PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

July 1, 2024

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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

CMS Releases New HCPCS Code for Traditional Healing Services | P20R1-24

REVISION: Effective immediately, Blue Cross is removing the requirement to bill using modifier -CG as this is not an appropriate use of the modifier.

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will operationalize new HCPCS Level II code H0051, Traditional Healing Services for use effective April 1, 2024.

The Centers for Medicare and Medicaid Services (CMS) added H0051 to list of new codes released and effective April 1, 2024. Blue Cross will require providers contracted under a specialty of Traditional Healing to bill HCPCS code H0051 beginning with date of service April 1, 2024.

Providers are not required to submit a narrative when billing with HCPCS Code H0051. Provider contract addendums will be updated to reflect this coding change upon renewal.

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**.

New and Updated Reimbursement Policies, Effective September 3, 2024 | P45-24

Effective September 3, 2024, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will publish the following updated reimbursement policy:

Policy #	Policy Title/Service
Commercial General Coding – 011	Community Health Workers • The policy has been revised to state that CHW's must bill using their National Provider Identifier (NPI) or their supervising provider's NPI. • Codes G0019 and G0022 have been added and may be reported when applicable.

Products Impacted
Commercial

Questions?
Please contact Provider Services at **651-662-5200** or **1-800-262-0820**.

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATES

Medical Policy Updates: Coupe Health and Self-Funded Benefit Plans Managed by Blue Cross and Blue Shield of Alabama | P46-24

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-161	Serologic Diagnosis of Celiac Disease
MP-168	Cardioverter Defibrillators: Implantable
MP-221	Extracranial Carotid Angioplasty/Stenting
MP-501	Implantable Sinus Stents and Drug-Eluting Implants for Postoperative Use Following Endoscopic Sinus Surgery and for Recurrent Sinus Disease

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-90691	Adstiladrin® (nadofaragene firadenovec-vncg)
PH-90242	Aranesp® (darbepoetin alfa)
PH-90663	Carvykti® (ciltacabtagene autoleucel)
PH-90660	Enjaymo® (sutimlimab-jome)
PH-90202	Entyvio® (vedolizumab)
PH-90243	Epoetin alfa:Epogen®; Procrit®; Retacrit®
PH-90347	Fasenra® (benralizumab)
PH-90312	Injectafer® (ferric carboxymaltose injection)
PH-90721	Izervay™ (avacincaptad pegol)
PH-90244	Mircera® (methoxy polyethylene glycol-epoetin beta)
PH-90524	Monoferric™ (ferric derisomaltose injection)
PH-90114	Soliris® (eculizumab)
PH-90427	Ultomiris® (ravulizumab-cwvz)
PH-90549	Uplizna® (inebilizumab-cdon)
PH-90709	Vyjuvek™ (beremagene geperpavec-svdt)
PH-9238	Botox® (onabotulinumtoxinA)
PH-9239	Dysport® (abobotulinumtoxinA)
PH-9241	Xeomin® (incobotulinumtoxinA)
PH-9071	Immune Globulins (immunoglobulin): Asceniv™; Alyglo™; Bivigam®; Flebogamma®; Gamunex-C®; Gammagard® Liquid; Gammagard® S/D; Gammaked™; Gammaplex®; Octagam®; Privigen®; Panzyga®
PH-9240	Myobloc® (rimabotulinumtoxinB)
PH-9527	Vyepti® (eptinezumab-jjmr)
PH-9468	Zolgensma® (onasemnogene abeparvovec-xioi)
PH-9059	SCIG (immune globulin SQ): Hizentra®, Gammagard Liquid®, Gamunex®-C, Gammaked™, HyQvia®, Cuvitru®, Cutaquig®, Xembify®

MINNESOTA HEALTH CARE PROGRAMS (MHCP) UPDATES

Minnesota Senior Health Options (MSHO) Model of Care Training Requirements | P43-24

The Centers for Medicare & Medicaid Services (CMS) require all Special Needs Plans to have a Model of Care (MOC). The SecureBlue Model of Care (SNP-MOC) is the Blue Plus plan for delivering coordinated care to SecureBlue members. The SNP-MOC documents the processes Blue Plus utilizes to simplify access to healthcare and reduce fragmentation of care delivery for SecureBlue members. The SNP-MOC ensures that Blue Plus, in partnership with its contracted providers and care coordination delegates, meets the unique needs of the SecureBlue population.

