PROVIDER BULLETIN
PROVIDER INFORMATION

October 2, 2023

WHAT'S INSIDE:

ADMINISTRATIVE UPDATES

Reminder: Medicare Requirements for Reporting Demographic Changes (published in every summary of monthly bulletins) — **Page 2**

CONTRACT UPDATES

Peer Specialist Benefit Expansion and Additional Contracting (P67-23) — **Page 2**

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATES

eviCore Healthcare Specialty Utilization Management (UM) Program: Medical Oncology Drug Prior Authorization Updates (P69-23) — **Page 3**

New Medical, Medical Drug and Behavioral Health Policy Management Updates (P70-23) — **Page 5**

Medical Policy Updates: Coupe Health and Self-Funded Benefit Plans managed by Blue Cross and Blue Shield of Alabama (P71-23) — **Page 6**

MINNESOTA HEALTH CARE PROGRAMS (MHCP) UPDATES

P72-23 Claims Reimbursement for Minnesota Health Care Programs (P72-23) — **Page 7**

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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

Peer Specialist Benefit Expansion and Additional Contracting | P67-23

Effective January 1, 2024, Blue Cross and Blue Shield of Minnesota (Blue Cross) is expanding the benefit set for commercial and Medicare Advantage subscribers to include a Peer Specialist benefit for members with a behavioral health diagnosis.

Peer Specialists have prior experience receiving mental health or substance use disorder (SUD) care and have completed training and certification exam specified by the Minnesota Department of Human Services (DHS).

Certified peer specialists, under treatment supervision of a mental health professional or certified rehabilitation specialist, must:

- Provide individualized peer support to the member.
- Promote member’s recovery goals, self-sufficiency, self-advocacy, and development of natural supports.
- Support the member’s maintenance of skills learned from other services.

Blue Cross will be offering this benefit to subscribers with qualifying diagnoses at a $0 cost share for services provided by in-network providers. No age limit will be applied. This benefit will be applicable to any outpatient facility and provider who offers peer services for SUD or MH support. Services are not covered while a member is admitted to an inpatient or residential facility.

Additional Contracting for Expansion of Benefits
Recovery Community Organization (RCO) providers with a Blue Plus-only contract will receive an Aware Provider

Service Agreement and Medicare Amendment that must be signed and executed prior to 12/1/23. Claims for peer services must be submitted in 837P format for dates of service on or after January 1, 2024. Outpatient Substance use disorder facilities that want to provide peer recovery services must request an additional professional Peer Recovery Services specialty contract at the following link: https://www.bluecrossmn.com/providers/network-participation/join-our-network/contracting-behavioral-health-or-substance-use

Service Types include certified family peer specialists, certified peer specialist and peer recovery specialists.

Products Impacted

- Fully Insured Commercial
- Self-Insured Commercial (must opt-in to include the benefit)
- Medicare Advantage

For further information, please see the **Provider Reference Guide** at the following link: https://www.bluecrossmn.com/sites/default/files/DAM/2023-08/peer-specialist-benefit-commercial-mapd-provider-reference-guide.pdf

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

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATES

eviCore Healthcare Specialty Utilization Management (UM) Program: Medical Oncology Drug Prior Authorization Updates | P69-23

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 has been added to the Medical Oncology program and will require prior authorization for oncologic reasons **beginning December 01, 2023.**

Drug Name	Code(s)
elranatamab-bcmm (Elrexfio)	C9399, J3490, J3590, J9999

The following drug has been added to the Medical Oncology program and will require prior authorization for oncologic reasons upon system update completion.

Drug Name	Code(s)
talquetamab-tgvs	C9399, J3490, J3590, J9999

The following drug is awaiting regulatory approval. When approved, the drug will automatically be added to the PA list for oncologic reasons effective immediately. CPT codes will be assigned closer to the approval date.

Drug Name
zolbetuximab

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 | P70-23

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 December 4, 2023:

Policy #	Policy Title/ Service	New Policy	Prior Authorization Requirement	Line(s) of Business
II-286	Valoctocogene roxaparvovec (Roctavian™)	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**.

