PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

September 1, 2023

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L08R04 (12/13)

ADMINISTRATIVE UPDATES

Reminder: Medicare Requirements for Reporting Provider Demographic Changes

(published in every summary of monthly bulletins)

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) collaborates with providers to ensure accurate information is reflected in all provider directories. In accordance with Medicare requirements, Blue Cross is required to maintain accurate provider network directories for the benefit of our Subscribers.

- 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

The appropriate form for each of these changes or updates can be located on the Blue Cross website at bluecrossmn.com/providers/provider-demographic-updates

Providers are obligated, per federal requirements, to update provider information contained in the National Plan & Provider Enumeration System (NPPES). Updating provider information in NPPES will provide organizations with access to a current database that can be used as a resource to improve provider directory reliability and accuracy. Providers with questions pertaining to NPPES may reference NPPES help at https://nppes.cms.hhs.gov/webhelp/nppeshelp/HOME%20PAGE-SIGN%20IN%20PAGE.html

Questions?
Please contact provider services at **(651) 662-5200** or **1-800-262-0820.**

CONTRACT UPDATES

Update: MHCP Enrollment for Managed Care Organization (MCO) In-network Only Providers | P47R1-23

*Update: To alleviate potential claims disruption, **effective September 1, 2023, Blue Cross will only accept new contract requests for providers enrolled with MHCP**. This policy **does not** affect the process for a provider that is already contracted with Blue Cross.*

Federal law (the 21st Century Cures Act) requires the state agency (DHS) to enroll and screen all Medicaid providers, both those in Medicaid fee-for-service (FFS) and those in managed care organization (MCOs) networks. This is detailed in the 6.12.1.1 “Provider Selection and Enrollment with the STATE” section of DHS managed care contracts.

Starting **July 17, 2023**, Minnesota Health Care Programs (MHCP) will start the screening and enrollment process for MCO in-network providers.

Enrollment required for all MCO In-network Providers
Refer to the Enrollment with MHCP manual page for a list of provider types DHS enrolls. All MCO in-network providers who already have an **existing contract** with an MCO must enroll by **July 15, 2024**, except for **the following provider types that will require a site visit from DHS**: Community Mental Health Center, Rehab Agency, Day Treatment, Private Duty Nurse, and Medical Transportation. These specialties must enroll by December 31, 2024.

The enrollment process with MCHP allows the provider to choose to provide services to MCO members only or FFS members only, or both.

Questions?
Please contact provider services at **(651) 662-5200** or **1-800-262-0820**.

Home Health Agencies are Required to Provide Minnesota Home Care Bill of Rights for Clients | P60-23

Home Health Care providers are required to provide the client or the client's representative with written notice of the Home Care Bill of Rights prior to the client's first home health services.

Providers should make all reasonable efforts to provide notice of the rights to the client or the client's representative in a language the client or client's representative can understand.

The Home Care Bill of Rights is available on the Minnesota Department of Health website (www.health.state.mn.us) under the Facility Certification, Regulation and Licensing section, and is available in several languages at the following link: **Minnesota Home Care Bill of Rights for Clients**

In addition, DHS recommends that Home Care providers provide the Home Care Bill of Rights to Subscribers at least 30 days before terminating a Subscriber's services.

Products Impacted
The information in this bulletin applies to all lines of business.

Questions?
Please contact provider services at (651) 662-5200 or 1-800-262-0820.

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATES

Services Removed from the Commercial Prior Authorization List | P59-23

Effective for dates of service beginning October 1, 2023, Blue Cross and Blue Shield of Minnesota (Blue Cross) will no longer require prior authorization for Skilled Nursing Visits for commercial subscribers.

Prior authorization requests received through either Availity or via fax for Skilled Nursing Visits will be closed and returned with a message that no prior authorization is required.

If there is an existing medical policy for a service, but prior authorization is not required, providers will be directed back to our medical policies to review our medical necessity criteria. If benefit coverage information is needed, providers will be guided to customer service for assistance with review of the member's benefits.

Please note, claims for services that are not on our prior authorization list will be processed through the claims system according to the subscribers' benefits.

Prior authorizations are still required for Medicare Advantage subscribers delegated to eviCore.

Products Impacted
This information only applies to commercial lines of business.

Questions?
Please contact provider services at **(651) 662-5200** or **1-800-262-0820**.