CMS requires all providers and appropriate staff to complete Model of Care training upon initial employment and annually thereafter. Providers and appropriate staff required to complete the training include any resources who participate in a SecureBlue member's Interdisciplinary Care Team, are responsible for implementation of the member's Care Plan or manage planned and unplanned transitions of care.

The SecureBlue SNP-MOC training is available online through the BCBSMN Learning and Development website supported by Availity.

- *Providers using Availity*, log in to the Availity portal. Click Payer Spaces | Blue Cross Blue Shield of Minnesota. Click Resources | Access BCBSMN Learning and Development. Providers will be directed to the Catalog. Search **Blue Plus SecureBlue Special Needs Plan Model of Care** – On-Demand, then click Enroll OR select "Minnesota Health Care Programs" under the Category dropdown to find the training.
- *Providers not using Availity*, use the link https://bcbsmn.availitylearningcenter.com to create your account. To create a new account, select Sign Up Now and follow the prompts. Use your email address as the username. Providers will be directed to the Dashboard. Click "Get Started" on the rotating banner titled Learn with Blue Cross and Blue Shield of Minnesota | then click on Access the Training Catalog | select **Blue Plus SecureBlue Special Needs Plan Model of Care**– On-Demand, then click Enroll.

Providers are required to maintain MOC training completion records and provide such records to Blue Plus upon request per the provider's Amendment to the Agreement – Medicare Programs, Article X. Training and Education.

Questions?
Questions can be sent to medicare.compliance.training@bluecrossmn.com.

Products Impacted
SecureBlue - Minnesota Senior Health Options (MSHO)

Unbundling Audits for Minnesota Health Care Programs Claims | P48-24

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will begin performing audits of hospital inpatient claims submitted for Minnesota Health Care Programs subscribers beginning on September 1, 2024.

Facility billing guidelines require providers to bill revenue codes to describe services provided. Revenue codes do not describe exact items, supplies and services provided during an inpatient hospitalization. Blue Cross may conduct a post payment audit of an itemized bill and associated medical records to verify that services are not unbundled, fragmented, or otherwise duplicative of charges billed for the same patient on the same day.

Blue Cross may request medical records and an itemized bill post-payment for certain inpatient claims reimbursed using a percent of charge payment methodology. Charges identified that are not in compliance with this policy will be recouped.

Additional information regarding the audits can be found in Chapter 11 of the Provider Policy and Procedure Manual: BCBSMN Provider Policy & Procedure Manual (bluecrossmn.com)

Products Impacted
- Families and Children
- MinnesotaCare

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

UTILIZATION MANAGEMENT UPDATES

eviCore Healthcare Specialty Utilization Management (UM) Program: Musculoskeletal Clinical Guideline Updates | P44-24

eviCore has released clinical guideline updates for the Musculoskeletal program. Guideline updates will become **effective September 1, 2024.**

Please review all guidelines when submitting a prior authorization request.

