PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

June 3, 2024

WHAT'S INSIDE:

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

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

New and Updated Reimbursement Policies, Effective August 5, 2024 | P39-24

Effective August 5, 2024, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will publish the following new and updated reimbursement policies:

Policy #	Policy Title/Service
Commercial, Medicaid and Medicare General Coding – 081	Inappropriate Diagnosis Code • This is a new policy that aligns with official ICD-10-CM guidelines and addresses the correct assignment and sequencing of diagnosis codes.
Commercial and Medicaid General Coding - 082	Spravato® (esketamine) • This is a new policy that addresses coding and reimbursement of Spravato® (esketamine) services.
Medicare DME - 001	DME & Supplies • This is a new policy that addresses a Blue Cross-specific requirement related to Negative Pressure Wound Therapy.
Medicaid Anesthesia Services - 001	Anesthesia • This is a new policy that addresses coding and reimbursement for anesthesia services. • As communicated in Provider Bulletin P36-24 “Anesthesia Calculation for Minnesota Health Care Programs,” anesthesia time is calculated by rounding to the hundredths.

Products Impacted
Commercial, Medicare, Medicaid

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

eviCore Healthcare Specialty Utilization Management (UM) Program: Cardiology & Radiology Clinical Guideline Updates | P38-24

eviCore has released clinical guideline updates for the Cardiology & Radiology program. Guideline updates will become **effective August 01, 2024.**

Please review all guidelines when submitting a prior authorization request.

Guidelines with substantive changes:

General Oncology Imaging-

- Small Cell Lung Cancer – Surveillance
- Esophageal Cancer – Surveillance
- Breast Cancer - Initial Work-up/Staging
- Breast Cancer - Restaging/Recurrence
- Soft Tissue Sarcoma – Surveillance
- Gastrointestinal Stromal Tumor (GIST)
- Colorectal cancer - Surveillance
- Cervical Cancer - Initial staging
- Cervical Cancer – Restaging
- T Cell Lymphomas

Cardiac Imaging-

- Transthoracic Echocardiography (TTE) Indications/initial evaluation
- Frequency of Echocardiography Testing
- Transesophageal Echocardiography (TEE)
- 3D Echocardiography
- 3D Predictive model generation for pre-planning of cardiac procedure
- Cardiac MRI and MRA Chest – Indications (excluding Stress MRI)
- Diagnostic Left heart Catheterization
- Right Heart Catheterization and Right and Left Heart Catheterization without Coronary Angiography
- Planned (Staged) Procedures
- Congestive Heart Failure

Chest Imaging-

- General Chest – 33.1

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. Laboratory Management)
- 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*
- Click on the **"Resources"** dropdown in the upper right corner
- Click **"Clinical Guidelines"**
- Select the appropriate solution: i.e., Laboratory Management (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.

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.

Medical Policy Updates: Coupe Health and Self-Funded Benefit Plans Managed by Blue Cross and Blue Shield of Alabama | P42-24

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-004	Minimally Invasive Approaches to Vertebral Fractures
MP-168	Cardioverter Defibrillators: Implantable
MP-221	Extracranial Carotid Angioplasty/Stenting

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-0751	Lenmeldy™ (atidarsagene autotemcel)
PH-0052	Alpha-1-Proteinase Inhibitors:Aralast NP®; Glassia®; Prolastin®-C; Zemaira®
PH-0017	Benlysta® (belimumab)
PH-0590	Breyanzi® (lisocabtagene maraleucel)
PH-0098	Denosumab:Prolia®; Jubbonti®; Xgeva®; Wyost®
PH-0339	Hemophilia Products Factor IX AlphaNine SD, Alprolix, BeneFIX, Idelvion, Ixinity, Mononine, Profilnine, Rebinyn, and Rixubis
PH-0080	Leuprolide Suspension:Lupron Depot®, Lupron Depot-Ped®, Eligard®, Fensolvi®, Camcevi™, Lutrate Depot™, Leuprolide Acetate Depot

Policy #	Policy Title
PH-0503	Reblozyl® (luspatercept-aamt)
PH-0111	Sandostatin® LAR (octreotide suspension)
PH-0614	Saphnelo® (anifrolumab-fnia)
PH0674	Spevigo® (spesolimab)
PH0002	Tocilizumab: Actemra®; Tofidence™; Tyenne®
PH-0131	Trelstar® (triptorelin)
PH-0146	Xolair® (omalizumab)
PH-90672	Zynteglo® (betibeglogene autotemcel)

MINNESOTA HEALTH CARE PROGRAMS (MHCP) UPDATES

Residential Treatment Claims for Minnesota Health Care Programs | P37-24

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will require Residential Treatment Facilities to submit a room and board line on residential claims submitted beginning 8/1/2024. Residential claims submitted without room and board will be rejected and a new claim with room and board must be submitted.