Inpatient Hospital Admission Prior Authorization Removed for Medicare Advantage; Pre-Admission Notification Required | P61-23

Effective for inpatient admissions with dates of service beginning November 1, 2023, Blue Cross and Blue Shield of Minnesota (Blue Cross) will be doing the following for Medicare Advantage members:

- Removing the prior authorization and concurrent review requirement for inpatient admissions for medical/ mental health, substance use, and non-MN admissions or non-participating facility
- Adding a pre-admission notification (PAN) requirement for inpatient admissions for medical/ mental health, substance use, and non-MN admissions or non-participating facility

No determination of medical necessity will be made by Blue Cross at the time of admission. Member admissions must be medically necessary and are subject to retrospective review or audit. Notifications can be completed under the Authorizations & Referrals tab in Availity Essentials (https://apps.availity.com) under Inpatient Authorization.

Why does Blue Cross require admission notifications?
Blue Cross uses admission and discharge data to identify members who may benefit from additional support or specialty services, such as case management, disease management and behavioral health support programs. The Blue Cross Case Management team also offers support to members as they transition back home or to a post-acute care facility. Blue Cross Case Managers review the discharge summary details and work with members to avoid preventable readmissions by ensuring they understand medication changes, signs and symptoms that would require immediate attention, attend scheduled follow-up appointments, and follow through with discharge instructions after they return home. For longer stays, Blue Cross may also work with the hospital case manager prior to discharge to help with discharge planning and coordinating post-acute care if needed.

Products Impacted
This information only applies to the Medicare Advantage line of business.

Questions?
Please contact provider services at **(651) 662-5200** or **1-800-262-0820**.

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eviCore Healthcare Specialty Utilization Management (UM) Program: Medical Oncology Drug Prior Authorization Updates | P62-23

The eviCore Healthcare Utilization Management Program will be making updates to the Medical Oncology Current Procedural Terminology (CPT) Prior Authorization (PA) Code List.

The following drug(s) have been REMOVED from eviCore's Medical Oncology program beginning **November 1, 2023**.

Drug Name	Code(s)
Tocilizumab (Actemra)	J3262

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

Guidelines with substantive changes:

- **Scope of Policy**
- **Medications Used for Supportive Treatment of Cancer Patients**

Prior authorization requests will be reviewed based on eviCore clinical guideline criteria. Providers can view the list of CPT codes that require prior authorizations, eviCore clinical guidelines, and other provider resources on the eviCore Implementation Resources website.

To view CPT Code lists:

- Access the 'Provider Section' of the Blue Cross website at **providers.bluecrossmn.com**
- Select **"See all tools and resources"** under *Tools and Resources*
- Select **"See medical policy and prior authorization info"** *under Medical policy and prior authorization*, read and accept the Blue Cross Medical Policy Statement
- Click on the "**Medical policies"** tab, then scroll down and click on the "eviCore healthcare clinical guidelines" link, which is located under *Other evidence-based criteria and guidelines we use and how to access them*
- Select **"Solution Resources"** and then click on the appropriate solution (ex. Medical Oncology)
- Select **"CPT Codes"** to view the current CPT code list that require a prior authorization.

To view Clinical Guidelines:

- Access the 'Provider Section' of the Blue Cross website at **providers.bluecrossmn.com**
- Select **"See all tools and resources"** under *Tools and Resources*
- Select **"See medical policy and prior authorization info"** *under Medical policy and prior authorization*, read and accept the Blue Cross Medical Policy Statement
- Click on the "**Medical policies"** tab, then scroll down and click on the "eviCore healthcare clinical guidelines" link, which is located under *Other evidence-based criteria and guidelines we use and how to access them*
- Click on the **"Resources"** dropdown in the upper right corner
- Click **"Clinical Guidelines"**
- Select the appropriate solution: i.e., Medical Oncology
- Type **"BCBS MN"** (space is important) in 'Search by Health Plan'
- Click on the **"Current," "Future,"** or **"Archived"** tab to view guidelines most appropriate to your inquiry.

To Provide Feedback on Future Guidelines:

Participating providers are invited to submit for consideration scientific, evidence-based information, professional consensus opinions, and other information supported by medical literature relevant to future guidelines managed by eviCore.

The future guidelines are available for physician comment for at least 45 days from the posting date found on the document. Make sure your voice is heard by providing feedback directly to us.

To submit feedback, complete the Provider feedback form for third-party clinical policies/guidelines/criteria PDF via https://www.bluecrossmn.com/providers/medical-management/medical-and-behavioral-health-policies.