Guidelines with substantive changes:

Joint

- Total Knee Replacement
- Partial Knee Replacement
- References (CMM-311)
- Meniscectomy or Meniscal Repair Indications
- Anterolateral Ligament (ALL) Reconstruction/Lateral Extra-Articular Tenodesis (LEAT)
- Procedures for Patellofemoral Conditions
- Lysis of Adhesions/Manipulation under Anesthesia (MUA)
- Hip Resurfacing Arthroplasty
- Hip Replacement
- Partial Hip Replacement Indications
- Total Hip Replacement Indications
- Total Hip Replacement Non-Indications
- Arthroscopic or Open Hip Surgery for Femoroacetabular Impingement (FAI) Indications
- Labral Repair or Reconstruction Indications
- Arthroscopic or Open Hip Surgery for Femoroacetabular Impingement (FAI) Indications
- Arthroscopic Capsular Release/Lysis of Adhesions/Manipulation under Anesthesia (MUA)
- Release Total Shoulder Arthroplasty (Replacement) Indications

Pain Management

- Non-Indications

Spine Surgery

- Definitions
- CMM-601.1- General Guidelines
- CMM-601.2- Osteotomy
- CMM-601.3- Anterior Cervical Discectomy
- CMM-601.4- Initial Primary Anterior Cervical Discectomy and Fusion (ACDF)
- CMM-601.5- Anterior Cervical Corpectomy
- CMM-601.6- Repeat Anterior Cervical Discectomy and Fusion (ACDF) at the Same Level
- CMM-601.7- Adjacent Segment Disease
- CMM-601.8- ACDF Following Failed Cervical Disc Arthroplasty Surgery
- CMM-601.9- Non-Indications
- Procedure (CPT®) Codes
- CMM-602.2- Initial Primary Cervical Total Disc Arthroplasty
- CMM-602.4- Adjacent Segment Disease Secondary to Cervical Total Disc Arthroplasty
- CMM-602.5- Non-Indications
- CMM-603.1- General Guidelines
- CMM-603.2- Initial Primary Posterior Cervical Decompression (Laminectomy/Hemilaminectomy/Laminoplasty)
- CMM-603.3- Repeat Posterior Cervical Decompression (Laminectomy/Hemilaminectomy/Laminoplasty)
- CMM-604.7- Repeat Posterior Cervical Decompression) at the Same Level
- CMM-604.1- General Guidelines
- CMM-604.2- Osteotomy
- CMM-604.3- Initial Primary Posterior Cervical Fusion for Conditions other than Pseudoarthrosis
- CMM-604.4- Initial Primary Posterior Cervical Fusion with Posterior Cervical Decompression for Conditions other than Pseudoarthrosis

- CMM-604.5- Posterior Cervical Fusion (Initial or Repeat) for Symptomatic Pseudoarthrosis
- CMM-604.6- Repeat Posterior Cervical Fusion at the Same Level for Conditions other than Pseudoarthrosis
- CMM-604.7- Posterior Cervical Fusion (with or without Decompression) Following Failed Cervical Disc Arthroplasty Surgery
- CMM-604.8- Non-Indications
- Procedure (CPT®) Codes (CMM-604)
- CMM-606.1- General Guidelines
- CMM-606.2- Initial Primary Lumbar Microdiscectomy (Laminotomy, Laminectomy or Hemilaminectomy)
- CMM-606.3- Repeat Lumbar Microdiscectomy (Laminotomy or Laminectomy) at the Same Level
- CMM-607.2- Indications
- CMM-607.3- Non-Indications
- CMM-608.1- General Guidelines
- CMM-608.2- Initial Primary Lumbar Decompression
- CMM-608.3- Corpectomy
- CMM-608.4- Repeat Lumbar Decompression at the Same Level
- Procedure (CPT®) Codes (CMM-608)
- CMM-609.1- General Guidelines
- CMM-609.2- Osteotomy
- CMM-609.3- Pediatric Spinal Deformity
- CMM-609.4- Lumbar Fusion (Arthrodesis) with Decompression (Indirect or Direct)
- CMM-609.5- Lumbar Fusion (Arthrodesis) without Decompression
- CMM-609.6- Adjacent Segment Disease
- CMM-609.7- Lumbar Fusion (with or without Decompression) Following Failed Lumbar Disc Arthroplasty Surgery
- CMM-609.8- Repeat Lumbar Fusion (Arthrodesis) at the Same Level
- CMM-609.9- Non-Indications
- Procedure (CPT®) Codes (CMM-609)
- CMM-610.2- Initial Primary Lumbar Total Disc Arthroplasty
- CMM-611.2- Minimally Invasive Sacroiliac Joint Fusion or Stabilization Indications
- CMM-611.3- Open Sacroiliac Joint Fusion Indications
- CMM-612.2- Recombinant Human Bone Morphogenetic Protein (rhBMP-2) (InFuse®)
- CMM-613.2- Initial Thoracic Decompression/Discectomy
- CMM-613.3- Corpectomy
- CMM-613.4- Repeat Thoracic Decompression/Discectomy at the Same Level
- Procedure (CPT®) Codes (CMM-613)
- CMM 614.2- Osteotomy
- CMM-614.3- Pediatric Spinal Deformity
- CMM-614.4- Initial Thoracic or Thoracolumbar Fusion (Arthrodesis) with Decompression
- CMM-614.5- Initial Thoracic or Thoracolumbar Fusion (Arthrodesis) without Decompression

