 55164-4033

DHS Ombudsman: 651-431-2660, TTY 711

DHS Appeals Unit
PO Box 64941
St. Paul, MN 55164-0249

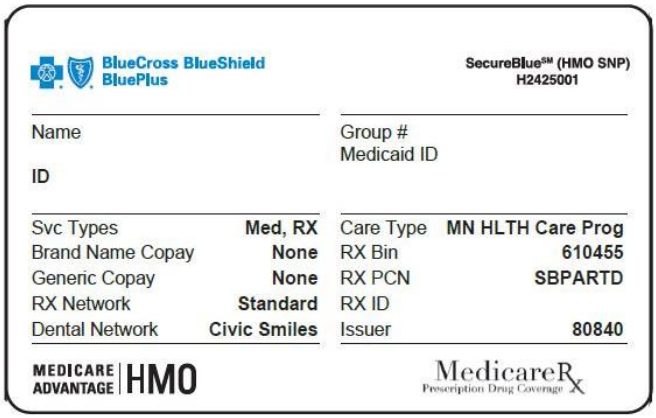
Providers: Submit claims to the local Blue Cross and/or Blue Shield plan.
Blue Plus
PO Box 61249
Virginia Beach, VA 23466

MN03 12/18

Member Services:	1-800-711-8862 TTY 711
24/7 NurseLine:	1-800-711-8862 TTY 711
Provider Service:	1-866-518-8448
Prime Therapeutics/ Prescription Questions:	1-844-786-5839
Pharmacist Only:	1-844-786-5840
Delta Dental of MN:	1-800-774-9049 TTY 711
Stop Smoking Program:	1-844-421-5661
Blue Ride:	1-866-340-8648

Blue Cross and Blue Shield of Minnesota and Blue Plus are nonprofit independent licensees of the Blue Cross and Blue Shield Association.

SecureBlue (MSHO):


BlueCross BlueShield BluePlus

SecureBlue℠ (HMO SNP)
H2425001

Name

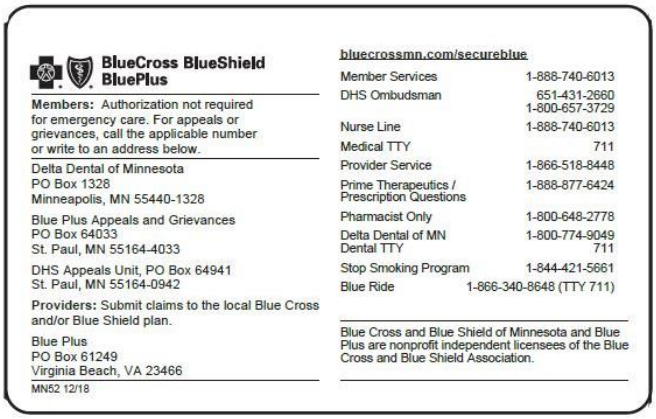
ID

Group #
Medicaid ID

Svc Types	Med, RX	Care Type	MN HLTH Care Prog
Brand Name Copay	None	RX Bin	610455
Generic Copay	None	RX PCN	SBPARTD
RX Network	Standard	RX ID	
Dental Network	Civic Smiles	Issuer	80840

MEDICARE ADVANTAGE | HMO

MedicareRx
Prescription Drug Coverage


BlueCross BlueShield BluePlus

bluecrossmn.com/secureblue

Members: Authorization not required for emergency care. For appeals or grievances, call the applicable number or write to an address below.

Delta Dental of Minnesota
PO Box 1328
Minneapolis, MN 55440-1328

Blue Plus Appeals and Grievances
PO Box 64033
St. Paul, MN 55164-4033

DHS Appeals Unit, PO Box 64941
St. Paul, MN 55164-0942

Providers: Submit claims to the local Blue Cross and/or Blue Shield plan.

Blue Plus
PO Box 61249
Virginia Beach, VA 23466

MN52 12/18

Member Services	1-888-740-6013
DHS Ombudsman	651-431-2660 1-800-657-3729
Nurse Line	1-888-740-6013
Medical TTY	711
Provider Service	1-866-518-8448
Prime Therapeutics / Prescription Questions	1-888-877-6424
Pharmacist Only	1-800-648-2778
Delta Dental of MN Dental TTY	1-800-774-9049 711
Stop Smoking Program	1-844-421-5661
Blue Ride	1-866-340-8648 (TTY 711)

Blue Cross and Blue Shield of Minnesota and Blue Plus are nonprofit independent licensees of the Blue Cross and Blue Shield Association.