Products Impacted

This change only applies to:

- Individual subscribers
- Fully insured commercial subscribers
- Self-insured commercial subscribers (Select Groups)
- Medicare Advantage subscribers

Prior Authorization Look Up Tool

Providers should use the Prior Authorization Look Up Tool on the Availity Provider Portal to quickly determine if an authorization is required. By entering Member Group Number, Date of Service and Procedure Code, the tool will indicate whether an Authorization is required. If an Authorization is not required, the tool will allow the user to print the results for their records. If an Authorization is required, the user will move directly into the next field in Authorization application to complete the request

To access the Prior Authorization Look Up Tool:

1. Log in at **Availity.com/Essentials**
2. Select **Patient Registration**, choose **Authorization & Referrals**, then **Authorizations**
3. Select Payer **BCBSMN**, your Organization, Transaction Type **Outpatient** and you will be redirected to the Authorization Look Up Tool application

To submit a Prior Authorization (PA) Request to eviCore
Providers submit eviCore PA requests via the free **Availity** provider portal. There is no cost to the provider for using the portal. Instructions on how to utilize this portal are found on the Availity website. Providers should reference the eviCore clinical guideline criteria, submit prior authorization requests via Availity, and submit all applicable clinical documentation with the PA request. Failure to submit required information may result in review delays or denial of the request due to insufficient information.

Note: An approved PA does not guarantee coverage under a subscriber's benefit plan. Subscriber benefit plans vary in coverage and some plans may not provide coverage for certain services discussed in the medical policies.

If a provider does not obtain a required prior authorization before rendering services, Blue Cross will deny claims as provider liability for lack of prior authorization.

Questions?
If you have questions and would like to speak to an eviCore representative call **844-224-0494**, 7:00 a.m. to 7:00 p.m. CST, Monday - Friday.

New Medical, Medical Drug and Behavioral Health Policy Management Updates | P63-23

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be expanding utilization management requirements, including prior authorization (PA) requirements.

As stewards of healthcare expenditures for our subscribers, we are charged with ensuring they receive the highest quality, evidence-based care. This is accomplished through expanded development of medical policies and through management of these policies to include the PA process. The primary purpose of the PA process is to ensure that evidence-based care is provided to our subscribers, driving quality, safety, and affordability.

The following prior authorization changes will be effective November 6, 2023:

Policy #	Policy Title/ Service	New Policy	Prior Authorization Requirement	Line(s) of Business
II-282	Teclistamab (Tecvayli®)	Yes *(Moving from Policy II-173)*	Continued	Commercial
II-283	Epcoritamab (Epkinly®)	Yes	Yes	Commercial

Products Impacted

- The information in this bulletin applies only to subscribers who have coverage through a Commercial line of business.

Submitting a PA Request when Applicable

- **Providers may submit PA requests for any treatment in the above table starting October 30, 2023.**
- Providers must check applicable Blue Cross policy and attach all required clinical documentation with the PA request. PA requests will be reviewed when patient-specific, relevant medical documentation has been submitted supporting the medical necessity of the service. Failure to submit required information may result in review delays or a denial of the request due to insufficient information to support medical necessity. If a

provider does not obtain the required PA before rendering services, Blue Cross will deny claims as provider liability for lack of prior authorization.

- PA approval will be based on the Blue Cross policy criteria. To review Blue Cross criteria:
  - Go to www.bluecrossmn.com/providers/medical-management
  - Select "See Medical and Behavioral Health Policies" then click "Search Medical and Behavioral Health Policies" to access policy criteria.
- Current and future PA requirements and related clinical coverage criteria can be found using *the Is Authorization Required* tool in the Availity Essentials® portal or at www.bluecrossmn.com/providers/medical-management prior to submitting a PA request.
- Prior authorization lists are also updated to reflect additional PA requirements on the effective date of the management change and includes applicable codes. To access the PDF prior authorization lists for all lines of business go to www.bluecrossmn.com/providers/medical-management

Prior Authorization Requests

- For information on how to submit a prior authorization please go to bluecrossmn.com/providers/medical-management
- 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 https://www.bluecrossmn.com/providers/medical-management
- Select "See Medical and Behavioral Health Policies" then click "See Upcoming Medical and Behavioral Health Policy Notifications."

Questions?