Medical Policy Updates: Coupe Health and Self-Funded Benefit Plans Managed by Blue Cross and Blue Shield of Alabama | P71-23

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-203	Home Non-Invasive Positive Airway Pressure Devices for the Treatment of Respiratory Insufficiency and Failure
MP-714	Diaphragmatic/Phrenic Nerve Stimulation and Diaphragm Pacing
MP-732	Testing Serum Vitamin D Levels

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-90718	Roctavian (valoctocogene roxaparvovec-rvox)
PH-90714	Rystiggo (rozanolixizumab-noli)
PH-90091	Orencia (abatacept)
PH-90117	Stelara (ustekinumab)
PH-90202	Entyvio (vedolizumab)
PH-90177	Ilaris (canakinumab)
PH-90358	Ilumya (tildrakizumab-asmn)
PH-90111	Sandostatin_LAR (octreotide suspension)
PH-90114	Soliris (eculizumab)
PH-90671	Skyrizi IV (rizankizumab-rzaa)
PH-90291	Spinraza (nusinersen)
PH-90673	Xenpozyme (olipudase-alfa)
PH-90633	Xipere (triamcinolone acetonide injectable suspension)

MINNESOTA HEALTH CARE PROGRAMS (MHCP) UPDATES

Claims Reimbursement for Minnesota Health Care Programs | P72-23

As communicated in Provider Quick Point QP95-22, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be transitioning MHCP Operations back to Blue Cross as of January 1, 2024.

Beginning on January 1, 2024, all claims (including replacement and void submissions along with new claim submissions) that are currently submitted to Amerigroup, appeals and provider inquiries should be directed to Blue Cross. Claims for dates of service prior to January 1, 2024, that have not yet been submitted to Amerigroup should be sent to Blue Cross for processing using Payer ID 00726, regardless of date of service. Blue Cross will be loading the historical claims data into the new operating system for processing. This will allow Blue Cross to process new claims, adjustments and appeals on previously processed claims for dates of service prior to January 1, 2024.

Claims that are currently submitted through Bridgeview, Payer ID FS802 will continue to be processed through Bridgeview. This includes Elderly Waiver and some Care Coordination Claims. Non-Emergency Transportation providers will continue to submit claims using Payer ID BLRDE.

New claims submitted to Blue Cross for dates of service prior to January 1, 2024, will be reimbursed based on the information below.

2023 RUNOUT FOR MEDICAID CLAIMS (INCLUDING FAMILIES & CHILDREN, MNCARE AND MSC+)

Claim Type	2022 and Prior Dates of Service	2023 Dates of Service
Professional	Claims will be paid at the rates in effect on 1/1/2023. Claims for CCBHC providers will be paid at the rates in effect for 2022.	Claims will be paid at the rates in effect on the date of service.
Inpatient Facility	Claims will be paid at the rates in effect on 1/1/2023.	Claims will be paid at the rates in effect on the date of service.
Outpatient Facility/ Non-EAPG methodology	Claims will be paid at the rates in effect on 1/1/2023. Claims for 1115 waiver providers will be paid at the rates in effect for 2022.	Claims will be paid at the rates in effect on the date of service.

Claim Type	2022 and Prior Dates of Service	2023 Dates of Service
Outpatient Facility/ EAPG methodology *(includes medically benefitted drugs):* Blue Cross is sunsetting the EAPG methodology for outpatient facility services.	Claims for dates of service (DOS) **prior to the transition date off EAPGs** will be paid at the rates in effect **on the transition date** *(e.g., Provider transitions off EAPGs on 10/1/2023. Any claims with DOS prior to 10/1/2023 will be priced at the rates in effect on 10/1/2023.)* Claims with dates of service **on and after the transition date off EAPGs** will be paid at the rate in effect **on the date of service** *(e.g., Provider transitions off EAPGs on 10/1/2023. Any claims with DOS on and after 10/1/2023 will be paid at the rates in effect on the DOS.)* *EAPG services for these DOS will be priced at rates effective on the transition date* ← Transition Date off EAPGs → *EAPG services for these DOS will be priced at rates effective on DOS*	

2024 RUNOUT FOR MSHO CLAIMS

Claim Type	2022 and Prior Dates of Service	2023 Dates of Service
Professional	Claims will be paid at the rates in effect on the date of service.	Claims will be paid at the rates in effect on the date of service.
Inpatient Facility	Claims will be paid at the rates in effect on the date of service. Claims for Critical Access Hospitals that are reimbursed via FI Rate Letter will be paid at the rates in effect 1/1/23.	Claims will be paid at the rates in effect on the date of service.
Outpatient Facility	Claims will be paid at the rates in effect on the date of service. Claims for Critical Access Hospitals and Rural Health Clinics that are reimbursed via FI rate letter will be paid at the rates in effect 1/1/23	Claims will be paid at the rates in effect on the date of service.

Products Impacted

- Families and Children [formerly known as Prepaid Medical Assistance Program (PMAP)]
- MinnesotaCare (MNCare)
- Minnesota Senior Care Plus (MSC+)
- Minnesota Senior Health Options (MSHO)

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