PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

February 1, 2024

WHAT'S INSIDE:

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

Medicare Advantage Peer Specialist Benefit Specifics | P9-24

Effective January 1, 2024, Blue Cross and Blue Shield of Minnesota (Blue Cross) is expanding the benefit set for Medicare Advantage subscribers to include a Peer Specialist benefit for members with specific behavioral health diagnoses. The following information is to issue clarity for providers on the peer specialist role & benefit specific for Medicare advantage.

Certified Peer Specialists & Peer Recovery Specialists Scope of Practice
Certified Peer Specialists provide non-clinical support to individuals with mental health or substance use concerns under supervision of a licensed mental health professional or certified rehabilitation specialist. Services they provide are drawn from their own personal experiences and can include:

- Social Connection that supports recovery.
  - Attends recovery and other support groups with the member.
  - Accompanies the member to appointments that support recovery.
  - Shares their own recovery experiences, models wellness, & resiliency.
- Connection to tools, resources appointments and care.
  - Promote the member's self-sufficiency, self-advocacy, and development of natural support.
  - Connects members to appropriate professional & community resources where needed.
  - Guides members to develop self-care skills to manage health conditions.
  - Provides education.
  - Supports the member's maintenance of skills learned from other services.
- Assist with developing recovery goals.

- Identifies members' strengths and encourages their abilities to assist in goal attainment.
- Works in collaboration with the member to create a self-directed recovery plan.
- Works with other health care professionals to support members' goals.
- Engaging members with strength-based wellness strategies.

Peer Core Competencies[1]
Peer core competencies were created by the Substance Abuse and Mental Health Services Administration (SAMHSA) in conjunction with mental health & recovery communities to promote best practices in the delivery of peer services. Peer services need to meet the following core competencies: recovery oriented, person centered, voluntary, self-directed, relationship focused, and trauma informed.

Medicare Advantage Covered Services
- Individualized peer support to the member.
- Group peer services are eligible for coverage if hosted by a speaker with expertise on a topic which is being addressed in the group and the billed time is focused, in its entirety, upon education, skill building and sharing recovery experiences.

Medicare Advantage Non-Covered Services
- Services are not covered while a member is admitted to an inpatient or residential facility.
- Group peer services that include recreational time such as group outings, movies, dinners, or other activities in which active educational content is not being presented for the entirety of the group session are not covered.

Benefit Specifics
Medicare advantage members need to have an active diagnosis, current assessment, identified goals & documentation of services to begin and remain in peer services in accordance with state statute.

Peer certification & supervision requirements
Mental health and recovery peers must adhere to training, certification and supervision standards found here:
- Certifications & Training | Minnesota Peer Resource Hub
- Mental Health Services - Certified Peer Specialist Services (state.mn.us)

Questions?
Send an email to peer.specialist.contract.support@bluecrossmn.com or contact Provider Services at **651-662-5200** or **1-800-262-0820**.

[1] Core Competencies for Peer Workers | SAMHSA

Updated Reimbursement Policies, Effective April 1, 2024 | P12-24

Effective April 1, 2024, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will publish the following updated reimbursement policies:

Policy #	Policy Title/Service
Medicaid Evaluation and Management -014	Online Digital Evaluation and Management Services (e-Visits) • Blue Cross will reimburse for online digital E/M services following CPT® guidelines.