Providers can call Provider Services at **1-866-518-8448** or download their PCC listing report within the Provider Online Reporting (POR) tool within the Availity application to determine which clinic is listed as the subscriber's PCC within the Amerigroup system.

POR registration

- From the Availity home page, select **Payer Spaces** from the top navigation.
- Select the health plan.
- From the *Payer Spaces* home page, select the **Application** or **Resources** tab.
- From the *Resources* tab, select **Provider Online Reporting**. If you don't see it in the list, select **Next** from the right-hand side at the bottom of the page.
- Select **Register/Maintain Organization** to register your organization's tax ID to the applicable program.
- Select **Register Tax ID** to register for the eligible program (subscriber reports or panel listings).
- Select **Maintain User/Register User** to grant access to users.
- Complete all fields on the *Register User* page. Select **ADD TO PREVIEW** and save.

PCC Subscriber Panel Reports

- From the Availity home page, choose **Payer Spaces** from the top navigation
- Select the health plan.
- From the *Payer Spaces* home page, select the **Applications** or the **Resources** tab and select **Provider Online Reporting**.
- Once the *POR* widow opens, from the *Provider Online Reporting* page, select **Subscriber Panel Listing**

Update to Behavioral Health Inpatient Admission Pre-certification and Outpatient Prior Authorization Requirements (P74-18, published 12/3/18)

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) previously communicated new pre-certification requirements in Provider Bulletin P48-18, entitled Migration of Minnesota Health Care Programs Subscribers to Amerigroup. This bulletin is an update to that document and details new pre-certification requirements for inpatient behavioral health (BH) hospital admissions.

Inpatient Pre-certification Requirements BH Inpatient Psychiatric and Substance Use Disorder (SUD) Hospitalization Admissions:

- Beginning February 1, 2019, all inpatient psychiatric and SUD hospitalization admissions will require pre-certification for Blue Advantage Families and Children (F&C) and Minnesota Senior Care Plus (MSC+) members.
- Providers should follow notification only process until February 1, 2019.
- Note, inpatient admissions for SecureBlue^{SM} members will remain notification only.

Emergent BH Inpatient Admissions:

- Emergent BH inpatient admissions require requests for authorization to be sent to Blue Cross within one business day of the admission.
- All BH emergent inpatient hospital admissions are reviewed within three calendar days of the facility notification to Blue Cross.
- Clinical information for the initial admission review will be requested at the time of the admission notification.
  - For BH admissions, facilities are required to provide requested clinical information within 24 hours of the request.
  - If information is not received within 24 hours, a lack of information adverse determination (a denial) may be issued.
  - If clinical information is received, a medical necessity review will be conducted using applicable nationally recognized clinical criteria.
  - Decisions are communicated verbally or via fax within 24 hours of the determination.

Inpatient BH Concurrent Reviews

- Inpatient BH concurrent reviews are the process of obtaining clinical information to establish medical necessity for a continued inpatient stay including review for extending a previously approved admission.
- To support continued stays, facilities are required to supply requested clinical information within 24 hours of the request. The location of this form and submission instructions are located under the heading "pre-certification and prior authorization request forms and submission."
- During each concurrent review interval, clinicians assess member progress and will help coordinate support prior to discharge. This is done to help facilitate a smooth transition for the member between levels of care or home and to avoid delays in discharge due to unanticipated care needs.
- In addition, attending providers are expected to coordinate with each member's PCP or outpatient specialty provider regarding follow-up care and services after discharge. The PCP or outpatient specialty provider is responsible for contacting the member to schedule all necessary follow-up care.

Planned/Elective Admissions:

Planned/elective admissions must receive approval at least 72 hours before the BH admission to ensure the proposed care is a covered benefit, medically necessary and performed at the appropriate level of care.

- If needed, additional supporting documentation may be requested to determine if the request is medically necessary.
- Determinations are communicated to the facility.
  - For standard requests, a decision is communicated as expeditiously as required by a member's condition- not to exceed 10 calendar days.
  - For expedited/urgent requests, decisions are communicated as expeditiously as required by a member's condition-not to exceed 72 hours.