Spine Surgery, continued

- CMM-614.7- Repeat Thoracic or Thoracolumbar Fusion (Arthrodesis) at the Same Level
- Procedure (CPT®) Codes
- CMM-615.2- Indications
- CMM-616- Vertebral Body Tethering for Adolescent Idiopathic Scoliosis

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.

MagellanRx Management, a Prime Therapeutics Company (UM) Program: Medical Drug Updates | P47-24

The MagellanRx Management, a Prime Therapeutics Company (Prime/MRx) program for medical drugs will be making updates to the Current Procedural Terminology (CPT) Prior Authorization (PA) Code List.

The following drug(s) have been added to the medical drug program and will require prior authorization for dates of service beginning **September 1, 2024**.

Drug Name	Code(s)	Line(s) of Business that will require Prior Authorization
Adzynma	J7171	Commercial, Medicare and Medicaid
Amtagvi	J9999	Commercial, Medicare and Medicaid
Anktiva	J9999	Commercial, Medicare and Medicaid
Bendamustine	J9034	Commercial, Medicare and Medicaid
Blincyto	J9039	Commercial, Medicare and Medicaid
Columvi	J9286	Commercial, Medicare and Medicaid
Cyramza	J9308	Commercial, Medicare and Medicaid
Darzalex Faspro	J9144	Commercial, Medicare and Medicaid
Elahere	J9063	Commercial, Medicare and Medicaid
Izervay	J2782	Commercial, Medicare and Medicaid
Jubbonti	J3590	Commercial, Medicare and Medicaid
Lenmeldy	J3590	Commercial, Medicare and Medicaid
Loqtorzi	J3263	Commercial, Medicare and Medicaid
Palonosetron	J2468	Commercial, Medicare and Medicaid
Ryzneuta	J9361	Commercial, Medicare and Medicaid
Tevimbra	J9999	Commercial, Medicare and Medicaid
Tyenne	J3590	Commercial, Medicare and Medicaid
Wyost	J3590	Commercial, Medicare and Medicaid

To view the Medical Drug 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 "Prime/MRx Medical Drug clinical guidelines" link, located under Other evidence-based criteria and guidelines we use and how to access them
- Medical Drugs are listed in alphabet order. To search for a specific drug, Ctrl + F and type in the drug name.
- Select the drug to view the Medical Policy for the selected drug.
- All drugs in the list apply to Medicare members. Please refer to CMS for the clinical guidelines that apply for Medicare members.
- A reference will be placed behind the drug name to indicate if the policy applies to Commercial, Medicaid, or both.

Products Impacted

- Commercial
- Medicare Advantage
- Minnesota Health Care Programs

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 Prime/MRx
Providers submit Prime/MagellanRx 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 Prime/MRx Medical Policies, 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 a Prime/MRx representative call 800-424-1706, 8:00 a.m. to 8:00 p.m. CST, Monday – Friday.