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

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eviCore Healthcare Specialty Utilization Management (UM) Program: Radiation Oncology Clinical Guidelines Updates | P65-23

eviCore has released clinical guideline updates for the Radiation Oncology program. Guideline updates will become **effective November 1, 2023**

Please review all guidelines when submitting a prior authorization request.

Guidelines with substantive changes:

- **Proton Beam Therapy Guidelines**
- **Brain Metastases Guidelines**
- **Bone Metastases Guidelines**
- **Breast Cancer Guidelines**
- **Non-Small Cell Lung Cancer Guidelines**
- **Oligometastases Guidelines**
- **Small Cell Lung Cancer Guidelines**
- **Thymoma and Thymic Guidelines**

Prior authorization requests will be reviewed based on eviCore clinical guideline criteria. Providers can view the list of CPT codes that require prior authorizations, eviCore clinical guidelines, and other provider resources on the eviCore Implementation Resources website.

To view CPT Code lists:

- Access the 'Provider Section' of the Blue Cross website at **providers.bluecrossmn.com**
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To view Clinical Guidelines:

- Access the 'Provider Section' of the Blue Cross website at **providers.bluecrossmn.com**
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The future guidelines are available for physician comment for at least 45 days from the posting date found on the document. Make sure your voice is heard by providing feedback directly to us.

To submit feedback, complete the Provider feedback form for third-party clinical policies/guidelines/criteria PDF via https://www.bluecrossmn.com/providers/medical-management/medical-and-behavioral-health-policies.

Products Impacted

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- Medicare Advantage subscribers

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Note: An approved PA does not guarantee coverage under a subscriber's benefit plan. Subscriber benefit plans vary in coverage and some plans may not provide coverage for certain services discussed in the medical policies.

If a provider does not obtain a required prior authorization before rendering services, Blue Cross will deny claims as provider liability for lack of prior authorization.

Questions?
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Medical Policy Updates: Coupe Health and Self-Funded Benefit Plans Managed by Blue Cross and Blue Shield of Alabama | P66-23

Participating providers are invited to submit for consideration scientific, evidence-based information, professional consensus opinions, and other information supported by medical literature relevant to our draft policies for Coupe Health and Self-Funded benefit plans managed by Blue Cross and Blue Shield of Alabama.

The draft policies are available for physician comment for 45 days from the posting date found on the document. At the conclusion of the 45 days, policies will go into effect. Make sure your voice is heard by providing feedback directly to us.

How to Submit Comments on Draft Medical Policies
Complete our medical policy feedback form online at https://mn-policies.exploremyplan.com/portal/web/mn-policies/feedback or send comments and supporting documentation to us by mail or fax:

Birmingham Service Center
Attn: Health Management - Medical Policy
P.O. Box 10527
Birmingham, AL 35202
Fax: 205-220-0878

Draft Medical Policies
Draft medical policies can be found at Policies & Guidelines (exploremyplan.com)

Policy #	Policy Title
MP-232	Biophysical Fetal Profile
MP-732	Testing Serum Vitamin D Levels
MP-058	Panniculectomy/Excision of Redundant Skin or Tissue

Draft Provider-Administered Drug Policies
Draft provider-administered drug policies can be found at Policies & Guidelines (exploremyplan.com) and Policies & Guidelines (exploremyplan.com)

Policy #	Policy Title
PH-90312	Injectafer (ferric carboxymaltose injection)
PH-90688	Hemgenix (etranacogene dezaparvovec-drlb)
PH-90712	Vyvgart Hytrulo (efgartigimod alfa-fcab and hyaluronidase-qvfc)
PH-90173	Elevidys (delandistrogene moxeparvovec-rokl)

MINNESOTA HEALTH CARE PROGRAMS (MHCP) UPDATES

Updated Minnesota Health Care Programs (MHCP) & Minnesota Senior Health Options (MSHO) Prior Authorization & Medical Policy Requirements | P68-23

Effective **November 1, 2023**, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be updating its government programs medical policy and pre-authorization/pre-certification/notification lists. The lists clarify medical policy, prior authorization, and notification requirements for MHCP (Families and Children, MinnesotaCare, and Minnesota Senior Care Plus) and MSHO products.

As stewards of healthcare expenditures for our subscribers, we are charged with ensuring they receive appropriate, quality care while also maintaining overall costs. The prior authorization process ensures that the health service or drug being proposed is medically necessary, and reflective of evidence-based medicine and industry standards, prior to treatment. This process helps us manage the cost and quality of care appropriately for our members.