Location of Forms
The following forms are used for psychiatric and SUD inpatient, psychiatric residential treatment facilities (inpatient level of care for children), children's mental health residential treatment (Rule 5), adult crisis/short-term mental health residential treatment, adult mental health residential treatment, and SUD residential treatment (children and adult):

- Behavioral Health Initial Review Form for Inpatient and Residential Treatment
- Behavioral Health Concurrent Review Form for Inpatient and Residential Treatment

- All forms are available on the Blue Cross website: (**https://www.bluecrossmn.com/healthy/public/personal/home/providers**)
- Path on Blue Cross website: For Providers > Migration of Minnesota Health Care Programs > Forms
- See below under *Pre-certification and Prior Authorization Request Forms & Submission* for information on other options for access to these forms and how to submit these forms.

Prior Authorization Requirements
Additional Services that are Notification Only:
The following services are not subject to a medical necessity review for BH only, but notification is required:

- H0038: self-help/peer services, per 15 minutes — level I
- H0038 HA: certified family peer specialist services
- H0038 HA HQ: certified family peer specialist services — group setting
- H0038 HQ: self-help/peer services, per 15 minutes — group
- H0038 U5: self-help/peer services, per 15 minutes — level II
- H0040: assertive community treatment program
- H0040 HA: assertive community treatment program
- H0040 HK: assertive community treatment program
- H2015: comprehensive community support services
- H2027: psychoeducational service
- H2027 HQ: family psychoeducation — recipient group
- H2027 HQ HR: family psychoeducation — family group
- H2027 HQ HS: family psychoeducation — family group
- H2027 HR: family psychoeducation — recipient and family
- H2027 HS: family psychoeducation — family

Mental Health - Targeted Case Management (MH-TCM) Services Notification of Potential Denial or Termination of Services
The *MH-TCM Services Notification of Potential Denial or Termination of Services Form* must be completed and sent to the Blue Cross BH department when MH-TCM services may be denied or terminated. Complete all contact/member information fields on this form. Complete either denial or termination information whichever applies to the situation. Fax completed form to **1-844-429-7757** within one business day of the determination/action.

- Denial of MH-TCM services is defined as the initial determination that a member does not meet the criteria for MH-TCM services.
- Termination of MH-TCM services is defined as the discontinuation of MH-TCM:
  - When the member no longer meets the eligibility criteria in *Minnesota Statutes* (Section 245.4871, Subd. 6) for a child or (245.462, Subd. 20) for an adult.
  - When the adult or the child's parent or legal representative requests that MH-TCM services end.
  - When no face-to-face contact has occurred between the case manager and the child for 90 consecutive days or between the case manager and the adult for 180 consecutive days because the child or adult has failed to keep an appointment or refused to meet with the case manager.

Early Intensive Developmental and Behavioral Intervention (EIDBI)
The EIDBI services are services offered to members under the age of 21 with autism spectrum disorder and related conditions.

- The Comprehensive multi-disciplinary evaluation (CMDE) and other forms needed to request or extend EIDBI services can be accessed from the following location:
  - **https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS-304331**
- Please fill out the form and submit the form by fax:**1-800-505-1193**

Pre-certification and Prior Authorization Request Forms and Submission
Pre-certification and prior authorization requests can be submitted online as well as by fax or phone.

- **Location of Forms:** All forms can be retrieved on the Blue Cross website: (**https://www.bluecrossmn.com/healthy/public/personal/home/providers**)
- Path on Blue Cross website: For Providers > Migration of Minnesota Health Care Programs > Forms
- **Web:** Log in to the Availity Portal to be automatically routed to the Interactive Care Reviewer (ICR) – the online pre-certification tool. From the Availity home page (**https://www.availity.com**), select **Patient Registration | Authorizations and Referrals | Authorizations** to access ICR.
- **Fax: 1-877-434-7578**
  - Fax forms are available on the Blue Cross website under forms: **https://www.bluecrossmn.com/healthy/public/personal/home/providers/medicaid-transition**
- **Phone: 1-866-518-8448**

Care Guidelines
Medical necessity reviews are conducted using applicable state and nationally recognized clinical criteria. Beginning February 1, 2019, MCG Care Guidelines will be used for all levels of care where applicable state guidelines do not apply. Blue Cross licenses and uses MCG Care Guidelines to guide utilization management decisions. For BH, the *MCG Behavioral Health Guideline* is used to manage, review and assess those facing hospitalization and outpatient care; condition-specific guidelines, goals and optimal care pathways as well as other decision support tools are used. Note, Blue Cross has the right to customize MCG Care Guidelines based on determinations by its medical policy and technology assessment committee.

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