Blue Cross will accept the room & board line with either the actual billed charge or a zero charge. Additional reimbursement will not be made on the room and board line as those charges should be submitted to the MN Department of Human Services for adjudication.

Residential Treatment Facilities must submit the appropriate value code to report the level of complexity on the claim. Providers are required to submit the value code from the column corresponding to your 1115 waiver status per your enrollment with DHS. Submitting a value code from the incorrect column will result in a claim denial. The list of value codes is located at: SUD Five Digit Value Codes (mn.gov)

Residential claims must use accurate claim frequency and patient status codes when submitting the 837I transaction. Providers submitting a claim frequency of 1 (admission to discharge claim) must submit a patient status of 01 indicating that the patient is discharged. A patient status of 30 is defined as still a patient in the facility and therefore a frequency code of 1 is incompatible. Using these values inappropriately will result in a claim denial. A replacement claim must be submitted with corrected data.

Products Impacted

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

Questions?
Please contact MHCP Provider Services at **1-866-518-8448**.

UTILIZATION MANAGEMENT UPDATES

MCG Care Guidelines 28th Edition | P40-24

Effective August 1, 2024, Blue Cross and Blue Shield of Minnesota and Blue Plus will upgrade to the 28th edition of MCG Care Guidelines for the modules listed below. A high-level summary of changes is available from MCG at MCG-28th-Edition-Summary-of-Changes.

- Ambulatory Care (AC)
- Behavioral Health Care (BHG)
- Home Care (HC)
- Inpatient & Surgical Care (ISC)
- General Recovery Care (GRG)
- Recovery Facility Care (RFC)

Blue Cross licenses and utilizes MCG Care Guidelines to guide utilization management decisions and has the right to customize MCG Care Guidelines, as applicable.

The MCG Care Guidelines transparency tool offering visibility into criteria and guideline information is available to providers within Availity Essential's Payer Spaces. To access the transparency tool, providers should log into Availity.com/Essentials, click "Payer Spaces | Blue Cross Blue Shield of Minnesota" and select the transparency tool option within "Resources". Once the tool has been selected, providers will need to follow prompts displayed to access the tool (i.e., accept terms and conditions, provide name, and select purpose for accessing, proceed through two-factor authentication process, and search, select and view applicable guidelines).

Products Impacted
This information only applies to Commercial, FEP, Minnesota Health Care Programs products including Families & Children, MinnesotaCare, MSC+ and MSHO.

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

Change to Management of Medical Specialty Drugs | P41-24

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) is committed to providing our members with access to high-quality health care that is consistent with evidence-based, nationally recognized clinical criteria and guidelines. Blue Cross will be implementing a change in the way that certain specialty drugs are managed when the specialty drug is reimbursed under the medical benefit.

Effective August 1, 2024, Magellan Rx Management, a Prime Therapeutics Company (Prime/MRx) will manage medical drugs. Beginning July 25, providers will have access to enter prior authorization requests for dates of service August 1 and beyond. Blue Cross will transfer prior authorizations previously approved by Blue Cross and/or eviCore Healthcare (eviCore) to Prime/MRx. A new authorization will not be necessary until the end date of the existing authorization.

Prior authorizations for medical specialty drugs, administered in the following settings, require prior authorization:

- Physician Office (POS 11)
- Patient Homes (POS 12)
- Outpatient Facilities (POS 19, 22)
- Inpatient Facilities for CAR-T only (POS 21)

To determine if a medical specialty drug requires authorization, review medical pharmacy policies, and/or post-service claim edit policies, providers can access the Prime/MRx provider portal, https://mrxgateway.com/bcbsmn/policydisplay/50. Prior authorization look-up tools in Availity essentials (Availity) and on the Blue Cross website will be updated mid-June.

Providers will begin the prior authorization process in Availity and will be routed to Prime/MRx via a single sign on. Beginning July 25, providers will have access to enter prior authorization requests for dates of service

August 1 and beyond. Blue Cross will transfer prior authorizations previously approved by Blue Cross and/or eviCore Healthcare (eviCore) to Prime/MRx. A new authorization will not be necessary.

Effective for dates of service beginning August 1, 2024, medical oncology drugs will no longer be managed by eviCore. Review the medical specialty drug list to determine which medical oncology drugs will require authorizations on or after August 1.

Prime/MRx will be hosting web-based training sessions in July of 2024. Training will include a demonstration of the Prime/MRx provider portal and how to navigate as well as Prime/MRx's process on how reviews and appeals are managed. A recorded online seminar and FAQ will be added to Availity essentials to view at your convenience. Please watch the provider resources page bluecrossmn.com/providers for updates and any additional information will be published via a Provider Quick Point.

Products Impacted

- Commercial
- Medicare Advantage
- Minnesota Health Care Programs

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**.