Commercial, Medicaid, and Medicare General Coding -003	Code Editing Policy • A valid 11-digit National Drug Code (NDC) and correlating HCPCS must be submitted when drugs are included on a professional (837P) or outpatient institutional (837I) electronic claim transaction. • NDCs must be reported using the "5-4-2 format". • Claims submitted without a valid NDC will be rejected through Availity Essentials. Please see Provider Quick Point QP123-20, Quick Point QP46-20, and Provider Bulletin P47-17.
Commercial and Medicaid General Coding -071	Bundled Services • Services designated on the National Physician Fee Schedule (NPFS) Relative Value File with a Status B, P, or T indicator will not be reimbursed separately.
Commercial, Medicaid, and Medicare Surgery/ Interventional Procedure -007	Global Surgical Package • Procedures with a global day assignment of 10 or 90 that are billed with modifier 78 will be reimbursed at 84 percent of the approved allowance. • Modifiers 54,55,56 will be moved to a new reimbursement policy, "Split Surgical Package", and modifier reductions will be revised.
Commercial, Medicaid and Medicare Surgery/ Interventional Procedure -024	Split Surgical Package • Addresses the coding and reimbursement of the surgical package when a transfer of care occurs during the global period of a procedure. • The appropriate modifier (54,55) must be submitted and will be reimbursed at the following percentages: – 54 – 80% of allowed amount – 55 – 20% of allowed amount – 56 – 0% • Reimbursement for split surgical packages will not exceed 100% of the total global surgical allowed amount.

Products Impacted
Commercial, Medicaid, Medicare Advantage

Questions?
For questions regarding MHCP subscribers, please contact MHCP Provider Services at **1-866-518-8448**. For all other lines of business, please contact Provider Services at **651-662-5200** or **1-800-262-0820**.

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATES

Removing 99606 Visit Limitation for Medication Therapy Management (MTM) Services in the Medicaid Population Starting April 1, 2024 | P6-24

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be removing the visit limitation for 99606 visits for MTM Services starting April 1, 2024.

For members needing more than seven follow-up visits for MTM services, the MTM provider is required to send documentation with the claim when it is submitted to justify the additional visit. If the documentation does not support the need for an additional visit, the provider will be asked to reverse the claim. Medication counseling, alone, is not a justifiable reason for a follow up visit.

Clinical Justification Documentation
Clinical information includes but is not limited to:

- Documentation of pharmacist's subjective, including reason for visit or additional visit.
- Objective information.
- Assessment of medications reviewed.
- Assessment of conditions reviewed and health status of each condition.
- Medication-therapy problems identified.
- Medication therapy problems resolved.
- Any additional plans to follow up, if appropriate to resolve medication-therapy problems.

Provider shall make available to Blue Cross, within 72 business hours, all information listed via email (MTM.Pharmacy@bluecrossmn.com) with subject line **Secure: Clinical Justification Documentation for Visit**

Products Impacted

- Families and Children
- MinnesotaCare (MNCare)
- Minnesota Senior Care Plus (MSC+)

Questions?
Contact the Medication Therapy Management team via email at MTM.Pharmacy@bluecrossmn.com or by phone at 651-662-5105 or 1-866-873-5941.

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eviCore Healthcare Specialty Utilization Management (UM) Program: Cardiology and Radiology Clinical Guideline Updates | P7-24

eviCore has released clinical guideline updates for the Cardiology & Radiology program. Guideline updates will become **effective April 1, 2024.**

Please review all guidelines when submitting a prior authorization request.

Guidelines with substantive changes:

- eviCore Cardiac Implantable Devices (CID) Guideline

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 **bluecrossmn.com/providers**
- 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. Cardiology & Radiology)
- 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 **bluecrossmn.com/providers**
- 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., Cardiology & Radiology
- 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 Availity.com/Essentials 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 at Availity.com/Essentials. There is no cost to the provider.

Instructions on how to utilize this portal are found at Availity.com/Essentials. Providers should reference the eviCore clinical guideline criteria, submit prior authorization requests 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.

eviCore Healthcare Specialty Utilization Management (UM) Program: Medical Oncology Drug Prior Authorization Updates | P8-24

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 drugs **already on the drug list will now have expanded use added** to the Medical Oncology program and will require prior authorization for oncologic reasons effective April 1, 2024.