The following policies and/or prior authorization requirements will be archived and **will not be applicable** under the medical benefit plan to subscriber claims on or after **November 1, 2023**.

Policy #	Policy name	Prior authorization required	
		MHCP	MSHO
SP-05	Spine – Lumbar Discectomy, Foraminotomy, and Laminotomy	Yes	Yes
SP-07	Spine – Lumbar Laminectomy	Yes	Yes
SP-09	Spine – Vertebroplasty/Kyphoplasty	Yes	Yes
JO-01	Joint Surgery – Hip Procedures: Hip Arthroplasty Hip Arthroscopy	Yes	Yes
JO-02	Joint Surgery – Knee Procedures: Knee Arthroplasty Knee Arthroscopy and Open Procedures Meniscal Allograft Transplantation of the Knee Treatment of Osteochondral Defects	Yes	Yes
JO-03	Joint Surgery – Shoulder Procedures: Shoulder Arthroplasty Shoulder Arthroscopy and Open Procedures	Yes	Yes
IP-01	Interventional Pain – Epidural Injection Procedures and Diagnostic Selective Nerve Root Blocks	Yes	Yes
IP-02	Interventional Pain – Paravertebral Facet Injection/Medical Branch Nerve Block/Neurolysis	Yes	Yes
IP-03	Interventional Pain – Regional Sympathetic Nerve Block	Yes	Yes

Policy #	Policy name	Prior authorization required	
		MHCP	MSHO
GT-04	Genetic Testing for Single Gene and Multifactorial Conditions: • Genetic Testing for Germline Conditions • Multifactorial (Non-Mendelian Conditions) • Chromosomal Microarray Analysis	No	No
AI-01	Advanced Imaging of the Brain: • PET Imaging of the Brain	Yes	Yes
AI-02	Advanced Imaging of the Chest: • PET Imaging of the Chest	Yes	Yes
AI-03	Advanced Oncologic Imaging: • PET Imaging for Oncologic Indications	Yes	Yes
AI-04	Advanced Imaging of the Extremities: • PET Imaging of the Extremities	Yes	Yes
AI-05	Advanced Imaging of the Heart: • Cardiac CT with Quantitative Evaluation of Coronary Calcification • Cardiac MRI • Myocardial Perfusion Imaging • Cardiac Blood Pool Imaging	Yes	Yes
CG-GENE-15	Genetic Testing for Lynch Syndrome, Familial Adenomatous Polyposis (FAP), Attenuated FAP and MYH-associated Polyposis	Yes	Yes
CG-GENE-18	Genetic testing for TP53 mutations	Yes	Yes

The following prior authorization requirements will be removed and **will not be applicable** to subscriber claims on or after November 1, 2023. However, the policies will remain in effect.

Code	Code description	Policy source
H2012 (UA)	Children's Therapeutic Services and Supports (CTSS), after the first 150 hourly units	MCG Care Guidelines
H2014 (UA)	Children's Therapeutic Services and Supports (CTSS), after the first 800 15-minute units	MCG Care Guidelines

Where do I find the current government programs *Precertification/Preauthorization/Notification List*?

- Go to **https://provider.publicprograms.bluecrossmn.com/docs/inline/MNMN_CAID_PriorAuthorizationList.pdf?v=202203311948**.

or

- Go to **bluecrossmn.com/providers** > Tools & Resources > Minnesota Health Care Programs site > Prior Authorization > *Prior Authorization List*.

Where do I find the current government programs *Medical Policy Grid*?

- Go to **https://provider.publicprograms.bluecrossmn.com/docs/gpp/MNMN_CAID_MedicalPolicyGrid.pdf?v=202203311949**.

or

- Go to **bluecrossmn.com/providers** > Tools & Resources > Minnesota Health Care Programs site > Resources > Manuals and Guidelines > Medical Policies and Clinical UM Guidelines > *Medical Policy Grid*.

Where can I access *Medical Policies*?

- MHCP policies: **http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_157386**
- Blue Cross policies: **https://www.bluecrossmn.com/providers/medical-policy-and-utilization-management**
- Amerigroup policies: **https://provider.publicprograms.bluecrossmn.com/minnesota-provider/medical-policies-and-clinical-guidelines**

and

https://www.anthem.com/pharmacyinformation/clinicalcriteria

Please note that the **Precertification Look-Up Tool** is not available for prior authorization look up.

Questions?

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