Drug Name	Code(s)
denosumab (Xgeva) -*primary use for Giant Cell Tumor.*	J0897
Pegfilgrastim-cbqv (Neulasta biosimilar)-*Udenyca OBI*	Q5111

The following drug has been added to the Medical Oncology program and will require prior authorization for oncologic reasons effective immediately. **This drug was previously communicated however has had a name change since the prior publication dated 12/1/2021 (P78-21).**

Drug Name	Code(s)
bevacizumab bevacizumab-tnjn (Avzivi) for (AVASTIN) biosimilar BAT-1706	C9399, J3490, J3590, J9999

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 **bluecrossmn.com/providers**
- Select "**Medical and behavioral health policies**" under "**Medical Management**"
- Scroll down and click on the "**eviCore healthcare clinical guidelines**" link, 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 **bluecrossmn.com/providers**
- Select "**Medical and behavioral health policies**" under "**Medical Management**"
- Scroll down and click on the "**eviCore healthcare clinical guidelines**" link, located under *Other evidence-based criteria and guidelines we use and how to access them*

To view Clinical Guidelines:

- Access the 'Provider Section' of the Blue Cross website at **bluecrossmn.com/providers**
- Select "**Medical and behavioral health policies**" under "**Medical Management**"
- Scroll down and click on the "**eviCore healthcare clinical guidelines**" link, 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 (Note: read and accept disclaimer)
- 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 Availity.com/Essentials 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.

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4. Log in at Availity.com/Essentials
5. Select **Patient Registration**, choose **Authorization & Referrals**, then **Authorizations**
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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.

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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, Effective April 1, 2024 | P10-243

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 April 1, 2024:

Policy	Policy Title / Service	New Policy	Prior Authorization Requirement	Line(s) of Business
II-290	Avacincaptad pegol (Izervay™)	Yes (Moving from Policy II-173)	Continued	Commercial
II-260	Efgartigimod alfa and hyaluronidase (Vyvgart Hytrulo®)	No (Moving from Policy II-173)	Continued	Commercial
L33394	Coverage for Drugs & Biologics for Label & Off-Label Uses: • Efgartigimod alfa and hyaluronidase (Vyvgart Hytrulo®) • Rozanolixizumab (Rystiggo®) Infliximab (Zymfentra™)	No	New	Medicare Advantage
II-173	Accepted Indications for Medical Drugs Which are Not Addressed by a Specific Medical Policy: Infliximab (Zymfentra™)	No	New	Medicaid

Members Impacted

The information in this bulletin applies only to subscribers who have coverage through Commercial, Medicare Advantage, or Minnesota Health Care Programs products including Families & Children, MinnesotaCare, MSC+ and MSHO.

Submitting a PA Request when Applicable

- **Providers may submit PA requests for any treatment in the above table starting March 25, 2024.**
- 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 “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 at http://www.availity.com/essentials or the *Prior Authorization Lookup* on www.bluecrossmn.com/providers 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 include applicable codes. To access the PDF prior authorization lists for all lines of business go to www.bluecrossmn.com/providers/medical-management/prior-authorization.

Prior Authorization Requests

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

Questions?
For questions regarding MHCP subscribers, please contact MHCP Provider Services at **1-866-518-8448**. For all other lines of business, 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 | P11-24

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. 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-557	Cardioverter Defibrillators: Wearable or External
MP-567	Biomarker Testing in Risk Assessment and Management of Cardiovascular Disease
MP-756	Sphenopalatine Ganglion Block for Headache
MP-757	Axillary Reverse Mapping for Prevention of Lymphedema
MP-758	Fractional Carbon Dioxide (CO2) Laser Ablation Treatment of Hypertrophic Scars or Keloids for Functional Improvement
MP-557	Cardioverter Defibrillators: Wearable or External

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-90091	Orencia (abatacept)
PH-90117	Ustekinumab
PH-90312	Injectafer (ferric carboxymaltose injection)
PH-90305	Radicava IV (edaravone)
PH-90714	Rystiggo (rozanolixizumab-noli)
PH-90659	Vabysmo (faricimab-svoa)
PH-90649	Vyvgart IV (efgartigimod alfa-fcab)
PH-90712	Vyvgart SQ (efgartigimod alfa-fcab and hyaluronidase-gvfc)
PH-90736	Adzynma (ADAMTS13, recombinant-krhn)
PH-90734	Omvoh (mirikizumab-mrkz)

MINNESOTA HEALTH CARE PROGRAMS (MHCP) UPDATES